ADMISSION AND DISCHARGE CRITERIA AND ASSESSMENT TOOLS MANUAL (REVISED)

Helping Clients Navigate Addiction Treatment in Ontario Using the Admission and Discharge Criteria and Standardized Tools

Susan Cross & Linda B. Sibley
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PREFACE

This manual will help you make the best use of these tools and criteria in your clinical practice. Even if you have had some previous training or experience with these materials, you will find that the information within these pages will increase your level of knowledge, and enhance your ability to deliver quality services and to interact with colleagues across the addiction treatment system.

The Standardized Assessment Tools package is based on current thinking in the addiction treatment field in Ontario. Current best-practice models are included in the appendixes. As new information in the field of addiction research becomes available, the tools of clinical practice will evolve as well.

The practical tips and clinical challenges we present in this manual grew out of the very rich discussions with and creative comments and suggestions from participants in training sessions across the province in 2000–2001. We thank the participants in these earliest training sessions for their enthusiasm and involvement during the process of this manual’s development.

The manual is divided into two parts. The first six chapters, Part One, review basic principles and approaches when using and interpreting the tools and forms with clients. Chapter 1, “Putting the client front and centre,” provides a framework to understand the history and evolution of this initiative. The next three chapters—Chapter 2, “The assessment process,” Chapter 3, “The interview process” and Chapter 4, “Clinical challenges with standardized tools”—focus on the clinical interviewing process. Chapter 5, “Working with clinical examples,” introduces the clinical case examples.

Each tool or form is described in detail in its own chapter in Part Two of this manual. We begin with the Psychoactive Drug History Questionnaire in Chapter 6 and conclude with the Health Screening Form in Chapter 13. Chapter 14, “Putting it all together,” shows you how to use the assessment results to create a clinical profile using the Clinical Profile Form and how to apply those results to the Admission and Discharge Criteria. The appendixes provide supplementary material on the tools and list other resources.

This manual contains clinical examples and reference materials to enhance your learning. Throughout the manual, there are:

1. Clinical tips
2. Clinical challenges
3. References to supplementary material or related resources
4. Case histories
5. Sample counsellor responses.
1. Clinical tips give quick reminders of how to use the tools and criteria. They are tips on how to use the best-practice parameters with specific populations or they present common approaches to counselling or motivational interviewing.

2. Clinical challenges are short pieces framed as questions that draw your attention to common clinical situations or problems. For each question, the manual offers a possible solution, presented with discussion. Remember that these are hypothetical cases designed to enhance learning. In real counselling situations, choices are sometimes complex and our reactions or decisions can be influenced by other contributing factors. There may be more than one solution for some problems, and you may want to consult a supervisor or peer to determine the right solution for the situation.

3. References direct you to further reading, other resources or sections within the manual that you may want to have at hand as you read appear throughout the chapters.

4. Case histories are included in the manual. You will meet Harry James and Joyce Smithers. Both are composite characters with fictitious names, but their stories are a combination of real cases from the Ontario addiction treatment continuum. Once you have read the case histories in Chapter 5, you will begin to find parts of Harry's story and Joyce's story woven into the chapters of Part Two. (Please note that when we refer in general to individual clients we alternate between the pronouns "he" and "she.")

Specific assessment tools and forms are discussed in Part 2 (Chapters 7 to 14). At the end of each chapter, you will find sample forms (the tool and any related scoring sheets) filled in correctly, one sample pertaining to Harry's case and one pertaining to Joyce's. For example, after the discussion of the Psychoactive Drug History Questionnaire (DHQ) in Chapter 6, you will find a DHQ completed with Harry's information and another completed for Joyce. These samples illustrate how to correctly complete the tools with data from a specific case history.

In this way, you will be learning more about Harry and Joyce just as if you were their counsellor and gathering information and understanding of their situations through each successive tool. The completed tools for Harry and Joyce provide an opportunity to practise interpreting the clinical information as if the clients had given the information personally. You will begin to build a clinical profile of each client as you progress through the chapters. We have written the clinical notes that relate to each tool; there are numerical codes or check marks in the boxes that the client or counsellor would normally fill in.

Interpretations of the clinical information related to each tool are provided at the end of each chapter. These interpretations will either confirm your thoughts, interpretations and analysis or introduce a different perspective on how to use the tools to develop a clinical profile.

As well, each tool is discussed in the context of the Admission and Discharge Criteria. Within each chapter you will have an opportunity to use the fictitious cases of Harry and Joyce to practise mapping onto the Admission and Discharge Criteria.

5. Sample counsellor responses are included in each chapter that discusses a specific tool. These responses show how you might pull information from the tool, the interview and clinical observations to form a response or query for the client. The examples developed use the data from each tool, information from the case history and motivational interviewing principles to draw more information from Harry and Joyce.
Chapter 14 is called “Putting it all together.” This last chapter incorporates the scores for Harry and Joyce and shows you how to fill in the Tracking Summary and Clinical Profile Form. At the end, you will have a working copy of each tool correctly completed, a discussion of the clinical information found in each tool and a summarizing discussion at the end of the chapter.
ACKNOWLEDGEMENTS

The authors would like to thank everyone who has helped us with this project! We appreciate all the time our committee spent coaching us while offering their guidance and support. Many thanks go to Pam Gardiner from the House of Friendship for her insights. We are very grateful to Christine Bois, Joanne Short, Virginia Carver, Jane Fjeld, Christine McDermid and Tammy Williams from CAMH. We made it!

We offer special thanks to Brian Rush for guidance in scientific direction and new research to read. We are grateful for the time that our external review committee spent poring over the text and offering their suggestions to make this a stronger document.

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We also want to acknowledge the support from our families who are very happy that we have completed this book!

We dedicate this manual to all the adults, youth and families who will choose to change their own substance use habits in the future; or who will support someone else who does. This book was written for you.
Part One
Principles and Approaches

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INTRODUCTION

Imagine if it was your role to develop a well-functioning, efficient and effective addiction treatment system. What would be the essential elements of the system? What tools could you give counsellors to help clients to move through the treatment system easily and effectively, accessing the level and type of service that best suited their current needs?

These were the questions those who developed Ontario’s Admission and Discharge Criteria asked themselves a decade ago. These people, from all parts of the addiction treatment continuum, began by compiling a list of the principles that represented the core values of the Ontario addiction treatment system. Their work, begun in 1996 and completed in 2000, created Ontario’s Admission and Discharge Criteria and the adoption of seven tools within a standardized assessment package. This manual will describe the tools in depth and how the results they yield are analyzed using the criteria. But first let’s look at the principles that guided the committee who developed the Admission and Discharge Criteria and that are embodied in the criteria.

ADMISSION AND DISCHARGE CRITERIA PRINCIPLES

1. The addiction treatment service system exists to meet the needs of people with addictions who are clients of the system rather than clients of individual agencies.

   This first principle challenges us to change our way of thinking. Historically, we have thought of clients as belonging to our own particular agency. However, when we view our clients as clients of the entire addiction treatment continuum, we open up a wider range of options for our clients. This new perspective obliges us to look beyond our doors for the most appropriate service to address a client’s current needs.

   Putting this first principle into action may take some practice. If it is not already standard practice for you, the next time you assist a client in constructing a treatment plan, remind yourself of this principle and envision what the system has to offer the client, rather than what your particular service alone can provide.

2. Addiction treatment service agencies, through a coordinated and integrated network of services, will meet each client’s individual needs, rather than fit clients into predetermined services.

   How can we satisfy this principle when the programs we provide are often set with a predetermined length and particular content? It can be extremely challenging for the addictions treatment system to put this principle into operation. For example, what if a client only needs to attend a program for two weeks, but the program offered is three weeks long? Is the client “failing to complete the program” by only attending for as long as she needs, or is she getting from the program what she needs right now?

* In 1996–97, two committees, with full representation across the addiction treatment system in Ontario and led by and reporting to the Ontario Substance Abuse Bureau, began a restructuring process to develop best practices and to increase efficiency and effectiveness in the addiction treatment system in Ontario. The planning and restructuring process is described in a provincial planning document called “Setting the Course” (OSAB, 1999). Through the committee’s field-wide representation and extensive consultation process, the addiction treatment system itself has been responsible for the development of the criteria and the tools. The final versions were released in June 2000 (Standardized Assessment Tools for Ontario) and September 2000 (Admission and Discharge Criteria).
Like the first principle, the second principle challenges us to think differently. Rather than obliging the client to always complete a set length or type of treatment, this principle encourages us to mould our services to meet the individual client’s needs. Customizing our services this way is truly fundamental to providing client-centred care.

