Toolbox Training: A Substance Abuse Educational Series for Mental Health Professionals  
First Edition  
Participant Guide  

Unifying science, education and service to transform lives
Toolbox Training:
A Substance Abuse Educational Series
for Mental Health Professionals     First Edition

Module 4
Clinical Evaluation:
Screening

Unifying science, education and service to transform lives
Module 4 - Clinical Evaluation: Screening

Goals and Objectives

Listed below are the goals and objectives of the module and the corresponding TAP 21 competencies.

<table>
<thead>
<tr>
<th>Module 4 Goals and Objectives</th>
<th>SAMHSA CSAT TAP 21 Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Evaluation: Screening</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong></td>
<td><strong>Clinical Evaluation</strong></td>
</tr>
<tr>
<td>Identify key elements of the co-occurring “screening” process to include alcohol and drug specific education, mental health, counselor and client rapport building, crisis management and data collection.</td>
<td>A. Screening</td>
</tr>
<tr>
<td><strong>Objectives:</strong></td>
<td></td>
</tr>
<tr>
<td>1. Introduce screening instruments and their uses</td>
<td>1. Establish rapport, including management of crisis situation and determination of need for additional professional assistance.</td>
</tr>
<tr>
<td>2. Implement motivation for change from a co-occurring perspective</td>
<td>2. Gather data systematically from the client and other available collateral sources, using screening instruments and other methods that are sensitive to age, developmental level, culture, and gender. At a minimum, data should include current and historic substance use; health, mental health, and substance related treatment history; mental status; and current social, environmental, and/or economic constraints.</td>
</tr>
<tr>
<td>3. Identify pharmacological therapies</td>
<td>3. Screen for psychoactive substance toxicity, intoxication, and withdrawal symptoms; aggression or danger to others; potential for self-inflicted harm or suicide; and coexisting mental health problems.</td>
</tr>
<tr>
<td>4. Define initial action plans specific to alcohol and drug addiction co-occurring with mental health issues</td>
<td>4. Assist the client in identifying the impact of substance use on their current life problems and the effects of continued harmful use or abuse.</td>
</tr>
<tr>
<td>5. Define DSM-IV-TR (APA, 2000) criteria for Substance Abuse Dependence from a co-occurring perspective.</td>
<td>5. Determine the client’s readiness for treatment and change as well as the needs of others involved in the current situation.</td>
</tr>
<tr>
<td></td>
<td>6. Review the treatment options that are appropriate for the client’s needs, characteristics, goals, and financial resources.</td>
</tr>
<tr>
<td></td>
<td>7. Apply accepted criteria for diagnosis of substance use disorders in making treatment recommendations.</td>
</tr>
<tr>
<td></td>
<td>8. Construct with client and appropriate others an initial action plan based on client needs, preferences, and resources available.</td>
</tr>
<tr>
<td></td>
<td>9. Based on initial action plan, take specific steps to initiate an admission or referral and ensure follow-through.</td>
</tr>
</tbody>
</table>
Module 4 - Clinical Evaluation and Screening

Pre-session Assignment

All participants to read:


Be prepared to reflect on and discuss this article at the training session.

Elective articles:


Other Alternatives:


Module 4 - Clinical Evaluation: Screening

Agenda

AGENDA “DAY ONE” – October 17th

8:30 REGISTRATION

9:00 WELCOME AND INTRODUCTIONS
   CLINICAL EVALUATION: SCREENING
   INTERACTIVE DISCUSSION: Stages of Change, Micro Skills, MI

10:45 Group Work: Journal Article
   INTERACTIVE DISCUSSION: Screening, Assessment

NOON Lunch will be served

1:00 GROUP WORK: Screening Tools
   INTERACTIVE DISCUSSION: Change, Brief Intervention, Treatment Options, Modalities, Resistance

2:00 WRAP-UP MODULE FOUR – CLINICAL EVALUATION: SCREENING

2:15 CLINICAL EVALUATION: ASSESSMENT

4:30 END OF DAY ONE

AGENDA “DAY TWO” – October 18th

8:30 REGISTRATION

9:00 WRAP-UP MODULE FIVE – CLINICAL EVALUATION: ASSESSMENT

11:15 CLINICAL EVALUATION: TREATMENT PLANNING

4:15 WRAP-UP, EVALUATION

4:30 END OF DAY TWO
## Module 4 - Handout 1

**Prochaska & DiClemente: Stages of Readiness to Change**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td>Not considering change</td>
<td>• Identify patient’s goals</td>
</tr>
<tr>
<td></td>
<td>Do not see their behavior as being a problem</td>
<td>• Provide information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bolster self-efficacy</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Ambivalent about change</td>
<td>• Develop discrepancy between goal &amp; behavior</td>
</tr>
<tr>
<td></td>
<td>Acknowledge the possibility that there is a problem</td>
<td>• Elicit self-motivational statements</td>
</tr>
<tr>
<td>Determination/Preparation</td>
<td>Committed to change</td>
<td>• Strengthen commitment to change</td>
</tr>
<tr>
<td></td>
<td>Have made a decision to change</td>
<td>• Plan strategies for change</td>
</tr>
<tr>
<td>Action</td>
<td>Involved in change</td>
<td>• Identify and manage new barriers</td>
</tr>
<tr>
<td></td>
<td>Actively implementing a plan.</td>
<td>• Recognize relapse or impending relapse</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Behavior change</td>
<td>• Assure stability of change</td>
</tr>
<tr>
<td></td>
<td>High confront level with new behavior</td>
<td>• Foster personal development</td>
</tr>
<tr>
<td>Relapse Cycle, and Recycle</td>
<td>Undesired behaviors</td>
<td>• Identify relapse when it occurs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reestablish self-efficacy and commitment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Behavioral strategies</td>
</tr>
<tr>
<td>Termination or Graduation</td>
<td>Change is very stable</td>
<td>• Assure stability of change</td>
</tr>
<tr>
<td></td>
<td>Problem behavior is resolved</td>
<td></td>
</tr>
</tbody>
</table>
Module 4 - Handout 2

A Stage Model of the Process of Change

Module 4 - Handout 3

Group Exercise - Role Play

- Divide into pairs.
  - Person One: client
  - Person Two: counselor

- Implement Screening Tools From Those Discussed
  - Reverse Roles Alternating Between Tools

  CAGE

  TWEAK

  RAPS4-QF

  MAST

  AUDIT

  SOGS

  SOGS-RA
Alcohol Metabolism

Metabolism is the body's process of converting ingested substances to other compounds. Metabolism results in some substances becoming more, and some less, toxic than those originally ingested. Metabolism involves a number of processes, one of which is referred to as oxidation. Through oxidation, alcohol is detoxified and removed from the blood, preventing the alcohol from accumulating and destroying cells and organs. A minute amount of alcohol escapes metabolism and is excreted unchanged in the breath and in urine. Until all the alcohol consumed has been metabolized, it is distributed throughout the body, affecting the brain and other tissues (1,2). As this Alcohol Alert explains, by understanding alcohol metabolism, we can learn how the body can dispose of alcohol and discern some of the factors that influence this process. Studying alcohol metabolism also can help us to understand how this process influences the metabolism of food, hormones, and medications.

When alcohol is consumed, it passes from the stomach and intestines into the blood, a process referred to as absorption. Alcohol is then metabolized by enzymes, which are body chemicals that break down other chemicals. In the liver, an enzyme called alcohol dehydrogenase (ADH) mediates the conversion of alcohol to acetaldehyde. Acetaldehyde is rapidly converted to acetate by other enzymes and is eventually metabolized to carbon dioxide and water. Alcohol also is metabolized in the liver by the enzyme cytochrome P450IIIE1 (CYP2E1), which may be increased after chronic drinking (3). Most of the alcohol consumed is metabolized in the liver, but the small quantity that remains unmetabolized permits alcohol concentration to be measured in breath and urine.

The liver can metabolize only a certain amount of alcohol per hour, regardless of the amount that has been consumed. The rate of alcohol metabolism depends, in part, on the amount of metabolizing enzymes in the liver, which varies among individuals and appears to have genetic determinants (1,4). In general, after the consumption of one standard drink, the amount of alcohol in the drinker's blood (blood alcohol concentration, or BAC) peaks within 30 to 45 minutes. (A standard drink is defined as 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof distilled spirits, all of which contain the same amount of alcohol.) The BAC curve, shown on the previous page, provides an estimate of the time needed to absorb and metabolize different amounts of alcohol (5). Alcohol is metabolized more slowly than it is absorbed. Since the metabolism of alcohol is slow, consumption needs to be controlled to prevent accumulation in the body and intoxication.

Factors Influencing Alcohol Absorption and Metabolism

Food. A number of factors influence the absorption process, including the presence of food and the type of food in the gastrointestinal tract when alcohol is consumed (2,6). The rate at which alcohol is absorbed depends on how quickly
the stomach empties its contents into the intestine. The higher the dietary fat content, the more time this emptying will require and the longer the process of absorption will take. One study found that subjects who drank alcohol after a meal that included fat, protein, and carbohydrates absorbed the alcohol about three times more slowly than when they consumed alcohol on an empty stomach (7).

**Gender.** Women absorb and metabolize alcohol differently from men. They have higher BAC's after consuming the same amount of alcohol as men and are more susceptible to alcoholic liver disease, heart muscle damage (8), and brain damage (9). The difference in BAC's between women and men has been attributed to women's smaller amount of body water, likened to dropping the same amount of alcohol into a smaller pail of water (10). An additional factor contributing to the difference in BAC's may be that women have lower activity of the alcohol metabolizing enzyme ADH in the stomach, causing a larger proportion of the ingested alcohol to reach the blood. The combination of these factors may render women more vulnerable than men to alcohol-induced liver and heart damage (11-16).

**Effects of Alcohol Metabolism**

**Body Weight.** Although alcohol has a relatively high caloric value, 7.1 Calories per gram (as a point of reference, 1 gram of carbohydrate contains 4.5 Calories, and 1 gram of fat contains 9 Calories), alcohol consumption does not necessarily result in increased body weight. An analysis of data collected from the first National Health and Nutrition Examination Survey (NHANES I) found that although drinkers had significantly higher intakes of total calories than nondrinkers, drinkers were not more obese than nondrinkers. In fact, women drinkers had significantly lower body weight than nondrinkers. As alcohol intake among men increased, their body weight decreased (17). An analysis of data from the second National Health and Nutrition Examination Survey (NHANES II) and other large national studies found similar results for women (18), although the relationship between drinking and body weight for men is inconsistent. Although moderate doses of alcohol added to the diets of lean men and women do not seem to lead to weight gain, some studies have reported weight gain when alcohol is added to the diets of overweight persons (19,20). When chronic heavy drinkers substitute alcohol for carbohydrates in their diets, they lose weight and weigh less than their nondrinking counterparts (21,22). Furthermore, when chronic heavy drinkers add alcohol to an otherwise normal diet, they do not gain weight (21).

**Sex Hormones.**

Alcohol metabolism alters the balance of reproductive hormones in men and women (23-28). In men, alcohol metabolism contributes to testicular injury and impairs testosterone synthesis and sperm production (24,29). In a study of normal healthy men who received 220 grams of alcohol daily for 4 weeks, testosterone levels declined after only 5 days and continued to fall throughout the study period (30,31). Prolonged testosterone deficiency may contribute to feminization in males,
for example, breast enlargement (32). In addition, alcohol may interfere with normal sperm structure and movement by inhibiting the metabolism of vitamin A, which is essential for sperm development (30,33). In women, alcohol metabolism may contribute to increased production of a form of estrogen called estradiol (which contributes to increased bone density and reduced risk of coronary artery disease) and to decreased estradiol metabolism, resulting in elevated estradiol levels (28). One research review indicates that estradiol levels increased in premenopausal women who consumed slightly more than enough alcohol to reach the legal limit of alcohol (BAC of 0.10 percent) acutely (28). A study of the effect of alcohol on estradiol levels in postmenopausal women found that in women wearing estradiol skin patches, acute alcohol consumption significantly elevated estradiol levels over the short term (34).

