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Clinical Pathways Resource Guide

This document is intended to provide basic guidance for counselors working with people with co-occurring conditions. Future documents will provide more extensive implementation manuals.

July 1, 2009

Table of Contents

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OMH/OASAS Recommendations

This document is intended to provide basic guidance for counselors working with people with co-occurring conditions. Future documents will provide more extensive implementation manuals.

Screening Instruments
(OASAS/OMH recommendations)

For mental disorders:

- *Mental Health Screening Form III* (MHSF III)
- *Modified MINI Screen* (MMS)
- *K6 Screening Scale* (K6)

For substance use disorders:

- *Modified Simple Screening Instrument for Substance Abuse* (MSSI-SA)
- *CAGE Adapted to Include Drugs* (CAGE-AID)
- *Alcohol, Smoking, and Substance Involvement Screening Test* (ASSIST) (v3)

Assessment Domains
(OMH/OASAS recommendations)

- Current symptoms & functioning
- Background
- Individual history
- Substance use
- Mental health
- Medical history
- Mental status examination
- Client perception(s)
- Presenting problem(s)
- Cultural and linguistic considerations
- Supports & strengths
- Diagnostic impressions on 5 DSM Axes

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Evidence-Based Practices
(OASAS/OMH recommendations)

For both disorders:

- Approved medications

For substance use disorders:

- Evidence-based individual, group, couples, and family treatments – *including*
  - motivational enhancement
  - CBT
  - 12-step facilitation
  - behavioral couples & family therapy
  - contingency management

For mental illness:

- CBT, medication

For serious mental illness:

- Managing illness (IDDT, education, medication, CBT) family psychoeducation, supported employment, social skills training
- Peer support

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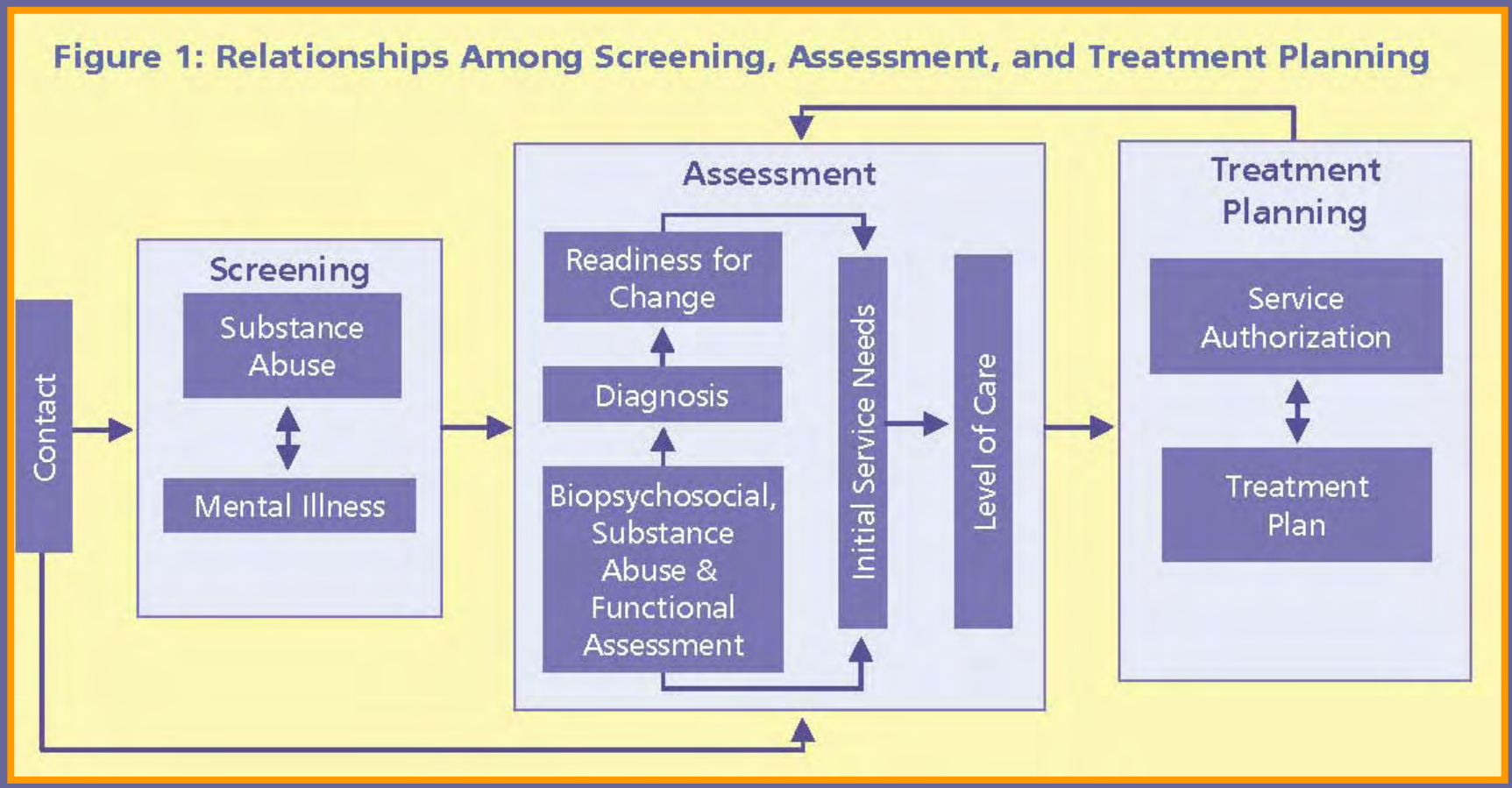
Screening

This document is intended to provide basic guidance for counselors working with people with co-occurring conditions. Future documents will provide more extensive implementation manuals.

SAMHSA's Definition of Co-Occurring Disorders

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

Relationships among Screening, Assessment and Treatment Planning



CSAT (2005c)

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COD TIP Definition: Screening

- A formal process of testing to determine whether a client does or does not warrant further attention at the current time in regard to a particular disorder and, in this context, the possibility of a co-occurring substance or mental disorder.

- The screening process for co-occurring disorders (COD) seeks to answer a “yes” or “no” question: Does the substance abuse [or mental health] client being screened show signs of a possible mental health [or substance abuse] problem?

- Note that the screening process does not necessarily identify what kind of problem the person might have, or how serious it might be, but determines whether or not further assessment is warranted.

Integrated Screening

- Integrated screening addresses both mental health and substance abuse, each in the context of the other disorder.
- A comprehensive screening process also includes exploration of a variety of related service needs including medical, housing, victimization, trauma and so on.

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The Goal: Universal Screening

- All individuals presenting for treatment of a substance use disorder should undergo at a minimum screening for any co-occurring mental disorders.
- All individuals presenting for treatment of a mental disorder should undergo at a minimum screening for any co-occurring substance use disorders.

Features of Screening Instruments

- High overall accuracy
- Brief
- Low cost and no cost
- Minimal staff training required
- Consumer friendly

Measures of Precision Defined

- Sensitivity: the probability that the screening test is positive given that the person has the disorder. This is also know as the true positive rate. A large sensitivity means that a negative test can rule out the disorder.

- Specificity: the probability that the screening test is negative given that the person does not have the disorder. This is also known as true negative rate. A large specificity means that a positive test can rule in the disorder.

- Overall Accuracy: the combination of sensitivity and specificity – the probability that the screening test is positive given that the person has the disorder combined with the probability that the screening test is negative given that the person does not have the disorder.

Screening Protocol and Processes

- Screening processes always should define a protocol for determining which clients screen positive and for ensuring that those clients receive a thorough assessment.
- Screening process establishes precisely how any screening tools or questions are to be scored and indicated what constitutes scoring positive for a particular possible problem (often called “establishing cut-off scores”).
- The screening protocol details exactly what takes place after a client scores in the positive range and provides the necessary standard forms to be used to document both the results of all later assessments and that each staff member has carried out his or her responsibilities in the process.

Counselor Role in Screening

- All counselors can be trained to screen for co-occurring substance use and mental disorders.
- Screening often entails having a client respond to a specific set of questions, evaluating the response, and then taking the next “yes” or “no” step in the process depending on the results and the design of the screening process.
- In substance abuse or mental health treatment settings, every counselor or clinician who conducts intake should be able to screen for the most common COD and know how to implement the protocol for obtaining COD assessment information and recommendations.

Minimum Screening Requirement

At a minimum, the program is responsible for conducting screening that:

1. Gathers information about thoughts, behavior or impulses related to self-harm or harm to others.

2. Screens for the presence of co-occurring substance use and mental disorders.

Screening Instruments
(OASAS/OMH recommendations)

For mental disorders:

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Screening- *FAQs*

Frequently Asked Questions:

- ***Can I administer a screening instrument over the phone?***

  While is better to administer a screening instrument in person, it can be done over the phone.

- ***Can I use only parts of a screening instrument?***

  It is better to make use of a screening instrument in its entirety, since this takes maximum advantage of its established psychometric properties and cut off scores.

- ***Can I add items?***

  It is possible to add items to the screening protocol, but not to the screening instrument per se. While you might want to add some particular items, you also want to ensure that you maintain the integrity of the standard instrument (i.e., do not delete items; use the standard scoring system and cut off scores for that instrument). Also, be careful not to add too many items and have the instrument become too extensive for what you are trying too accomplish with a screener.

- ***Is it necessary to add a screener if you are already completing a full assessment on everyone who enters?***

  There are several advantages to using a screener: 1) it can preserve some resources in that although COD is quite prevalent, it is not present in all referrals and thus use of a screener could preserve assessment resources; 2) it permits the gathering of data concerning the prevalence of COD and trends which could be helpful in reporting and in planning resource allocation; 3) clinically, it is often beneficial in establishing a first contact between the client and the clinic. An alternative that might be useful is administering the screener on the phone or as the first part of the full assessment.

Screening Instruments for Mental Disorders

The Mental Health Screening Form-III (MHSF-III)

- The Mental Health Screening Form-III (MHSF-III) has only 18 simple questions and is designed to screen for present or past symptoms of most of the main mental disorders (Carroll and McGinley 2001).
- It is available to the public at no charge from the Project Return Foundation, Inc.
- The MHSF-III was developed within a substance abuse treatment setting and it has face validity—that is, if a knowledgeable diagnostician reads each item, it seems clear that a "yes" answer to that item would warrant further evaluation of the client for the mental disorder for which the item represents typical symptomatology.
- The MHSF-III is only a screening device as it asks only one question for each disorder for which it attempts to screen. If a client answers "no" because of a misunderstanding of the question or a momentary lapse in memory or test-taking attitude, the screen would produce a "false-negative," where the client might have the mental disorder but the screen falsely indicates that the person probably does not have the disorder.
- In a recent article the MHSF-III is referred to as a "*rough screening device"* (Carroll and McGinley 2001, p. 35), and the authors make suggestions about its use, comments about its limitations, and review favorable validity and reliability data.
- There is no operational manual for the MHSF-III. However, the article has useful information similar to material usually found in a manual.

MHSF-III *(continued)*

Purpose: The Mental Health Screening Form-III was initially designed as a rough screening device for clients seeking admission to substance abuse treatment programs.

Clinical utility: The Mental Health Screening Form-III is a brief inventory that can be successfully used by chemical dependency clinicians to screen for mental health problems commonly found among clients in substance abuse treatment programs. It is designed to be a qualitative aid for non-mental health staff to discover any past and/or present forms of psychopathology of their clients.

Groups with whom this instrument has been used: Adults

Format: The instrument is comprised of 18 yes or no questions. It can be administered one on one by provider to client or be given directly to the client for self-administration. In either mode of administration, all "yes" answers should be reviewed and probed by the staff member in order to determine how to use the information. The authors recommend that for certain questions which receive a "yes" response, the client be referred to a mental health professional.

Administration time: 15 minutes

Scoring time: 2 minutes

Computer scoring? No

Administrator training and qualifications: Minimal training required, non-clinician

Fee for use: The Mental Health Screening Form-III may be used, free of charge without permission.

Available from:

Jerome F. X. Carroll, PhD
4318 Atlantic Avenue
Brooklyn, NY 11224
E-mail: jfac4318@aol.com

MHSF III

page 1

Mental Health Screening Form III

Instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation, this is why each question begins –"Have you ever ...."

1) Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? YES NO

2) Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? YES NO

3) Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? YES NO

4) Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? YES NO

5) Have you ever heard voices no one else could hear or seen objects or things which others could not see? YES NO

6) a) Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? YES NO
b) Did you ever attempt to kill yourself? YES NO

7) Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? YES NO

8) Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? YES NO

9) Have you ever given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property? YES NO

J.F.X. Carroll, Ph.D. & John J. McGinley, M.S., M.S.W., M.A. © 4/2000 by Project Return Foundation, Inc.

OVER

MHSF III

page 2

10) Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? YES NO

11) Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? YES NO

12) Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? YES NO

13) Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything? YES NO

14) Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint? YES NO

15) Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate.
YES NO

16) 1.Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling? YES NO

17) Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?
YES NO

Print Client's Name: _____ Program to which client will be assigned: _____
Name of Admissions Counselor: _____ Date: _____
Reviewer's Comments: _____

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Total Score: _____ (each yes = 1 pt.)

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Modified M.I.N.I. Screen (MMS)

Available from: Medical Outcomes Systems, Inc.
http://medical-outcomes.com

- A 22 item screening instrument that covers 3 major categories of psychiatric disorders: mood, anxiety, and psychotic.
- The MMS is part of the M.I.N.I. (Mini International Neuropsychiatric Interview) family of instruments which haves been translated into 43 languages and are used by mental health professionals and health organizations in more than 100 countries.
- There are a number of other versions of the instrument available, including the a full structured diagnostic interview that covers 20 disorders, the MINI Plus and the eMINI Software Suite.

MMS *(continued)*

- 4 page, 22 item version for screening for mental health symptoms only (Mood, Anxiety, and Psychotic Disorders). Administration time: 5-10 minutes.
- Adapted for use in substance abuse settings.
- Contains a screen (1 question) for risk of self-injury.
- Can be administered by interviewer with minimal training or be self-administered.
- Instrument is divided into 3 sections; a summary score is used to determine the likelihood of mental illness. Scoring time <5 minutes.

Modified M.I.N.I. Screen (MMS)

page 1

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Modified Mini Screen (MMS)

Patient Name _____ OASAS ID _____

Weeks since admission _____ Interviewer _____

Today's Date _____ Supervisor Initials (optional) _____

SECTION A

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past 2 weeks?	YES	NO
2. In the past 2 weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?	YES	NO
3. Have you felt sad, low or depressed most of the time for the last two years?	YES	NO
4. In the past month, did you think that you would be better off dead or wish you were dead?	YES	NO
5. Have you ever had a period of time when you were feeling up, 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.)	YES	NO
6. Have you ever been so irritable, grouchy or annoyed for several days, that you had arguments, verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way?	YES	NO
PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 1-6		

Rev. 6/05

Modified M.I.N.I. Screen (MMS)

page 2

SECTION B

7. Note this question is in 2 parts. a. Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable or uneasy even when most people would not feel that way? YES NO b. If yes, did these intense feelings get to be their worst within 10 minutes? YES NO If the answer to BOTH a and b is YES, code the question YES. If the answer to either or both a and b is NO, code the question NO	YES	NO
8. Do you feel anxious or uneasy in places or situations where you might have the panic-like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult? Examples include: ❑ Being in a crowd ❑ Standing in a line ❑ Being alone away from home or alone at home ❑ Crossing a bridge ❑ Traveling in a bus, train or car	YES	NO
9. Have you worried excessively or been anxious about several things over the past 6 months? If no to Question 9, answer "no" to Question 10 and proceed to Question 11.	YES	NO
10. Are these worries present most days?	YES	NO
11. In the past month, were you afraid or embarrassed when others were watching you, or when you were the focus of attention? Were you afraid of being humiliated? Examples include: ❑ Speaking in public ❑ Eating in public or with others ❑ Writing while someone watches ❑ Being in social situations	YES	NO
12. In the past month, have you been bothered by thoughts, impulses, or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive or distressing? Examples include: ❑ Were you afraid that you would act on some impulse that would be really shocking? ❑ Did you worry a lot about being dirty, contaminated or having germs? ❑ Did you worry a lot about contaminating others, or that you would harm someone even though you didn't want to? ❑ Did you have any fears or superstitions that you would be responsible for things going wrong? ❑ Were you obsessed with sexual thoughts, images or impulses? ❑ Did you hoard or collect lots of things? ❑ Did you have religious obsessions?	YES	NO

2

Modified M.I.N.I. Screen (MMS)

page 3

SECTION B (CONTINUED)

13. In the past month, did you do something repeatedly without being able to resist doing it? Examples include: ❑ Washing or cleaning excessively ❑ Counting or checking things over and over ❑ Repeating, collecting, or arranging things ❑ Other superstitious rituals	YES	NO
14. Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples include: ❑ Serious accidents ❑ Sexual or physical assault ❑ Terrorist attack ❑ Being held hostage ❑ Kidnapping ❑ Fire ❑ Discovering a body ❑ Sudden death of someone close to you ❑ War ❑ Natural disaster	YES	NO
15. Have you re-experienced the awful event in a distressing way in the past month? Examples include: ❑ Dreams ❑ Intense recollections ❑ Flashbacks ❑ Physical reactions	YES	NO
PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 7-15		

Modified M.I.N.I. Screen (MMS)

page 4

SECTION C

16. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?	YES	NO
17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?	YES	NO
18. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or, have you ever felt that you were possessed?	YES	NO
19. Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you?	YES	NO
20. Have your relatives or friends ever considered any of your beliefs strange or unusual?	YES	NO
21. Have you ever heard things other people couldn't hear, such as voices?	YES	NO
22. Have you ever had visions when you were awake or have you ever seen things other people couldn't see?	YES	NO
PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 16-22	YES	NO

K6 Screening Scale

Purpose: A screening tool for severe psychological distress associated with serious mental illness.

Clinical utility: The brevity, strong psychometric properties, and ability to discriminate DSM-IV cases from non-cases makes the K6 attractive for use in general-purpose health surveys.