3. **The addiction treatment system will reflect and use best practices.**

Addiction treatment in Ontario has adopted a “best practice” format. Best practices are those operations, approaches and guidelines that describe the “best we know at this point in time” about providing addictions treatment. Best-practice documents are based on both research and experience and outline the best way to provide treatment in general or for a particular population.

Best practices for addiction treatment have changed rather dramatically over the past 20 years. For example, harm reduction is a relatively new concept that has allowed clients who previously would not have accessed our system to receive care directed to their current goals and needs. It is important that each of us takes responsibility for keeping apprised of new research and best-practice documents and to see that they are used in improving our service delivery system. As a starting point, Appendix C, “Resources,” and the References section in this manual will point you to a number of documents describing best practices.

4. **Clients will receive an appropriate level of assessment that is individualized and tailored to their needs and that recognizes the importance of previous assessment information and avoids duplication.**

The core package of assessment tools was developed to follow this principle. The core package has been set up so that the information gathered will move with the client through the system to minimize duplication, that is, to avoid multiple interactions within the system asking similar questions and gathering similar information from the client.

5. **Clients will be offered the least intrusive intervention that is most likely to help them regain their health.**

This principle reinforces the need to offer the client the type and level of treatment that will cause the least disruption to his life, while offering him the level of intensity and support that meets his needs. For example, day treatment has many of the same components as residential treatment. It is an effective treatment option for those clients who can remain in the local community and do not require the structure and milieu of residential treatment.

This principle recommends that clients who have not attended treatment in the past should start with this less intrusive treatment, unless the Admission and Discharge Criteria clearly indicate they need more care and support.

6. **Addiction treatment service agencies will adopt a stepped approach to care, placing clients in the least intrusive intervention that will meet their needs, and then, as their needs change, helping them to move easily through the system.**
With a “stepped” approach to care, the client begins at the least intrusive level of care that meets their current needs. They move up to a more intensive level of care if they are not progressing, and they move down to a less intensive level of care as they become able to function with a lower level of support.

According to these principles, the level of intensity may not be increased unless the assessment process indicates the client needs it. The client must meet the admission criteria for a particular service category in order to access that level of care.

7. Clients will be continually assessed and reassessed throughout their treatment to ensure that the services they receive match their needs.

As clients move through treatment, their needs change. A stepped approach to care requires that the client be reassessed regularly so that treatment planning decisions may be revised as needed. The core assessment package was designed to allow reassessment with the same instruments in order to monitor change. However, not all the tools need to be re-administered—only those relevant to decision making about the next step or steps in an individual’s treatment plan.

8. Clients will be referred to residential medical or psychiatric treatment services only when they have serious psychiatric or medical problems and require specialized treatment in a multidisciplinary setting.

There are so few facilities for specialized medical or psychiatric treatment that only those with serious problems should be referred to these facilities. That is, these facilities should be reserved for those who require these specialized services in order to achieve treatment goals.

9. Services can be provided in a variety of settings (including outside the addiction treatment system).

Many of the services we provide are portable. Persons with addiction problems can be found in many different locales. Best practice for some populations—for example, older adults and youth—indicates that it is preferable to provide services within their realm of daily activity. In addition, we have many service sector partners who may also be providing services to our clientele and who may welcome addictions programming, for example, addictions counselling on a psychiatric unit of a hospital.
10. **Addiction treatment services will be coordinated and avoid unnecessary duplication.**

   In order to make sure that our clients get the most integrated and coordinated services that we can provide, and in order to make most effective use of the system’s scarce resources, we need to ensure that we work together as a system, eliminate duplication and address service shortfalls and gaps as best we can. It takes time and effort to forge new, collaborative relationships and to work out who should be providing specific services to meet local, regional and provincial needs.

11. **Addiction treatment agencies will develop common protocols and agreements to ensure that clients can move easily between different levels and intensities of service.**

   This principle recognizes that being specific about protocols and putting service agreements between agencies into place are very helpful mechanisms in ensuring a clear communication plan.

**HOW DO THE CRITERIA “WORK”?**

The Admission and Discharge Criteria are designed to help agencies determine the level, intensity and type of services that clients need throughout their treatment. They ensure that the entire system will be considered when working with a client to determine the most appropriate service. Each part of the continuum of care has a specific set of criteria to be used for admission and another set of criteria to be used for discharge planning, either to another part of the continuum or to the general community. As the criteria are used consistently across the province, clients should more easily reach the service that matches their current needs; retention of clients in treatment should improve; and the treatment system as a whole should function more efficiently. All of these changes should result in improved client outcome.

**USING THE CRITERIA TO DEVELOP A TREATMENT PLAN**

The very practical function of the criteria is to develop a treatment plan with the client. Following the administration of the core assessment package, a clinical profile is constructed and feedback of assessment results is shared with the client. It is also at this time that advice about the level and type of treatment is usually given. How do you determine where the client fits based on the criteria?

The assessment results will help you determine whether your client matches the criteria for a particular referral. Many of the criteria also require clinical observation and interaction to determine whether the criteria have been met. After scoring and putting the results into a Clinical Profile Form (discussed in detail in Chapter 14, “Putting it all together”) it is often clear where you would start reviewing the admission criteria. A detailed examination of how to use the criteria can be found in Chapter 2, “The assessment process,” and in the clinical case examples throughout Part 2.

In Ontario, different agencies did not always take into account the same rationale when admitting or discharging. For example, readiness to change is a relatively new concept for our system to consider as an admission criterion. The goal of the criteria is to admit clients who are assessed to be at the action stage of change and thus ready to
make changes in their lives and participate in structured treatment. In addition, according to the criteria, clients referred to treatment should be physically and cognitively able to participate in the treatment program. Clients who are clear-headed and in the action stage of change can, obviously, function well with structured treatment, and the treatment staff can then focus on assisting clients to move forward, rather than encouraging them to begin the process of change.

The criteria for admission do not mean that clients who are not in the action stage of change or who are physically or emotionally unwell should not be provided with service. In fact, they mean that these clients should receive services that are more appropriate to their needs. If clients are not ready to participate in structured treatment, they require a different level and intensity of care.

The Admission and Discharge Criteria have introduced a preparation and stabilization phase that allows clients to address issues that might interfere with their treatment. For example, a client who is not at the action stage of change should receive motivational counselling in a community treatment setting. A client who is physically or emotionally fragile may need a period of stabilization at a residential support service before attending structured treatment.

These criteria also differentiate between treatment and housing needs. For example, a client could attend day treatment while living at home, or live in a residential support facility while attending community treatment, rather than automatically attending a residential treatment facility.

WHAT ABOUT CLIENT PREFERENCE?

Clients may have a treatment preference right from the start. Often the client’s preference is appropriate and the referral can proceed.

However, sometimes the client’s preference is based on indicators that have little bearing on his or her own needs. For example, a client may request a referral to a particular service because an acquaintance went there, or an external referral source may have suggested a particular service because that is where they refer all clients with a substance use problem. These “preferences” may not be suitable for the client sitting before you. This is when it is helpful to provide individualized feedback on assessment results, and to point out why a certain type and intensity of treatment is more likely to be helpful than others. It is important to focus on an individualized treatment plan that takes into account the assessment information and the criteria, in order to formulate a plan that is the most suitable for the individual client.

The basic rule to remember is that clients may always choose to step down from the recommended level of care, for example, participate in community treatment rather than residential treatment, but they may not step up from the recommended level of care (for example, be referred to residential treatment while meeting the criteria for community treatment) unless there are unique circumstances that make community treatment unavailable (for example, if the only services available in the client’s language are through a residential program).
HOW DO THE CRITERIA BENEFIT CLIENTS?

1. Clients will receive consistent advice and direction about how to use the system of care no matter where they access the treatment system.

2. Clients will be referred to the place on the continuum of care that best meets their current needs.

3. The waiting period for appropriate treatment should decrease as clients are matched, using the criteria, to the type of treatment most suitable for them.