Medications.

Chronic heavy drinking appears to activate the enzyme CYP2E1, which may be responsible for transforming the over-the-counter pain reliever acetaminophen (Tylenol™) and many others) into chemicals that can cause liver damage, even when acetaminophen is taken in standard therapeutic doses (3,35,36). A review of studies of liver damage resulting from acetaminophen-alcohol interaction reported that in alcoholics, these effects may occur with as little as 2.6 grams of acetaminophen (four to five "extra-strength" pills) taken over the course of the day in persons consuming varying amounts of alcohol (35,37). The damage caused by alcohol-acetaminophen interaction is more likely to occur when acetaminophen is taken after, rather than before, the alcohol has been metabolized. Alcohol consumption affects the metabolism of a wide variety of other medications, increasing the activity of some and diminishing the activity, thereby decreasing the effectiveness, of others (35).
### Module 4 - Handout 5
### Substance Overview

#### Drug Classification (used in this training)

<table>
<thead>
<tr>
<th>Class</th>
<th>Some examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Nervous System (CNS) depressants</td>
<td>Alcohol hypnotics, antianxiety drugs</td>
</tr>
<tr>
<td>CNS sympathomimetic or stimulants</td>
<td>Amphetamine, methylphenidate, all forms of cocaine, weight-reducing products</td>
</tr>
<tr>
<td>Opiates</td>
<td>Heroin, morphine, methadone, and almost all prescription and analgesics</td>
</tr>
<tr>
<td>Canabinols</td>
<td>Marijuana, hashish</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>Lysergic acid diethylamide (LSD), mescaline, psilocybin, ecstasy</td>
</tr>
<tr>
<td>Solvents</td>
<td>Aerosol sprays, glues, toluene, gasoline, paint thinner</td>
</tr>
<tr>
<td>Over-the-counter drugs</td>
<td>Contain: atropine, scopolamine, weak stimulants, antihistamines, weak analgesics</td>
</tr>
<tr>
<td>Others</td>
<td>Phencyclidine (PCP)</td>
</tr>
</tbody>
</table>

#### DEA Drug Schedules with Examples

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>I (high abuse, low usefulness)</td>
<td>Heroin, Hallucinogens, Marijuana, Methaqualone (Quaalude)</td>
</tr>
<tr>
<td>II</td>
<td>Opium or morphine, Codeine, Synthetic opiates (e.g., meperidine (Demerol)), Barbiturates (e.g., secobarbital (Seconal)), Amphetamines, methylphenidate (Ritalin), and phenmetrazine (preludin), Gluethimide (Doriden)</td>
</tr>
<tr>
<td>III</td>
<td>Asprin with codeine, Paregoric, Methypylon (noludar)</td>
</tr>
<tr>
<td>IV</td>
<td>PCP, Chloral hydrate (Noctec), Ethchlorvynol (Placidyl), Flurazepam (Dalmane), Pentazocine (Talwin), Chlordiazepoxide (Librium), Propoxyphene (Darvon), Diethylpropion (Tenuate)</td>
</tr>
<tr>
<td>V (low abuse, high usefulness)</td>
<td>Narcotic – atropine mixtures (Lomotil), Codeine mixtures</td>
</tr>
</tbody>
</table>

#### A Brief List of “Street” Drug Names

**Central Nervous System Depressants (depression of excitable tissue)**

<table>
<thead>
<tr>
<th>Amies</th>
<th>Double trouble</th>
<th>Peanus</th>
<th>Sleepers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue birds</td>
<td>Downers</td>
<td>Peter (chloral hydrate)</td>
<td>Soapers</td>
</tr>
<tr>
<td>Blue devil</td>
<td>Downs</td>
<td>Quads</td>
<td>T-bird</td>
</tr>
<tr>
<td>Blue heaven</td>
<td>Goofballs</td>
<td>Rainbows</td>
<td>Tooies</td>
</tr>
<tr>
<td>Blues</td>
<td>Green and whites (Librium)</td>
<td>Red birds</td>
<td>Toolies</td>
</tr>
</tbody>
</table>
### Bullets
- Grenies
- Red devils
- Tranq (Librium-type)

### Candy
- Ludes
- Roaches (Librium)
- Wallbangers

### Christmas trees
- Nebbies
- Seccy
- Yellow jackets

### Dolls
- Nembies
- Seggy
- Yellows

#### Stimulants (stimulation of CNS)

<table>
<thead>
<tr>
<th>Amphetamines</th>
<th>Cocaine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bennies</td>
<td>Double cross</td>
</tr>
<tr>
<td>Blue angels</td>
<td>Footballs</td>
</tr>
<tr>
<td>Blue beauties</td>
<td>Green and clears</td>
</tr>
<tr>
<td>Chris</td>
<td>Greenies</td>
</tr>
<tr>
<td>Christine</td>
<td>Hearts</td>
</tr>
<tr>
<td>Christmas tree</td>
<td>LA turnarounds</td>
</tr>
<tr>
<td>Coast to coast</td>
<td>Lip poppers</td>
</tr>
<tr>
<td>Copilot</td>
<td>Meth</td>
</tr>
<tr>
<td>Crisscross</td>
<td>Oranges</td>
</tr>
<tr>
<td>Crossroads</td>
<td>Peaches</td>
</tr>
<tr>
<td>Crystal (IV methamphetamine)</td>
<td>Pep pills</td>
</tr>
<tr>
<td>Pinks</td>
<td></td>
</tr>
</tbody>
</table>

#### Analgesics (decrease pain)

<table>
<thead>
<tr>
<th>Heroin</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bomb</td>
<td>Horse Black (pium) PG or PO (paregoric)</td>
</tr>
<tr>
<td>Brother</td>
<td>Junk Blue Velvet (paregoric plus antihistamine) Pinks and grays (Darvon)</td>
</tr>
<tr>
<td>Brown</td>
<td>Mexican Mud Dollies (methadone) Poppy (opium)</td>
</tr>
<tr>
<td>Cat</td>
<td>Scat M (morphine) Tar (opium)</td>
</tr>
<tr>
<td>Chinese white</td>
<td>Shit Microdots (morphine) Terp (terpin hydrate or cough syrup with codeine)</td>
</tr>
<tr>
<td>Dogie</td>
<td>Skag Miss Emma (morphine) Ts and blues (talwin and antihistamine)</td>
</tr>
<tr>
<td>Duji</td>
<td>Smack Morphy (morphine)</td>
</tr>
<tr>
<td>Duster (cigarette)</td>
<td>Snow O (opium)</td>
</tr>
<tr>
<td>H</td>
<td>Stuff Pellets (opium)</td>
</tr>
<tr>
<td>H and stuff</td>
<td>Tango and cash</td>
</tr>
</tbody>
</table>

#### Cannabinols (THC) (euphoria and altered sense of time)

<table>
<thead>
<tr>
<th>Marijuana</th>
<th>Hashishlike (generally more potent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acapulco gold</td>
<td>Grass Locoweed Sativa Bhang Hash</td>
</tr>
<tr>
<td>Afghan</td>
<td>Hay Mary Jane Stick Charas Rope</td>
</tr>
<tr>
<td>A stick</td>
<td>Hemp Mexican Stuff Gage Sweet Lucy</td>
</tr>
<tr>
<td>Boo</td>
<td>J Mj Tea Ganja THC</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Bomb</td>
<td>Jane</td>
</tr>
<tr>
<td>Brick</td>
<td>Jive</td>
</tr>
<tr>
<td>Buddha sticks</td>
<td>Joint</td>
</tr>
<tr>
<td>Columbian Key</td>
<td>Roach</td>
</tr>
<tr>
<td>Gold</td>
<td>Lid</td>
</tr>
</tbody>
</table>

**Phencyclidine (PCP) (hallucinogens)**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Angel</td>
<td>Criptal</td>
<td>Hog</td>
<td>Mist</td>
<td>Shemans</td>
</tr>
<tr>
<td>Aurora</td>
<td>Dummy mist</td>
<td>Jet</td>
<td>Mumm dust</td>
<td>Sherms</td>
</tr>
<tr>
<td>Bust bee</td>
<td>Goon</td>
<td>K</td>
<td>Peace pill</td>
<td>Special L.A.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>coke</td>
</tr>
<tr>
<td>Cheap cocaine</td>
<td>Green</td>
<td>Lovely</td>
<td>Purple</td>
<td>Superacid</td>
</tr>
<tr>
<td>Cosmos</td>
<td>Guemilla</td>
<td>Mauve</td>
<td>Rocket fuel</td>
<td>Supercoke</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Whack</td>
</tr>
</tbody>
</table>

**Hallucinogens (enhanced sensory perception)**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acid (LSD)</td>
<td>Crystal</td>
<td>Love drug (MDMA)</td>
<td>Mescal (mescaline)</td>
<td>Pearly gates (morning glory seeds)</td>
</tr>
<tr>
<td>Blue dots (LSD)</td>
<td>Cube (LSD)</td>
<td>Lysergide (LSD)</td>
<td>Mexican mushroom (psilocybin)</td>
<td>Sugar (LSD)</td>
</tr>
<tr>
<td>Blue heaven (LSD)</td>
<td>D (LSD)</td>
<td>Magic Mushroom (psilocybin)</td>
<td>Microdots (LSD)</td>
<td>Sugar (LSD)</td>
</tr>
<tr>
<td>Buttons (peyote)</td>
<td>Deaths head (mushroom)</td>
<td>Mellow drug of America (MDA)</td>
<td>Mushroom (psilocybin)</td>
<td>White lightning (LSD)</td>
</tr>
<tr>
<td>Cactus (mescaline)</td>
<td>Heavenly blue (LSD)</td>
<td>Mesc (mescaline)</td>
<td>Owsleys (LSD)</td>
<td>25 (LSD)</td>
</tr>
</tbody>
</table>

Module 4 - Slide Outline with Notes

Title Slide - Toolbox Training: A Substance Abuse Educational Series
Module 4 - Clinical Evaluation: Screening
October 17, 2007
Presented by:
Anne Helene Skinstad, PhD and Peter Nathan, PhD
Content guided by:
Candace Peters, MA, CADC

Welcome

Prairielands Addiction Technology Transfer Center
Anne Helene Skinstad, PhD
Project Director
Candace Peters, MA, CADC
Director of Training
Ros Hayslett
Projects Coordinator
Duane Mackey, EdD
Native American Initiative Regional Coordinator
Peter Nathan, PhD
Faculty Consultant, University of Iowa
Ken Winters, PhD
Faculty Consultant

Unifying science, education and service to transform lives

Toolbox Training: Substance Abuse Educational Series For Mental Health Professionals
Module 4 - Clinical Evaluation: Screening
Module 5 - Clinical Evaluation: Assessment
Module 6 - Treatment Planning

Content guided by:
Candace Peters, MA, CADC

Welcome
Announcements & Logistics

- Logistics
  - Sign-in beginning of first day and sign-out end of second day
  - Lunch will be served at noon
  - Self-care
- Course Expectations: Interactive participation
  - Small group discussion
  - Role play
  - Large group discussion
  - Journal article review
  - Module review exercises
- Evaluation Forms
  - GPRA: Consent, Pre, Customer Survey, Follow-up
  - Iowa Consortium on Mental Health Evaluation

ATTC Updates

Substance Abuse and Mental Health Administration, Center for Substance Abuse Treatment

- September 14, 2007, 15 ATTC’s funded, 2007-2012
- The ATTC’s support the workforce that provides addiction treatment services to the 3.9 million Americans age 12 and older who received treatment for alcohol or illicit drug problems in the past year (National Survey on Drug Use and Health, 2005).
- “By training treatment providers and other professionals in the latest evidence-based practices, ATTC’s help ensure that those who need treatment receive the best care,” said SAMHSA Administrator Terry Cline, Ph.D. “ATTC’s are an integral part of SAMHSA’s work to improve access to information on tested interventions and to speed their use in the field.”
ATTC Updates -- continued

- Together with SSA’s, treatment provider associations, addiction counselors, multidisciplinary professionals, faith and recovery community leaders, family members of those in recovery, and other stakeholders, the ATTCs assess the training and development needs of the substance use disorders workforce. They develop and conduct training and technology transfer activities to meet identified needs. Particular emphasis is placed on raising awareness of and improving skills in using evidence-based and promising treatment/recovery practices in recovery-oriented systems of care.