Groups with whom this instrument has been used: Adolescents and adults, different cultures

Format: The tool consists of 6 items, each with a with 0-4 point rating scale, that screen for general distress in the last 30 days.

Administration time: <5 minutes

Scoring time: <5 minutes

Computer scoring? No

Administrator training and qualifications: Low level, minimal training

Fee for use: Available at no cost

Available from: http://www.hcp.med.harvard.edu/ncs/k6_scales.php

K6 Screening Scale (K6)

K6 MENTAL HEALTH SCREENING TOOL

About the Scale: The K6 Screening Scale was developed by Dr. Ronald Kessler, Professor of Healthcare Policy at Harvard Medical School, with support from the U.S. Government's National Center for Health Statistics. The scale was distributed for use by aging service providers as part of the University of Kansas School of Social Welfare Office of Aging and Long Term Care's pilot project, "Connecting Older Kansans with Community Mental Health Resources", funded in part by the Kansas Department on Aging and the Kansas Department of Social and Rehabilitation Services.

The K6 is not distributed for use as a diagnostic tool, but as a format to assist aging services providers and their customers in identifying a potential mental health problem from which older adults might benefit from referral to mental health resources. Please reproduce as needed.

Customer Identification: _____ **Date:**_____

The following questions ask a person how he/she has been feeling during the past 4 weeks. For each question, please circle the number that best describes how often she/he had this feeling.

In the last 4 weeks, about how often did you feel...	All of the time	Most of the time	Some of the time	A little of the time	None of the time	Don't know	Refused
a...so sad that nothing could cheer you up?	4	3	2	1	0	0	0
b...nervous	4	3	2	1	0	0	0
c...restless or fidgety	4	3	2	1	0	0	0
d...hopeless	4	3	2	1	0	0	0
e...everything was an effort	4	3	2	1	0	0	0
f...worthless	4	3	2	1	0	0	0

* If necessary, for question e., prompt: How often did you feel everything was hard and difficult to do?

TOTAL SCORE:_____

In the last 4 weeks, how many times have you seen a doctor or other health professional about these feelings? _____

Don't know_____ **Refused**_____

Comments _____

** *If the customer scores 13 or higher, it is recommended that service provider consider referring the customer to a mental health resource for further support. If the score is below 13, the customer may not need a referral; however, if the service provider or the customer feels that a referral to a resource should be made, proceed with the referral. If a mental health crisis is suspected, follow service provider organization's standard procedures.*

For more information about the K6 and related mental health screening instruments, please visit:
http://www.hcp.med.harvard.edu/ncs/k6_scales.php

Screening Instruments for Substance Use Disorders

Substance Abuse Screening in Mental Health Settings

- Screen for substance use, substance related problems, and substance-related disorders (this report presents recommended instruments for this purpose).

- Screen for acute safety risk related to serious intoxication or withdrawal (this report recommends the inclusion of this in the screening process).

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Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)

Purpose: The SSI-SA is brief screening survey derived from 13 other existing screening and assessment tools. It is designed to include a high degree of sensitivity and is very broad in its efforts to detect alcohol and drug abuse. The MSSI-SA is a very slightly modified version- it was modified by the New York City Department of Mental Hygiene to include prescription and over-the-counter medications/drugs.

Clinical utility: Use of the tool in New York City is being widely expanded as a result of the Quality IMPACT project that demonstrated its utility; it is also widely used in State correctional systems.

Groups with whom this instrument has been used: Adults and adolescents

Format: The instrument is self-administered and contains 16 questions. It can also be administered by a service provider.

Administration time: 10 minutes or less

Scoring time: 5 minutes

Computer scoring? No

Administrator training and qualifications: Minimal training required, non-clinician

Fee for use: The MSSI-SA may be used, free of charge without permission

Available at: http://www.nyc.gov/html/doh/html/qi/qi_samhpriority.shtml#1

MSSI-SA

page 1

NAME _____
DATE _____

Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)
Interview Form

Introductory Statement:
"I'm going to ask you a few questions about your use of alcohol and other drugs, including prescription and over-the-counter medication/drugs, during the past 6 months. Your answers will be kept private. Your answers *will assist us in identifying your needs and providing you with services. Your answers will not exclude you from services, care or treatment at this program.* Based on your answers to these questions, we may advise you to get a more complete assessment. This would be voluntary it would be your choice whether to have an additional assessment or not."

During the last 6 months…

1a. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants) (yes/no)

1b. Have you used prescription or over-the-counter medication/drugs? (Such as sleeping pills, pain killers, sedatives, or anti-anxiety medication like Valium, Xanax, or Ativan) (yes/no)

2. Have you felt that you use too much alcohol or other drugs? (Other drugs also include prescription or over-the-counter medication more than recommended.) (yes/no)

3. Have you tried to cut down or quit drinking or using drugs? (yes/no)

4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.) (yes/no)

5. Have you had any of the following?
   - Blackouts or other periods of memory loss
   - Injury to your head after drinking or using drugs
   - Convulsions, or delirium tremens ("DTs")
   - Hepatitis or other liver problems
   - Feeling sick, shaky, or depressed when you stopped drinking or using drugs
   - Feeling "coke bugs," or a crawling feeling under the skin after you stopped using drugs
   - Injury after drinking or using drugs
   - Using needles to shoot drugs.

6. Has drinking or other drug use caused problems between you and your family or friends? (yes/no)

7. Has your drinking or other drug use caused problems at school or at work? (yes/no)

8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.) (yes/no)

9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? (yes/no)

(Continue on next page)

MSSI-SA

page 2

NAME _____
DATE _____

Modified Simple Screening Instrument for Substance Abuse (continued)

10. Are you needing to drink or use drugs more and more to get the effect you want? (yes/no)
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? (yes/no)
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? (yes/no)
13. Do you feel bad or guilty about your drinking or drug use? (yes/no)

Now I have some questions that are not limited to the past 6 months.

14. Have you ever had a drinking or other drug problem? (yes/no)
15. Have any of your family members ever had a drinking or drug problem? (yes/no)
16. Do you feel that you have a drinking or drug problem now? (yes/no)

- Thanks for answering these questions.
- Do you have any questions for me?
- Is there something I can do to help you?

Notes:

_____
_____
_____
_____
_____
_____

Observation Checklist:

The following signs and symptoms may indicate a substance abuse problem in the individual being screened:

- Needle track marks
- Skin abscesses, cigarette burns, or nicotine stains
- Tremors (shaking and twitching of hands and eyelids)
- Unclear speech: slurred, incoherent, or too rapid
- Unsteady gait: staggering, off balance
- Dilated (enlarged) or constricted (pinpoint) pupils
- Scratching
- Swollen hands or feet
- Smell of alcohol or marijuana on breath
- Drug paraphernalia such as pipes, paper, needles, or roach clips
- "Nodding out" (dozing or falling asleep)
- Agitation
- Inability to focus
- Burns on the inside of the lips (from freebasing cocaine)

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CAGE Adapted to Include Drugs (CAGE-AID)

Purpose: Screen for alcohol and substance abuse

Clinical utility: Because the CAGE-AID is a widely used brief screen, many clinicians are familiar with it, including in primary care

Groups with whom this instrument has been used: Adults and adolescents

Format: A modified version of the CAGE screen for alcohol problems, the CAGE-AID is a four-item conjoint screen for alcohol and substance abuse.

Administration time: <5 minutes

Scoring time: 1 minute

Computer scoring? No

Administrator training and qualifications: Low level, minimal training

Fee for use: No cost

Available from:

https://www.mhn.com/static/pdfs/CAGE-AID.pdf

CAGE-AID

The CAGE Questionnaire Adapted to Include Drugs (CAGE-AID)

1. **Have you felt you ought to cut down on your drinking or drug use?**
2. **Have people annoyed you by criticizing your drinking or drug use?**
3. **Have you felt bad or guilty about your drinking or drug use?**
4. **Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?**

Score: __ /4

2/4 or greater = positive CAGE, further evaluation is indicated

Source: **Reprinted with permission from the *Wisconsin Medical Journal.* Brown, R.L., and Rounds, L.A. Conjoint screening questionnaires for alcohol and drug abuse. *Wisconsin Medical Journal* 94:135-140, 1995.**

Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST-v3)

Purpose: An instrument developed for the World Health Organization (WHO) by an international group of substance abuse researchers to detect and manage substance use and related problems in primary and general medical care settings.

Clinical utility: Screening test for alcohol, cigarettes, and illegal drugs.

Groups with whom this instrument has been used: Adults and adolescents, valid for cross-cultural use.

Format: The questionnaire consists of eight questions covering 10 main substance groups.

Administration time: 5-10 minutes

Scoring time: 1 minute

Computer scoring? no

Administrator training and qualifications: Low level, minimal training

Fee for use: Free for research

Available from: http://www.who.int/substance_abuse/activities/assist/en/

ASSIST (v3)

page 1

A. WHO - ASSIST V3.0

INTERVIEWER ID _____ COUNTRY ___ CLINIC _____

PATIENT ID _____ DATE ___ ___ ___ ___ ___ ___

INTRODUCTION *(Please read to patient)*

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card).

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

NOTE: BEFORE ASKING QUESTIONS, GIVE **ASSIST** RESPONSE CARD TO PATIENT

Question 1
(if completing follow-up please cross check the patient's answers with the answers given for Q1 at baseline. Any differences on this question should be queried)

In your life, which of the following substances have you ever used? *(NON-MEDICAL USE ONLY)*	No	Yes
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

Probe if all answers are negative:
"Not even when you were in school?"

If "No" to all items, stop interview.

If "Yes" to any of these items, ask Question 2 for each substance ever used.

ASSIST (v3)

page 2

Question 2

In the past three months, how often have you used the substances you mentioned *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6.

If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

Question 3

During the past three months, how often have you had a strong desire or urge to use *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	6

ASSIST (v3)

page 3

Question 4

During the past three months, how often has your use of *(FIRST DRUG, SECOND DRUG, ETC)* led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

Question 5

During the past three months, how often have you failed to do what was normally expected of you because of your use of *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products					
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8

ASSIST (v3)

page 4

Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1)

Question 6

Has a friend or relative or anyone else ever expressed concern about your use of *(FIRST DRUG, SECOND DRUG, ETC.)*?	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 7

Have you ever tried and failed to control, cut down or stop using *(FIRST DRUG, SECOND DRUG, ETC.)*?	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

ASSIST (v3)

page 5

Question 8

	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
Have you ever used any drug by injection? *(NON-MEDICAL USE ONLY)*	0	2	1

IMPORTANT NOTE:

Patients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention.

Pattern of Injecting	Intervention Guidelines
Once weekly or less or Fewer than 3 days in a row	→ Brief Intervention including "risks associated with injecting" card
More than once per week or 3 or more days in a row	→ Further assessment and more intensive treatment*

How to calculate a specific substance involvement score.

For each substance (labelled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be calculated as: **Q2c + Q3c + Q4c + Q5c + Q6c + Q7c**

Note that Q5 for tobacco is not coded, and is calculated as: **Q2a + Q3a + Q4a + Q6a + Q7a**

The type of intervention is determined by the patient's specific substance involvement score

	Record specific substance score	no intervention	receive brief intervention	more intensive treatment *
a. tobacco		0 - 3	4 - 26	27+
b. alcohol		0 - 10	11 - 26	27+
c. cannabis		0 - 3	4 - 26	27+
d. cocaine		0 - 3	4 - 26	27+
e. amphetamine		0 - 3	4 - 26	27+
f. inhalants		0 - 3	4 - 26	27+
g. sedatives		0 - 3	4 - 26	27+
h. hallucinogens		0 - 3	4 - 26	27+
i. opioids		0 - 3	4 - 26	27+
j. other drugs		0 - 3	4 - 26	27+

NOTE: *Further assessment and more intensive treatment may be provided by the health professional(s) within your primary care setting, or, by a specialist drug and alcohol treatment service when available.

ASSIST (v3)

page 6

B. WHO ASSIST V3.0 RESPONSE CARD FOR PATIENTS

Response Card - substances

a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
b. Alcoholic beverages (beer, wine, spirits, etc.)
c. Cannabis (marijuana, pot, grass, hash, etc.)
d. Cocaine (coke, crack, etc.)
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)
i. Opioids (heroin, morphine, methadone, codeine, etc.)
j. Other - specify:

Response Card (ASSIST Questions 2 – 5)

Never: not used in the last 3 months

Once or twice: 1 to 2 times in the last 3 months.

Monthly: 1 to 3 times in one month.

Weekly: 1 to 4 times per week.

Daily or almost daily: 5 to 7 days per week.

Response Card (ASSIST Questions 6 to 8)

No, Never

Yes, but not in the past 3 months

Yes, in the past 3 months

ASSIST (v3)

page 7

C. ALCOHOL, SMOKING AND SUBSTANCE INVOLVEMENT SCREENING TEST (WHO ASSIST V3.0) FEEDBACK REPORT CARD FOR PATIENTS

Name_____ **Test Date** _____

Specific Substance Involvement Scores

Substance	Score	Risk Level
a. Tobacco products		0-3 Low 4-26 Moderate 27+ High
b. Alcoholic Beverages		0-10 Low 11-26 Moderate 27+ High
c. Cannabis		0-3 Low 4-26 Moderate 27+ High
d. Cocaine		0-3 Low 4-26 Moderate 27+ High
e. Amphetamine type stimulants		0-3 Low 4-26 Moderate 27+ High
f. Inhalants		0-3 Low 4-26 Moderate 27+ High
g. Sedatives or Sleeping Pills		0-3 Low 4-26 Moderate 27+ High
h. Hallucinogens		0-3 Low 4-26 Moderate 27+ High
i. Opioids		0-3 Low 4-26 Moderate 27+ High
j. Other - specify		0-3 Low 4-26 Moderate 27+ High

What do your scores mean?

Low: You are at low risk of health and other problems from your current pattern of use.

Moderate: You are at risk of health and other problems from your current pattern of substance use.

High: You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent

Are you concerned about your substance use?

ASSIST (v3)

page 8

a. tobacco	Your risk of experiencing these harms is:..... Low ☐ Moderate ☐ High ☐ (tick one) **Regular tobacco smoking is associated with:**
	Premature aging, wrinkling of the skin
	Respiratory infections and asthma
	High blood pressure, diabetes
	Respiratory infections, allergies and asthma in children of smokers
	Miscarriage, premature labour and low birth weight babies for pregnant women
	Kidney disease
	Chronic obstructive airways disease
	Heart disease, stroke, vascular disease
	Cancers

b. alcohol	Your risk of experiencing these harms is:..... Low ☐ Moderate ☐ High ☐ (tick one) **Regular excessive alcohol use is associated with:**
	Hangovers, aggressive and violent behaviour, accidents and injury
	Reduced sexual performance, premature ageing
	Digestive problems, ulcers, inflammation of the pancreas, high blood pressure
	Anxiety and depression, relationship difficulties, financial and work problems
	Difficulty remembering things and solving problems
	Deformities and brain damage in babies of pregnant women
	Stroke, permanent brain injury, muscle and nerve damage
	Liver disease, pancreas disease
	Cancers, suicide

c. cannabis	Your risk of experiencing these harms is:..... Low ☐ Moderate ☐ High ☐ (tick one) **Regular use of cannabis is associated with:**
	Problems with attention and motivation
	Anxiety, paranoia, panic, depression
	Decreased memory and problem solving ability
	High blood pressure
	Asthma, bronchitis
	Psychosis in those with a personal or family history of schizophrenia
	Heart disease and chronic obstructive airways disease
	Cancers

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ASSIST (v3)

page 9

d. cocaine	Your risk of experiencing these harms is:.... Low ☐ Moderate ☐ High ☐ (tick one) **Regular use of cocaine is associated with:**
	Difficulty sleeping, heart racing, headaches, weight loss
	Numbness, tingling, clammy skin, skin scratching or picking
	Accidents and injury, financial problems
	Irrational thoughts
	Mood swings - anxiety, depression, mania
	Aggression and paranoia
	Intense craving, stress from the lifestyle
	Psychosis after repeated use of high doses
	Sudden death from heart problems

e. amphetamine type stimulants	Your risk of experiencing these harms is:..... Low ☐ Moderate ☐ High ☐ (tick one) **Regular use of amphetamine type stimulants is associated with:**
	Difficulty sleeping, loss of appetite and weight loss, dehydration
	jaw clenching, headaches, muscle pain
	Mood swings –anxiety, depression, agitation, mania, panic, paranoia
	Tremors, irregular heartbeat, shortness of breath
	Aggressive and violent behaviour
	Psychosis after repeated use of high doses
	Permanent damage to brain cells
	Liver damage, brain haemorrhage, sudden death (ecstasy) in rare situations

f. inhalants	Your risk of experiencing these harms is:..... Low ☐ Moderate ☐ High ☐ (tick one) **Regular use of inhalants is associated with:**
	Dizziness and hallucinations, drowsiness, disorientation, blurred vision
	Flu like symptoms, sinusitis, nosebleeds
	Indigestion, stomach ulcers
	Accidents and injury
	Memory loss, confusion, depression, aggression
	Coordination difficulties, slowed reactions, hypoxia
	Delirium, seizures, coma, organ damage (heart, lungs, liver, kidneys)
	Death from heart failure

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Center for Excellence in Integrated Care

ASSIST (v3)

page 10

g. sedatives	Your risk of experiencing these harms is:	Low ☐	Moderate ☐ (tick one)	High ☐
	Regular use of sedatives is associated with:			
	Drowsiness, dizziness and confusion			
	Difficulty concentrating and remembering things			
	Nausea, headaches, unsteady gait			
	Sleeping problems			
	Anxiety and depression			
	Tolerance and dependence after a short period of use.			
	Severe withdrawal symptoms			
	Overdose and death if used with alcohol, opioids or other depressant drugs.			

h. hallucinogens	Your risk of experiencing these harms is:.....	Low ☐	Moderate ☐ (tick one)	High ☐
	Regular use of hallucinogens is associated with:			
	Hallucinations (pleasant or unpleasant) – visual, auditory, tactile, olfactory			
	Difficulty sleeping			
	Nausea and vomiting			
	Increased heart rate and blood pressure			
	Mood swings			
	Anxiety, panic, paranoia			
	Flash-backs			
	Increase the effects of mental illnesses such as schizophrenia			

i. opioids	Your risk of experiencing these harms is:	Low ☐	Moderate ☐ (tick one)	High ☐
	Regular use of opioids is associated with:			
	Itching, nausea and vomiting			
	Drowsiness			
	Constipation, tooth decay			
	Difficulty concentrating and remembering things			
	Reduced sexual desire and sexual performance			
	Relationship difficulties			
	Financial and work problems, violations of law			
	Tolerance and dependence, withdrawal symptoms			
	Overdose and death from respiratory failure			

ASSIST (v3)

page 11

D. RISKS OF INJECTING CARD – INFORMATION FOR PATIENTS

Using substances by injection increases the risk of harm from substance use.