4. The client will be able to move easily throughout the system, taking advantage of available options without being constantly reassessed for admission into each program. Only appropriate components of the assessment package will be re-administered to determine next steps.

5. Clients will be admitted and discharged based on common criteria that match their particular needs rather than being slotted into available programming.

HOW DO THE CRITERIA BENEFIT THE COUNSELLOR?

1. The criteria provide guidelines for matching clients to the most appropriate treatment. Guidelines were previously unavailable for this purpose.

2. Common language and criteria provide a forum for case discussion with colleagues throughout the system.

3. Training and good clinical judgement are required to use the tools and criteria. They provide a clinical challenge to addictions counsellors.

4. Staff from different parts of the continuum of care will be communicating more frequently with respect to treatment planning and will be better informed about the system and how to best use it.

5. The criteria and tools are professional and credible. This makes it easier to justify a position of admission or discharge with other service sectors.

6. The tools and criteria provide you with a structure and format to develop a treatment plan that best serves the client.

7. Roles of different parts of the continuum should become clearer as the criteria are used, as there will be less duplication in service provision.

HOW DO THE CRITERIA BENEFIT THE SYSTEM?

1. The criteria will be used consistently across the system, encouraging services within the addiction treatment continuum to function as a system rather than as isolated, separate services.

2. Because the level and intensity of care to which clients are admitted should be appropriate for their needs, gaps in service will be identified within districts and across the province.

3. The system should become more streamlined and effective in providing appropriate care at the right stage for the client.
4. If waiting periods do not decrease with the Admission and Discharge Criteria implemented across the system, then those working in addiction treatment services have a stronger case to support requests for increased funding.

5. Clients will receive treatment at the community level when the assessment or their particular personal circumstances indicate it. Treatment plans must be based on the principle of least intrusive level of care first. This principle ensures that more expensive, intrusive residential treatment is reserved for clients with more severe problems or for those who require the supportive structure of the residential setting. Clients who are referred to residential treatment services must be at a stage of change that indicates that they are ready to make changes in their lives.

6. The introduction of stabilization as a pre-treatment phase should free some residential treatment beds for those who are ready to participate. Clients requiring stabilization should receive those services at less expensive, less structured facilities. When clients are stable and have dealt with situations that might interfere with their involvement in treatment, they will be better able to focus on and participate in addictions treatment.

**THEN AND NOW: HOW DO WE MEASURE CLIENT FUNCTIONING?**

**BACKGROUND**

Over the decades, Ontario’s assessment practices have evolved to become a part of every sector in the addiction treatment system of Ontario. Ontario first developed a standardized assessment protocol in the middle of the 1970s. Most communities received funding for agencies that would conduct assessments, develop treatment plans and make referrals. The concept of a separate place on the continuum for assessment was new to Ontario and was not common elsewhere prior to the middle of the 1970s. In 1978 Dr. Joan Marshman, the President of the Addiction Research Foundation (ARF), released a report suggesting that there be an objective source of assessment and referral in each community in Ontario.

In the 1980s and 1990s, more and more assessment tools and protocols were developed and implemented across the continuum, so that the process moved away from standardization. During these decades, agencies had a significant amount of autonomy in the selection of tools and many individual protocols were developed, with the result that the client might have different assessment experiences from agency to agency within the same community. The benefits of standardization to the client have been discussed earlier in this chapter, but we will repeat that it is the client who benefits most from less duplication in the assessment process.

Client matching is considered to be a critical element in treatment planning. The collective experience across the addiction treatment continuum in Ontario in these early years demonstrated that there are many factors that must be taken into consideration when developing a treatment plan with the client and experience taught us that matching the client to treatment through the use of the scores of tools rating dependency levels was not always the most critical element in treatment planning decisions. Rather, the client’s motivation to change (Prochaska et al., 1994, Miller, 1996) and the perceived costs and benefits of drug use (Cunningham et al., 1997) provide insight into the client’s readiness to negotiate a treatment plan. These issues shape the treatment plan far more than the actual dependency level determined from scores on tools.
The work of Prochaska et al. shaped how we understood behaviour change and affected the assessment protocols. Counsellors report that Prochaska et. al’s Transtheoretical Model, popularly known as the “Stages of Change” model, to be very helpful in understanding client behaviour change. Determining the client’s stage of change has become very important in the efficient and effective delivery of treatment resources in Ontario and is embedded in the Standardized Assessment Package and the Admission and Discharge Criteria.

The development and acceptance of a briefer assessment format has been the result of the development of stage-based interventions and other innovative approaches found in the research (Miller & Rollnick, 1991). The impact of increasing service demands and a shortage of human resources to meet these demands also facilitates the need for increased efficiencies and less duplication. The briefer assessment has been used extensively for clients in the precontemplation stage and other clients who may not require or benefit from a more comprehensive assessment.

WHAT DID WE LEARN IN THOSE EARLY YEARS?

1. Clients may need to be re-assessed using some or all of the tools should their treatment plan need revision.
2. The length of the assessment depends on the personal circumstances of the client and his or her needs, as well as on the stage of change he or she presents.
3. The assessment may be completed over a number of appointments or even between agencies in order to meet the needs of the client.
4. Clients benefit from the assessment phase because they have an opportunity to learn about their use patterns, the drinking norms and habits of the community, as well as about potential treatment options that are available.
5. Clients have strengths as well as needs that must be featured in the treatment plan.
6. Clients who participate in their own treatment planning will feel more involved and responsible for their success in meeting treatment goals.
7. Assessment is part of the treatment process. Objective measures and standards in assessment practice create a professional environment in which the client feels safe and confident about the assessment specifically, as well as about the treatment experience as a whole.
8. Motivational interviewing strategies and techniques are helpful in the assessment process because the strategies reduce barriers.
9. Treatment planning is a flexible and individualized process of matching client circumstances to a level of clinical intervention. The personal strengths and needs of the client are essential in the development of the treatment plan.
10. Ontario needs multiple points of entry on the continuum. Most urban communities need several points of entry.
11. In order to evaluate service delivery and to monitor standards of care and client outcomes, the addiction treatment system must use common tools and protocols to create consistency from service to service.
When the committee began to discuss how to search for the best tools, the following questions were posed:

- What is it that we want to measure?
- What do we need to know about the client to create a treatment plan?
- What are the most important client characteristics to assess to determine next steps?

The committee reflected on research, provincial evaluation reports and best practice models and recognized that their task was to choose tools that would generate the kind of information that would:

- embrace the principles of the Admission and Discharge Criteria
- reflect the client’s strengths and needs in the criteria
- assist with individualized treatment planning
- accommodate the clients’ perceptions of their needs
- embrace the “Stages of Change” model
- provide feedback to help increase or maintain client motivation.

**THE SEVEN AREAS OF CLIENT STRENGTH**

The seven areas of client strengths and needs were developed in the criteria so that both counsellor and client would have clear information about the impact of substance abuse as well as the protective factors and stressors that exist in each individual client’s personal history.

The seven areas are:

1. Levels of intoxication and withdrawal needs
2. Medical and psychiatric needs
3. Emotional and behavioural needs
4. Treatment readiness
5. Recovery environment
6. Relapse potential
7. Barriers and resources

Table 1 shows which tools specifically map onto the seven areas of strengths and needs. The List A tools are those that are part of the current standardized assessment package and are described in depth within this manual. The List B tools are others that have been used within the addiction treatment system in the past and that are still available to counsellors if they would like to do more assessment in particular areas; however, the use of these tools is optional and they are not included within the standardized assessment package. Several tools measure more than one area of strength and need. Table 1 does not include the Health Screening Form.
Table 1: Relationship between the Admission and Discharge Criteria categories of Client Strengths and Needs, and Selected Assessment Tools

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<td>A</td>
<td>B</td>
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<td>Intoxication and Withdrawal</td>
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<tr>
<td>Relapse Potential</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Key for List A:
A. Psychoactive Drug History Questionnaire
B. The Adverse Consequences of Drug Use questionnaire
C. Stages of Change Readiness and Treatment Eagerness Scale
D. Drug-Taking Confidence Questionnaire
E. Treatment Entry Questionnaire
F. Behaviour and Symptom Identification Scale
G. Perceived Social Support

Key for List B:
H. Alcohol Dependency Scale
I. Drug Abuse Screening Test
J. Michigan Alcohol Screening Test
K. Short Form Alcohol Dependence Data Questionnaire
L. Rosenberg Self-Esteem Scale (SES)
M. Guided Format
N. Personal Experience Screening Questionnaire

These areas can and should be re-assessed using the seven tools throughout the treatment process to measure progress and movement in the treatment plan. You can re-administer any tools that are appropriate to the need to revise the client’s treatment plan. The treatment plan may need to be revised as new information is collected throughout the treatment experience. This will be more completely discussed in Chapter 2, “The assessment process.”