- **New England ATTC** serving ME, NH, VT, MA, CT, RI, Brown University, Providence, R.I.;
- **Central East ATTC** serving DE, DC, MD, NJ, Danya Institute Inc., Silver Spring, MD;
- **Southern Coast ATTC** serving FL, AL, MS, Florida Certification Board, Tallahassee, FL;
- **Northeast ATTC** serving NY, PA, Institute for Research, Education, and Training in Addictions, Pittsburgh, PA;
- **Southeast ATTC** serving GA, NC, SC, Morehouse School of Medicine, Atlanta, GA;
- **Northwest Frontier ATTC** serving AK, WA, OR, HI, Pacific Islands, Oregon Health and Sciences University, Portland, OR;
- **Pacific Southwest ATTC** serving CA, AZ, Regents of the University of California, Los Angeles;
- **Caribbean Basin and Hispanic ATTC** serving Puerto Rico and the U.S. Virgin Islands;
- **Great Lakes ATTC** serving IL, OH, IN, MI, University of Illinois at Chicago, Chicago, IL;
- **PrairieLands ATTC** serving IA, MN, ND, SD, WI, University of Iowa, Iowa City;
- **Mid-America ATTC** serving AR, KS, MO, OK, NE, University of Missouri-Kansas City, Kansas City, MO;
- **National Coordinating Center** serving the ATTC Network, University of Missouri, Kansas City, MO;
- **Mountain West ATTC** serving NV, MT, WY, UT, CCO, ID, University of Nevada-Reno, Reno, NV;
- **Gulf Coast ATTC** serving TX, LA, NM, University of Texas-Austin, Austin, TX;
- **Mid-Atlantic ATTC** serving VA, WB, KY, TN, Virginia Commonwealth University, Richmond, VA.
### Series Design

**This Series is Designed To:**
- Enhance participant co-occurring substance abuse and mental health knowledge
- Enhance knowledge for existing addiction counselors
- Improve overall counselor competence and treatment outcome
- Introduce Technical Assistance Publication (TAP) #21
- Introduce the National Institute on Drug Abuse’s (NIDA) Principles of Drug Addiction Treatment: A Research-Based Guide

**Limitations**
- This Training Series is designed as a broad overview.
- Previous education or training is recommended
- Each module covers a wide range of topics and some topics are addressed only briefly.
- Participants are responsible to seek additional preparatory help if necessary.

### Toolbox Training Module Series

1. The Addiction Complex Simplified
2. Basic Counseling Skills
3. Professional and Ethical Responsibilities
4. Clinical Evaluation: Screening
5. Clinical Evaluation: Assessment
7. Treatment Knowledge
8. Referral, Service Coordination, and Documentation
9. Professional Readiness: Attitudes and Values
10. Group Counseling
11. Counseling Families, Couples, and Significant Others
12. Client, Family, and Community Education
Message from SAMHSA

Every day, countless lives are enriched or saved because of the work carried out by addiction counselors.

In a myriad of settings, competent, well-trained counselors form the relationships and carry out the strategies that help their clients move from life-threatening addiction to life-affirming recovery...

We can state with certainty that thousands of addiction counselors accomplish their missions with distinction.

Today’s Presenter’s

Anne Helene Skinstad, PhD – see biographies for more information.

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Agenda

8:30  Registration

9:00  INTRODUCTIONS AND REVIEW MODULE 3

9:00  CLINICAL EVALUATION: Screening
     Interactive Discussion: Stages of Change, Micro
     Skills, MI

10:45 CLINICAL EVALUATION: Screening
     GROUP EXERCISE: JOURNAL ARTICLE

11:00 CLINICAL EVALUATION: Screening
     INTERACTIVE DISCUSSION: Screen, Assessment,
     etc.

12:00 LUNCH WILL BE SERVED

1:00  CLINICAL EVALUATION: Screening
     INTERACTIVE DISCUSSION: Change, Brief
     Intervention, etc.

2:15  CLINICAL EVALUATION: Assessment

3:45  CLINICAL EVALUATION: Assessment

4:30  Close of Day One

Review Activity

Presenter will provide instructions.

A MOCK JEOPARDY EXERCISE ENHANCES ETHICAL AWARENESS
THROUGH THE USE OF EXAMPLE “ETHICAL DILEMMAS.”

Professional & Ethical Responsibilities

<table>
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<th>Legal or Ethical Issues</th>
<th>Iowa Code of Ethics</th>
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Toolbox Training: A Substance Abuse Educational Series
For Mental Health Professionals First Edition

The University of Iowa
Goals - Module 4

Goal: Identify key elements of the co-occurring “screening” process to include alcohol and drug specific education, mental health, counselor and client rapport building, crisis management and data collection.

Objectives:
1) Introduce screening instruments and their uses
2) Implement motivation for change from a co-occurring perspective
3) Identify pharmacological therapies
4) Define initial action plans specific to alcohol and drug addiction co-occurring with mental health issues

Title Slide - Prochaska & DiClemente

Stages of Readiness to Change
Unifying science, education and service to transform lives.

Toolbox Training: A Substance Abuse Educational Series
For Mental Health Professionals First Edition

Prochaska & DiClemente: Stages of Readiness to Change

What happens to people as they go through Behavior change?

- Experiential: a person experiences an event that creates a new way of thinking and feeling that, in turn, leads to change.
  - Consciousness raising (awareness)
  - Emotional arousal (intense event)
  - Self-reevaluation (experiences causing reflection)

- Behavioral: consisting of activities that reinforce the changes that people are making.
  - Stimulus control (managing barriers)
  - Self-liberation (creating a plan)

See Module 4– Handout 1 for details.

Prochaska & DiClemente: Stages of Readiness to Change

- Precontemplation
- Contemplation
- Determination/Preparation
- Action
- Maintenance
- Relapse and Recycle
- Termination or Graduation

Prochaska & DiClemente: Stages of Readiness to Change

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Pre-contemplation</td>
<td>Not considering change Do not see their behavior as being a problem</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Ambivalent about change Acknowledge the possibly that there is a problem</td>
</tr>
</tbody>
</table>
Prochaska & DiClemente: Stages of Readiness to Change

See Module 4 – Handout 1 for details.

Prochaska & DiClemente: Stages of Readiness to Change

See Module 4 – Handout 1 for details.

A Stage Model of the Process Change

See Module 4 – Handout 2 for details.
A Stage Model of the Process Change

See Module 4 – Handout 2 for details.

Title Slide – Micro-counseling Skills

Allen E. Ivey

Attending Behavior

- Encourages client talk
- Active Listening
  - Eye contact:
    - interesting/dilate, uncomfortable/contract
    - cultural differences
  - Attentive body language
  - Vocal qualities
  - Verbal tracking—keep to the client’s topic...
  - Silence
Open and Closed Questions

- Open Questions: can not be answered in a few words, offer encouragement, and a client will speak more freely
  - what, how, why, or could
- Closed questions: will focus the dialog, tend to turn the focus on the professional
  - are or do

Client Observation Skills

- Nonverbal behavior: 85%
- Verbal behavior: key words
- Discrepancies:
  - Mixed messages
  - Contradictions
  - Conflicts
  - Incongruities

Encouraging, Paraphrasing, and Summarization

- Encouraging: using exact words and statements are used for clarification
  - Restatement
  - Repetition of key words
- Paraphrasing
  - If done correctly you will get “that’s right”
- Summarizing
  - Encompass a longer period of conversation
**Reflection of Feeling**

Feeling words used by the client
- **Non-verbal**
  - worried, relaxed, happy, jumpy
- **Verbal**
  - feeling down, ticked off, confusion

**The Five-stage Interview Structure**

- **Rapport/Structuring**
  - Positive regard
  - Respect and warmth
  - Concreteness
  - Immediacy/in the moment
  - Nonjudgmental attitude
- **Defining the problem/gather the data**
- **Defining a goal**
- **Exploration of alternatives and confronting incongruity**
  - statements, say and do, verbal and non-verbal, statements and context, between people
- **Generalization to daily life**

**Confrontation**

- Identifying mixed messages, conflict, and incongruity
- Pointing out these issues clearly and assisting in resolution
- Evaluate the effectiveness
Focusing
- Directs the client conversation to the chosen focus of the clinician
  - client
  - main theme and problem
  - others
  - family
  - mutual issues
  - clinician
  - cultural/environmental/contextual issues: not apparent

Reflection of Meaning
- finding the deeply held thoughts and feelings underlying life experience
- paraphrase is to thoughts, as reflection is to feelings
- breaks down complex behaviors into parts

Influencing Skills and Strategies, Developmental Skills
- directives: clear and concrete
- logical consequences: warnings, triggers
- self-disclosure or client self-talk, advise, information, explanation, instruction
  - Fairly close to the client’s experiences
  - Timely
    - ULTIMATELY – DO NOT HARM !!!!!
- feedback, influencing summary
  - Provide clear data on performance and/or how others may view them
Skill Integration

- Different theories call for different patterns of skill usage.
- Different situations call for different patterns of skill usage.
- Different cultural groups call for different patterns of skill usage.

Determining Personal Style and Theory

- gradually evolve
- develop skills
- personal growth
- self-awareness
  - Race
  - Ethnicity
  - Family history
  - gender

Motivational Interviewing

William R. Miller, PhD
Stephen Rollnick, PhD
Motivational Interviewing

- client-centered approach
  - enhances motivation to change
  - explores and resolves ambivalence
- increases clients' adherence to treatment
- improves treatment outcomes

Rationale

- Clinicians commonly think that they are already practicing Motivational Interviewing since most clinical training encompasses basic counseling skills such as active listening, use of open-ended questions, use of affirmation, and summarizing.
- What makes Motivational Interviewing a unique counseling approach is how its skills are employed by clinicians.
- Motivational Interviewing requires attention to timing issues, specific strategies and application methods, and maximizing the effectiveness of these skills.