This harm can come from:

- **The substance**
  - If you inject any drug you are more likely to become dependent.
  - If you inject amphetamines or cocaine you are more likely to experience psychosis.
  - If you inject heroin or other sedatives you are more likely to overdose.
- **The injecting behaviour**
  - If you inject you may damage your skin and veins and get infections.
  - You may cause scars, bruises, swelling, abscesses and ulcers.
  - Your veins might collapse.
  - If you inject into the neck you can cause a stroke.
- **Sharing of injecting equipment**
  - If you share injecting equipment (needles & syringes, spoons, filters, etc.) you are more likely to spread blood borne virus infections like Hepatitis B, Hepatitis C and HIV.

❖ **It is safer not to inject**

❖ **If you do inject:**

- ✓ always use clean equipment (e.g., needles & syringes, spoons, filters, etc.)
- ✓ always use a new needle and syringe
- ✓ don't share equipment with other people
- ✓ clean the preparation area
- ✓ clean your hands
- ✓ clean the injecting site
- ✓ use a different injecting site each time
- ✓ inject slowly
- ✓ put your used needle and syringe in a hard container and dispose of it safely

❖ **If you use stimulant drugs like amphetamines or cocaine the following tips will help you reduce your risk of psychosis.**

- ✓ avoid injecting and smoking
- ✓ avoid using on a daily basis

❖ **If you use depressant drugs like heroin the following tips will help you reduce your risk of overdose.**

- ✓ avoid using other drugs, especially sedatives or alcohol, on the same day
- ✓ use a small amount and always have a trial "taste" of a new batch
- ✓ have someone with you when you are using
- ✓ avoid injecting in places where no-one can get to you if you do overdose
- ✓ know the telephone numbers of the ambulance service

ASSIST (v3)

page 12

E. TRANSLATION AND ADAPTATION TO LOCAL LANGUAGES AND CULTURE: A RESOURCE FOR CLINICIANS AND RESEARCHERS

The ASSIST instrument, instructions, drug cards, response scales and resource manuals may need to be translated into local languages for use in particular countries or regions. Translation from English should be as direct as possible to maintain the integrity of the tools and documents. However, in some cultural settings and linguistic groups, aspects of the ASSIST and it's companion documents may not be able to be translated literally and there may be socio-cultural factors that will need to be taken into account in addition to semantic meaning. In particular, substance names may require adaptation to conform to local conditions, and it is also worth noting that the definition of a standard drink may vary from country to country.

Translation should be undertaken by a bi-lingual translator, preferably a health professional with experience in interviewing. For the ASSIST instrument itself, translations should be reviewed by a bi-lingual expert panel to ensure that the instrument is not ambiguous. Back translation into English should then be carried out by another independent translator whose main language is English to ensure that no meaning has been lost in the translation. This strict translation procedure is critical for the ASSIST instrument to ensure that comparable information is obtained wherever the ASSIST is used across the world.

Translation of this manual and companion documents may also be undertaken if required. These do not need to undergo the full procedure described above, but should include an expert bi-lingual panel.

Before attempting to translate the ASSIST and related documents into other languages, interested individuals should consult with the WHO about the procedures to be followed and the availability of other translations. Write to the Department of Mental Health and Substance Dependence, World Health Organisation, 1211 Geneva 27, Switzerland.

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Contact Information

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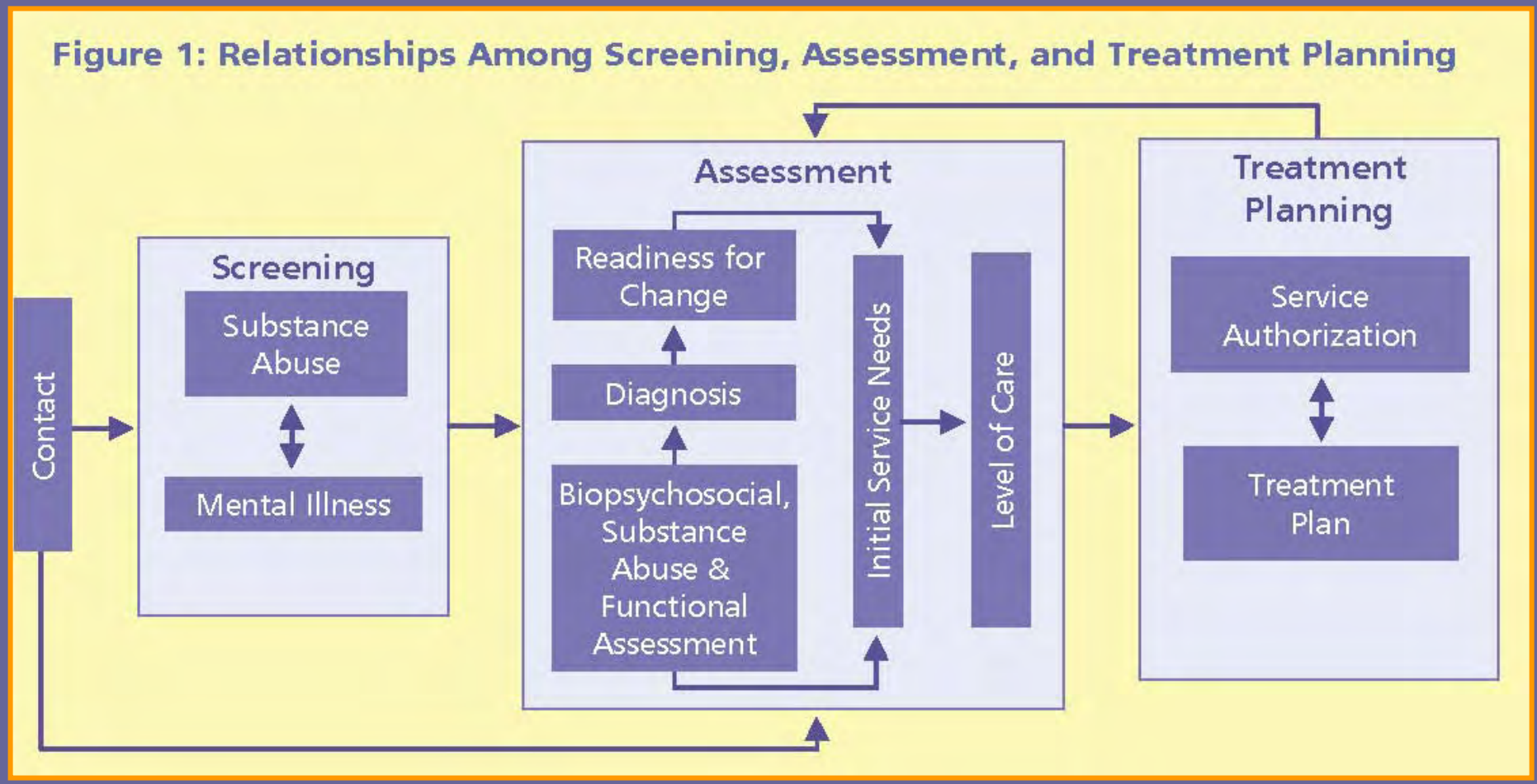
Assessment and Treatment Planning

This document is intended to provide basic guidance for counselors working with people with co-occurring conditions. Future documents will provide more extensive implementation manuals.

Relationships Among Screening, Assessment, and Treatment Planning



Assessment

Definition of Assessment

Assessment

- gathers information and engages in a process with the clients that enables the provider to establish (or rule out) the presence or absence of a co-occurring disorder;
- determines the client's readiness for change;
- identifies client strengths or problem areas that may affect the processes of treatment and recovery; and
- engages the client in the development of an appropriate treatment relationship.

CSAT, 2005a

Basic Assessment Consists of:

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

- *Substance use* is established by age of first use, primary drugs used, patterns of drug use (including information related to diagnostic criteria for abuse or dependence), and past or current treatment. It is important to identify periods of abstinence of 30 days or longer to isolate the mental health symptoms, treatment, and disability expressed during these abstinent periods.

Basic Assessment *(continued)*

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

Assessment Domains
(OMH/OASAS recommendations)

- Current symptoms & functioning
- Background
- Individual history
- Substance use
- Mental health
- Medical history
- Mental status examination
- Client perception(s)
- Presenting problem(s)
- Cultural and linguistic considerations
- Supports & strengths
- Diagnostic impressions on 5 DSM Axes

How is the Assessment Integrated?

- The assessment for COD is integrated by analyzing and using data concerning one disorder in light of data concerning the other disorder.
  - For example, attention to mental health symptoms, impairments, diagnoses, and treatments during past episodes of substance abuse and abstinence can illuminate the role of substance abuse in maintaining, worsening, and/or interfering with the treatment of any mental disorder.

Integrated Assessment

There is no one integrated assessment process for all clients

- The integrated assessment process must be tailored to meet the needs of the specific client. For example:
- Cultural identity may play a significant role in determining the clients view of the problem and the treatment.
- Members of some non-ethnic subcultures (e.g. sex workers, gang members) may hold beliefs and values that are unfamiliar to non members.
- Clients may participate in treatment cultures (12-step recovery, dual recovery self-help, alternative healing practices) that affect how they view treatment and treatment providers.
- A clients sexual orientation and family situation will enhance understanding of the client's personal identity, living situation, and relationships.

Integrated Assessment

What is the purpose of integrated assessment?

- Integrated assessment addresses both mental health a substance abuse, each in the context of the other disorder.

- Integrated assessment seeks (1) to establish formal diagnoses (2) evaluate levels of functioning (i.e. current cognitive capacity, social skills, and other abilities) to identify factors that could interfere with the ability to function independently and/or to follow treatment recommendations.(3) determine the clients readiness for change and (4) make initial decisions about appropriate levels of care.

- Integrated assessment should also consider cultural and linguistic issues, amount of social support, and special life circumstances (e.g. HIV/AIDS, tuberculosis) that may effect service choices and the clients ability to profit from them.

Integrated Assessment

Who is responsible, and in what setting does it occur?

- Integrated assessment may be conducted by any mental health or substance abuse professional who has the specialized training and skills required.

- DSM-IV-TR diagnosis is accomplished by referral to a psychiatrist, clinical psychologist, licensed clinical social worker, or other qualified healthcare professional who is licensed by the State to diagnose mental health disorders. (note: certain assessment instruments can only be obtained and administered by a licensed psychologist) In some cases, an assessment team including substance abuse and mental health professional and other service providers may be needed to complete the assessment.

- Generally assessment occurs in a mental health or substance abuse treatment facility.

Integrated Assessment

Methods that are used

An assessment may include a variety of information gathering methods including:

- the administration of assessment instruments
- an in-depth clinical interview
- a social history
- a treatment history
- interviews with friends and family (after receipt of appropriate client authorizations)
- a review of medical and psychiatric records
- a physical examination
- laboratory tests (tests for infectious diseases and organ system damage, etc.)

Integrated Assessment

There is no one integrated assessment process for all clients

The integrated assessment process must be tailored to meet the needs of the specific client.

For example:

- Cultural identity may play a significant role in determining the clients view of the problem and the treatment.
- Members of some non-ethnic subcultures (e.g. sex workers, gang members) may hold beliefs and values that are unfamiliar to non members.
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- A clients sexual orientation and family situation will enhance understanding of the client's personal identity, living situation, and relationships.

12 Steps in the Assessment Process

Step 1. Engage the client	Step 7. Determine disability and functional impairment
Step 2. Identify and contact collaterals (family, friends, other treatment providers) to gather additional information	Step 8. Identify strengths and supports
Step 3. Screen for and detect COD	Step 9. Identify cultural and linguistic needs and supports
Step 4. Determine quadrant and locus of responsibility	Step 10. Identify problem domains
Step 5. Determine level of care	Step 11. Determine stage of change
Step 6. Determine diagnoses	Step 12. Plan treatment

Assessment Step 1: Engage the Client

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

Assessment Step 2:
Identify and Contact Collaterals

- Client may be unwilling, or unable, to accurately report past or present circumstances.
- Collaterals - family, friends, or other providers.
- Strict adherence to guidelines and laws regarding confidentiality.

Assessment Step 3: Detect Acute Conditions Associated with COD

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

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

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

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Example of Comprehensive Longitudinal Assessment

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

West Institute, 2003

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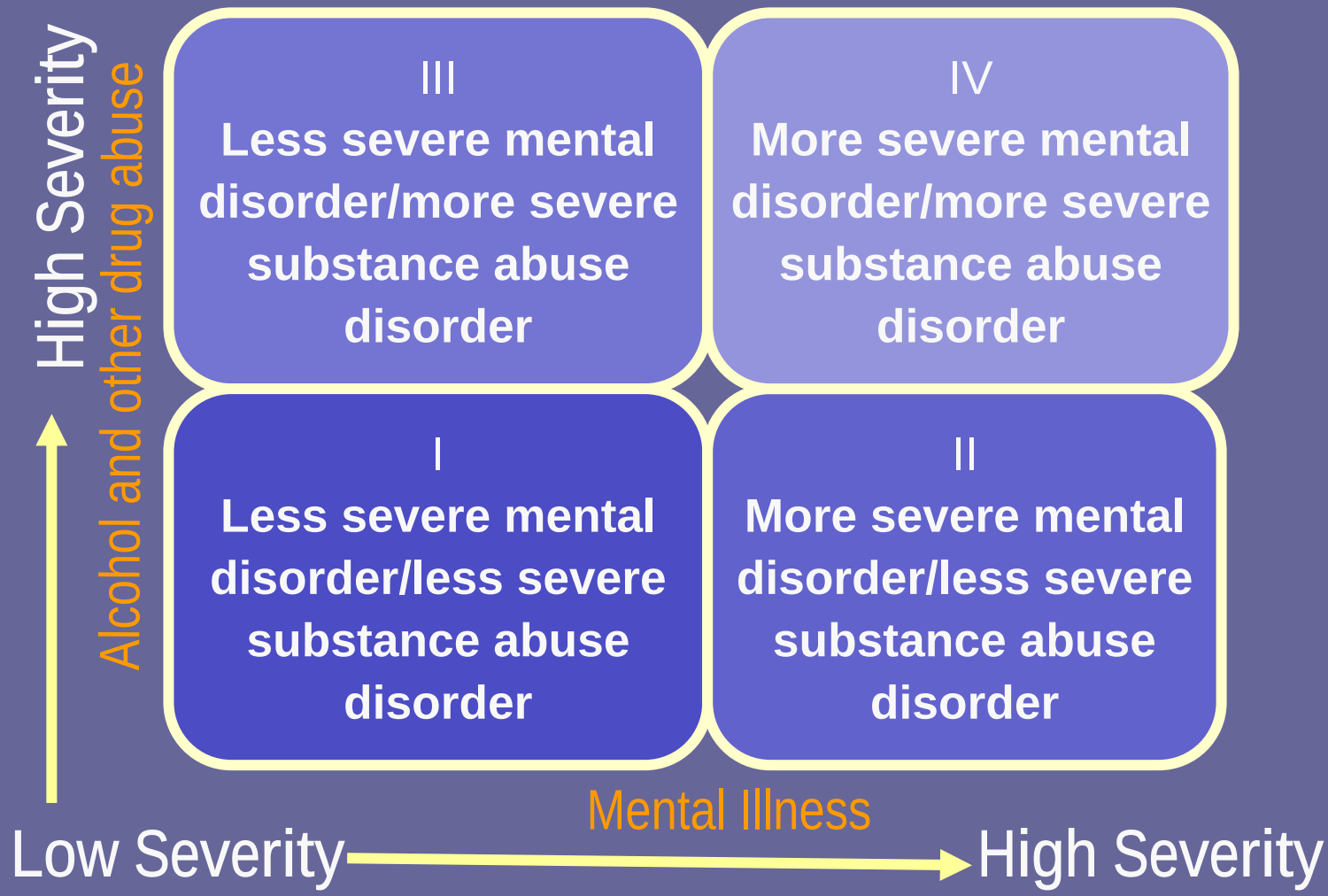
Assessment Step 4: Determine Quadrant & Locus of Responsibility

- Determine Severity of Mental Illness
  - Use State Criteria
  - Is client already receiving priority mental health services?
  - Dimension 3 subscales of ASAM PPC-2R or LOCUS
- Determine Severity of Substance Use Disorder
  - Active or unstable substance dependence; or
  - Serious substance abuse
  - If either criteria then consider for quadrant III or IV
- Determine the need for basic (“capable”) or advanced (“enhanced”) services.

The Four Quadrants



Assessment Step 5: Determine Level of Care
SA [ASAM PPC-2R Dimensions]

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

Assessment Step 5: Determine Level of Care
MH LOCUS Dimensions

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

Assessment Step 6:
Determine Diagnosis: Principles

1. Diagnosis is established more by history than by current symptoms.
2. It is important to document prior diagnoses even if assessor is not licensed to make diagnoses.
3. It is critical to tie mental health symptoms to specific periods of time, particularly times when active substance use was not present.
4. Contextualize the assessment – where, when, with whom, how much, why??…..pros and cons of use or med/tx compliance.