The Local Health Integration Networks have adopted the Standardized Assessment Package—seven tools that are mandatory for use by agencies funded by Local Health Integration Networks in the addiction treatment system. (There are appropriate clinical exceptions that are discussed throughout the rest of the manual.)

The Admission and Discharge Criteria are also mandatory in the funded addiction treatment system. The first round of training took place in 2000 and since then tools have been provided to each LHIN agency. New service definitions were developed and are discussed below. It is important to use this terminology and definitions when speaking with colleagues and the community.
SERVICE DEFINITIONS

Ontario developed service definitions to ensure consistency in terminology across the addiction treatment continuum as well as across different regions in the province (Table 2). Communities now offer services that are called the same thing from one community to another. This shared terminology makes access easier for community members.

“Service” refers to the broad category of specialized addiction treatment or support activities that take place. Services offer “programs” and “programs” are comprised of specific “activities.”

Table 2: Standardized service definitions, Ontario addiction treatment system

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry</td>
<td>Inquiry contact, intake, screening activities. Sharing of information with potential clients of the system.</td>
</tr>
<tr>
<td>Initial assessment and treatment planning</td>
<td>Mutual investigation and exploring of goals, problems and potential solutions. Process results in treatment planning based on seven areas of client strength and need. Results of assessment are used to map onto the Admission and Discharge Criteria.</td>
</tr>
<tr>
<td>Case management</td>
<td>Process of ongoing assessment, linking, planning, monitoring, coordination of services and advocacy. A primary worker is designated.</td>
</tr>
<tr>
<td>Community treatment</td>
<td>One- to two-hour sessions of addiction-specific counselling weekly in group sessions or individual formats while client lives elsewhere. Includes outreach, education, prevention and wellness activities.</td>
</tr>
<tr>
<td>Community medical and psychiatric treatment</td>
<td>Same as above or offered in day/evening format. Programs are specifically designed for clients with medical needs or concurrent disorder. May be found in hospital settings or where there is access to medical personnel.</td>
</tr>
</tbody>
</table>

Continued on next page.
The following three levels of service apply to both community and residential withdrawal management services. Clients at all levels who are not taking any medication are considered for admission.

**LEVEL I**

- Client symptoms can be safely monitored by staff that is not medically trained.
- The intensity or severity of symptoms can be managed, as required, with medical consultation being provided by a physician at an after-hours clinic, health centre or hospital emergency department.
- Client to staff ratios do not permit high-intensity symptom monitoring.
- In consultation with a physician, if necessary, consider and assess individuals for admission who are taking the following types of medication:
  - medications for medical problems
  - medications for diagnosed psychiatric problems
  - pain medications only for acute injuries or recent surgery.

---

**Table 2: Standardized service definitions, Ontario addiction treatment system (cont’d)**

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community day or evening treatment</td>
<td>A structured schedule of addiction-specific counselling activities taking place over the day or in the evening. Programs are provided five days per week while client resides elsewhere.</td>
</tr>
<tr>
<td>Residential treatment</td>
<td>A structured scheduled program of activities designed to treat addictions specifically. Client lives on-site. Client has access to 24-hour support and the residential treatment milieu.</td>
</tr>
<tr>
<td>Residential medical and psychiatric treatment</td>
<td>A structured scheduled program of addiction treatment activities provided for clients with special medical needs or concurrent disorder. Clients must require individualized medical or psychiatric care to attend. Client has 24-hour access to the residential milieu and support.</td>
</tr>
</tbody>
</table>
| Residential supportive treatment       | Level I: Housing and related recovery support in stable sober environment. Coaching for activities of daily living, community reintegration while client prepares for and attends treatment elsewhere or as post-treatment. If client is in treatment, they attend treatment elsewhere.  
Level II: Accommodation in alcohol and other drug–free setting. Addiction treatment not offered on-site. Stabilization services offered for clients prior to assessment or for pre- or post-treatment. |
| Community withdrawal management        | Assistance with voluntary withdrawal from substances. Clients may be using residential support services at the same time or may be living at home or in another community setting. Assistance is provided with or without drug therapy. There are three levels of services in withdrawal management services. |
| Residential withdrawal management      | Assistance with voluntary withdrawal from substances. Care is provided within the structure of a wms or in the hospital. Assistance is provided with or without drug therapy. There are three levels of services in withdrawal management services. |
LEVEL II

• Client symptoms can be safely monitored by staff that is not medically trained.

• The intensity or severity of symptoms can be managed, as required, with medical consultation being provided by a physician at an after-hours clinic, health centre or hospital emergency department.

• Routine medical consultation and sufficient staff resources are available to consider management of the following medications and situations:
  ◦ all medications as listed in Level I
  ◦ clients on methadone
  ◦ clients being tapered from benzodiazepines or narcotics.

LEVEL III

• Client symptoms require monitoring by medically trained staff.

• Medical consultation and staff are available on a constant basis to monitor and manage the following medications and situations:
  ◦ all medications as listed in Level I
  ◦ circumstances as listed in Level II
  ◦ medically assisted withdrawal.

Some of the service types listed above may not yet exist in each community across Ontario. Where possible, some communities may plan to develop services where there are currently “gaps” through mandate changes or reallocation of resources.

The service definitions above describe a complete continuum of care. The provincial planning initiatives support the existence of a full continuum, although in practice, it is acknowledged that there are still “gaps.” In principle, this document supports the concept of a full continuum in each community and although in the long term, it is hoped that there will be each service type in every community. In the short term, counsellors will continue to need to be creative and innovative in treatment planning to address the needs of the client when there is a service gap. Many clients will routinely be able to fit within the Admission and Discharge Criteria, and in these cases the criteria must be followed.

It is a complex initiative to develop and implement a standardized assessment format, new terminology and Admission and Discharge Criteria across the province. It has been a worthwhile investment to develop standards of assessment practice and to focus on the development of an integrated system that can address the diversity of client needs.
Chapter 2

THE ASSESSMENT PROCESS

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THE PURPOSE OF ASSESSMENT

The counsellor’s knowledge and beliefs about the purpose of assessment will impact on how the assessment is conducted and used clinically. Some counsellors view assessment as the beginning of treatment, as a clinical opportunity to engage the client in moving towards change, while others may see it as a mandatory exercise in paperwork, a task to be completed as quickly as possible before getting to the real work of treatment.

The service definitions adopted by the Ontario Substance Abuse Bureau in 1999 describe an initial assessment as “a process involving mutual investigation or exploration that provides the clinician with detailed information for the purpose of determining with the client, specific needs, goals, characteristics, problems and Stage of Change” (OSAB, 1999).

This chapter focuses on how the assessment process can contribute to a vital, dynamic interaction with the client. When assessment is perceived as a process rather than as a static, one-time procedure, the client’s progress throughout treatment is greatly enhanced. Assessment can be divided into initial assessment and ongoing assessment.

INITIAL ASSESSMENT

At first contact with the system, initial assessment identifies critical information that can be used by both clinician and client to make important next-step decisions. This information also provides baseline information to establish client functioning at treatment entry.

ONGOING ASSESSMENT

Components of the assessment can be re-administered throughout treatment to measure a client’s progress and to determine if changes should be made to the client’s treatment plan as the client proceeds through the system. In addition, client outcome can be tracked.

Both initial and ongoing assessment is essential to a client’s ability to move through the system of care with ease and in accordance with his or her needs. Because agency staff will likely be engaged in admission or discharge functions, which require the use of the tools and criteria to some extent, agency staff throughout the continuum must be able to administer, score and interpret the tools, and relate them to the Admission and Discharge Criteria.

The Models of Intake and Assessment report, issued in 1997, identifies several important functions of assessment.