Two Phases Assist in Client Change

- Building motivation for change
  - Open-ended questions
  - Affirmation
  - Reflections
  - Summary
- Strengthening commitment to change
  - Build on the clients’ motivation
  - Resolve to change
Rationale and Basic Principles: Implementation of Skills

- Express empathy
- Develop discrepancy
- Avoid argumentation and direct confrontation
- Roll with resistance
- Support self-efficacy and optimism

TIP 35, pgs 41-49

Principles of Motivational Interviewing

- **Advice:**
  - Target advice to stage of change;
  - Give advice only when individuals will be receptive;
  - Limit advice giving.
- **Reduce Barriers:**
  - Bolster self-efficacy
  - Address logistical barriers
- **Provide Choices:**
  - It’s the individual’s choice; Whether to change; How to change

Principles of Motivational Interviewing (continued)

- **Decrease Desirability:**
  - Help individuals decrease their perceptions of the desirability of the behavior;
  - Identify other behaviors to replace the positive aspects of alcohol use
- **Empathy:**
  - Develop and communicate an understanding of the individual’s situation and feelings around the behavior;
  - Explore pain around the behavior
- **Feedback:**
  - Help the individual identify and understand relevant--Risks of the behavior
  - Negative consequences of the behavior
Motivational Interviewing

- Fundamental Approach
  - Collaboration
  - Evocation/Suggestion
  - Autonomy/Self Rule
- Four Principles
  - Express empathy (not sympathy)
  - Develop discrepancy
  - Roll with resistance
  - Support self-efficacy

Title Slide - Group Exercise

Group Exercise: Journal Article

Group Exercise: Journal Article

Differences Between Screening Goals and Assessment Goals

- **Screening** instruments reflect likelihood of presence of substance abuse.

- **Assessment** instruments may also do so as well, but they also typically provide a broader range of information on degree, kind, causes for, and possible treatments of the abuse.

Differences Between Screening Goals and Assessment Goals

- **Screening** instruments are typically brief, require yes or no answers, can be administered by non-experts, and are obvious to their intent.

- **Assessment** instruments are generally more time consuming, can require more complex historically-based information, benefit from use by experienced examiners, and are not always so obvious in intent.
Detecting Alcohol Problems: Screening Instruments (CAGE)

- **CAGE Questionnaire (Ewing, 1984)** - A cut point of 1 detects about 90% of those with alcohol-related disorder, with 48% false positives.
  1. Have you ever felt you should **Cut** down on your drinking?
  2. Have people **Annoyed** you by criticizing your drinking?
  3. Have you ever felt bad or **Guilty** about your drinking?
  4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

Detecting Alcohol Problems: Screening Instruments (TWEAK)

- **TWEAK Test (Russell et al., 1991)** - Originally designed to screen for risky drinking during pregnancy; at a cut point of 2, sensitivity approximates and specificity is better than the CAGE.
  1. **(Tolerance):** How many drinks can you ‘hold’ or how many drinks does it take before you begin to feel the first effects of alcohol?
  2. **(Worried):** Have close friends or relatives *Worried* or complained about your drinking in the past year?
  3. **(Eye-Opener):** Do you sometimes take a drink in the morning when you first get up?
  4. **(Amnesia/Blackouts):** Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?
  5. **Could you sometimes feel the need to **Cut** down on your drinking?**
Detecting Alcohol Problems: Screening Instruments (RAPS4-QF)

RAPS4 & RAPS4-QF (Cherpitel, 2002) - Sensitivity better than CAGE with good specificity; addition of QF questions outperforms the CAGE for alcohol abuse at a cut point of 1 across a wide range of groups.

1. During the last year have you had a feeling of guilt or remorse after drinking?
2. ... has a friend or family member ever told you about things you said or did while you were drinking that you could not remember? (Amnesia)
3. ... have you failed to do what was normally expected from you because of drinking? (Perform)
4. Do you sometimes take a drink in the morning when you first get up? (Starter)

Detecting Alcohol Problems: Screening Instruments (MAST)

Michigan Alcoholism Screening Test (MAST) – Several brief versions of the MAST are also available; specificity and sensitivity approximate the CAGE and TWEAK.

- A quantifiable, self-report instrument that asks for yes-no responses to questions about experience with a range of alcohol-related problems, diminished control over drinking, tolerance, and withdrawal.

Detecting Alcohol Problems: Screening Instruments (AUDIT)

Alcohol Use Disorders Identification Test (AUDIT) - The 10-item core questionnaire assesses three domains, alcohol dependence, harmful drinking, and hazardous drinking; linked to ICD-10.

- Sample Item: “How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
  (Never, scored 0; Less than monthly, 1; Monthly, 2; Weekly, 3; Daily or almost daily, 4)
Detecting Alcohol Problems: Screening Instruments (LSI)

- The LSI-R is a quantitative survey of attributes of offenders and their situations relevant to the decisions regarding level of service
  - 54 items either “yes-no” or “0-3” rating
  - 12 subscales, one of which targets drug and alcohol problems.
  - Used to identify needs and level of service

Detecting Problem Gambling

South Oaks Gambling Screen (SOGS)

- Developed by Henry Lesieur, PhD, and Sheila Blume, MD
- Screening for compulsive gambling
- The South Oaks Gambling Screen is a 20-item questionnaire based on DSM-III criteria for pathological gambling.
- May be self-administered or administered by nonprofessional or professional interviewers.
- A total of 1,616 subjects were involved in its development: 867 patients with diagnoses of substance abuse and pathological gambling, 213 members of Gamblers Anonymous, 384 university students, and 152 hospital employees.
- Independent validation by family members and counselors was obtained for the calibration sample, and internal consistency and test-retest reliability were established.
- The instrument correlates well with the criteria of the revised version of DSM-III (DSM-III-R).
- It offers a convenient means to screen clinical populations of alcoholics and drug abusers, as well as general populations, for pathological gambling.

Am J Psychiatry 1987; 144:1184-1188
DSM-IV-TR Criteria for Substance Abuse (one required)

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school, neglect of children or household).

2. Recurrent substance-related legal problems.

3. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).

4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

The symptoms have never met the criteria for Substance Dependence for this class of substance.
DSM-IV-TR Criteria for Substance Dependence (three or more required)

1. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
   b. Markedly diminished effect with continued use of the same amount of the substance.

2. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for the substance.
   b. The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.

3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite that an ulcer was made worse by alcohol consumption.)
Unifying science, education and service to transform lives

Title Slide - Group Exercise

Group Exercise

Group Exercise: Role Play

See Module 4 - Handout 3

- Divide into pairs.
  - Person One: client
  - Person Two: counselor
- Implement Screening Tools From Those Discussed
- Reverse Roles Alternating Between Tools

Title Slide - Facts About Change

Facts About Change
Facts About Change
- Change is a natural process
- Brief counseling can speed up the change process
- Faith and hope are important elements
- Helps to have other supports
- Counselors “do” matter
- Empathy is not merely having a similar experience
- People engage in change talk and resistance talk

Brief Intervention for Alcohol Problems
- Six common elements of brief intervention (FRAMES) (Miller & Sanchez, 1993):
  - Feedback of personal risk
  - Responsibility of the patient
  - Advice to change
  - Menu of ways to reduce drinking
  - Empathetic counseling style
  - Self-efficacy of the patient

Treatment Options
- Detoxification
- Pharmacological maintainance
- Outpatient: extended and intensive
- Partial hospitalization
- Inpatient/residential
- Aftercare, support groups
Treatment Modalities

- Individual Psychosocial Treatment
- Evidence-based treatments
- Cognitive-behavioral treatment
  - Social skills training
  - Community reinforcement approach
- Motivational Enhancement Therapy
- 12-step Approaches
- Community Reinforcement approach
- Family
  - Behavioral marital therapy
- Group treatment
- Motivational Incentives

Treatment Modalities

- Pharmacological Treatments
  - Disulfiram (Antabuse)
  - Naltrexone
  - Methadone
  - Buprenorphine
  - Treating withdrawal
- Co-occurring disorders
- Historical perspective
- Aftercare
  - Evidence points to importance of aftercare after completion of primary treatment
  - Appropriately

Tips to Avoid Increasing Resistance

- Behaviors to avoid as they damage rapport, increase resistance, and create conflict between client and counselor.
  - Arguing for change
  - Assuming the expert role
  - Criticizing, shaming, or blaming
  - Labeling the client’s behavior
  - Being in a hurry
  - Claiming to know what is best
Summary and Questions

- Review: Ethics
- Stages of Change
- Micro-Counseling Skills
- Motivational Interviewing
- Screening vs. assessment
- Screening instruments
- Diagnostic criteria
- Treatment options and modalities
- Facilitating change
Module 5
Clinical Evaluation: Assessment

Toolbox Training: A Substance Abuse Educational Series
for Mental Health Professionals

Toolbox Training: A Substance Abuse Educational Series
For Mental Health Professionals First Edition
Module 5- Clinical Evaluation: Assessment

Goals and Objectives

Listed below are the goals and objectives of the module and the corresponding TAP 21 competencies.

<table>
<thead>
<tr>
<th>Module 5 Goals and Objectives</th>
<th>SAMHSA CSAT TAP 21 Competencies</th>
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<tbody>
<tr>
<td><strong>Goal:</strong></td>
<td><strong>Clinical Evaluation</strong></td>
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<tr>
<td>Initiate alcohol and drug specific &quot;assessment&quot; process from a co-occurring perspective.</td>
<td><strong>A. Assessment</strong></td>
</tr>
<tr>
<td><strong>Objectives:</strong></td>
<td>1. Select and use a comprehensive assessment process that is sensitive to age, gender, racial and ethnic cultural issues, and disabilities.</td>
</tr>
<tr>
<td>1. Define assessment process specific to alcohol and drug addiction co-occurring with mental health issues;</td>
<td>2. Analyze and interpret the data to determine treatment recommendations.</td>
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<tr>
<td>2. Discuss and implement assessment instruments;</td>
<td>3. Seek appropriate supervision and consultation.</td>
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<tr>
<td>4. Describe ASAM levels of care and diagnostic and dimensional criteria from co-occurring perspective;</td>
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<tr>
<td>5. Discuss individual assessment process to include: culture, age, gender, client strengths, support systems, mental health, substance abuse, physical health, physical/emotional/social abuse, family and social networks from a co-occurring perspective.</td>
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Module 5 - Agenda

AGENDA “DAY ONE” – October 17th

8:30 REGISTRATION
9:00 WELCOME AND INTRODUCTIONS
   CLINICAL EVALUATION: SCREENING
Noon Lunch
1:00 CLINICAL EVALUATION: SCREENING
2:15 INTERACTIVE DISCUSSION: REVIEW
2:30 CLINICAL EVALUATION: ASSESSMENT
   DEFINE ASSESSMENT PROCESS
   • Sequential Assessment
   • Multidimensional Assessment
   • Content of Screening, Problem Assessment, Personal Assessment
   • Detection, Classification, Functional Assessment, Functional Analysis, Treatment Planning

ASSESSMENT INSTRUMENTS
- ASI
- SCQ
- CDP
- SASSI
- TLFB
- GAIN
- IDS

3:30 15-MINUTE BREAK
3:45 DSM-IV TR CRITERIA
   • Substance Abuse
   • Substance Dependence
   • Specifiers/Course Specifiers
   • Multiaxial Assessment

4:30 END OF DAY ONE

AGENDA “DAY TWO” – October 18th

8:30 REGISTRATION AND WELCOME
9:00 CLINICAL EVALUATION: ASSESSMENT
   GROUP WORK: JOURNAL ARTICLE, PRE-TRAINING ASSIGNMENT

LEVELS OF CARE
- Early Intervention
- Outpatient
- Intensive Outpatient
- Residential/Inpatient
- Medically Managed Intensive Inpatient

SMALL GROUP ACTIVITY: ASAM Levels Of Care and Criteria

10:45 SUMMARY, QUESTION/ANSWER, CLOSE OF MODULE FIVE
11:00 15-MINUTE BREAK
11:15 CLINICAL EVALUATION: TREATMENT PLANNING

4:30 END OF DAY TWO
Module 5 - Handout 1

Group Exercise: Case Study

Jason: The client is a 35-year-old Native American male school teacher. He was adopted at the age of three into a white upper middle class family where he was raised in a Christian belief system which he currently practices. He teaches math at a junior high school and is in some difficulty because of “calling in sick much too much.”