Assessment Step 7:
Determine Disability and Functional Impairment

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

Assessment Step 8:
Identify Strengths and Supports

- Talents and interests
- Vocational or educational competency
- Areas connected with high levels of motivation to change
- Existing supportive relationships or interest in re-unification
- Previous successful treatment efforts

Assessment Step 9:
Identify Cultural & Linguistic Needs and Supports

- Ability to fit into treatment culture
- Cultural identification and perceived barriers
- Language capacity
- Problems with literacy

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Assessment Step 10: Identify Problem Domains

- Medical
- Legal
- Financial
  - Housing
  - Income supports
  - Access to Health Care

- Vocational
- Family
- Social
- Transportation
- Child Care

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

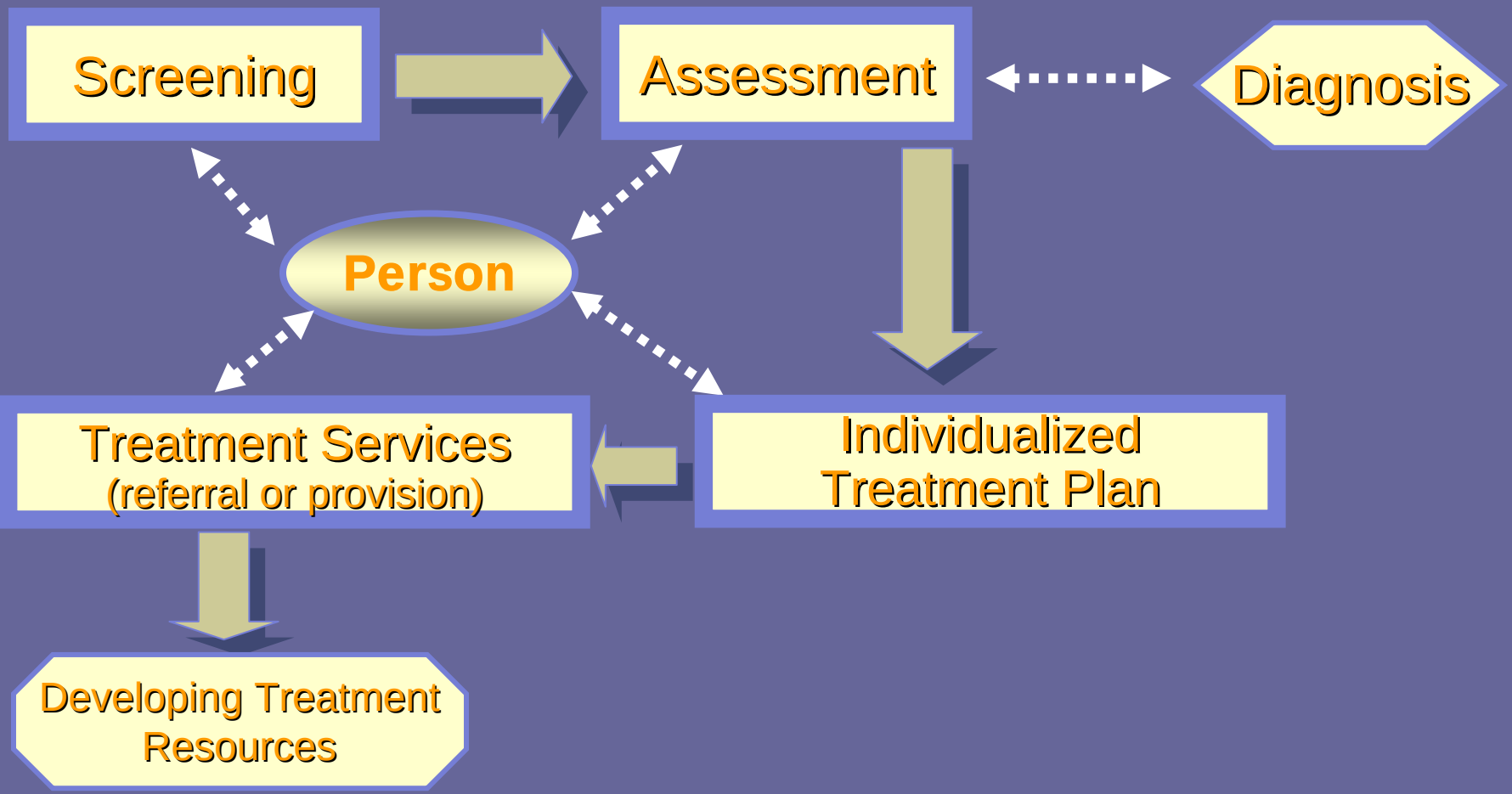
- Prochaska and DiClemente
  - Precontemplation
  - Contemplation
  - Preparation
  - Action
  - Maintenance
- SOCRATES/URICA

- Osher and Kofoed (& others)
  - Engagement
  - Persuasion
  - Active Treatment
  - Relapse Prevention
- SATS

Assessment Step 12:
Plan Treatment

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

The Clinical Planning Process



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Additional Considerations

- Assessment should be a clinical driven process- involves clinician making connection with the client.
- Consider the client in a context (i.e. setting) and fit assessment process to the setting.
- Take into account the system of care the person is in – think of systems available so you can do treatment planning.
- Allocate time for assessment that is realistic in terms of the COD clients' ability to concentrate and participate.

Other Discussion Issues

- Structured Instruments and Clinical Processes/Judgment
- Population & Setting
- Agency & System
- Amount of Information/Use of Information

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List of Selected Assessment Instruments

Substance Abuse

- Addiction Severity Index (ASI)
- Global Appraisal of Individual Needs (GAIN)
- Individual Assessment Profile (IAP)

Mental Health

- Beck Depression Inventory–II (BDI–II)
- Beck Hopelessness Scale (BHS)
- Brief Psychiatric Rating Scale (BPRS)
- Brief Symptom Inventory (BSI)
- General Behavioral Inventory (GBI)
- Mini-International Neuropsychiatric Interview (M.I.N.I.)
- Referral Decision Scale (RDS)

Trauma Informed

- Post-traumatic Stress Symptom Scale Self Report (PSS-SR)
- Trauma History Questionnaire (THQ)

List of Selected Assessment Instruments *(continued)*

General Health

— Medical Outcomes Study Short Form (SF-36)

Diagnostic

— Diagnostic Interview Schedule (DIS-IV)
— Structured Clinical Interview for DSM-IV Disorders (SCID)

Motivation and Readiness to Change

— Circumstances, Motivation, and Readiness Scales (CMR Scales)
— Readiness to Change Questionnaire
— Stages of Change, Readiness and Treatment Eagerness Scale (SOCRATES)
— University of Rhode Island Change Assessment (URICA)

Treatment Planning

— Recovery Attitude and Treatment Evaluator (RAATE)

Level of Care

— Level of Care Utilization System (LOCUS)

Instruments-
Substance Abuse

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Addiction Severity Index (ASI)

Purpose: The ASI is most useful as a general intake screening tool. It effectively assesses a client's status in several areas, and the composite score measures how a client's need for treatment changes over time.

Clinical utility: The ASI has been used extensively for treatment planning and outcome evaluation. Outcome evaluation packages for individual programs or for treatment systems are available.

Groups with whom this instrument has been used: Designed for adults of both sexes who are not intoxicated (drugs or alcohol) when interviewed. Also available in Spanish.

Format: Structured interview

Administration time: 50 minutes to 1 hour

Scoring time: 5 minutes for severity rating

Computer scoring? Yes

Administrator training and qualifications: A self-training packet is available as well as onsite training by experienced trainers.

Fee for use: No cost; minimal charges for photocopying and mailing may apply.

Available from:

A. Thomas McLellan, Ph.D.
Building 7
PVAMC
University Avenue
Philadelphia, PA 19104
Phone: (800) 238-2433

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Global Appraisal of Individual Needs (GAIN)

Purpose: The GAIN was developed to implement an integrated biopsychosocial model of treatment assessment, planning, and outcome monitoring that can be used for evaluation, clinical practice, and administrative purposes.

Clinical utility: The GAIN embeds questions for documenting substance use disorder, attention deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, and pathological gambling; dimensional patient placement criteria for intoxication/withdrawal, health distress, mental distress, and environment distress to guide movement among and between levels of care, to aid in treatment planning, to assist states in reporting requirements related to State client data system; and to measure clinical status and service utilization outcomes.

Groups with whom this instrument has been used: Adults and adolescents

Norms: Yes

Format: The content of the GAIN is divided into eight areas: background and treatment arrangements, substance use, physical health, risk behaviors, mental health, environment, legal, and vocational. In each area, the questions check for major problem areas and the currency of any problems.

Administration time: 30-90 minutes

Scoring time: 20 minutes

Computer scoring? Yes

Administrator training and qualifications: Required training for the full instrument and additional training for computer software (if used).

Fee for use: The GAIN and its products are tools that are proprietary products owned by Chestnut Health Systems either exclusively or jointly and protected under U.S. copyright laws. The current work can be downloaded and reviewed for free. A one time license fee of $100 for all GAIN materials and $1000 for software and initial setup is required to use the instruments. Initial costs are usually waved if you pay for training/support.

Available from: The Lighthouse Institute
Chestnut Health Systems
720 West Chestnut
Bloomington, IL 61701

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Individual Assessment Profile (IAP)

Purpose: To assess clients for treatment planning purposes.

Clinical utility: The IAP is a structured clinical interview that provides measures of eight life areas: demographic background, admission source information, living arrangements, tobacco/alcohol/drug use, illegal activities, source of support/employment, medical health, and mental health.

Groups with whom this instrument has been used: Adults.

Norms: Yes.

Format: Structured clinical interview, Computer –assisted personal interview (CAPI) available.

Administration time: 50 minutes.

Scoring time: Forthcoming

Computer scoring? Yes.

Administrator training and qualifications: 1-3 days of training recommended. A training manual is available from the author.

Fee for use: None, public domain.

Available from:

Dr. Patrick M. Flynn
Substance Abuse Treatment Research Program
Research Triangle Institute
3040 Cornwallis Road
Research Triangle Park, NC 27709-2194
1-800-334-8571

Instruments-
Mental Health

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Beck Depression Inventory–II (BDI–II)

Purpose: Used to screen for the presence and rate the severity of depression symptoms.

Clinical utility: Like its predecessor, the BDI–II consists of 21 items to assess the intensity of depression. The BDI-II can be used to assess the intensity of a client's depression, and it can also be used as a screening device to determine whether there is any current indication of the need for a referral for further evaluation. Each item is a list of four statements arranged in increasing severity about a particular symptom of depression. These new items bring the BDI–II into alignment with *Diagnostic and Statistical Manual for Mental Disorders, 4th edition* (DSM-IV) criteria.

Items on the new scale replace items that dealt with symptoms of weight loss, changes in body image, and somatic preoccupation. Another item on the BDI that tapped work difficulty was revised to examine loss of energy. Also, sleep loss and appetite loss items were revised to assess both increases and decreases in sleep and appetite.

Groups with whom this instrument has been used: All clients age 13 through 80 who can read and understand the instructions, and clients who cannot read (requires reading the statements to them).

Format: Paper-and-pencil self-administered test.

Administration time: 5 minutes, either self-administered or administered verbally by a trained administrator.

Scoring time: N/A

Computer scoring? No. Any staff member can perform the simple scoring.

Administrator training and qualifications: Doctoral-level training or masters-level training with supervision by a doctoral-level clinician are required to interpret test results.

Fee for use: $66 for manual and package of 25 record forms.

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

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Beck Hopelessness Scale (BHS)

Purpose: Designed to measure negative attitudes about the future; originally developed to predict who would commit suicide and who would not.

Clinical utility: The Beck Hopelessness Scale is a 20-item assessment device designed to assess the extent of positive and negative beliefs about the future during the past week. It measures three aspects of hopelessness: feelings about the future, loss of motivation, and expectations. There have been several studies that have supported the predictive validity of the BHS for suicide attempts and completed suicide.

Groups with whom this instrument has been used: Has been used with adolescents from age 13, but age 17 and older is recommended.

Norms? Yes.

Format: Self-report instrument, 20 true-false statements, written or oral.

Administration time: 5-10 minutes.

Scoring time: Score is calculated by summing the pessimistic responses for each of the 20 items; 3 minutes.

Computer scoring? No.

Administrator training and qualifications: May be administered by a range of mental health workers but the interpretation needs to be supervised by an appropriately trained clinical psychologist or psychiatrist.

Fee for use: Complete kit $73.00 (includes manual, 25 record forms, and scoring key).

Available from: Harcourt Assessment, Inc.
19500 Bulverde Road
San Antonio, Texas 78259
1-800-211-8378
http://harcourtassessment.com

Brief Psychiatric Rating Scale (BPRS)

Purpose: An unstructured interview widely used in clinical practice.

Clinical utility: The BPRS is an 18-item scale measuring positive symptoms, general psychopathology and affective symptoms. Some items (e.g. mannerisms and posturing) can be rated simply on observation of the patient; other items (e.g. anxiety) involve an element of self-reporting by the patient.

Groups with whom this instrument has been used: Adults and the Elderly. The BPRS has also been modified for use with children (CBPRS).

Norms: Forthcoming

Format: Clinician-rated instrument, 18-item scale, each rated on a seven-point scale (1=not present to 7=extremely severe). Ratings made after a brief unstructured interview with the patient.

Administration time: 15-20 minutes.

Scoring time: Forthcoming

Computer scoring? No.

Administrator training and qualifications: Administered by experienced psychiatrists, psychologists, or other raters trained in the assessment and diagnosis of psychopathology.

Fee for use: None, public domain; use with due acknowledgement: (Overall, J. E. & Gorham, D. R. The brief psychiatric rating scale. Psychol Rep 1962; 10: 799- 812)

Available from: http://www.geocities.com/HotSprings/8517/EasyTestCreator

Brief Symptom Inventory (BSI)

Purpose: The Brief Symptom Inventory (BSI) is designed to reflect psychological symptom patterns of psychiatric and medical patients as well as non-patients. This self-report is the short form of the SCL-90-R instrument.

Clinical utility: Like the SCL-90-R instrument, the BSI instrument can be useful in initial evaluation of patients at intake as an objective method of screening for psychological problems. The BSI instrument is especially appropriate in clinical situations where debilitation results in reduced attention and endurance, in research with limited interview schedules, and in outpatient clinics where testing procedures demand brevity. The BSI instrument is also frequently used in measuring patient progress during treatment or in the assessment of treatment outcomes.

Groups with whom this instrument has been used: 13 and older (6th grade reading level).

Norms: Yes.

Format: 53 items/ self-report.

Administration time: 10-12 minutes.

Scoring time: Using answer key, 5 minutes.

Computer scoring? Yes.

Administrator training and qualifications: Self-administered, low-level interviewer.

Fee for use: Yes.

Available from: Pearson Assessments
5601 Green Valley Drive
Bloomington, MN 55437
www.pearsonassessments.com/tests/bsi.htm

General Behavioral Inventory (GBI)

Purpose: To assesses mood disorders in adults. Focuses on depression and mania.

Clinical utility: Is a multi-method, time-logged assessment of persistent negative mood involving self-report measures. Used to identify potentially recurrent or chronic-intermittent depressives who may not be depressed at the time of assessment.

Groups with whom this instrument has been used:

Norms: Forthcoming

Format: 73 item self-report questionnaire

Administration time: Forthcoming

Scoring time: Forthcoming

Computer scoring? Forthcoming

Administrator training and qualifications: None

Fee for use: Forthcoming

Available from: Dr. Richard Allen Depue
607-257-7316
rad5@cornell.edu

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Mini-International Neuropsychiatric Interview (M.I.N.I.)

Purpose: The Mini-International Neuropsychiatric Interview assists in the assessment of 20 mental disorders including substance use disorders.

Clinical utility: The M.I.N.I. is not designed or intended to be used in place of a full medical and psychiatric evaluation by a qualified licensed physician-psychiatrist.

It is intended only as a tool to facilitate accurate data collection and processing of symptoms elicited by trained personnel.

Groups with whom this instrument has been used: Adults

Format: An abbreviated psychiatric structured interview that uses decision tree logic to assess the major adult Axis I disorders in DSM-IV and ICD-10. It elicits all the symptoms listed in the symptom criteria for DSM-IV and ICD-10 for 15 major Axis I diagnostic categories, one Axis-II disorder and for suicidality. Its diagnostic algorithms are consistent with DSM-IV and ICD-10 diagnostic algorithms.

Administration time: 15 to 20 minutes

Scoring time: 5 minutes

Computer scoring? A computerized version of the M.I.N.I. is available in six languages in the MINI Outcomes program.

Administrator training and qualifications: The M.I.N.I. was designed to be used by trained interviewers who do not have training in psychiatry or psychology.

Fee for use: The M.I.N.I. is made available at no charge on the internet, mainly for researchers who may make single copies for their own use.

Available from: hhtps://www.medical outcomes.com/indexSSL.htm

Referral Decision Scale (RDS)

Purpose: The RDS is a screening tool designed to identify those persons who have a high probability of major mental disorder so that a fuller assessment may occur. It was developed for use in the criminal justice system.

Clinical utility: Used to predict DIS lifetime diagnoses of schizophrenia, bipolar disorder and major depressive disorder. The questions included in the RDS were distilled from the Diagnostic Interview Schedule.

Groups with whom this instrument has been used: Adults in the criminal justice system.

Norms: Yes.

Format: 14 questions, self-administered.

Administration time: 5 minutes.

Scoring time: Summing of yes responses; 1 minute.

Computer scoring? No.

Administrator training and qualifications: Interviewers must be trained on DIS flowchart.

Fee for use: None, public domain.

Available from: Dr. Linda Teplin
l_teplin@northwestern.edu

Instruments-
Trauma Informed

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Post-traumatic Stress Symptom Scale Self Report (PSS-SR)

Purpose: Designed to assess DSM-IV symptoms of PTSD relating to a single traumatic event.

Clinical utility: The PSS-SR is the self-report version of Foa's structured interview for PTSD by the same name (PSS-I). Diagnoses for PTSD based on the PSS-SR are slightly more conservative than those based on the PSS-I. The PSS-SR is intended for use with individuals who have a known assault history, and should thus be accompanied by a trauma screen when assessing individuals for whom basic background information is lacking.