• **Information**: One important function of assessment is that it provides information to clients about the link between their problems and substance use. Many clients see their substance use as separate from the rest of their lives. The assessment helps them to realize the role alcohol and other drugs play in their lives, and examine the consequences of their use on important life areas.

• **Feedback**: Assessment provides motivational feedback to clients by providing a personalized individual
profile of the assessment results. Individualized feedback presented in a motivational manner assists in engaging the client in treatment planning.

- **Planning:** Treatment planning and matching help to select the appropriate level and intensity of treatment based on the Admission and Discharge Criteria.

- **Monitoring:** Monitoring the treatment plan through ongoing assessment helps to determine whether clients should continue their current level of service or move to a different level of service.

- **Baseline data:** Gathering baseline levels of client functioning allows for comparison between the clients’ levels of functioning at the onset of contact with the treatment system with their level of functioning at various points throughout their recovery journey.

- **Database:** Creating a database or information system allows Ontario to establish client population norms for the assessment tools, conduct evaluation of the treatment system and plan for appropriate services.

**PURPOSE OF THE CORE ASSESSMENT PACKAGE**

The process of assessment, which includes initial and ongoing components, is the glue that holds the treatment system together. The intent in developing a core assessment package that would be used by all LHIN-funded agencies was to create a vehicle to assist clients to move through the system of care easily, based on their current needs. In addition, it allows clinicians from all parts of the continuum of care to communicate with each other using common standards and a common language.

The primary purpose of the core assessment package—known as List A—is to assist in determining the most appropriate level and intensity of care that the client needs at that point in time. The core assessment package provides essential information on the client’s level of functioning, enabling clinicians to use the Admission and Discharge Criteria as effectively as possible.

The core assessment package was not designed to collect all the information that would be valuable to determine specific treatment needs. Rather, it provides sufficient information to make decisions about where the client best fits within the system of care. Initial assessment provides a core set of information upon which to make these decisions.

Ongoing assessment continues at the treatment site and may include collection of relevant information to assist in determining specific treatment needs and goals within a particular treatment service.

In addition, client progress can be monitored using ongoing assessment. Ideally, the assessment package should move with the client throughout treatment, by mail, courier, fax, or electronic transfer, with the client’s consent. Some components of the package need to be re-administered at discharge or at turning points in the client’s life to assist in using the Discharge Criteria and in planning next steps with the client. In addition, follow-up can be conducted to determine client outcome.
A number of criteria were used to select the assessment tools:

- The tools had to provide information on client functioning in the seven areas of client strengths and needs.
- The tools could be used to independently measure client progress through treatment.
- The tools had to have sound psychometric properties.
• The tool needed to be relatively brief in administration.
• The tools could be used with both alcohol and other drugs.
• The tools were available at low cost.
• The tools could be used for clinical evaluation purposes.

Although there are several good multi-dimensional tools available, none of them was chosen because the entire instrument would have to be administered in order to be valid. Rather, a number of briefer tools were selected to provide flexibility in the administration, that is, one or more tools could be administered individually at relevant times throughout the client’s treatment or all the tools could be administered as a complete package at the initial assessment. It was important that the core package of tools in its entirety provide multi-dimensional information on client functioning, as specified by the areas of client strengths and needs, while still enabling the individual administration of one or more tools to monitor client progress and outcome.

WHY USE STANDARDIZED TOOLS?

There are a number of advantages to clients, clinicians and the addictions treatment system to using standardized tools.

For clients

• **Efficiency**: The assessment process is shorter, because only information necessary to make treatment and referral decisions is gathered.
• **Consistency**: Clients will receive consistent assessment no matter where they enter the addiction treatment system.
• **Individualized assessment**: The assessment process and choice of tools are tailored to meet each client’s needs. By using a number of different tools rather than a single instrument, clinicians can structure assessments to meet a client’s needs, without compromising the psychometric properties of the assessment.
• **Credible process**: Clients generally consider formal objective tools to be credible.
• **Useful information**: The results provide useful feedback, which is important, because feedback of assessment data is believed to contribute to treatment-seeking behaviour (Institute of Medicine, 1990), and is seen as a key element in the process of negotiating an optimal treatment program with the client (Allen et al., 1991).
• **Less duplication**: Clients can give consent to have their assessment results shared with other service providers and agencies and avoid having to be reassessed as they move from one service to another within the addiction treatment system.
• **A means to assess progress**: When a client is re-assessed, either during or after treatment, any change in the client’s scores can provide useful information for the client as well as the clinician.
For clinicians

- **Efficiency:** A series of short tools is an efficient way to collect information and to help agencies respond to clients in a timely way. Clinicians can spend more time determining the needs of clients with more complex problems, if necessary.

- **Integrity and validity:** By using a number of different tools rather than a single multi-dimensional instrument, clinicians can provide client-focused assessments without compromising the psychometric integrity of the process.

- **Accuracy:** Standardized tools provide accurate and consistent information clinicians can use to determine treatment needs and to develop treatment plans.

- **Better communication:** It is easier to communicate results to other clinicians, because everyone will be using the same tools and understand the results.

- **Less duplication:** The use of common assessment tools will eliminate extensive duplication of assessments.

- **Link with Admission and Discharge Criteria:** The standardized tools measure factors associated with the categories of client strength and needs (see Chapter 1, Table 1) used as the basis for admission, referral and discharge decisions. They will help clinicians operationalize the Admission and Discharge Criteria.

For the addiction services system

- **Consistency:** The common tools will ensure more consistency among clinicians and among agencies from different parts of the continuum. This is particularly important as the addiction services system moves to provide multiple entry points to the addiction treatment system (OSAB, 1999).

- **Better data:** Using the same assessment tools across all the agencies will provide a significant database for outcome monitoring. Over time, examination of the assessment results will provide valuable information about trends and changes in the client population. The assessment data generated with these tools can also be used to meet LHIN requirements for outcome measures.

- **Better policies and practices:** The information the system will gather from results of standardized assessments will help shape policies and best practices for clinicians.

- **Flexibility:** As new tools become available, they can be substituted for previous ones. This flexibility allows for continuous improvements to the assessment process.

**OVERVIEW OF THE CORE TOOLS (LIST A)**

1. **Drug History Questionnaire (DHQ)**

   - Gathers information on all psychoactive drugs used in the past 12 months, with more detailed information on drugs used over the past 90 days.

   - Uses the DATIS drug classifications.*

---

* The DATIS drug classifications include alcohol, cocaine, amphetamines and other stimulants, cannabis, benzodiazepines, barbiturates, heroin/opioids, prescription opioids, over-the-counter codeine preparations, hallucinogens, glue and other inhalants, tobacco, other psychoactive drugs and steroids.
• Is unique in its ability to collect indicators of quantity for illegal drugs.
• Requires administration by a counsellor.

2. Adverse Consequences of Drug Use

• Pinpoints those adverse consequences that are directly related to substance use (including alcohol).
• Records adverse consequences in eight life areas:
  - physical health
  - cognitive health
  - emotional health
  - relationships
  - abuse towards others
  - school/work
  - legal
  - financial.
• Provides a measure of the severity of the problem.
• Requires administration by a counsellor.

3. Drug-Taking Confidence Questionnaire (dtcq-8)

• There are separate versions for alcohol and other drug use.
• Is an eight-item questionnaire in which clients rate their confidence levels in being able to cope in high-risk situations.
• Assists in determining relapse potential in the most common high-risk situations.
• Can be self-administered by a client.

4. The Stages of Change Readiness and Treatment Eagerness Scale (SCARATES)

• There are separate versions for alcohol and drug use.
• Assesses a client’s general readiness to change.
• Yields three scores:
  - recognition
  - ambivalence
  - taking steps.
• Provides comparative norms with persons entering a treatment program.
• Can be self-administered by a client following instructions.

5. Treatment Entry Questionnaire (TEQ)

• Measures reasons why clients enter treatment.
• Yields 3 scores:
  o Internal Positive: client’s internal values are aligned with goals of treatment
  o Internal Negative: internal conflict of guilt and shame are associated with decision to enter treatment
  o External Coercion: treatment sought because of external pressures or coercion
• Can be self-administered by a client.