Although he has been injecting heroin on and off since he was 16, he has never been arrested. He has been through many episodes of heroin detoxification, mostly outpatient methadone detoxification but has also been in three inpatient drug treatment programs. The last inpatient program was a 28-day, biopsychosocial recovery program, and he remained both heroin and alcohol free for about six months following treatment. Although he wanted to be on methadone maintenance, he could not “document” his history of heroin addiction (this was 10 years ago). His psychiatric evaluation indicate possible depression, however he has not received a formal diagnosis. His wife is in recovery, and insisted that he return to treatment after she discovered he was taking large quantities of codeine pills from several doctors for a back injury following an automobile accident. She is unaware that he was also shooting heroin at least once daily. He has been alcohol abstinent for the past two years.

His only current medical problem is that he is hepatitis C positive, and he has been so for at least 10 years. He and his wife have incurred debt with numerous credit card holders and they are behind three months on mortgage payments. He has past medical bills at the hospital and treatment facilities for care. His daughter’s teachers repeatedly send home notices requesting he attend school activities to support his daughter. His daughter recently began missing athletic practice at school and when questioned why she stated, “my dad needs me at home sometimes”. His two cars are paid for, however one has mechanical problems. He enjoys working out at the gym, his membership is intact, but has not gone for two months.

“I’m an addict through and through. I don’t think I’ve ever stopped being an addict, even when I was going to AA every day. I wasn’t using, but I thought about using every day. My wife cleaned up when she was pregnant with our daughter and she just got her 12-year chip. She moved on with her life, but I’m stuck. My back injury really threw me into a tailspin. At first, I really needed the codeine, but now I’m just sucking them up so that I don’t go in to withdrawal. We’ve got to be really careful here. If my wife finds I’m back on the needle, she’ll be out the door this time.”
Module 5 - Handout 1 (continued)

- What stage of change is the client in based on Prochaska and DiClemente’s model?

- Is this client substance abusive or dependant based on the DSM IV? Why?

- What screening and assessment tools would you utilize with this client?

- What ASAM level of care would you recommend? Why?

- Develop four questions/sentences you might utilize when working with this client based on Miller’s Motivational Interviewing.
Title Slide - Toolbox Training: A Substance Abuse Counselor Training Program

Module 5 - Clinical Evaluation: Assessment

October 17, 2007

Presented by:
Anne Helene Skinstad, PhD and Peter Nathan, PhD

Content guided by:
Candace Peters, MA, CADC

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Agenda

See Agenda Handout for additional information.

Review Activity

Presenter will provide instructions.

Cross Word Questions

(Also available as a pre-session handout)
Goals

Goal: Initiate alcohol and drug specific “assessment” process from a co-occurring perspective.

Objectives

1) Define assessment process specific to alcohol and drug addiction co-occurring with mental health issues
2) Discuss an implement assessment instruments
3) Define DSM-IV-TR (APA, 2000) criteria for Substance Abuse and Dependence from a co-occurring perspective
4) Describe ASAM levels of care and diagnostic and dimensional criteria from a co-occurring perspective
5) Discuss individual assessment process to include: culture, age, gender, client strengths, support systems, mental health, substance abuse, problem gambling, physical health, physical/emotional/social abuse, family and social networks from a co-occurring perspective.
What is Assessment?

Assessment is the **systematic process** of interaction with an individual to **observe, elicit, and subsequently assemble the relevant information required** to deal with his or her case, both immediately and for the foreseeable future.

Sequential Assessment

- **Screening:** Presence or absence of a problem and the likelihood that specialized treatment may be required.
- **Problem Assessment:** Characterization of the problem that screening has indicated is present.
- **Personal Assessment:** Nature of the individual who is experiencing the problem is fully and uniquely characterized; emphasis on areas in which personal problems are being experienced.
- Overall goal of assessment is to produce sufficient information to make treatment relevant decisions.
**Multidimensional Assessment**

Information is sought along 3 dimensions:
- The use of alcohol and drugs.
- The signs and symptoms of alcohol and drug use.
- The consequences of alcohol and drug use.

**Content of Screening**

A brief process that answers two questions:
- Whether an alcohol and/or drug problem is present.
- If so, whether it is likely to require brief intervention or specialized treatment.

Examples include: Alcohol Clinical Index, CAGE and AUDIT.

**Content of Problem Assessment**

- Examines problems attributable to alcohol and/or drug consumption.
- **Use of alcohol and/or drugs** is explored by examining level of use, pattern of use and history of use.

Three techniques are available:
- Retrospective methods
- Prospective methods
- Laboratory determinations
**Content of Problem Assessment**

**Signs and symptoms of alcohol and/or drug use.**
- These make up DSM IV criteria
- Self-report questionnaires can be used.
  - Examples include: Alcohol Dependence Questionnaire

**Content of Problem Assessment**

**Consequences of alcohol and/or drug use.**
- Examples include the
  - Michigan Alcoholism Screening Test (MAST)
  - Alcohol Use Inventory (AUI)
  - Addiction Severity Index (ASI).

**Content of Personal Assessment**

Examines problems to determine if they are attributable to use.
- Medical status
- Psychiatric status
- Vocational issues
- Personal problems
- Sexual problems
- Social support
- Family structure
Content of Personal Assessment (continued)

- Use of leisure time
- Demographics
- Family history
- Prior treatment history
- Intelligence
- Cognitive functioning
- Personality
- Treatment Goals
- Social Stability
- Situational Factors

Overview of Assessment Process

Five step process consisting of:

- Detection
- Classification
- Functional Assessment
- Functional Analysis
- Treatment Planning

Detection

- To identify clients who may be experiencing problems related to substance abuse.
- Explore past use of substances before current use.
- Use lab tests to screen for substance use.
- If use is detected, screen for presence of negative consequences.
Classification

- To determine, which, if any, DSM diagnoses apply to the client.
- Rate worst period of use.
- Tap multiple sources of information.
- Stick to evidence and get more information if needed.

Functional Assessment

- To gather information about the client’s adjustment across different domains of functioning and his/her pattern of substance use.
- Obtain information about background, psychiatric illness and treatment, physical health and safety, psychosocial adjustment, substance use.
- Use all sources of information.
- Assess the client’s range of different needs.
- Identify the client’s strengths.

Functional Analysis

- To identify factors that maintain substance abuse, interfere with sobriety, or pose a risk of relapse.
- Use information obtained from functional assessment.
- Explore possible motives for using substances and costs of giving them up (e.g., reduced socialization, self-medication, pleasure/leisure, structure).
- View identified motives and costs as working hypotheses, not facts.
Treatment Planning

- To develop an integrated treatment plan that addresses substance abuse and mental illness through concurrent treatment.
- First address pressing needs.
- Evaluate client motivation to address substance abuse.
- Identify treatment goals and target behaviors.
- Select interventions for achieving goals.
- Choose measures to monitor outcomes of goal setting.
- Follow up and modify treatment plans as necessary.

Methods of Obtaining Assessment Information

- Face-to-face interviewing
- Semi-structured interview and structured interview
- Paper-and-pencil tests
- Computerized assessments
Addiction Severity Index (ASI)

- Semi-structured interview assessing:
  - medical status
  - employment and support
  - drug use
  - alcohol use
  - legal status
  - family/social status
  - psychiatric status

- One hour to complete
- Recent (past 30 days) & lifetime problems

Comprehensive Drinking Profile (CDP)

- History and current status of drinking problems and related manners.
- Consumption and problematic behaviors.

- Structured intake interview takes 1-2 hours
- Brief Drinker Profile, Follow-Up Drinker Profile and Collateral Interview form are also available.

Time Line Follow-Back (TLFB)

- Analyzes the
  - patterns (daily, weekly, sporadically)
  - intensity (light, heavy) of drinking/drugging behavior.

- Connections between use and significant events are established.
Inventory of Drinking Situations (IDS)

- Assess situations in which client drank heavily over the past year.
- Examines 8 categories
  - Negative Emotional States
  - Positive Emotional States
  - Urges and Temptations
  - Testing Personal Control
  - Negative Physical States
  - Positive Physical States
  - Interpersonal Conflict
  - Social Pressure to Drink

Situational Confidence Questionnaire (SCQ)

- Self-report instrument which parallels the drinking situations from the IDP.
- Clients imagine themselves in each situation
  - Rate on scale of 0-100, (0=not confident to 100=very confident)
  - How likely they will be able to resist the urge to use heavily in that situation.

Substance Abuse Subtle Screening Inventory (SASSI)

- One-page self report that classifies individuals as non-chemically dependent and chemically dependent.
- Resistance to faking is its most important attribute.
- Effective in identifying early stage CD individuals who are either in denial or deliberately trying to conceal their CD pattern.
Global Appraisal of Individual Needs (GAIN)
- Eight core sections:
  1. background
  2. substance use
  3. physical health
  4. risk behaviors
  5. mental health
  6. environment
  7. legal
  8. vocational.
- Questions assess how recent the problems are, breadth of symptoms, recent prevalence in days or times, as well as lifetime service utilization, recency of utilization and frequency of utilization.
- Use of DSM-IV based diagnosis, ASAM based level of care placement and JCAHO based treatment planning.
DSM-IV-TR Criteria for Substance Abuse (one required) - 12 months -

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school, neglect of children or household).
2. Recurrent substance-related legal problems.
3. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

DSM-IV-TR Criteria for Substance Dependence (three or more required)

1. Tolerance, as defined by either of the following:
   c. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
   d. Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:
   c. The characteristic withdrawal syndrome for the substance.
   d. The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.
DSM-IV-TR Criteria for Substance Dependence (three or more required)

8. The substance is often taken in larger amounts or over a longer period than was intended.
9. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
10. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.
11. Important social, occupational, or recreational activities are given up or reduced because of substance use.
12. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite that an ulcer was made worse by alcohol consumption.

Specifiers

- **With Physiological Dependence:** Used when Substance Dependence is accompanied by evidence of tolerance (Criterion 1) or withdrawal (Criterion 2).

- **Without Physiological Dependence:** Used when there is no evidence of tolerance (Criterion 1) or withdrawal (Criterion 2). Substance Dependence is characterized by a pattern of compulsive use (at least 3 items from Criteria 3-7).
Course Specifiers

- **Early Full Remission**: 1 month but for less than 12 months, no criteria have been met.
- **Early Partial Remission**: 1 month but less than 12 months, 1 or more criteria have been met.
- **Sustained Full Remission**: No criteria met for 12 months or more.
- **Sustained Partial Remission**: Full criteria for dependence not met for 12 months or more, however 1 or more criteria have been met.

Multiaxial Assessment

**Axis 1: Clinical Disorders/Other Conditions That May Be A Focus of Clinical Attention**

- Report all the various disorders or conditions in the Classification except for the Personality Disorders and Mental Retardation.
- Principal diagnosis or reason for visit should be listed first.

**Axis II: Personality Disorders/Mental Retardation**

**Axis III: General Medical Conditions**

**Axis IV: Psychosocial and Environmental Problems**

- For example: problems with primary support group, social environment, education, occupation, housing, economic, access to health care services, interaction with legal system/crime and other.
Multiaxial Assessment

Axis V: Global Assessment of Functioning (GAF)

- **100-91**: Superior functioning in a wide range of activities
- **90-81**: Absent or minimal symptoms
- **80-71**: If symptoms are present, they are transient and expectable reactions to psychosocial stressors
- **70-61**: Some mild symptoms
- **60-51**: Moderate symptoms
- **50-41**: Serious symptoms
- **40-31**: Some impairment in reality testing or communication
- **30-21**: Behavior is considerably influenced by delusions or hallucinations
- **20-11**: Some danger of hurting self or others
- **10-1**: Persistent danger of severely hurting self or others.