Groups with whom this instrument has been used:

Norms: Forthcoming

Format: 17 items, self-report, symptom frequency over the preceding two weeks is reported on a four-point scale.

Administration time: 15-20 minutes.

Scoring time: Total score is obtained by summing each symptom rating. Subscale scores are calculated by summing symptoms in the re-experiencing (4 items), avoidance (7 items), and arousal (6 items) clusters.

Computer scoring? Forthcoming

Administrator training and qualifications: Forthcoming

Fee for use: Forthcoming

Available from:

Edna Foa, PhD.
Department of Psychiatry
University of Pennsylvania
3535 Market Street
Philadelphia, PA 19104-3309
215-746-3327
email: foa@mail.med.upenn.edu

Trauma History Questionnaire (THQ)

Purpose: To gather a history of exposure to potentially traumatic events.

Clinical utility: The THQ lists 23 traumatic events in three categories: crime-related, general disasters and trauma, and unwanted physical and sexual experiences. Respondents indicate lifetime occurrence, frequency, age at first occurrence, and relationship to perpetrator.

Groups with whom this instrument has been used: Adults.

Norms: Forthcoming

Format: Self-report, 24 items.

Administration time: 5-15 minutes.

Scoring time: Forthcoming

Computer scoring? Forthcoming

Administrator training and qualifications: Forthcoming

Fee for use: Forthcoming

Available from:

Bonnie L. Green, Ph.D.
Department of Psychiatry
Georgetown University
611 Kober Cogan Hall
Washington, DC 20007
202-687-6529
Email: greenb@guner.georgetown.edu

Instruments-
General Health

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Medical Outcomes Study Short Form (SF-36)

Purpose: Designed as a survey of general health concepts for use in clinical practice and research, health policy evaluations, and general population surveys.

Clinical utility: The SF-36 is useful for descriptive purposes such as documenting differences between sick and well patients and for estimating the relative burden of different medical conditions. It is also useful for evaluating the benefits of alternative treatments.

Groups with whom this instrument has been used: 14 and older.

Norms: Yes.

Format: 36 questions, suitable for self administration, computerized administration, or administration by a trained professional.

Administration time: 5-10 minutes.

Scoring time: Complicated scoring including recoding and converting raw scores to scale scores.

Computer scoring? Yes.

Administrator training and qualifications: Trained interviewer.

Fee for use: The cost of the instrument varies, depending on who is using it and for what purpose.

Available from: Medical Outcomes Trust, Inc.
20 Park Plaza, Suite 1014
Boston, MA 02116
www.sf-36.org
http://www.qualitymetric.com/products/ProductDetails.aspx?productID=468&categoryid=1

Instruments-
Diagnostic

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Diagnostic Interview Schedule (DIS-IV)

Purpose: To obtain a psychiatric diagnosis according to DSM-IV criteria.

Clinical utility: In addition to determining whether criteria for diagnosis are met, information is gained about course, onset, and regency of positive symptoms.

Groups with whom this instrument has been used: Adults (a version for children is also available- DISC).

Norms: Forthcoming

Format: Fully structured diagnostic interview designed to be administered by non-clinicians, the computerized version can be interviewer-administered or self-administered, 526 items.

Administration time: 90-120 minutes.

Scoring time: Forthcoming

Computer scoring? Yes.

Administrator training and qualifications: 4 day training course is recommended.

Fee for use: $1000 per project for investigator's license/ $2000 for license plus training course

Available from:

Department of Psychiatry
Washington University School of Medicine
40 N. Kingshighway, Suite 4
St. Louis, MO 63108
Attn: Dr. Linda Cottler
tel: 314-286-2252
email: cottler@epi.wustl.edu

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Structured Clinical Interview for DSM-IV Disorders (SCID)

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

Clinical utility: A psychiatric interview.

Groups with whom this instrument has been used: Psychiatric, medical, or community-based normal adults.

Norms: No.

Format: A psychiatric interview form in which diagnosis can be made by the examiner asking a series of approximately 10 questions of a client.

Administration time: Administration of Axis I and Axis II batteries may require more than 2 hours each for patients with multiple diagnoses. The Psychoactive Substance Use Disorders module may be administered by itself in 30 to 60 minutes.

Scoring time: Approximately 10 minutes.

Computer scoring? No. Diagnosis can be made by the examiner asking a series of questions of a client.

Administrator training and qualifications: Designed for use by a trained clinical evaluator at the master’s or doctoral level, although in research settings it has been used by bachelor’s level technicians with extensive training.

Fee for use: Yes.

Available from: American Psychiatric Publishing, Inc.
1400 K Street, N.W.
Washington, DC 20005
http://www.appi.org/

Instruments-
Motivation and Readiness to Change

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Circumstances, Motivation, and Readiness Scales (CMR Scales)

Purpose: The instrument is designed to predict retention in treatment and is applicable to both residential and outpatient treatment modalities.

Clinical utility: The instrument consists of four derived scales measuring external pressure to enter treatment, external pressure to leave treatment, motivation to change, and readiness for treatment. Items were developed from focus groups of recovering staff and clients and retain much of the original language. Clients entering substance abuse treatment perceive the items as relevant to their experience.

Groups with whom this instrument has been used: Adults.

Norms: Norms are available from a large secondary analysis of more than 10,000 clients in referral agencies, methadone maintenance, drug-free outpatient and residential treatment. Norms are also available for special populations, such as clients with COD, prison-based programs, and women's programs.

Format: 18 items at approximately a third-grade reading level. Responses to the items consist of a 5-point Likert scale on which the individual rates each item on a scale from Strongly Disagree to Strongly Agree. Versions are also available in Spanish and Norwegian.

Administration time: 5 to 10 minutes

Scoring time: Can be easily scored by reversing negatively worded items and summing the item values.

Computer scoring? No

Administrator training and qualifications: Self-administered; no training required for administration.

Fee for use: N/A

Available from:

George De Leon, Ph.D., or Gerald Melnick, Ph.D.,
National Development and Research Institutes, Inc.
71 West 23rd Street, 8th Floor, New York, NY 10010
Phone: (212) 845-4400 Fax: (917) 438-0894
E-mail: gerry.melnick@ndri.org http://www.ndri.org

Readiness to Change Questionnaire

Purpose: Designed to assist the clinician in determining the stage of readiness for change among problem drinkers or people with alcohol use disorders.

Clinical utility: Assesses drinker's readiness to change drinking behaviors; may be useful in assignment to different types of treatment.

Groups with whom this instrument has been used: Adults, adolescents.

Norms: Yes. Excessive drinkers identified in general medical practice at general hospital.

Format: A brief 12-item questionnaire consisting of three subscales.

Administration time: 2 to 3 minutes

Scoring time: 1 to 2 minutes

Computer scoring? No

Administrator training and qualifications: No training is required.

Fee for use: No

Available from:

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

Stages of Change, Readiness and Treatment Eagerness Scale (SOCRATES)

Purpose: Designed to assess alcohol abusers' readiness for change.

Clinical utility: Since motivation for change is an important predictor of treatment compliance, the SOCRATES can assist clinicians with information necessary for treatment planning.

Groups with whom this instrument has been used: Adults.

Norms: Forthcoming

Format: 40 items, self-administered, self-report (version 8 consists of 19 items).

Administration time: 5 minutes.

Scoring time: 5 scales scored separately, each scale has 8 items which are summed to derive the scale score; 3 minutes.

Computer scoring? No.

Administrator training and qualifications: No training required.

Fee for use: None, public domain.

Available from:

William R. Miller, Ph.D.
University of New Mexico
Center of Alcoholism, Substance Abuse and Addictions
2350 Alamo SE
Albuquerque, NM 87106
505-925-2378
email: wrmiller@unm.edu

University of Rhode Island Change Assessment (URICA)

Purpose: The URICA operationally defines four theoretical stages of change—precontemplation, contemplation, action, and maintenance—each assessed by eight items.

Clinical utility: Assessment of stages of change/readiness construct can be used as a predictor, treatment matching, and outcome variables.

Groups with whom this instrument has been used: Both inpatient and outpatient adults

Norms: Yes, for outpatient alcoholism treatment population

Format: The URICA is a 32-item inventory designed to assess an individual's stage of change located along a theorized continuum of change.

Administration time: 5 to 10 minutes to complete

Scoring time: 4 to 5 minutes

Computer scoring? Yes, computer scannable forms.

Administrator training and qualifications: N/A

Fee for use: No; instrument is in the public domain. Available from author.

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

Treatment Planning

Individual Treatment Plan

Treatment Planning based on:

- Evidence- & Consensus-based Practices (ECBPs), client preferences, shared decision making and clinical expertise
- Integrated SA and MH Treatments
- A focus on dual recovery/self-management of both disorders
- Addressing housing, vocational, family, legal, and medical problems
- Approaches that are recovery-oriented, person centered, culturally competent

Integrated Treatment Planning
The Process

During integrated treatment planning phases, initial decisions are made about the following:

- What services the client needs and wants
- Where these services will be provided
- Who will share responsibility with the client for monitoring progress
- How the services of different providers will be coordinated
- How services will be reimbursed

Treatment planning should be client centered, addressing client's goals and using treatment strategies that are acceptable to them.

Integrated Treatment Planning
The Process (continued)

- Screening and assessment data provide information that is integrated by the clinician and the client in the treatment planning process. Screening and assessment data also are useful in establishing a client's baseline of signs, symptoms and behaviors that can be used to assess progress.

- The treatment plan is never a static document. As changes in the client's status occur and as new relevant information comes to light, the treatment plan must be reconsidered and adjusted.

Integrated Treatment Planning

Responsibility for integrated treatment planning

- The client- centered treatment plan is the joint responsibility of the clinician or clinical team and the client.
- The client- centered plan is guided by what the client wishes to accomplish and the methods that are acceptable to him or her.
- In the system where care is managed, some aspects of the plan may require authorization by payers.
- Securing service authorization is the responsibility of the providers.
- If service authorization is refused, the client and the provider should explore together what modifications to the treatment plan will best meet the client needs and also satisfy reimbursement requirements.

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The Components of a Client-Centered Treatment Plan *(adapted from Mueser et al. 2003)*

Acute Safety Needs	Determines the need for immediate acute stabilization to establish safety prior to routine assessment
Severity of Mental and Substance Use Disorder	Guides the choice of the most appropriate setting for treatment
Appropriate Care Setting	Determines the client's program assignment (See American Society of Addiction Medicine, 2001)
Diagnosis	Determines the recommended treatment intervention
Disability	Determines case management needs and whether an enhanced level of intervention is required
Strengths and Skills	Determines areas of prior success around which to organize future treatment interventions and determines areas of skill-building needed for management of either disorder
Availability and Continuity of Recovery Support	Determines whether continuing relationships need to be established and availability of existing relationships to provide contingencies to promote learning
Cultural Context	Determines most culturally appropriate treatment interventions and settings
Problem Priorities	Determines problems to be solved specifically, and opportunities fir contingencies to promote treatment participation
State of Recovery/ Client's Readiness to Change Behaviors Relating to Each Problem	Determines appropriate treatment interventions and outcomes for a client at a given stage of recovery or readiness for change (See TIP 35, Enhancing Motivation for Change in Substance Abuse Treatment [CSAT, 1991]

Source: CSAT 2005b

Instruments-
Treatment Planning

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Recovery Attitude and Treatment Evaluator (RAATE)

Purpose: Designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting appropriateness of discharge.

Clinical utility: The RAATE provides objective documentation to assist in making appropriate treatment placement decisions; it strengthens individualized care and facilitates more individualized treatment planning; it measures treatment process; and it assesses the need for continuing care and discharge readiness.

Groups with whom this instrument has been used: Adults

Norms: Yes

Format: A 35-item structured interview

Administration time: 20 to 30 minutes

Scoring time: Less than 5 minutes

Computer scoring? No

Administrator training and qualifications: Training is required for administration. The RAATE is administered by trained chemical dependency professional/RAATE-CE and patient/RAATE-QI.

Fee for use: Yes. The RAATE manual is available for $35.00 and the scoring templates are $8.75.

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

Instruments-
Level of Care

NYSHealth Center for Excellence in Integrated Care

Level of Care Utilization System (LOCUS)

Purpose: To assess immediate service needs (e.g., for clients in crisis); to plan resource needs over time, as in assessing service requirements for defined populations; to monitor changes in status or placement at different points in time.

Clinical utility: LOCUS is divided into three sections. The first section defines six evaluation parameters or dimensions: (1) Risk of Harm; (2) Functional Status; (3) Medical, Addictive, and Psychiatric Co-Morbidity; (4) Recovery Environment; (5) Treatment and Recovery History; and (6) Engagement. A five-point scale is constructed for each dimension and the criteria for assigning a given rating or score in that dimension are elaborated. In dimension IV, two subscales are defined, while all other dimensions contain only one scale.

Groups with whom this instrument has been used: Adults

Norms: N/A

Format: A document that is divided into three sections.

Administration time: 15 to 30 minutes

Scoring time: 20 minutes

Computer scoring? No

Administrator training and qualifications: N/A

Fee for use: No

Available from: American Association of Community Psychiatrists
http://www.wpic.pitt.edu/aacp/find.html

What are the Advantages and Disadvantages of Assessment Instruments?

- Assessment instruments constitute a structured method for gathering information in many areas, and for establishing assessment scores that define problem areas.
- Assessment instruments also can function as 'ticklers' or memory aids to the clinician or team, assisting in making sure that all relevant topics are covered.
- Assessment instruments should be viewed as providing information that is part of the assessment process.
- They do not themselves constitute as assessment. In particular, instruments do not accomplish the interpersonal goals of assessment.
- Making the client feel welcome in the treatment system, engaging the client as an active partner in his or her care, and beginning the therapeutic alliance that will exist throughout the client's relationship with helping resources.

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Conclusion

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

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Contact Information

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Evidence-Based Practices for Treatment of Persons with Co-occurring Disorders

This document is intended to provide basic guidance for counselors working with people with co-occurring conditions. Future documents will provide more extensive implementation manuals.

What is an Evidence-Based Practice?

Definition:

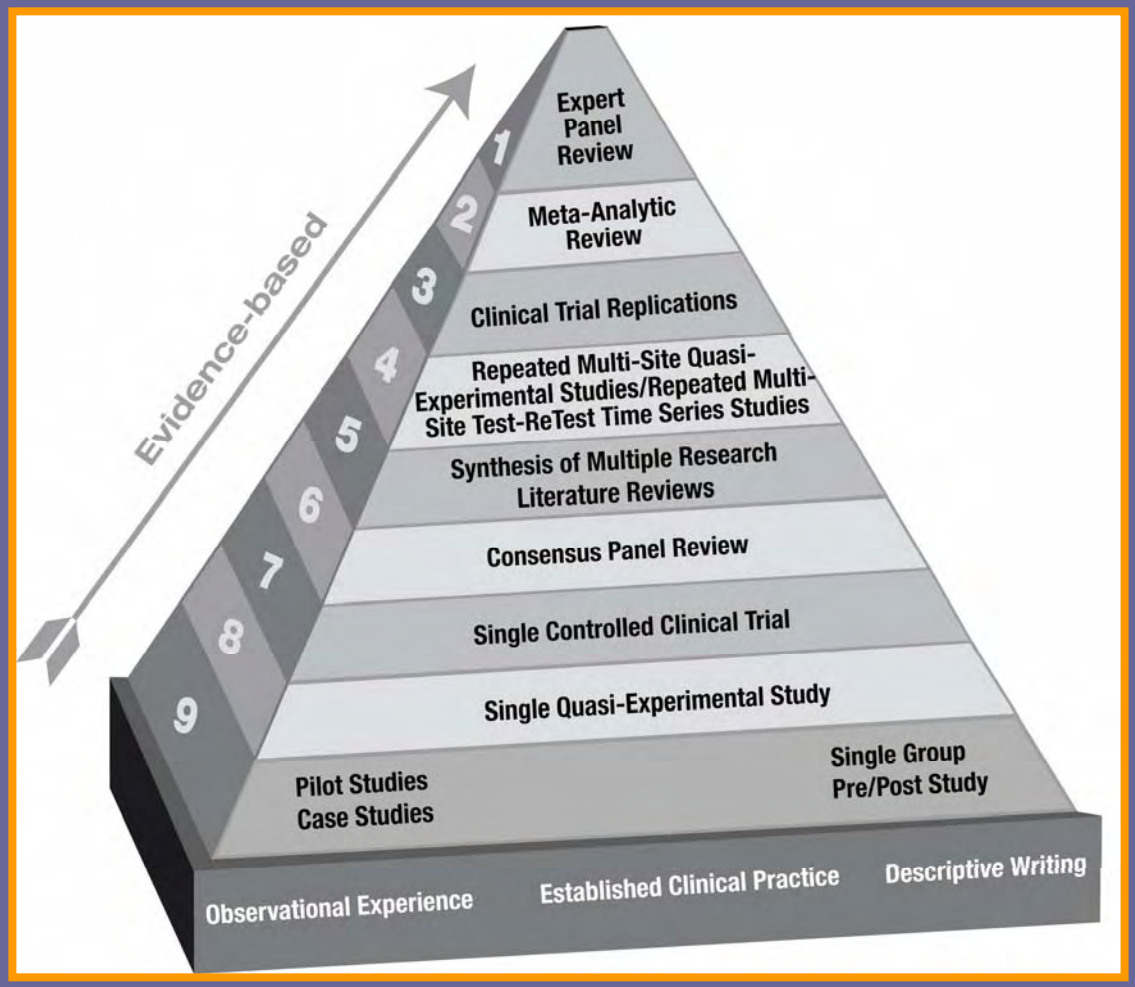
The Center for Excellence in Integrated Care defines evidence-based practice in the field of co-occurring substance use and mental disorders as *the use of current and best research evidence in making clinical and programmatic decisions about the care of client(s).*

Evidence-Based Practice *(continued)*

The Institute of Medicine (2000) added *clinical expertise* and *patient values* to older definitions of evidence-based practice which only focused on best research evidence to recognize the importance of considering other factors in the process of making clinical decisions.