6. Behaviour and Symptom Identification Scale (BASIS-32)

• Provides a measure of mental health status in five major areas:
  o relation to self/others
  o daily living/role functioning
  o depression/anxiety
  o impulsive/addictive behaviour
  o psychosis.
• Used to determine if daily living skills or mental health functioning would likely interfere with addictions treatment.
• Measures functioning only over the past week.
• Can be self-administered by a client.

7. The Perceived Social Support survey (PSS)

• Describes client’s subjective view of social support.
• Separate measures for family and friends.
• Can be self-administered by a client.

8. The Health Screening Form (HSF)

• Not an assessment tool; rather it is a form to record medical history.
• Should be administered by a counsellor.

9. The Decision Tracking Summary
• This mandatory form is used to record all of the final scores for the tools that are scored (scorates, teq, dtcq-8, basis-32, pss) as well as the relevant comments for the remaining tools (dhq, Adverse Consequences, Health Screening Form).

• The form is particularly helpful as a method of summarizing the results of the administration of the tools all in one place. This form can be used as a face sheet in a client file, as well as a referral form that can be sent with appropriate client consent to potential referral destinations. Completed samples of this form illustrate the case studies in Chapter 14, “Putting it all together.”

Table 3, at the end of this chapter, gives more detail on the characteristics of the List A tools.

**OPTIONAL TOOLS (LIST B)**

List B was developed to provide a set of screening and assessment tools with sound psychometric properties that could be used to glean additional information from clients based on individual and agency needs. These tools are optional and suggested only as a guide for the use of other sound tools. Table 4, at the end of this chapter, summarizes the characteristics of the List B tools.

**THE CLIENT PROFILE FORM**

This form can help the clinician generate a client profile. It allows the clinician to note all of the relevant information pertaining to the client. The methodical examination of each of the areas of strength and need, and the additional information that often is collected during the assessment process, is noted, creating a clinical profile of the client. The seven assessment tools should be thought of as a minimum data set. The information gathered through the administration of all seven tools would not be the only information necessary to develop a treatment plan.

The Client Profile Form can be used as a summary of assessment information for the file and can also be used in sharing referral information with referral destinations. This is an optional form and can be used if the agency does not have a similar form or feels that this form is more useful.

Completed samples of this form illustrate the case studies in Chapter 14, “Putting it all together.”

**WHO GETS THE CORE PACKAGE?**

In general, clients who are stable enough to participate in an addictions treatment program and who are considering change or want help maintaining their goals must have the core package administered.

The purpose of the core package is to gather information that is necessary to determine, using the Admission and Discharge Criteria, the level and intensity of treatment that is best for the client.
Although the Admission and Discharge Criteria are to be used with all clients entering the continuum of care, the assessment package need only be used with those clients who are considering change in their substance use (or requesting help with goal maintenance), and who are sufficiently stable to participate in addictions treatment planning to access scheduled structured addictions treatment. The core package helps clinicians determine whether the client should be referred to community treatment, residential treatment, residential medical and psychiatric services or residential support services.

YOUTH UNDER THE AGE OF 18

It is acknowledged that not all of the tools in the core assessment package (List A) have been used extensively with adolescents. There are three assessment tools that are most suitable to use with adolescents:

- The DHQ
- The Adverse Consequences of Substance Use questionnaire
- BASIS-32.

The administration of these three tools and the Health Screening Form is required if the client is stable and considering changing his or her substance use. As well, among the optional tools (List B), there is an additional assessment tool appropriate for youth, the Drug Avoidance Self-Efficacy Scale (DASES), which can be substituted for the DTCQ-8 to measure client self-efficacy and relapse potential (Martin, 1992). However, if the adolescent is being referred to residential treatment, all seven tools in the core package must be administered and the Tracking Form completed.

WHO MIGHT NOT GET THE CORE PACKAGE?

CLIENTS IN THE PRECONTEMPLATION STAGE

Those clients who do not recognize the existence of a substance abuse problem or who make contact with the system only because of external coercion do not require the core assessment package, as they likely do not intend to enter structured treatment. Although not required, it is well known that information and personalized feedback are extremely helpful in moving from the precontemplation stage to a later stage of change. In fact, many services are using all or some of the tools with those in the precontemplation stage of change due to their effectiveness in providing individualized feedback. It is an individual agency decision whether or not to use the core package with clients in the precontemplation stage of change.
CLIENTS REQUIRING STABILIZATION

Clients who are not physically, cognitively or emotionally healthy enough to fully participate in completing the tools do not require the complete core assessment package to receive stabilization services. Once the client is stable, and she or he is interested in pursuing treatment, the full core assessment package is required.

CLIENTS ENTERING WITHDRAWAL MANAGEMENT SERVICES

Clients who enter withdrawal management services and are interested in accessing structured treatment services require the full core assessment to move to community or residential treatment. Those who do not intend to move on to formal treatment could still benefit from the administration of some of the tools, but it is not required. For example, if a client had been referred to residential support services for stabilization and expressed interest in remaining there for life skills training, the core package would need to be administered and the Admission and Discharge Criteria applied.

CONSIDERING DIVERSITY

Clients who do not speak English or French, and who can access only one treatment program in their language and sensitive to their culture, need not have the core assessment tools administered, although the procedure might be useful in developing their treatment plan. Those clients who might go on to access other formal treatment programs would require the core package administered, with the help of a cultural interpreter, if necessary.

WEARING THE ASSESSOR HAT

We wear many hats as counsellors working in addiction treatment. What does it feel like to wear the assessor hat? In what ways is it different from the treatment hat? What is helpful? What is not so helpful in the assessor role?

At the initial assessment interview, clients may present in all stages of change. Some clients:

- do not recognize their substance use as problematic at all
- are seeking information about substances, but do not want to make a change in their lives
- are interested in reducing the harm of substance use, but not necessarily changing their substance use
- are interested in changing the use of one substance, but not another
- are thinking about making changes in their substance use, but are ambivalent about moving forward
- are ready and committed to making positive changes in their substance use.
We need to provide interventions to clients that are appropriate to their stage of change. We should not assume they are in the action stage. In fact, it is estimated that only 20 per cent of those with a substance abuse problem are in the action stage of change at any one time (Prochaska et al., 1994).

Because clients making first contact with the system of care are frequently in precontemplation or contemplation, weaving motivational counselling strategies into the administration of the assessment tools is a vital role for the assessor.

Counsellors may ask how the administration of a rather lengthy set of assessment tools can be used to encourage the client to change. Is the assessment package a barrier to change, an obstacle of paperwork that might turn the client away?

It is a clinical challenge for the assessor to learn how to administer the tools, construct a clinical profile, and provide feedback of the assessment results in a way that motivates the client to make changes. But with training and practice it can be done! If you are required to wear the assessor hat, ensure that you have sufficient training and supervision to wear the hat with confidence and pride.

It is not the role of the assessor to provide treatment; rather the role focuses on the determination of which part of the continuum of care will most appropriately respond to the client’s strengths and needs. It is a role of collecting only enough information to make that determination using the tools and Admission and Discharge Criteria, and then to move the client forward to the next step in their recovery path.

At initial assessment, the role is very focused and the counsellor provides a specific functional service to the client. In addition, this role requires a high level of clinical skill and expertise.

**Clinical tip**

At times, the assessor may feel pressured to provide the client with immediate treatment. After all, the window of opportunity may soon close and the client may not return. Remember that the vital task at initial stages of contact is to establish rapport and ensure that the client knows you are committed to working out the best possible treatment plan given the individual client’s circumstances and treatment available. Rushing into immediate treatment is not always in the best interest of the client.

**PHASES OF INITIAL ASSESSMENT AND TREATMENT PLANNING**

There are three distinct phases to the assessment process and therapeutic relationship. It is important to do the right things at the right time. A premature focus on tools or data gathering may make client engagement difficult. The opposite is also true; lack of attention paid to gathering personal information about the client can make him feel that his personal situation is not important; he may question the value of further sessions.
The phases are:

1. Setting the stage
2. Interaction with a purpose
3. Client feedback

SETTING THE STAGE

The first time you meet with your client, you will have an opportunity to set the tone for all later meetings. Whether you work in a community treatment setting, a withdrawal management service or a residential setting, you will have an opportunity to create an impression of your nature and personality. You may, in fact, create an impression of the entire addiction treatment continuum, and you have tremendous responsibility to represent it accurately and in a non-judgmental fashion.