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Title Slide - Group Exercise

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Group Exercise

**Required Reading:**

**Optional Reading:**
Title Slide - ASAM Criteria

Levels of Care

ASAM Criteria-Six Dimensions

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

Levels of Care-
Level 0.5 Early Intervention

- One-on-one counseling with at-risk individuals and educational programs for first-time OWI offenders.
- Appropriate for those with problems or risk factors related to substance use but not meet criteria for Substance-Related Disorder.
- Meets one of the specifications in Dimensions 4, 5 or 6.
- Any identifiable problems in Dimensions 1, 2 or 3 are stable or being addressed through medical or mental health services.
Levels of Care:

**Level I - Outpatient Treatment**

Therapies include

- Individual and group counseling
- Motivational enhancement
- Opioid substitution therapy
- Family therapy
- Educational groups
- Occupational and recreational therapy
- Psychotherapy
- Other therapies.

- Motivational enhancement and engagement strategies are used in preference to confrontational approaches.
- Meet diagnostic criteria for Substance-Related Disorders.

**Level I-Outpatient Treatment**

**Dimensional Admission Criteria**

Dimension 1: No withdrawal signs or symptoms
Dimension 2: Biomedical concerns stable
Dimension 3: (a) or (b) and (c) and (d)
  (a) No co-occurring mental disorder symptoms or symptoms are mild and stable.
  (b) Psychiatric symptoms are mild but mental health monitoring is needed.
  (c) Mental status doesn’t interfere with understanding and participation
  (d) No risk of harm to self or others

Dimension 4: (a) and (b) or (c) or (d)
  (a) Willingness to comply with treatment plan
  (b) Acknowledges substance use and wants help
  (c) Ambivalent about substance use
  (d) Doesn’t recognize substance use

Dimension 5: Able to achieve or maintain abstinence only with support and therapeutic contact to assist with preoccupation with use, craving, peer pressure, lifestyle and attitude changes.
Level I-Outpatient Treatment
Dimensional Admission Criteria

Dimension 6: **(a) or (b) or (c)**
(a) Supportive environment for treatment
(b) Inadequate support system but willing to obtain a support system
(c) Family is supportive but needs intervention to improve chances of success.

Level II.1 Intensive Outpatient
Dimensional Admission Criteria

- 9 or more hours of treatment per week.
- Dimension 1: No withdrawal signs or symptoms
- Dimension 2: Biomedical stable or monitored concurrently with no interference.

Level II.1 Intensive Outpatient
Dimensional Admission Criteria

- Dimension 3: **(a) or (b)**
  (a) Abuse of family and needs IOP to reduce further deterioration
  (b) Diagnosed emotional, behavioral or cognitive disorder that requires IOP monitoring to minimize treatment distractions.

- Dimension 4: **(a) or (b)**
  (a) Needs structure to promote progress because lower level interventions have failed or would not be successful
  (b) Patient’s perspective inhibits ability to make changes without repeated, structured interventions.
Level II.1 Intensive Outpatient

Dimensional Admission Criteria

- Dimension 5: Active at lower level of care but symptoms are intensifying and functioning is deteriorating.

- Dimension 6: (a) or (b)
  (a) Continued exposure to current environment makes recovery unlikely
  (b) Lacks social contacts or has inappropriate social contacts that jeopardize recovery.

Level II.5 Partial Hospitalization

Dimensional Admission Criteria

- 20 or more hours of programming per week
- Dimension 1: Same as II.1
- Dimension 2: Same as II.1
- Dimension 3: History of mild to moderate psychiatric decompensation.
- Dimension 4: Interventions at II.1 have not succeeded.
- Dimension 5: Same as II.1 with inclusion of high likelihood of relapse due to unawareness of relapse triggers, lack of coping skills or ambivalence towards treatment.
- Dimension 6: Same as II.1 with inclusion of family unsupportive or passively opposed to treatment.

Level III-Residential/Inpatient

- Level III.1-Halfway House
- Level III.3-Therapeutic Rehabilitation Facility
- Level III.5-Therapeutic Community or Residential Treatment Center
- Level III.7-Inpatient Treatment Center
Level III.1 Low-Intensity Residential Dimensional Admission Criteria

- At least 5 hours per week of treatment
- Dimension 1 - No withdrawal symptoms
- Dimension 2 - Biomedical stable
- Dimension 3 - (a) or (b) or (c) or (d) and (e)
  (a) Mental health related to substance use and no risk to self or others
  (b) Unable to maintain mental stability in non-residential setting
  (c) Unable to maintain stable behavior
  (d) Co-occurring disorders are being addressed concurrently
  (e) Mental status is stable at this level of care.

Level III.1 Low-Intensity Residential Dimensional Admission Criteria

- Dimension 4: (a) or (b) or (c) or (d)
  (a) Acknowledges problems
  (b) Early stage of readiness and needs motivational strategies
  (c) Motivating strategies have failed in the past
  (d) Patient’s perspective impairs ability to make behavior changes

Level III.1 Low-Intensity Residential Dimensional Admission Criteria

- Dimension 5: (a) or (b) or (c) or (d)
  (a) Imminent relapse danger with dangerous consequences due to lack of coping skills
  (b) Understands disorders but is unable to address at lower level of care
  (c) Needs staff support to maintain engagement while transitioning
  (d) High risk of use or deteriorated mental functioning with dangerous consequences without 24 hour support.
Level III.1 Low-Intensity Residential Dimensional Admission Criteria
Dimension 6: (a) or (b) or (c) or (d) or (e) and (f)
(a) High risk of abuse or substance use that makes relapse imminent
(b) Inappropriate social contacts that jeopardize recovery
(c) Living environment is filled with substance users
(d) Continued exposure to environment makes recovery unlikely
(e) In danger of victimization by another
(f) Able to cope outside 24 hour structure to pursue clinical, vocational, educational and community activities.

Level III.3 Medium-Intensity Residential Dimensional Admission Criteria
- Dimension 1: Same as III.1
- Dimension 2: Same as III.1
- Dimension 3: (a) or (b) or (c) and (d)
  (a) Psychiatric condition stabilizing but has depression, violence, stress behaviors or personality disorder
  (b) Same as III.1
  (c) Mild risk to self, others or property
  (d) Same as III.1

Level III.3 Medium-Intensity Residential Dimensional Admission Criteria
- Dimension 4: (a) or (b) or (c) or (d)
  (a) Little awareness of problems and need for treatment
  (b) Despite consequences, doesn’t understand problems
  (c) Danger to self or others with continued use
  (d) Perspective impairs ability for behavior change
### Level III.3 Medium-Intensity Residential Dimensional Admission Criteria

- **Dimension 5:** (a) or (b) or (c) or (d)
  - (a) Doesn’t recognize relapse triggers and has dangerous consequences with continued use
  - (b) Symptoms are increasing for CD or MH
  - (c) Cognitive impairment limits ability to cope with relapse
  - (d) Continued use at lower level of care

- **Dimension 6:** (a) or (b) or (c) or (d) or (e) or (f)
  - (a) Same as III.1
  - (b) Significant danger of victimization
  - (c) Same as III.1
  - (d) Same as III.1
  - (e) Same as III.1
  - (f) Unable to cope outside 24 hour setting.

### Level III.5 High-Intensity Residential Dimensional Admission Criteria

- **Dimension 1:** Same as III.3
- **Dimension 2:** Same as III.3
- **Dimension 3:** (a) or (b) or (c) or (d) or (e) and (f)
  - (a) Same as III.3
  - (b) Repeated inability to control impulses
  - (c) Significant antisocial patterns present
  - (d) Significant functional deficits are present
  - (e) Significant personality disorders
  - (f) Sufficient mental status
Level III.5 High-Intensity Residential Dimensional Admission Criteria

- Dimension 4: Same as III.3
- Dimension 5: (a) or (b) or (c) or (d) or (e)
  (a) Unaware of relapse triggers
  (b) Unable to control use with harm to self or others
  (c) Psychiatric or addiction symptoms increasing
  (d) Imminent danger of relapse with serious consequences due to a crisis
  (e) Continued use at a lower level of care.
- Dimension 6: Environment characterized by abuse, social network of users, social isolation or withdrawal, lives with a user or dealer, unable to cope outside 24 hour care, criminal behavior.

Level III.7 Medically Monitored Intensive Inpatient Treatment Dimensional Admission Criteria

- Dimension 1: Meets criteria for detoxification services.
- Dimension 2: Needs 24 hour nursing and medical monitoring but not acute care.
- Dimension 3: (a) or (b) or (c) or (d) or (e) or (f)
  (a) Psychiatric condition is unstable
  (b) Unable to manage activities of daily living
  (c) Significant functional deficits
  (d) Moderate risk to self or others
  (e) Actively intoxicated with violence towards self or others
  (f) Thought disorder that needs stabilization
Level IV Medically Managed Intensive Inpatient Treatment

Dimensional Admission Criteria

Dimension 1: Meets criteria for detoxification services.

Dimension 2:
- Biomedical problems require 24 hour medical management or skilled nursing care
- Is experiencing seizures
- Is experiencing Antabuse reaction
- Has life-threatening symptoms
- Use is complicating a medical condition
- Medical status is worsening.

Dimension 3:
- Requires psychiatric management and skilled care
- Uncontrolled behavior is imminent danger to self or others
- Mental confusion or orientation is danger to self or others
- Extreme depression poses imminent risk to safety
- Unable to manage daily living activities
- Continued use complicates psychiatric disorder
- Altered mental status

Dimension 4: Same as Level III.

Dimension 5: Same as Level III.

Dimension 6: Same as Level III.
Toolbox Training: A Substance Abuse Educational Series
For Mental Health Professionals First Edition

Title Slide - Group Exercise

Group Exercise: Case Study

Activity Assignment: ASAM Levels of Care and Criteria
See Module 5 - Handout 1 for case study and questions.

Case Study

Activity Assignment: ASAM Levels of Care and Criteria - continued
See Module 5 - Handout 1 for case study and questions.
Activity Assignment: ASAM Levels of Care and Criteria - continued

See Module 5 – Handout 1 for case study and questions.

- What stage of change is the client in based on Prochaska and Diclemente’s model?
- Is this client substance abusive or dependant based on the DSV-IV-R? Why?
- What screening and assessment tools would you utilize with this client?
- What ASAM level of care would you recommend? Why?
- Develop four questions/sentences you might utilize when working with this client based on Miller’s Motivational Interviewing.

Summary

Goal: Initiate alcohol and drug specific “assessment” process from a co-occurring perspective.

Objectives

- Define assessment process specific to alcohol and drug addiction co-occurring with mental health issues
- Discuss an implement assessment instruments
- Define DSM-IV-TR (APA, 2000) criteria for Substance Abuse and Dependence from a co-occurring perspective
- Describe ASAM levels of care and diagnostic and dimensional criteria from a co-occurring perspective
- Discuss individual assessment process to include: culture, age, gender, client strengths, support systems, mental health, substance abuse, problem gambling, physical health, physical/emotional/social abuse, family and social networks from a co-occurring perspective.
Module 6
Clinical Evaluation: Treatment Planning
Module 6 - Clinical Evaluation: Treatment Planning

Goals and Objectives

Listed below are the goals and objectives of the module and the corresponding TAP 21 competencies.