- *Best research evidence will be highlighted in subsequent slides.*
- *Clinician expertise is defined as the ability to use clinical skills and past experience to identify each client's unique health state and diagnoses, and individual risks and benefits of potential interventions.*
- *Client values refers to the unique preferences, concerns, and expectations that each client brings to a clinical encounter.*

Pyramid of Research Evidence



Evidence-Based Practices
(OASAS/OMH recommendations)

For both disorders:
- Approved medications

For substance use disorders:
- Evidence-based individual, group, couples, and family treatments – *including*
  - motivational enhancement
  - CBT
  - 12-step facilitation
  - behavioral couples & family therapy
  - contingency management

For mental illness:
- CBT, medication

For serious mental illness:
- Managing illness (IDDT, education, medication, CBT) family psychoeducation, supported employment, social skills training
- Peer support

Evidence-Based Practices in Substance Abuse Treatment

- Motivational Enhancement
- Cognitive Behavioral Therapy
- Participation in Mutual Self-Help Groups
- Contingency Management
- Relapse Prevention

Motivational Enhancement

Motivational interviewing is a "client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller and Rollnick, 2002, p. 25). Motivational interviewing has proven effective in helping clients clarify goals and make commitment to change.

Motivational Interviewing

- Motivational Interviewing (MI) is a “client-centered, non-directive, method for enhancing intrinsic motivation to change by exploring and resolving ambivalence”.
- MI has proven effective in helping clients clarify goals and make commitment to change.
- This approach shows so much promise that it is one of the first two psychosocial treatments being sponsored in multi-site trials in the National Institute on Drug Abuse Clinical Trials Network program.

Applying the Motivational Interviewing Approach to Clients with COD

To date, motivational interviewing strategies have been successfully applied to the treatment of clients with COD, especially in:

- Assessing the client's perception of the problem
- Exploring the client's understanding of his or her clinical condition
- Examining the client's desire for continued treatment
- Enduring client attendance at initial sessions
- Expanding the client's assumption of responsibility for change

Adapted from Substance Abuse Treatment for Persons With Co-Occurring Disorders, TIP 42

Cognitive–Behavioral Therapy

This therapeutic approach seeks to modify negative or self-defeating thoughts and behavior and is aimed at both thought and behavior change—that is, coping by thinking differently and coping by acting differently (Carroll, 1998). One technique is known as *cognitive restructuring*; for example, a client may initially think, "The only time I feel comfortable is when I'm high," but learn through counseling to think instead, "It's hard to learn to be comfortable socially without doing drugs, but people do so all the time."

Cognitive-Behavioral Therapeutic Techniques

- An underlying assumption of CBT is that the client systematically and negatively distorts her view of the self, the environment, and the future.
- Therefore, a major tenet of CBT is that the person's thinking is the source of difficulty and that this distorted thinking creates behavioral problems.
- CBT approaches use cognitive and/or behavioral strategies to identify and replace irrational beliefs with rational beliefs.
- At the same time, the approach prescribes new behaviors the client practices. These approaches are educational in nature, active and problem-focused, and time-limited.

Cognitive-Behavioral Therapy and COD

- Distortions in thinking are generally more severe with people with COD. For example, a person with depression and an alcohol use disorder who has had a bad reaction to a particular antidepressant may claim that all antidepressant medication is bad and must be avoided at all costs.
- Likewise, individuals may use magnification and minimization to exaggerate the qualities of others, consistently presenting themselves as “losers” who are incapable of accomplishing anything. Clients with COD are, by definition, in need of better coping skills.

Participation in Mutual Self-help Groups

The use of mutual self-help groups is a key tool for the clinician to assist clients with substance use disorders as well as clients with mental disorders (Dupont, 1994). Dual recovery mutual self-help approaches are becoming increasingly common in larger communities. Clinicians are advised to seek resources for those who do not speak English.

Participation in Mutual Self-help Groups *(continued)*

The clinician can assist the client by doing the following—

- Help the client locate an appropriate group.
- Help the client find a sponsor.
- Help the client prepare to participate appropriately in the group.
- Help overcome barriers to group participation.
- Debrief with the client after he or she has attended a meeting to help process reactions and prepare for future attendance.

Contingency Management

Contingency management maintains that the form or frequency of behavior can be altered through a planned and organized system of positive and negative consequences (Higgins et al., 1986). Contingency management assumes that neurobiological and environmental factors influence substance use behaviors and that the consistent application of reinforcing environmental consequences can change these behaviors.

Contingency Management *(continued)*

Contingency management for substance abuse treatment has been structured around four central principles (Higgins and Petry, 1999)—

1. The clinician provides positive reinforcement—mutually agreed upon—when abstinence is demonstrated.
2. The clinician arranges regular drug testing to ensure any use of targeted substance(s) is detected readily.
3. The clinician withholds designated incentives from the individual when the substance is detected.
4. The clinician helps the client establish alternate and healthier activities.

Contingency Management *(continued)*

Contingency management techniques are best applied to specific targeted behaviors, such as—

- Drug abstinence
- Clinic attendance and group participation
- Medication adherence
- Following treatment plan
- Attaining particular goals

Contingency Management *(continued)*

Common reinforcers are—

- Cash
- Vouchers
- Prizes
- Retail items
- Privileges

CM Techniques—Implications for People with COD

Some recent examples of the use of CM techniques have direct implications for people with COD:

- housing and employment contingent upon abstinence;
- managing benefits and establishing representative payeeships;
- a token economy for homeless clients with COD.

Relapse Prevention

Although the literature describes a variety of relapse prevention models, all clinical approaches to relapse prevention have a central element that anticipates the emergence of problems in maintaining change (Gorski, 2000 and Marlatt, 1999). High-risk situations for resumed substance use are identified, and counselors help clients to develop effective strategies that will enable them to cope with these situations without relapsing to substance use.

Use of Relapse Prevention Techniques

- A central element of all clinical approaches to relapse prevention is anticipating problems that are likely to arise in maintaining change and labeling them as high-risk situations for resumed substance use, then helping clients to develop effective strategies to cope with those high-risk situations without having a lapse.
- A key factor in preventing relapse is to understand that relapses are preceded by triggers or cues that signal that trouble is brewing and that these triggers precede exposure to events or internal processes (high-risk situations) where or when resumed substance use is likely to occur.

Relapse Prevention and COD

- Relapse education should be provided and related to the individual's mental disorder. The latter is particularly important because the pattern typically followed by clients with COD begins with an increase in substance use leading to lowered efficacy or discontinuation of psychiatric medication, or missed counseling sessions.
- As a consequence, psychiatric symptoms reappear or worsen, the client's tendency to self-medicate through substance use is exacerbated, and the downward spiral is perpetuated.

Relapse Prevention and COD *(continued)*

- Clients with COD need effective strategies to cope with pressures to discontinue their prescribed psychiatric medication.
- One such strategy is simply to prepare clients for external pressure from other people to stop taking their medications.
- Rehearsing circumstances in which this type of pressure is applied, along with anticipating the possibility, enables clients with COD to react appropriately.

EBP in Mental Health Treatment

- Integrated Dual Disorders Treatment
- Illness Management & Recovery
- Supported Employment
- Family Psycho-Education

Integrated Dual Disorders Treatment (IDDT)

For the past 15 years extensive efforts have been made to develop integrated models for individuals with serious mental illnesses and co-occurring substance use disorders. The general findings across multiple studies of IDDT support the effectiveness of this approach (Drake et al, 2001).

What is Integrated Dual Disorders Treatment (IDDT)?

Six Core Components

1. Integration of Services
2. Blending of Services
3. Stage-wise Treatment
4. Integrated Assessment
5. Motivational Treatment
6. Substance abuse counseling

What is Fidelity?

- Fidelity is the degree of implementation of an evidence-based practice.
- Programs with high-fidelity are expected to have greater effectiveness than low-fidelity programs in achieving desired consumer outcomes.
- Fidelity scales assess the critical ingredients of an EBP.

IDDT Fidelity Scale
Program-Specific Items

- Multidisciplinary Team with Integrated Substance Abuse Specialist
- State-wise interventions
- Comprehensive COD Services
- Time-unlimited services
- Outreach
- Motivational Interventions
- Substance Abuse Counseling
- Group COD Treatment
- Family Psychoeducation
- Self-Help Group Participation
- Pharmacological Treatment
- Interventions to Promote Health
- Secondary Interventions for Non-responders

Illness Management and Recovery

- Illness management and recovery are aimed at helping consumers acquire the information and skills needed to collaborate effectively with professionals and significant others in their treatment, to minimize-the effects of the mental illness on their lives, and to be able to pursue personally meaningful goals.
- Variety of methods are aimed at helping consumers deal more effectively with their disorder, including psycho-education about mental illness and its- treatment, teaching strategies that promote effective use of medication, developing relapse prevention skills, and improving methods for coping with symptoms.
- Additional techniques that can be subsumed under the broad category of illness management and recovery include social skills training to address social dysfunction and cognitive therapy for psychosis.

Adapted from Mueser, K., Torrey, W.C., Lynde, D., Singer, P. & Drake, R.E. (2003) and from the Substance Abuse Treatment for Persons With Co-Occurring Disorders, TIP 42

Supported Employment

- Refers to vocational services based on helping clients rapidly acquire Competitive jobs paying competitive wages.
- Takes place in integrated community settings working alongside non-disabled workers and providing ongoing supports to facilitate success on the job or a smooth transition to another job.
- Contrast to traditional vocational services that use extensive preemployment experiences such as assessment, skills training, counseling, sheltered work experiences, and work trials, prior to placement in a competitive job. Individuals tend to become stalled in these prevocational experiences and never make the transition to competitive employment.

Adapted from Mueser, K., Torrey, W.C., Lynde, D., Singer, P. & Drake, R.E. (2003) and from the Substance Abuse Treatment for Persons With Co-Occurring Disorders, TIP 42

Family Psycho-education

- A variety of different models of family intervention have been developed over the past two decades.
- Models of family interventions differ in their format (e.g., multiple family vs. single family sessions), theoretical orientation (e.g., cognitive-behavioral, broad-based supportive, modified family systems), duration of treatment (e.g., time-limited or unlimited), and locus of services (clinic- or home-based).
- Despite the many differences between models, effective family programs share many features
  - usually last for at least 6 months;
  - provide information to families about the psychiatric illness and its management;
  - strive to decrease tension and stress in the family, give social support and empathy;
  - focus on improving the future (rather than exploring the past), improve functioning in all family members (not just the consumer); and
  - seek to form a collaborative relationship between the treatment team and family.

Adapted from Mueser, K., Torrey, W.C., Lynde, D., Singer, P. & Drake, R.E. (2003) and from the Substance Abuse Treatment for Persons With Co-Occurring Disorders, TIP 42

Issues in Evidence-Based Practices
Context

When the circumstances surrounding the application of the practice change to the extent that the practice must be modified, the original evidence or consensus base may well prove to be insufficient. Specifically, the generalization of findings across settings and populations can be problematic when:

- the supporting evidence has been accumulated in the treatment of one disorder, but the application in question is for treatment of clients with combined or multiple disorders;
- the supporting evidence has been established in one field (either the mental health field or the substance abuse field), but the application of the treatment technique is in the other;
- the supporting evidence has been demonstrated for a co-occurring disorders population with particular characteristics (e.g., homeless) and in a particular setting (e.g., shelters), but the application in question is among a co-occurring disorders group of clients with differing characteristics (women and children) and/or in another setting (prisons);
- the supporting evidence has been found to be effective among a subgroup of clients with co-occurring disorders who have specific demographic characteristics, but the application is to be generalized to another subgroup who have different background characteristics (e.g., age, culture, language).

Issues in Evidence-Based Practices
Transferability

Even once established across a range of client groups and settings, the transferability of treatment techniques and models is not assured. Determining factors include:

- a treatment strategy must match the needs and functioning of the clients— as with any treatment intervention, the course of treatment proposed must be jointly embraced (or at least tolerated) by both the client and the clinician;
- the successful application of an evidence-based practice requires both skills building and organizational readiness— support structures and institutional commitment, as well as staff skills, need to be considered before deciding to implement an evidence-based practice;
- the cost and personnel required for a given treatment must not exceed the capacity of the treatment setting; similarly, new initiatives must conform to policy constraints that influence program functioning— e.g., financial rewards or vouchers may be an effective strategy for encouraging program compliance, but may also be a practice that is unacceptable to program governing bodies;

Adapted from COCE Overview Paper Consensus- and Evidence-Based Practices

Issues in EBP Transferability *(continued)*

- the tendency is to assume more robust treatment effects than can be produced; unrealistically optimistic promises must be guarded against, even when the treatment technique or model has clear evidentiary support— in general, psychosocial interventions have weak to moderate effects (which may be one reason why repeated episodes of care appear beneficial), and a specific individual's response to treatment is not assured. A magic bullet has not been found for the treatment of substance abuse or co-occurring disorders, although addiction treatment outcomes are no less positive than those for diabetes, asthma, and hypertension (McLellan, Lewis, O'Brien & Kleber, 2000);
- evidence-based practice evaluations must assess the intervention's usefulness in "real world" community programs, and additional study may be necessary to determine the effectiveness of research-based interventions in community-based program settings— efficacy established in federally funded research does not necessarily equate with effectiveness in real world settings, at least partly because studies typically use highly qualified treatment staff under close supervision to preserve the fidelity of the intervention, conditions that are not common to clinical settings.

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Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders

Overview Paper 2

COCE
SAMHSA's Co-Occurring Center for Excellence

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Center for Substance Abuse Treatment
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About COCE and COCE Overview Papers

The Co-Occurring Center for Excellence (COCE), funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a leading national resource for the field of co-occurring mental health and substance use disorders (COD). COCE's mission is threefold: (1) to receive and transmit advances in treatment for all levels of COD severity, (2) to guide enhancements in the infrastructure and clinical capacities of service systems, and (3) to foster the infusion and adoption of evidence- and consensus-based COD treatment and program innovations into clinical practice. COCE consists of national and regional experts including COCE Senior Staff, Senior Fellows, Steering Council, affiliated organizations (see inside back cover), and a network of more than 200 senior consultants, all of whom join service recipients in shaping COCE's mission, guiding principles, and approaches. COCE accomplishes its mission through technical assistance and training, delivered through curriculums and materials online, by telephone, and through in-person consultation.

COCE Overview Papers are concise and easy-to-read introductions to state-of-the-art knowledge in COD. They are anchored in current science, research, and practices. The intended audiences for these overview papers are mental health and substance abuse administrators and policymakers at State and local levels, their counterparts in American Indian tribes, clinical providers, other providers, and agencies and systems through which clients might enter the COD treatment system. For a complete list of available overview papers, see the back cover.

For more information on COCE, including eligibility requirements and processes for receiving training or technical assistance, direct your e-mail to coce@samhsa.hhs.gov, call (301) 951-3369, or visit COCE's Web site at www.coce.samhsa.gov.

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SUMMARY

Screening, assessment, and treatment planning (see Table 1, Key Definitions) constitute three interrelated components of a process that, when properly executed, informs and guides the provision of appropriate, client-centered services to persons with co-occurring disorders (COD). Clients with COD are best served through an integrated screening, assessment, and treatment planning process that addresses both substance use and mental disorders, each in the context of the other. This paper discusses the purpose, appropriate staffing, protocols, methods, advantages and disadvantages, and processes for integrated screening, assessment, and treatment planning for persons with COD as well as systems issues and financing.

INTRODUCTION

Screening and assessment instruments are tools for information gathering, as are laboratory tests. However, the use of these tools alone does not constitute screening or assessment. Screening and assessment must allow flexibility within their formalized structures, balancing the need for consistency with the need to respond to important differences among clients. Screening and assessment data provide information that is evaluated and processed by the clinician and the client in the treatment planning process.

Screening, assessment, and treatment planning are not stand-alone activities. They are three components of a process that may be conducted by different agencies. Effective information sharing and following of clients most frequently occurs in systems where relevant agencies have a formal network, cross-training for staff, and formal procedures for information sharing and referral.

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LITERATURE HIGHLIGHTS

Integrated screening, assessment, and treatment planning (see Table 1, Key Definitions):

> . . . begins at the earliest point of contact with the client, [and] continues through the relapse prevention stage. Information regarding a client's substance abuse and functional adjustment is gathered throughout the treatment process, along with evidence regarding the effects of interventions (or lack thereof). Treatment plans are then modified accordingly (Mueser et al., 2003, p. 49).

A compendium of relevant COD screening and assessment instruments can be found in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Appendixes G and H, pages 487–512 (Center for Substance Abuse Treatment [CSAT], 2005).

Table 1: Key Definitions

Screening	Determines the likelihood that a client has co-occurring substance use and mental disorders or that his or her presenting signs, symptoms, or behaviors may be influenced by co-occurring issues. The purpose is not to establish the presence or specific type of such a disorder, but to establish the need for an in-depth assessment. Screening is a formal process that typically is brief and occurs soon after the client presents for services.
Assessment	Gathers information and engages in a process with the client that enables the provider to establish (or rule out) the presence or absence of a co-occurring disorder. Determines the client's readiness for change, identifies client strengths or problem areas that may affect the processes of treatment and recovery, and engages the client in the development of an appropriate treatment relationship.
Treatment Planning	Develops a comprehensive set of staged, integrated program placements and treatment interventions for each disorder that is adjusted as needed to take into account issues related to the other disorder. The plan is matched to the individual needs, readiness, preferences, and personal goals of the client.
Integrated Screening, Assessment, and Treatment Planning	Screening, assessment, and treatment planning that address both mental health and substance abuse, each in the context of the other disorder.

A vast amount of literature exists on screening, assessment, and treatment planning in substance abuse treatment and an equally vast amount in mental health settings. Considerably less material has been published on screening, assessment, and treatment planning specifically addressing persons with (or suspected of having) COD. However, a clinically meaningful and useful screening, assessment, and treatment planning process will necessarily include procedures, practices, and tools drawn from both the substance abuse and mental health fields.