The initial interview is usually to gather or confirm demographic information that may have been initially collected over the phone or in a screening session. You may also be gathering medical information about stages of withdrawal, symptom management, ability to engage in next steps, and so on.

In some situations or with specific populations, the first interview may not be an appropriate time to administer any or all of the tools. You should use your clinical judgment to decide whether the client is able to participate and benefit from the experience on that day. Although the use of the standardized tools is mandatory for LHIN-funded agencies, there is no expectation that all appropriate tools be administered in the first interview.

Setting the stage for a good interview means that you have addressed issues such as:

- privacy and anonymity
- environmental comfort
- personal client states
- timeliness of the interview
- establishing rapport.

Privacy and anonymity

- Can the client speak freely and confidentially?
- If the client is using the computer, can anyone else see the screen?
- Can anyone else hear the client?
- Can the client hear anyone else?
- Has the client been informed of her right to confidentiality, and the limits on confidentiality that exist?
Environmental comfort

- Is the environment comfortable?
- Have barriers to access been addressed?
- Does the client feel safe entering and leaving?
- Is there enough personal space?
- Can the client have a break if needed?

**Clinical tip**

_Some clients will be more comfortable than others using a computer. Do not assume that the client does not want to enter her own information into a software program. Many Ontarians, regardless of age, use computers regularly and are used to the Internet, keyboards and personal computers._

Personal client states

- Is the client feeling well enough physically to participate?
- Is there any situation that will make it difficult for him to focus?
- Is he able emotionally to participate?

Timeliness of interview

- Is the timing of the appointment suitable to the client?
- Has she been on a waiting list that causes them some upset?
- Is the interview scheduled too early in her recovery (suffering from withdrawal symptoms)?

Establishing rapport

To establish rapport with your clients, remember to:

- Introduce yourself.
- Describe the length of the appointment.
- Explain your role.
- Explain their role.
- Tell them they can stop the interview and ask questions.
- Explain how important it is that they participate as fully as they can right now and that they can add information next time.
• Explain that you will explore together the issues and concerns that they have or that others may have.

• Describe any tools that will be administered, the process involved and say that you will explain fully the interpretation and scoring. Give them an opportunity to ask questions and address any concerns or fears they may have. Some clients have had negative experiences around school testing which may cause some anxiety for them.

• Take time to explain tools that are to be self-administered, including what each measures. Be available to clients to answer questions and ask them for their feedback after they have completed each tool.

• Familiarize the client with any tools on the computer; describe the screens, process and how they are to enter data. Be available to them and check in from time to time to answer questions.

It is important to ensure that the stage is set for an interview that is sensitive to the needs of individual clients and their emotional, physical and psychological functioning at that time. A good clinician is aware that interviews must accommodate the differences of individual clients from diverse population groups.

It is appropriate to conduct interviews in other settings if it will assist you in giving a good interview. Your interviews may be informal, for example, during a leisure activity, such as a game of pool, or may be formally conducted in an office at an allotted time and place. You may use an individual format or group structure to do your work. Sometimes one must shorten the amount of allotted time for an interview (for example, when working with seniors) or take a break, if according to your clinical judgment, it would help the client to focus later. If the task at hand seems too arduous or difficult, don’t be afraid to set it aside and return to it later.

Clinical tip

When working with youth, it might be a good idea to walk outside or take them somewhere where they feel comfortable. It is appropriate to take the interview to the client, depending on the situation. Make sure that there is appropriate space to meet in and privacy.

MAPPING ONTO THE ADMISSION AND DISCHARGE CRITERIA

The Admission and Discharge Criteria are the road map to the treatment system. One navigates through the road map via the assessment tools. Both the Admission and Discharge Criteria and the assessment tools were based on the premise that a finite amount of information about client functioning in seven areas of strengths and needs would allow for decisions to be made about navigating the treatment system effectively. To repeat, the seven areas of strengths and needs are:

• acute intoxication and withdrawal needs
• medical and psychiatric needs
• emotional and behavioral needs
• treatment readiness
The assessment results will give you clinical information about the client’s functioning in these seven areas and guide your clinical decisions about the Admission and Discharge Criteria.

It is important to remember that the Admission and Discharge Criteria must be used for all clients entering the addictions treatment continuum of care. The exceptions to the administration of the tools do not apply to the Admission and Discharge Criteria. It is imperative to use the Admission and Discharge Criteria with all clients receiving service from any point on the continuum of care.

**NAVIGATING THE ADMISSION AND DISCHARGE CRITERIA**

For the next section, you will need to refer to the Admission and Discharge Criteria, which can be found in Appendix A. Print the pages you need or open the document and minimize the screen so that you can work back and forth between the criteria and this manual. Begin with the first of 16 decision trees, the “Admission decision tree.” It provides an overview of the Admission and Discharge Criteria, illustrating the path that a counsellor would follow to determine next steps for the client. Each of the figures has a corresponding page, outlining the full criteria.

At the top of the page is “Initial screening/problem identification.” If you turn to the next page, the Admission and Discharge Criteria directs you through the screening process to determine what the client wants and to help you to deal with any significant presenting problems that require immediate attention prior to the client’s entering the addiction treatment system.

Assuming that immediate problems are resolved, the next step in the assessment is to review the four “bubbles” in the centre of the “Admission decision tree.” These are important areas to assess prior to directing the client to formalized addictions treatment. The first of the four “bubbles” relates to assessment for withdrawal management services. If withdrawal management is an issue for your client, you will move on to the two-part decision tree “Assessing the client for appropriate level/intensity of withdrawal management services.” The first of these two trees focuses on complex medical problems. The criteria down the left side of three review acute medical complications, which would warrant a referral to emergency services. The criteria on the right review potential medical complications warranting medical consultation. The second of these trees reflects the criteria for referral to a residential withdrawal management service (criteria on the left) or to community withdrawal management, if available in your community (criteria on the right).

The second “bubble” on the “Admission decision tree” addresses the need for stabilization services. Clients requiring a stabilization phase may access either community treatment or residential support services. In addition, temporary or initial stabilization may begin at withdrawal management services.
Clients accessing community treatment for stabilization fall into two categories:

1. People who are not yet ready to make a change in their substance use and would likely benefit from motivational counselling.
2. People who are not healthy enough to participate in structured treatment either because of poor physical health or cognitive limitations, which might improve with basic care and time, and who have a safe supportive place to reside while attending community stabilization services.

Clients who have the same limitations to participating in treatment as described in the second point above but who are without a safe supportive residence may benefit more from moving through the stabilization phase at a residential support service that could provide basic care and support.

Clients who may require community or residential stabilization need to be screened using these admission criteria for stabilization services (see the “Assessing the client’s need for stabilization services” tree). The BĀSIS-32 and the Health Screening Form are two important components of the core assessment package, which could be used to assist in determining areas of difficulty.

If, once the client is stabilized, she intends to participate in structured treatment, the core set of tools should be administered.

The third bubble on the original “Admission decision tree” addresses the need for medical or psychiatric services. The tree “Assessing the client’s need for medical/psychiatric services” outlines the criteria with which to make this decision.

If the client has at least one of the listed problems at a level serious enough to interfere with addiction treatment and is not currently under medical and psychiatric care, a referral for medical or psychiatric assessment may be warranted.

The fourth bubble in the “Admission decision tree” examines the need for residential support services. These services do not have in-house structured treatment programs, however, clients may live in these environments while attending treatment programs elsewhere in the community. Clients may be entering residential support services either prior to treatment (for stabilization), as a place to live while receiving treatment at another location, or post-treatment. Clients entering residential support services for stabilization do not need the seven tools administered prior to admission. However, once stable, the tools would be administered if the client chooses to move on to participate in a treatment program. The two other categories of clients entering residential support (living at the residence and receiving treatment elsewhere or for post treatment support) would have had the tools administered before the referral was made. Of course, all referrals to residential support services would have the Admission and Discharge Criteria applied, even in the absence of the tools, to ensure the admission was appropriate.