<table>
<thead>
<tr>
<th>Module 6 Goals and Objectives</th>
<th>SAMHSA CSAT TAP 21 Competencies</th>
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<tbody>
<tr>
<td><strong>Clinical Evaluation: Treatment Planning</strong></td>
<td><strong>Clinical Evaluation</strong></td>
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<tr>
<td>Goal:</td>
<td>II. Treatment Planning</td>
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<tr>
<td>Address the purpose, philosophy and implementation of co-occurring (substance abuse and mental health) &quot;treatment planning&quot;.</td>
<td>1. Obtain and interpret all relevant assessment information.</td>
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<td>Objectives:</td>
<td>2. Explain assessment findings to the client and significant others involved in potential treatment.</td>
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<tr>
<td>1. Define Treatment Planning from a co-occurring perspective;</td>
<td>3. Provide the client and significant others with clarification and further information as needed.</td>
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<td>2. Discuss the correlation between assessment and treatment planning;</td>
<td>4. Examine treatment implications in collaboration with the client and significant others.</td>
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<td>3. Identify the significance of collaborating with client’s significant others;</td>
<td>5. Confirm the readiness of the client and significant others to participate in treatment.</td>
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<td>4. Address the effects of the stages of change and motivational incentive models;</td>
<td>6. Prioritize client needs in the order they will be addressed.</td>
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<td>5. Identify service coordination approaches;</td>
<td>7. Formulate mutually agreed upon and measurable treatment outcome statements for each need.</td>
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<td>6. Develop discharge plans and documentation.</td>
<td>8. Identify appropriate strategies for each outcome.</td>
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<td>9. Coordinate treatment activities and community resources with prioritized client needs in a manner consistent with the client’s diagnosis and existing placement criteria.</td>
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<td>10. Develop with the client a mutually acceptable plan of action and method for monitoring and evaluating progress.</td>
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<td>11. Inform client of confidentiality rights, program procedures that safeguard them, and the exceptions imposed by regulations.</td>
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<td>12. Reassess the treatment plan at regular intervals and/or when indicated by changing circumstances.</td>
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Module 6 - Clinical Evaluation: Treatment

Pre-session Assignment

All participants to read:


Be prepared to reflect on and discuss this article at the training session.

Elective article:


Module 6 - Clinical Evaluation: Treatment Planning

AGENDA “DAY ONE” – October 17th

8:30  REGISTRATION
9:00  CLINICAL EVALUATION: SCREENING
2:15  CLINICAL EVALUATION: ASSESSMENT
4:30  END OF DAY ONE

AGENDA “DAY TWO” – October 18th

8:30  REGISTRATION
9:00  CLINICAL EVALUATION: ASSESSMENT
11:00 15-MINUTE BREAK

11:15 CLINICAL EVALUATION: TREATMENT PLANNING
What is treatment planning and what makes it different from screening.

Noon Lunch will be served

1:00 CLINICAL EVALUATION: TREATMENT PLANNING
Biopsychosocial Model, Program Driven, Individualized Treatment Planning

2:45 15-MINUTE BREAK

3:00 CLINICAL EVALUATION: TREATMENT PLANNING
Treatment Planning M.A.R.T.S., Treatment Plan Components Documentation

4:15 Wrap-Up, Evaluation

4:30 End of Day Two
Group Exercise: Case Study

Jason: The client is a 35-year-old Native American male school teacher. He was adopted at the age of three into a white upper middle class family where he was raised in a Christian belief system which he currently practices. He teaches math at a junior high school and is in some difficulty because of “calling in sick much too much.”

Although he has been injecting heroin on and off since he was 16, he has never been arrested. He has been through many episodes of heroin detoxification, mostly outpatient methadone detoxification but has also been in three inpatient drug treatment programs. The last inpatient program was a 28-day, biopsychosocial recovery program, and he remained both heroin and alcohol free for about six months following treatment. Although he wanted to be on methadone maintenance, he could not “document” his history of heroin addiction (this was 10 years ago). His psychiatric evaluation indicate possible depression, however he has not received a formal diagnosis. His wife is in recovery, and insisted that he return to treatment after she discovered he was taking large quantities of codeine pills from several doctors for a back injury following an automobile accident. She is unaware that he was also shooting heroin at least once daily. He has been alcohol abstinent for the past two years.

His only current medical problem is that he is hepatitis C positive, and he has been so for at least 10 years. He and his wife have incurred debt with numerous credit card holders and they are behind three months on mortgage payments. He has past medical bills at the hospital and treatment facilities for care. His daughter’s teachers repeatedly send home notices requesting he attend school activities to support his daughter. His daughter recently began missing athletic practice at school and when questioned why she stated, “my dad needs me at home sometimes”. His two cars are paid for, however one has mechanical problems. He enjoys working out at the gym, his membership is intact, but has not gone for two months.

“I’m an addict through and through. I don’t think I’ve ever stopped being an addict, even when I was going to AA every day. I wasn’t using, but I thought about using every day. My wife cleaned up when she was pregnant with our daughter and she just got her 12-year chip. She moved on with her life, but I’m stuck. My back injury really threw me into a tailspin. At first, I really needed the codeine, but now I’m just sucking them up so that I don’t go in to withdrawal. We’ve got to be really careful here. If my wife finds I’m back on the needle, she’ll be out the door this time.”
Module 6 - Handout 1, page 2

**Group Exercise: Case Study**
*(15 minutes)*

1) Break up into groups of 5 or less

2) Develop a Treatment Plan Utilizing
   - Individualize Model
   - Program Driven Model

3) Discuss pro's and con's of each model

4) Each group will report back - designate a spokesperson.

5) Open discussion in larger group
Title Slide - Toolbox Training: A Substance Abuse Counselor Training Program

Module 6 - Clinical Evaluation: Treatment Planning

Today's Presenter
Module 6- Clinical Evaluation: Treatment Planning
October 17, 2007
Presented by:
Anne Helene Skinstad, PhD and Peter Nathan, PhD

Content guided by:
Candace Peters, MA, CADC

Agenda
See Agenda Handout for additional information.
Goals and Objectives - Module 6

**Goal:** Address the purpose, philosophy and implementation of co-occurring (substance abuse and mental health) “treatment planning”.

**Objectives:**
1. Define Treatment Planning from a co-occurring perspective
2. Discuss the correlation between assessment and treatment planning
3. Identify the significance of collaborating with client’s significant others
4. Address the effects of the stages of change and motivational incentive models
5. Identify service coordination approaches
6. Develop discharge plans and documentation

**Review Activity**

Presenter will provide instructions.
What is Treatment Planning?

What is a Treatment Plan?
- A result of collaborative process between the client and the counselor
- Counselor + client develop goals and identify strategies (interventions) for achieving those goals

Treatment Plans Incorporate Information Gathered from the Assessment
- Results of an ASI (+other instruments)
- Clinical Interview
- Collateral information from sources such as family, legal, EAP, physicians, treatment facilities.
- Presenting Problems
Bridging Assessment with Treatment Planning

- Obtain and interpret all relevant assessment information.
- An integrated treatment plan addresses substance abuse and mental illness through concurrent treatment.
- First address pressing needs.
- Evaluate client motivation to address substance abuse.
- Identify treatment goals and target behaviors.
- Select interventions for achieving goals.
- Choose measures to monitor outcomes of goal setting.
- Follow up and modify treatment plans as necessary.

Treatment Planning

- At a minimum the treatment plan addresses the identified substance use disorder(s), as well as issues related to treatment progress, including relationships with family and significant others, employment, education, spirituality, health concerns, and legal needs.

1) Obtain and interpret all relevant assessment information.

- Stage of change and readiness for treatment, i.e. Prachaska and DiClemente.
- The treatment planning process.
- Motivation and motivating factors.
- The role and importance of client resources and barriers to treatment.
- The impact that the client and family systems have on treatment decisions and outcomes.
- Other sources of assessment information.
2) Explain assessment findings to the client and significant others involved in potential treatment.

- Confidentiality regulations
- Effective communication styles
- Factors effecting the client’s comprehension of assessment findings
- Roles and expectations of others potentially involved in treatment

3) Provide the client and significant others with clarification and further information as needed.

- Effective communication styles
- Methods to elicit feedback

4) Examine treatment implications in collaboration with the client and significant others.

- Available treatment modalities, client placement criteria, and cost issues
- The effectiveness of the various treatment models based on current research
- Implications of various treatment alternatives, including no treatment.
5) Confirm the readiness of the client and significant others to participate in treatment.
- Motivational processes
- Stages of change model

6) Prioritize client needs in the order they will be addressed.
- Treatment sequencing and the continuum of care.
- Hierarchy of needs
- Interrelationship among client needs and problems.

7) Formulate mutually agreed upon and measurable treatment outcome statements for each need.
- Levels of client motivation
- Treatment needs of diverse populations
- How to write measurable outcome statements
8) Identify appropriate strategies for each outcome.
- Intervention strategies
- Level of client’s interest in making specific changes
- Treatment issues with diverse populations

9) Coordinate treatment activities and community resources with prioritized client needs in a manner consistent with the client’s diagnosis and existing placement criteria.
- Treatment modalities and community resources.
- Contributions of other professions and mutual-help or self-help support groups.
- Current placement criteria.
- The importance of client’s racial or ethnic culture, age, developmental level, gender, and life circumstances in coordinating resources to client needs.

10) Develop with the client a mutually acceptable plan of action and method for monitoring and evaluating progress.
- The relationship among problem statements, desired outcomes, and treatment strategies.
- Short- and long-term treatment planning
- Evaluation methodology.
11) Inform client of confidentiality rights, program procedures that safeguard them, and the exceptions imposed by regulations.

- Federal, State, and agency confidentiality regulations, requirements, and policies.
- Resources for legal consultation.
- Effective communication styles.

12) Reassess the treatment plan at regular intervals and/or when indicated by changing circumstances.

- Evaluate treatment and stages of recovery.
- Review and revise the treatment plan.

Title Slide - Group Exercise: Journal Article Review
Journal Article Review

Required Reading:

Optional Reading:
Introduction of the Biopsychological Model

- The Biopsychosocial Model of medicine, coined in 1977 by a psychiatrist named George Engel, is widely used as a backdrop in explaining substance abuse and mental health disorders.
- By most standards, the model is comprehensive and supports several different theories and practices.
- The strength of the biopsychosocial model is that one theory is not necessarily discounted in favor of another theory.
- The model allows for differing views.
- Theories can be organized in such a way that they actually complement one another and yet highlight differences in explaining the complexity of treating multiple disorders.

Minimum standard:

- Identifies substance use disorder
- Issues related to treatment progress
  - Family/significant others
  - Health & legal issues
  - Employment & other
From:
Mid-America Addiction Technology Transfer Center. (2005)

What may be addressed in the Plan?

- Possible Mental Disorders
- Mental Status
- Risk Assessments
- Treatment History
- Reasons for Treatment
- Physical Health & Nutrition
- Substance Use History
- Obstacles to Recovery
- Work History
- Family History
- Sexuality & Intimate Relations
- Beliefs and Values
- Education History
- Finances History
- Military History
- Legal Problems
- Free time
- Special Issues
- Assets
- Liabilities
- Readiness to learn
Treatment Plans Are . . .

- Meaningless & time consuming
- Ignored
- Same plan, different names

Frequently Heard Comments About Treatment Plans
It’s meaningless and time consuming
It’s never seen again or ignored in the treatment process
I copy the same form and just change the name at the top of the form. All our clients go through the same program, so they have the same plan

Clinicians intend to provide ethically sound individual treatment plans, however barriers often inhibit good intention.