Clients with COD are best served when screening, assessment, and treatment planning are integrated, addressing both substance abuse and mental health disorders, each in the context of the other. Diagnostic certainty cannot be the basis for service planning and design, and COCE encourages the use of a broad definition of COD based on client service needs. For example, some clients' mental health and substance abuse problems may not, at a given point in time, fully meet the criteria for diagnoses in categories from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000). Nonetheless, they would be included in a broad definition of COD to allow responses to the real needs of consumers.

The process of integrated screening, assessment, and treatment planning will vary depending on the information available at the time of initial contact with the client. The special challenge of screening, assessment, and treatment planning in COD is to explore, determine, and respond to the effects of two mutually interacting disorders. Because neither substance abuse nor mental illness should be considered primary for a person with COD (Lehman et al., 1998; Mueser et al., 2003), an existing diagnosis of mental illness or substance abuse is a point of departure only.

The complexity of COD dictates that screening, assessment, and treatment planning cannot be bound by a rigid formula. Rather, the success of this process depends on the skills and creativity of the clinician in applying available procedures, tools, and laboratory tests and on the relationships established with the client and his or her intimates.

KEY QUESTIONS AND ANSWERS

Overview Question

1. How do screening, assessment, and treatment planning relate to one another?

Figure 1 (page 3) summarizes the relationships among screening, assessment, and treatment planning and their usual ordering in time. Note the iterative relationship between treatment planning and assessment. Rather than being one-time events, these activities constitute a process of continual refinement and adaptation to changing client circumstances. Figure 1 introduces the concept of *Contact* (see left-hand side of the figure), which refers to the fact that there is "no wrong door" through which a client can enter the COD system of care. The capacity for screening and the ability to recognize that some form of assistance is required should be available at any point in the service system (CSAT, 2000).

Integrated Screening (see Table 1, Key Definitions, page 1)

1. What is the purpose of integrated screening?

Integrated screening addresses both mental health and substance abuse, each in the context of the other disorder. Integrated screening seeks to answer a yes/no question: "Is there sufficient evidence of a substance use and/or other mental disorder to warrant further exploration?" A comprehensive screening process also includes exploration of a variety of related service needs including medical, housing, victimization, trauma, and so on. In other words, screening expedites entry into appropriate services. At this point in the screening, assessment, and treatment planning process, the goal is to identify everyone who *might* have COD and related service needs.

2. Who is responsible for integrated screening and in what settings does it occur?

There are seldom any legal or professional restraints on who can be trained to conduct a screening. If properly trained staff are available, integrated screening can occur in any health or human services context as well as within the criminal justice, homeless services, and educational systems. The broader the range of relevant contexts in which screening can occur in a given community, the greater the probability that persons with COD will be identified and referred for further assessment and treatment. Ideally, screening should take place in a wide variety of settings.

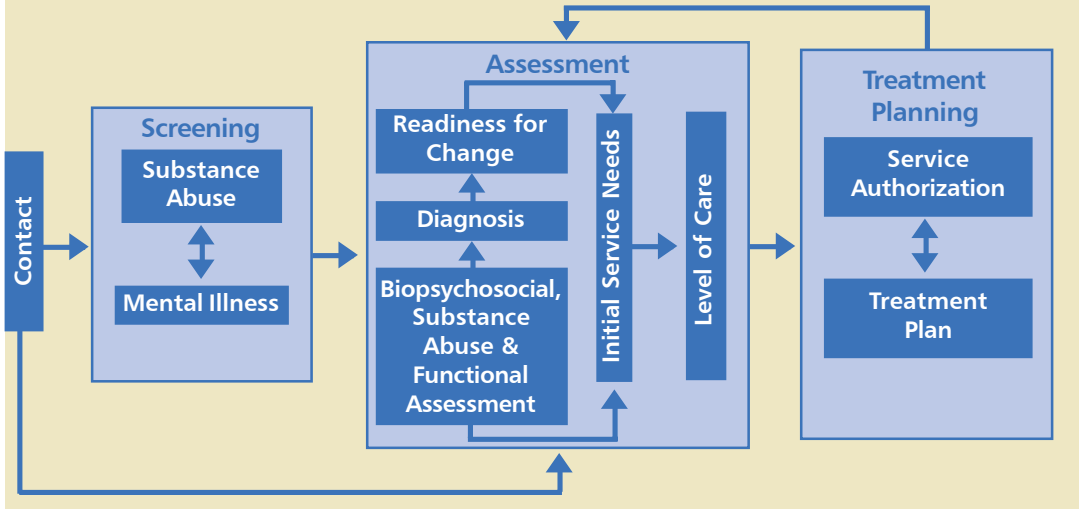
3. What protocols are allowed in conducting an integrated screening?

Any screening protocols, including integrated screening, must specify the methods to be followed and the questions to be asked. If tools or instruments are to be used, integrated screening protocols must indicate what constitutes scoring positive for a specific potential problem (often called "establishing cut-off scores"). Additionally, the screening protocol must detail exactly what is to take place when the client scores in the positive range (e.g., where the client is to be referred for further assessment). Finally, a screening protocol should provide a format for recording the results of the screening, other relevant client information, and the disposition of the case. See also TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005).

4. *What methods are used to conduct an integrated screening?*

Information-gathering methods for screening may include screening instruments, laboratory tests, clinical interviews, and personal contact. The circumstances of contact, the client's demeanor and behavior, signs of acute intoxication, physical signs suggesting drug use or attempts at self-harm, and information offered spontaneously by the client or intimates can be indicators of substance use and/or mental disorders.

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



5. *What are the advantages and disadvantages of screening instruments?*

Screening instruments can be an efficient form of information gathering. **A compendium of relevant screening instruments can be found in TIP 42, Appendixes G and H, pages 487–512 (CSAT, 2005).** The advantages of using screening tools are the simplicity of their use and scoring, the generally limited training needed for their administration, and, for well-researched tools, a known level of reliability and the availability of cut-off scores. One disadvantage of screening instruments is that they sometimes become the *only* component of the screening process. A second disadvantage is that a routinely administered screening instrument provides little opportunity to establish a connection with the client. Such a connection may be important in motivating the client to accept a referral for assessment if needed.

6. *Is there one right integrated screening process for all clients?*

Both the screening process and the interpretation of screening information will depend on the client's language of preference, culture, and age. For all of these reasons, the screening process must allow flexibility within its formalized structure, balancing the need for consistency with the need to respond to important differences among clients.

Integrated Assessment (see Table 1, Key Definitions, page 1)

1. *What is the purpose of integrated assessment?*

Like integrated screening, integrated assessment addresses both mental health and substance abuse, each in the context of the other disorder. Integrated assessment seeks to (1) establish formal diagnoses (see the COCE Overview Paper titled "Definitions and Terms Relating to Co-Occurring Disorders"), (2) evaluate level of functioning (i.e., current cognitive capacity, social skills, and other abilities) to identify factors that could interfere with the ability to function independently and/or follow treatment recommendations, (3) determine the client's readiness for change, and (4) make initial decisions about appropriate level of care. Integrated assessment also should consider cultural and linguistic issues, amount of social support, special life circumstances (e.g., women with children), and medical conditions (e.g., HIV/AIDS, tuberculosis) that may affect services choices and the client's ability to profit from them.

The assessment process should be client-centered in order to fully motivate and engage the client in the assessment and treatment process. *Client-centered* means that the client's perceptions of his or her problem(s) and the goals he or she wishes to accomplish are central to the assessment and to the recommendations that derive from it.

2. *Who is responsible for integrated assessment, and in what settings does it occur?*

Integrated assessment may be conducted by any mental health or substance abuse professional who has the specialized training and skills required. DSM-IV-TR diagnosis is accomplished by referral to a psychiatrist, clinical psychologist, licensed clinical social worker, or other qualified healthcare professional who is licensed by the State to diagnose mental disorders. Note that certain assessment instruments can only be obtained and administered by a licensed psychologist. In some cases (e.g., persons without a confirmed diagnosis of either a substance use or mental health disorder, and persons with additional special needs such as homeless or dependent adults), an assessment team including substance abuse and mental health professionals and other service providers may be needed to complete the assessment. Generally, assessment occurs in a mental health or substance abuse treatment

facility. In some cases, communities or large systems within communities (e.g., the corrections system) may establish freestanding assessment centers.

3. *What protocols are followed in conducting an integrated assessment?*

As shown in Table 2, there are 12 specific steps in the assessment process. Chapter 4 in TIP 42 (CSAT, 2005) describes these steps in detail. Through these steps, the assessment seeks to accomplish the following aims:

- Obtain a detailed chronological history of past symptoms, diagnoses, treatment, and impairment for both mental health and substance abuse.
- Obtain a detailed description of current strengths, supports, limitations, and cultural barriers related to following the recommended treatment regimen for any disorder or problem.
- Determine stage of change for *each problem*. (If a clinician is asked, "What stage of change is the client in?" the correct answer is *always*, "For which problem?")
- Identify social supports and other factors that might help promote treatment adherence.
- Find out what clients want, in terms of their perception of the problem, what they want to change, and how they think that change will occur.

The assessment for COD is integrated by analyzing data concerning one disorder in light of data concerning the other disorder. For example, attention to mental health symptoms, impairments, diagnoses, and treatments during past episodes of substance abuse and abstinence can illuminate the role of substance abuse in maintaining, worsening, and/or interfering with the treatment of any mental disorder.

4. *What methods are used to conduct an integrated assessment?*

An assessment may include a variety of information-gathering methods including the administration of assessment instruments, an in-depth clinical interview, a social history, a treatment history, interviews with friends and family after receipt of appropriate client authorization(s), a review of medical and psychiatric records, a physical examination, and laboratory tests (toxicology screens, tests for infectious diseases and organ system damage, etc.).

5. *What are the advantages and disadvantages of assessment instruments?*

Assessment instruments constitute a structured method for gathering information in many areas, and for establishing assessment scores that define problem areas. **Appendix G, pages 487–495 of TIP 42 (CSAT, 2005) provides relevant examples of instruments that may be used in the assessment of COD.** Assessment instruments also can function as "ticklers" or memory aids to the clinician or team, assisting in making sure that all relevant topics are covered. Assessment instruments should be viewed as providing information that is part of the assessment process. They do not themselves constitute an assessment. In particular, instruments do not accomplish the interpersonal goals of assessment: making the client feel welcome in the treatment system, engaging the client as an active partner in his or her care, and beginning the therapeutic alliance that will exist throughout the client's relationship with helping resources.

Table 2: The 12-Step Assessment Process

1. Engage the client
2. Upon receipt of appropriate client authorization(s), identify and contact collaterals (family, friends, other treatment providers) to gather additional information
3. Screen for and detect COD
4. Determine severity of mental and substance use disorders
5. Determine appropriate care setting (e.g., inpatient, outpatient, day-treatment)
6. Determine diagnoses
7. Determine disability and functional impairment
8. Identify strengths and supports
9. Identify cultural and linguistic needs and supports
10. Identify additional problem areas to address (e.g., physical health, housing, vocational, educational, social, spiritual, cognitive, etc.)
11. Determine readiness for change
12. Plan treatment

6. *Is there one correct integrated assessment process for all clients?*

No, there is not. The integrated assessment process must be tailored to the needs of the specific client. For example:

- Cultural identity may play a significant role in determining the client's (and his or her intimates') view of the problem and the treatment. Ethnic culture may affect perception of what constitutes a "problem," the meaning of help seeking, and attitudes toward caregivers and institutions.
- Members of some nonethnic subcultures (e.g., sex workers, gang members) may hold beliefs and values that are unfamiliar to nonmembers.
- Clients may participate in treatment cultures (12-Step recovery, Dual Recovery Self-Help, various alternative healing practices) that affect how they view treatment and treatment providers.
- A client's sexual orientation and family situation will enhance understanding of the client's personal identity, living situation, and relationships.

Integrated Treatment Planning (See Table 1, Key Definitions, page 1)

1. What is the process of integrated treatment planning, and how does this process relate to integrated screening and assessment?

Integrated treatment planning addresses both mental health and substance abuse, each in the context of the other disorder. During integrated treatment planning phases, initial decisions are made about what services the client needs and wants, where these services will be provided, who will share responsibility with the client for monitoring progress, how the services of different providers will be coordinated, and how services will be reimbursed. The latter will sometimes involve seeking service authorization to obtain reimbursement, which may, in turn, place constraints on the treatment plan or require revisions of it. Treatment planning should be client centered, addressing clients' goals and using treatment strategies that are acceptable to them.

Screening and assessment data provide information that is integrated by the clinician and the client in the treatment planning process. Screening and assessment data also are useful in establishing a client's baseline of signs, symptoms, and behaviors that can then be used to assess progress.

Table 3 (adapted from Mueser et al., 2003) describes the components of a client-centered treatment plan. The treatment plan is never a static document. As changes in the client's status occur and as new relevant information comes to light, the treatment plan must be reconsidered and adjusted.

2. Who is responsible for integrated treatment planning?

The client-centered treatment plan is the joint responsibility of the clinician or clinical team and *the client*. The client-centered plan is guided by what the client wishes to accomplish and the methods that are acceptable to him or her. In systems where care is managed, some aspects of the plan may require authorization by payors. Securing service authorization is the responsibility of the providers. If a provider is unable to obtain service authorization, the client and the provider should explore together what possible modifications to the treatment plan will best meet the client's needs and satisfy reimbursement requirements.

Systems Issues and Financing

1. Why is service integration crucial to screening, assessment, and treatment planning?

Screening, assessment, and treatment planning are not stand-alone activities. They are three components of a treatment process. Screening, assessment, and treatment planning may be conducted by multiple agencies. Information must be shared accurately and efficiently between agencies, while conforming to Federal confidentiality laws. Equally important, making referrals among agencies requires monitoring to ensure that clients referred actually arrive at the referral site and receive needed services. Effective information sharing and tracking of clients most likely occurs in systems where relevant agencies have formal relationships (e.g., memoranda of understanding), receive cross-training,

Table 3: The Components of a Client-Centered Treatment Plan (adapted from Mueser et al., 2003)

Acute Safety Needs	Determines the need for immediate acute stabilization to establish safety prior to routine assessment
Severity of Mental and Substance Use Disorders	Guides the choice of the most appropriate setting for treatment
Appropriate Care Setting	Determines the client's program assignment (see American Society of Addiction Medicine, 2001)
Diagnosis	Determines the recommended treament intervention
Disability	Determines case management needs and whether an enhanced level of intervention is required
Strengths and Skills	Determines areas of prior success around which to organize future treatment interventions and determines areas of skill-building needed for management of either disorder
Availability and Continuity of Recovery Support	Determines whether continuing relationships need to be established and availability of existing relationships to provide contingencies to promote learning
Cultural Context	Determines most culturally appropriate treatment interventions and settings
Problem Priorities	Determines problems to be solved specifically, and opportunities for contingencies to promote treatment participation
State of Recovery/ Client's Readiness to Change Behaviors Relating to Each Problem	Determines appropriate treatment interventions and outcomes for a client at a given stage of recovery or readiness for change (see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT, 1991])

and have formal procedures for information sharing and referral.

2. How are screening, assessment, and treatment planning reimbursed?

In healthcare settings (mental health, substance abuse, primary care, etc.), screening may be reimbursed as part of an initial visit. In other settings (criminal justice, schools, homeless services), screening activities are not likely to be "reimbursed" as they are usually conducted by a salaried employee (e.g., probation officer, school psychologist) who is performing screening services on behalf of an agency that mandates or allows screening to be conducted in the ordinary course of its business.

Assessment is a necessary part of treatment and accordingly may be reimbursed as part of the services provided by a qualified treatment program. However, cases may arise in which the costs of assessment are not completely reimbursable.

In some instances, not all treatment services required by persons with COD will be reimbursable or reimbursable at intensities or durations commensurate with the integrated treatment plan. Significant variations exist within States and among health plans concerning the nature and type of behavioral health services that are covered. In cases where reimbursement is unavailable or inadequate, providers must arrive at alternate treatment plans in concert with their clients, and document the adequacy and goals of the alternate plan.

3. What is the legal exposure for a program that identifies problems in the screening and assessment process for which the program cannot provide treatment?

Not all programs are expected to be able to treat every type of disorder, even if those disorders are identified by the program's screening and assessment procedures. To avoid negative legal consequences and fulfill ethical obligations to clients, at a minimum, programs must be able to refer clients with identified disorders or combinations of disorders for appropriate treatment.

FUTURE DIRECTIONS

The technology of screening, assessment, and treatment planning for COD is constantly under refinement. One pressing need is for screening, assessment, and treatment planning protocols that are designed to meet the needs of a variety of special populations, including adolescents; lesbian, gay, and bisexual individuals; women with children; and older adults. The processes of knowledge transfer and adoption must also be better refined to facilitate the widespread and informed use of valid and reliable screening and assessment instruments, and treatment planning protocols.

At the system level, policies and regulations can encourage standardized, integrated screening, assessment, and treatment planning processes to increase the provision of appropriate services to people with COD and to enable outcomes-monitoring across programs. Encouraging trends in this regard are to be found in several States that are moving toward statewide screening and assessment standards.

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SAMHSA's Co-Occurring Center for Excellence

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A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
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Understanding Evidence-Based Practices for Co-Occurring Disorders

Overview Paper 5

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About COCE and COCE Overview Papers

The Co-Occurring Center for Excellence (COCE), funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a leading national resource for the field of co-occurring mental health and substance use disorders (COD). The mission of COCE is threefold: (1) to receive and transmit advances in treatment for all levels of COD severity, (2) to guide enhancements in the infrastructure and clinical capacities of service systems, and (3) to foster the infusion and adoption of evidence- and consensus-based COD treatment and program innovations into clinical practice. COCE consists of national and regional experts including COCE Senior Staff, Senior Fellows, Steering Council, affiliated organizations (see inside back cover), and a network of more than 200 senior consultants, all of whom join service recipients in shaping COCE's mission, guiding principles, and approaches. COCE accomplishes its mission through technical assistance and training, delivered through curriculums and materials on-line, by telephone, and through in-person consultation.

COCE Overview Papers are concise and easy-to-read introductions to state-of-the-art knowledge in COD. They are anchored in current science, research, and practices. The intended audiences for these OPs are mental health and substance abuse administrators and policymakers at State and local levels, their counterparts in American Indian tribes, clinical providers, other providers, and agencies and systems through which clients might enter the COD treatment system. For a complete list of available overview papers, see the back cover.

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SUMMARY

The advantages of employing evidence-based practices (EBPs) (see Table 1, Key Definitions) are now widely acknowledged across the medical, substance abuse (SA), and mental health (MH) fields. This overview paper discusses EBPs and their role in the treatment of co-occurring disorders (COD).

Practitioners seldom have as much evidence as they would like about the best clinical approach to use in any given clinical situation. To choose the optimal approach for each client, clinicians must draw on research, theory, practical experience, and a consideration of client perspectives. Picking the best option at the moment using the best information available has been termed "evidence-based thinking" (Hyde et al., 2003) (see Table 1, Key Definitions).

This paper discusses EBPs and their use in treating persons with COD, discusses how evidence (see Table 1, Key Definitions) is used to determine if a given practice should be labeled as evidence based, and gives some brief examples of EBPs for COD.

There is still considerable debate concerning how EBPs should be defined. This paper presents various points of view and offers COCE's perspective as a starting point for further discussion by the field.

LITERATURE HIGHLIGHTS

Both researchers and practitioners increasingly perceive EBPs as essential for improving treatment effectiveness in the medical, SA, and MH fields. The use of EBPs permits clinicians and programs to more reliably improve services and achieve optimal outcomes. In substance abuse treatment, EBPs have influenced service delivery in areas ranging from initial engagement (e.g., in the use of motivational enhancement strategies) to community re-entry (e.g., in the focus on cognitive-behavioral strategies for relapse prevention). The National EBP Project (e.g., Torrey et al., 2001) exemplifies the focused attention on translating science to service that is taking place for the treatment of persons with serious mental illnesses in mental health systems.

The earliest definitions of EBPs emphasized scientific research and contrasted scientific evidence with approaches based on "global subjective judgment," consensus, preference, and other forms of "nonrigorous" assessment (Eddy, 2005). This "research only" approach was recently rearticulated for the field of mental health by Kihlstrom (2005): "Scientific research is the only process by which clinical psychologists and mental health practitioners should determine what evidence guides EBPs" (p. 23).

Critics of the "research only" approach note that the true performance of an intervention often remains uncertain even when research evidence is available (Claxton et al., 2005), that certain types of interventions are more amenable to research than are others and are therefore more likely to be supported by research evidence (Reed, 2005), and that definitions of successful outcomes are not universally shared, especially in behavioral health (Messer, 2005). Reed (2005) suggests that the dichotomy between research and "everything else" in defining EBPs unnecessarily restricts the definition of evidence and precludes important knowledge based on nonexperimental research (e.g., case studies) and clinical and patient

Table 1: Key Definitions

Evidence-Based Practice	A practice which, based on research findings and expert or consensus opinion about available ***evidence***, is expected to produce a specific clinical outcome (measurable change in client status).
Evidence-Based Thinking	A process by which diverse sources of information (research, theory, practice principles, practice guidelines, and clinical experience) are synthesized by a clinician, expert, or group of experts in order to identify or choose the optimal clinical approach for a given clinical situation.
Evidence	Facts, theory, or subject matter that support or refute the claim that a given practice produces a specific clinical outcome. Evidence may include research findings and expert or consensus opinions.
Expert Opinion	A determination by an expert, through a process of ***evidence-based thinking***, that a given practice should or should not be labeled "evidence based."
Consensus Opinion	A determination reached collectively by more than one expert, through a process of ***evidence-based thinking***, that a given practice should or should not be labeled "evidence based."
Strength of Evidence	A statement concerning the certainty that a given practice produces a specific clinical outcome.

experiences. It has also been argued that clinical decisionmaking (Messer, 2005) and health policy (Atkins et al., 2005) involve factors and trade-offs related to patient and community values, culture, and competing priorities that are not generally informed by research. An alternative to the "research only" approach that addresses these concerns is the "multiple streams of evidence" approach (Reed, 2005).

The Institute of Medicine (IOM; 2001) suggests a definition of EBPs that reflects the "multiple streams of evidence" approach. The IOM argues for three components of EBPs:

1. **Best research evidence**—the support of clinically relevant research, especially that which is patient centered
2. **Clinician expertise**—the ability to use clinical skills and past experience to identify and treat the individual client
3. **Patient values**—the integration into treatment planning of the preferences, concerns, and expectations that each client brings to the clinical encounter

These "streams of evidence" can be integrated through "evidence-based thinking" (see Table 1, Key Definitions). Evidence-based thinking may be undertaken to designate practices as evidence based or in day-to-day clinical decisionmaking. See Messer (2005) for two case-based examples of evidence-based thinking in clinical practice; see Atkins and colleagues (2005) for examples related to health policy.

KEY QUESTIONS AND ANSWERS

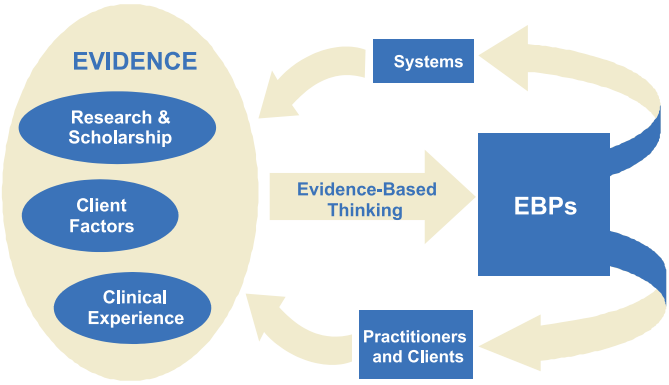
1. *What do we mean by evidence-based practices for co-occurring disorders?*

COCE has adopted the "multiple streams of evidence" approach to EBPs discussed above. COCE also takes the position that the integration of multiple streams of evidence requires the application of evidence-based thinking. Accordingly, EBPs are defined by COCE as practices which, based on expert or consensus opinion about available evidence, are expected to produce a specific clinical outcome (i.e., measurable change in client status). Figure 1 illustrates the process by which streams of evidence (i.e., research and scholarship, client factors, and clinical experience) are combined using evidence-based thinking to arrive at recommendations concerning EBPs. The systems, practitioners, and clients who use these EBPs contribute to the evidence base for future evidence-based thinking.

2. *How much evidence is needed before a practice can be called an EBP?*

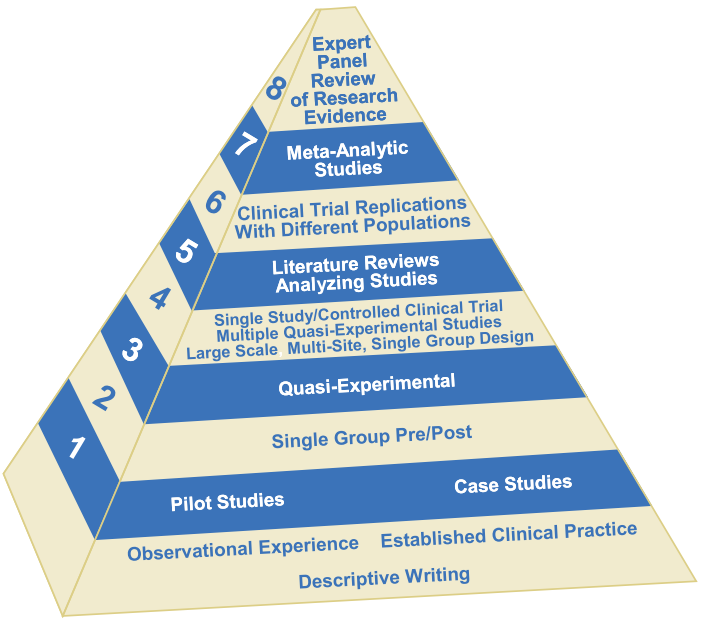
There is no simple answer to this question. In general, the designation of a practice as an EBP derives from a review of research and other evidence by experts in the field (see Question 1). Different organizations use different processes and standards to determine whether or not practices are evidence based.

Figure 1: Evidence-Based Thinking



The key question in determining whether a practice is evidence based is: What is the strength of evidence indicating that the practice leads to a specific clinical outcome? There is no gold standard for assessing strength of evidence, especially evidence derived from clinical experience. However, COCE has developed a pyramid to represent the level or strength of evidence derived from various research activities. As can be seen in Figure 2, evidence may be obtained from a range of studies including preliminary pilot investigations and/or case studies through rigorous clinical trials that employ experimental designs. Higher levels of research evidence derive from literature reviews that analyze studies selected for their scientific merit in a particular treatment area, clinical trial replications with different populations, and meta-analytic studies of a body of research literature. At the highest level of the pyramid are expert panel reviews of the research literature.

Figure 2: Pyramid of Evidence-Based Practices



In evaluating evidence, it is important to understand the distinction between efficacy and effectiveness. Efficacy means that a treatment or intervention produces positive results in a controlled experimental research trial. Effectiveness means that treatment or intervention produces positive results in a usual or routine care setting (i.e., in the real world). Efficacy established in controlled research does not necessarily equate with effectiveness in real world settings. For example, it may be impractical to provide real world clinicians with the level of training and supervision provided to clinicians in research studies, or real world target populations and community contexts may differ from those used in the research.

3. Why should EBPs be used?

There are several reasons to use EBPs. Foremost, when services are informed by the best available evidence, the quality of care is improved. Second, using EBPs increases the likelihood that desired outcomes will be obtained. EBPs that are based upon research typically have carefully described service components, and many have manuals to guide their implementation. This supports consistent delivery of the practice and high fidelity to the model. Third, by employing these practices, providers will often more efficiently use available resources.

4. What are the differences among EBPs, "consensus-based practices," "science-based practices," "best practices," "promising practices," "emerging practices," "effective programs," and "model programs"?

A number of terms have been used at different times, and by different groups, to describe practices that are expected to produce a specific clinical outcome. These terms are somewhat interchangeable. The terms "promising" and "emerging" are consistent with the notion that the strength of evidence varies among practices deemed likely to produce specific clinical outcomes. COCE avoids descriptors like "best" and "model" because they may imply that there is a single best approach to treating all persons with COD. COCE also avoids the term "effective" because no hard criterion exists for the level of evidence by which "effectiveness" is established.

The term "consensus based" refers to a process by which evidence is commonly evaluated and synthesized to determine if a given practice is an EBP. Other common processes include evaluation of evidence using standardized criteria and numerical scores, meta-analysis, and synthesis by a single scholar. COCE views the consensus process as the best way to identify and evaluate EBPs.

5. Is all manualized treatment evidence-based treatment? Have all EBPs been manualized?

Just because a practice is documented in manual form does not mean it has risen to the level of an EBP. Manual development can be an early step in outcome research, and that research may show the manualized treatment to be ineffective. Moreover, manuals are sometimes developed as marketing tools for treatments that have undergone little research.

However, once an EBP is established, the development of treatment manuals and practice guidelines are an important part of the dissemination process and help make the EBP accessible to providers. Manuals can minimize the need for costly trainings and often contain fidelity measures and outcome assessment strategies. They can also improve clinical decisionmaking by laying out guidelines for critical circumstances. Practice manuals vary in their level of detail and may not be useful as stand-alone products. Not all EBPs have manuals, but many do.

6. What is EBP fidelity and why does it matter?

Fidelity is the extent to which a treatment approach as actually implemented corresponds to the treatment strategy as designed. Following the initial design with high fidelity is expected to result in greater success in achieving desired client outcomes than deviating from the design (i.e., having low fidelity).

7. What are some evidence-based practices for co-occurring disorders?

Because the treatment of COD is a relatively new field, there has not been time for the development and testing of a large number of EBPs specifically for clients with COD. Clearly, EBPs developed solely for MH or SA should be considered in the treatment of people with COD.

EBPs for COD should combine both treatment elements (e.g., the use of motivational strategies) and programmatic elements (e.g., composition of multidisciplinary teams). COCE has outlined the critical components of COD practices (see Overview Paper 3, Overarching Principles) that should guide the selection of these elements.

At the *treatment level*, interventions that have their own evidence to support them as EBPs are frequently a part of a comprehensive and integrated response to persons with COD. These interventions include:

- Psychopharmacological Interventions (e.g., desipramine and bupropion for people with cocaine dependence and depression [Rounsaville, 2004])
- Motivational Interventions (e.g., motivational enhancement therapy [Miller, 1996; Miller & Rollnick, 2002])
- Behavioral Interventions (e.g., contingency management [Roth et al., 2005; Shaner et al., 1997])

At the *program level*, the following models have an evidence base for producing positive clinical outcomes for persons with COD:

- Modified Therapeutic Communities (CSAT, 2005; De Leon et al., 2000; Sacks et al., 1998, 1999)

- Integrated Dual Disorders Treatment (CMHS, 2003; Drake et al., 1998b, 2004; Mueser et al., 2003)
- Assertive Community Treatment (Drake et al., 1998a; Essock et al., 2006; Morse et al., 1997; Wingerson & Ries, 1999)

The current state of the science highlights the need for evidence-based thinking in making both programmatic and clinical decisions in the treatment of people with COD.

8. How can I learn about new developments in EBPs?

At SAMHSA, the National Registry of Effective Programs and Practices (NREPP) is a decision-support tool that assesses the strength of evidence and readiness for dissemination of a variety of mental health and substance abuse prevention and treatment interventions. The NREPP system is available through a new Web site (www.nationalregistry.samhsa.gov). In Great Britain, the Cochrane Collaborative maintains the Cochrane Library, which contains regularly updated evidence-based healthcare databases (see www.cochrane.org) on a comprehensive array of health practices. Relevant specialty organizations (e.g., American Psychological Association) also publish lists of evidence-based practices. These compilations of programs and interventions may be generalizable to persons with COD, and the reader should look for specific reference to COD populations.

9. What issues should be considered in the use of EBPs?

Most EBPs are not universally applicable to all communities, treatment settings, and clients. If communities, treatment settings, and/or clients vary from those for which the EPB is designed, or if the human and facilities resources needed for the EBP are not available, effectiveness may be reduced. The various issues that must be considered in the use of an evidence-based practice include:

- Client population characteristics including culture, socioeconomic status, and the existence of other health and social issues that may complicate service delivery (e.g., pregnancy, incarceration, disabilities)
- Staff attitudes and skills required by the EBP
- Facilities and resources required by the EBP
- Agency policies and administrative procedures needed to support the EBP
- Interagency linkages or networks to provide needed additional services (e.g., vocational, educational, housing assistance, etc.)
- State and local regulations
- Reimbursement for the specific services to be provided under the EBP

10. Are there financial incentives to use EBPs? Are there components of EBPs that are not reimbursable?

The financing of EBPs for COD varies greatly by State. Some States (e.g., New York) have included evidence-based practice language in their licensing and regulation standards to create an incentive for providers receiving State support to use EBPs (New York State Office of Mental Health, 2005). Other States now require that programs demonstrate the use of EBPs in order to receive funding. In Oregon, for example, programs that receive State funds must show that a percentage of those funds are used to pay for EBPs (Oregon Department of Human Services, 2005).

For evidence-based program model EBPs, like assertive community treatment, some States will use Medicaid dollars to support a case rate, and other States use a fee-for-service methodology to reimburse providers.

11. What should be done to facilitate/enable program administrators and staff to adopt EBPs?

The implementation of EBPs will present both psychological challenges (e.g., resistance to change, commitment to current practices) and practice challenges (e.g., need for training and supervision, need for organizational changes, new licensures or certifications). Several practical guides to facilitating adoption of new practices are available, including sections from SAMHSA's Evidence-Based Practice Implementation Resource Kits available at www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/default.asp and Module 6 of COCE's Evidence- and Consensus-Based Practice curriculum (CSAT, in development)

12. How can one bridge the gap between the diverse needs of people with COD and the limited number of EBPs?

The reality is that the number of EBPs available to the clinician is insufficient to the task of treating COD. Clients with COD present a variety of disorders, and appropriate treatment covers a wide spectrum of services—screening, assessment, engagement, intensive treatment, and re-entry. The clinician will need to use evidence-based thinking to determine the optimal course of action for each patient. As discussed earlier, inputs to evidence-based thinking include research, theory, practice principles, practice guidelines, and clinical experience.

Two documents provide substantial information to inform evidence-based thinking: TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005) and *Service Planning Guidelines: Co-Occurring Psychiatric and Substance Disorders* (Minkoff, 2001). These

documents incorporate EBPs where appropriate and emphasize recommended treatment interventions for people with COD in substance abuse treatment settings.

FUTURE DIRECTIONS

Much has been accomplished in the field of COD over the last 10 years, and a body of knowledge has been acquired that is appropriate for broad dissemination and application. There are now several well-articulated, evidence-based practices that are ready for application in clinical programs. Despite this considerable progress, far more research is needed to answer the host of questions that surround the treatment of persons with COD. Research is needed that will:

- *Survey typical treatment facilities* to understand their capabilities (with particular regard to staffing) and current activities (regarding identifying and serving clients with COD)
- *Clarify the characteristics* of those clients with COD for whom substance abuse treatment alone is not sufficient to achieve significant improvement in their substance use and mental disorders
- *Develop and test strategies to engage* clients with COD of different degrees of severity
- *Develop and test strategies to maximize adherence* to substance abuse and mental health counseling services, medication, and medical regimens
- *Clarify the optimum length of treatment* for clients with COD who manifest different severities of disorders
- *Develop and test strategies and techniques for ensuring successful transition* to continuing care (also known as aftercare) and for determining the effectiveness of different aftercare service models
- *Evaluate the dual recovery mutual self-help approaches* that are emerging nationally
- *Study the principles, practices, and processes of technology transfer* in the field of COD treatment
- *Facilitate integrated treatment through policies and workforce development strategies* that overcome legal and other barriers to the provision of a full spectrum of behavioral health services by the substance abuse treatment workforce

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