Recent report indicates . . .

Treatment programs are choking on data collection requirements . . .
Almost none of the data collected were used in clinical decision-making or program planning – it was just paperwork.

(McLellan, A.T.; Carise, D; Kieber, H. “Can the National Addiction Treatment Infrastructure Support the Public’s Demand for Quality Care?” 2004 Report)
From: Mid-America Addiction Technology Transfer Center. (2005)

**Things to thin about . . .**

Consider information required by funding entities/managed care

Is there duplication of information collected?

Do we use technology?

How can paperwork become useful in treatment planning?

**TITLE SLIDE:**

**PROGRAM DRIVEN TREATMENT PLANNING**
Field of Substance Abuse Treatment: Early Work - “One Size Fits All”

Historically, the field of substance abuse treatment operated from a “one size fits all” treatment philosophy.

- The focus was on a limited number of tools and strategies that had worked with some consistency.
- Programs used the same tools, in the same way, with everyone regardless of their specific problems
- Unique aspects of client problems and treatment needs were not reflected in treatment planning.
- Most of the time, treatment plans were developed without client involvement and “put in the chart” for the duration of treatment.

What is a Program - Drive Plan?

The client must fit into the program’s regimen. A program-Driven Treatment Plan reflects the components and/or standard activities and services available within the treatment program. There is little difference among clients’ treatment plans. This type of plan will be referred to as the old method of treatment planning.
Program Drive Plans

Client will:
- attend 3 AA Meetings a Week
- complete steps 1, 2, & 3
- ATTEND GROUP SESSIONS 3X/WK
- Meet with counselor 1x/wk
- Complete 28-day program

Program-Driven Plans - Other Common Problems “Only baggy jeans?”

- Identify only those services or program elements immediately available and readily delivered in the agency.
- Based on the client’s assessment, additional services may be necessary. Program-driven plans often do not reflect referrals to community service providers such as psychiatric clinics, training programs, or HIV testing clinics.
Title Slide

Treatment Planning: A paradigm Shift

From:
Mid-America Addiction Technology Transfer Center. (2005).

Paradigm Shift to Individualized Treatment Plans
What caused the shift?

Clinicians and researchers wanted to:
- Improve treatment outcomes.
- Effectively target clients’ needs
- Reflect the variety of techniques and medications used in treatment today.

In addition, payers wanted to contain costs of care by using the lower (less expensive) levels of care when justifiable (Kadden & Skerker, 1999).
Individualized Treatment Planning

What should be addressed in a Plan?

NO GOLD STANDARD

Clinicians focus on marrying the processes of assessment and treatment planning
- By focusing on “marrying” the assessment and treatment planning processes, the treatment plan serves as a real guide to service delivery.

Building S.M.A.R.T. Treatment Objectives and Interventions

- Objectives are what the client will do to achieve the goal.
- Interventions are what the staff will do to assist the client in meeting those goals.
Treatment Objectives and Interventions are S.M.A.R.T.

S=SPECIFIC
- Objectives and interventions are specific and goal-focused allowing both client and counselor to note progress (or lack of progress).
- Specific behaviors are targeted which will help clients reduce symptoms and improve level of functioning.

M=MEASURABLE
- Objectives are measurable so that the client and counselor can document change.
- Interventions are measurable and hold the counselor and treatment program accountable.
- Dates, occasions of a behavior, and rating scale scores may be included in the objectives.

Examples of measurable indicators include:
- ASI Severity Scores, including interviewer Severity Ratings (e.g., severity rating in the medical domain)
- Other evaluation scales, test scores, changes in level of risk scales (e.g., Beck’s Depression Scale score drops two points)
- Mental status or behavioral changes (e.g., number of days alcohol free, number of emergency room visits, days of medical problems)
- Type and frequency of services received (e.g., attended five support sessions).
From:
Mid-America Addiction Technology Transfer Center. (2005).

A = ATTAINABLE

- Goals, objectives, and interventions should be achievable in the active treatment phase.
- Remember to focus on “improved functioning” or improved functional impairment rather than the “end” or “cure” of the problem.
- Example – Fill out job application vs. become employed full time.
- Identify those goals that can be attained in the level of care provided.
- Identify those clients that need referrals to outside agencies.
- Objectives and interventions may need to be revised when client moves from one level of care to another.

From:
Mid-America Addiction Technology Transfer Center. (2005).

R = REALISTIC

- Objectives are realistic.
- It is reasonable to expect that the client can attain the objective in a specific time period.
- Goals and objectives are achievable given client environment, supports, diagnosis, levels of functioning or level of functional impairment.
- Have a realistic expectation that a client is able to achieve goals and take steps on her or his own behalf.
T=TIME-LIMITED

- Specific, time-limited goals and objectives are emphasized
- Achievement of goals, objectives, and interventions can be reviewed within a specific time period.

S.M.A.R.T. Clinical Example:

Develop 2 S.M.A.R.T. objectives and 2 or more interventions for the following Problem Statement:

- Client reports three emergency room visits for physical injuries (bruised ribs, broken arm) in the last six months due to physical altercations with a live-in boyfriend.
Why Make the Effort?

Individualized Treatment Plans
- Improve treatment outcomes
- Increase retention rates

Clients matter !!!!!!!

From:
Mid-America Addiction Technology Transfer Center. (2005).

Research Supports Individualized Plans
- Retention in treatment improves when services are matched to a client’s problems.
- Clients “whose problems are identified at admission and then receive services that are matched to those problems, stay in treatment longer.”

(Carise et al., 2004; Hser, Polinsky, Magilone, & Anglin, 1999; Kosten et al., 1987; McLellan et al., 1999)
From:
Mid-America Addiction Technology Transfer Center. (2005).

**Treatment Plan Components**

1. **Problem Statements** are based on the information the counselor gathers during the assessment.
2. **Goal Statements** are based on the problem statements. Goals included in the plan should be reasonably achievable in the active treatment phase.
From:
Mid-America Addiction Technology Transfer Center. (2005).

**Treatment Plan Components**

3. **Objectives** are defined as what the client will do to meet those treatment goals.
4. **Interventions** are defined as what the staff will do to assist the client.

From:
Mid-America Addiction Technology Transfer Center. (2005).

**Is Plan Consistent with . . . ?**

- Level of Service
- Provider Role
- Scope of Practice
Treatment Plan should reflect...

Involvement of . . .

- Client (a must)
- Significant Other (a plus)

Did You Know a Treatment Plan . . . ?

Helps you and the client stay . . .

- Focused
- Goal-oriented
Did You Know a Treatment Plan ...?

- Maximizes use of counselor time in session or activity
- Offers protection from possible litigation

Individualized Treatment Plan is “Sized” to Match Client Problems and Needs

- Not all clients have the same needs or are in the same situation
- The individualized treatment plan is made to “fit” the client based on her/his unique:
  - Abilities
  - Goals
  - Lifestyle
  - Socioeconomic realities
  - Work history
  - Educational background
  - Culture

  - When treatment programs do not offer services that address specific client needs, referrals to outside services are necessary.
GROUP EXERCISE: Treatment Planning

Case Study

See Module 6 – Handout 1

Documentation
Documentation: The Progress Note

Documentation Includes:
- Type of Session (individual, group, family, collateral);
- Level of Care
- Date
- Client Name
- Counselor Name (typed)
- Counselor Signature and Credentials

Progress Note Formats
- NAPT: Narrative, Assessment, Plan, Time/Duration
- SOAP: Subjective Impression, Objective Measurable Information, Assessment, Plan
- BIRP: Behaviors/Symptoms/Skill Deficits, Intervention/Treatment Objectives, Response/Consumer, Plan

From:
Mid-America Addiction Technology Transfer Center. (2005).

Documentation: Keep in Mind . . .

Basic Guidelines
- Notes are dated, signed, and legible.
- Client name and identifier are included on each page of the clinical record.
- Referral information has been documented.
- Sources of information are clearly documented.
- Client strengths and limitations in achieving goals are noted and considered.
- The style of documentation should be consistent and standardized throughout the agency/institution.
- Abbreviations should be standardized and used in consistent context.
- Documentation should reflect changes in client status including response to and outcome of interventions.
From:  
Mid-America Addiction Technology Transfer Center. (2005).

**Basic Guidelines**

- Entries should include the clinician’s professional assessment and continued plan of action.
- Changes in client status should be documented (e.g., change in level of care provided or discharge status).
- Client response to and outcome of interventions should be included.
- Observed behavior should be noted.
- Include documentation of progress towards goals and completion of objectives.
Basic Guidelines

Entries should include: Your professional assessment and plan of action to be taken

Legal Issues and Recommendations

- Document non-routine calls, missed sessions, and consultations with other professionals.
- Avoid reporting staff problems in the case notes, including staff conflict and rivalries.
- Chart client’s non-conforming behavior.
- Record unauthorized discharges and elopements.
- Note limitations being provided to the client.

Recognized Documentation Formats

Progress Notes (S.O.A.P.)
- Subjective – the patient’s observations or thoughts, a client’s direct statement
- Objective – the clinician’s observations during the session
- Assessment – the clinician’s understanding of the problem and test results
- Plans – goals, objectives, and interventions reflective of problems/needs identified during assessment or ongoing assessment

Progress Notes (D.A.P.)
- D = Describe (or Data)
- A = Assess
- P = Plan

Appelbaum and Gutheil (1982) recommend counselors take the perspective that treatment records will have future readers. Entries will be read or scrutinized by others.
Presentation Summary
Module 5: Treatment Planning

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2) Explain assessment findings to the client and significant others involved in potential treatment.
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4) Examine treatment implications in collaboration with the client and significant others.
5) Confirm the readiness of the client and significant others to participate in treatment (motivation level).
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Presentation Summary
Module 6: Treatment Planning

7) Formulate mutually agreed upon and measurable treatment outcome statements for each need
8) Identify appropriate strategies for each outcome
9) Coordinate treatment activities and community resources with prioritized client needs in a manner consistent with the client’s diagnosis and existing placement criteria
10) Develop with the client a mutually acceptable plan of action & method for monitoring progress
11) Inform client of confidentiality rights, program procedures that safeguard them, and the exceptions imposed by regulations
12) Reassess the treatment plan at regular intervals and/or when indicated by changing circumstances.

Evaluations and Certificates

- Please complete the evaluations: consent, pre, post/survey
- Sign out
- You will receive a follow-up survey in approximately 30 days—Returned this survey in the self-addressed envelope
- Your certificate of completion will be available at the end of the series. If you need adaptations to this format please speak to Brenda Hollingsworth.

  Treatment Knowledge
  Referral, Service Coordination and Documentation
  Professional Readiness: Attitudes and Values

- THANK YOU FOR ATTENDING!!
This training series integrates:

- CSAT’s **TAP 21**: Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice
- NIDA’s Principles of Drug Addiction Treatment: A Research-Based Guide
- Overview of empirically supported innovations

**Center for Substance Abuse Treatment (CSAT)**

**TAP 21: Addiction Counseling Competencies:**
The Knowledge, Skills, and Attitudes of Professional Practice

**Principles of Drug Addiction Treatment: A Research-Based Guide**

- Frequently Asked Questions
- Drug Addiction Treatment in the U.S.
- Scientifically Based Approaches to Drug Addiction Treatment
- Resources
References

See the reference pages at end of module for complete list of references.

Toolbox Training: A Substance Abuse Education Series for Mental Health Professionals

Thank you for taking the time out of your very important work to ensure quality service through education to the persons we serve.

Candace Peters, MA, CADC