Determination of where the client best fits in the service system always requires the use of the Admission and Discharge Criteria, but does not always require the administration of the tools. The client may not have had the tools administered at the point when you are assessing whether your client meets the admission criteria. The client may access the services in these four bubbles because they require stabilization or a treatment intervention that does not entail attending scheduled, structured treatment. The core assessment package is specifically for clients
intending to access formalized treatment, either at the community level or the residential level. Therefore, should a client who is referred to withdrawal management or residential support services express interest in formalized treatment, the entire package of tools would need to be administered prior to attending treatment.

The box below the bubbles on the “Admission decision tree” indicates that many clients who use the services specified in the bubbles will move on to structured treatment services. It is at this point in the assessment that the assessment tools are particularly useful and, in fact, are mandatory in deciding, according to the criteria, whether residential or community treatment is most appropriate for the client’s strengths and needs. The remaining trees help you navigate through the progressive pathways till you arrive at the best possible treatment option based on your client’s characteristics, client preference and treatment issues. The Admission and Discharge Criteria used in conjunction with a clinical profile derived from the administration of the core assessment tools and any other essential information-gathering procedures will ensure that all clients arrive at the doorstep of the most appropriate service available in the addiction treatment system of care.

The “Discharge decision tree” directs you to the criteria that are used to determine if a client is ready to be discharged from their current level of service, either to another level of service (more intensive or less intensive), or to the community. Re-administration of some of the assessment tools should be done to compare current client scores with scores at initial assessment. This gives you a measure of change in client functioning and information to use when examining the discharge criteria.

**USING DATIS**

DATIS is a provincial database of client demographics, indicators of substance use, problem gambling and services provided to Ontarians. The database pertains to information about clients who have attended addiction services funded by the Local Health Integration Networks. Each LHIN-funded program submits client data and service activities on a semi-annual basis. A provincial picture is created as well as an agency profile.

This is a mandatory requirement for LHIN-funded agencies. The software is called Catalyst and program staff enters data into Catalyst pertaining to gender, age, drug of choice, use patterns and identified drugs of concern.

Catalyst incorporates means to fully support the principles of standardized assessment and Admission and Discharge Criteria. The Standardized Assessment Tools and other mandatory forms are found in Catalyst and provision may be made for program staff to download and print the forms from the DATIS Web site. Assessment tool responses, scales and scores can be entered directly into Catalyst, and the tools that require scoring have been programmed to calculate the client’s scores on these tools (TEQ, SCORATES, BASIS-32, DTCQ, PSS).

The Health Screening Form information has been embedded into the health section of Catalyst. Catalyst also provides for electronic referral of clients to other participating agencies. Selected information and data can be shared electronically between agencies as long as the client has given informed consent. Reminders to secure client consent to the transmittal of referral and assessment information to another agency are built into Catalyst.
Table 3: Primary characteristics of the core assessment tools—List A

<table>
<thead>
<tr>
<th>Measure</th>
<th>Purpose</th>
<th>Clinical utility</th>
<th>Age of target population</th>
<th>Norms available</th>
<th>Referenced or documented psychometric properties</th>
<th>Options</th>
<th>Time</th>
<th>Training needed</th>
<th>Fee for use</th>
<th>Substance(s) if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHQ</td>
<td>To obtain detailed history of client’s alcohol and other drug use in past 90 days</td>
<td>Level of treatment, goal planning</td>
<td>Adults and adolescents</td>
<td>N/A</td>
<td>Test retest reliability, Partially structured interview</td>
<td>20 mins (depending on how extensive client’s use has been in past)</td>
<td>Yes</td>
<td>Permission to use</td>
<td>Use DATIS drug classes</td>
<td></td>
</tr>
</tbody>
</table>
| Adverse Consequences of Substance Use | To measure severity and range of adverse consequences | Level of treatment, goal planning | Adults and adolescents | No              | None                                           | Interview             | 10 mins          | Minimal          | Permission to use | Combines consequences across all substances used in the period
| SOCRATES         | To measure readiness for change                                         | Level of treatment, treatment goal planning | Adults         | Yes              | Test and retest reliability, Paper, pencil self-test | 10 mins | Minimal          | No               | 8A: version for alcohol, 8D: version for drugs |

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<table>
<thead>
<tr>
<th>Measure</th>
<th>Purpose</th>
<th>Clinical utility</th>
<th>Age of target population</th>
<th>Norms available</th>
<th>Referenced or documented psychometric properties</th>
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<th>Time</th>
<th>Training needed</th>
<th>Fee for use</th>
<th>Substance(s) if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>BASIS-32</td>
<td>To measure level of difficulty in various areas of life functioning within past week</td>
<td>Mental health status</td>
<td>Adults and adolescents</td>
<td>Yes</td>
<td>Reliability and validity (4, 5)</td>
<td>Paper and pencil self, structured interview</td>
<td>10 mins</td>
<td>Yes</td>
<td>MOHLTC to hold provincial licence</td>
<td>Relation to self &amp; others, daily living &amp; role functioning, depression &amp; anxiety, impulsive or addictive behaviour, psychosis</td>
</tr>
<tr>
<td>PSS</td>
<td>To assess quality of relationships with family and friends</td>
<td>Assists in assessment of client’s potential recovery environment</td>
<td>Adults</td>
<td>Yes</td>
<td>Rice &amp; Longabaugh, 1996</td>
<td>Paper and pencil self</td>
<td>Two mins</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>DTCQ-8</td>
<td>Provides profile of client’s perceived ability to resist drinking heavily or use other drugs in variety of situations</td>
<td>Monitors a client’s progress in treatment, relapse potential</td>
<td>Adults</td>
<td>Yes, by age and sex</td>
<td>Reliability (2, 3), validity</td>
<td>Paper and pencil self, computer self</td>
<td>Three mins</td>
<td>Minimal</td>
<td>Permission to use</td>
<td>Client responds with reference to single problem substance, including alcohol</td>
</tr>
<tr>
<td>TEQ</td>
<td>To measure motivation level</td>
<td>Level of autonomous external and introjected motivation</td>
<td>Adults</td>
<td>Reliability, validity</td>
<td>Paper, pencil self</td>
<td>10 mins</td>
<td>Minimal</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure</td>
<td>Purpose</td>
<td>Clinical utility</td>
<td>Age of target population</td>
<td>Norms available</td>
<td>Referenced or documented psychometric properties</td>
<td>Options</td>
<td>Time</td>
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<td>Fee for use</td>
<td>Substance(s) if applicable</td>
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</tr>
<tr>
<td>ADS</td>
<td>To measure level of alcohol dependence, based on alcohol dependence syndrome</td>
<td>Screening and case finding, level of treatment &amp; goal planning</td>
<td>Adults</td>
<td>Yes, various treatment samples</td>
<td>Reliability &amp; validity (6, 7)</td>
<td>Paper and pencil self, interview, computer self</td>
<td>5 mins</td>
<td>Yes</td>
<td>Alcohol</td>
<td>Substances other than alcohol &amp; tobacco</td>
</tr>
<tr>
<td>DAST</td>
<td>To measure level of drug problem</td>
<td>Screening and case finding, level of treatment &amp; goal planning</td>
<td>Adults</td>
<td>Yes</td>
<td>Reliability &amp; validity (8, 9)</td>
<td>Paper and pencil self</td>
<td>5 mins</td>
<td>Basic</td>
<td>Yes</td>
<td>Substances other than alcohol &amp; tobacco</td>
</tr>
<tr>
<td>DASES</td>
<td>To measure self-efficacy</td>
<td>To assess relapse potential; treatment &amp; goal planning</td>
<td>Youth</td>
<td>Yes, young multiple-drug users</td>
<td>Predictive validity, reliability, validity</td>
<td>Paper &amp; pencil self, interview</td>
<td>10 mins</td>
<td>No</td>
<td>No</td>
<td>Questions refer to drugs/alcohol</td>
</tr>
<tr>
<td>MAST</td>
<td>Provides a rapid &amp; effective screening for lifetime alcohol-related problems</td>
<td>To screen for alcoholism with a variety of populations</td>
<td>Adults</td>
<td>No</td>
<td>Reliability, validity</td>
<td>Paper and pencil self</td>
<td>10 mins</td>
<td>No</td>
<td>No</td>
<td>Alcohol only, see DAST for drug equivalent</td>
</tr>
</tbody>
</table>

Continued on next page.
Table 4: Primary characteristics of the core assessment tools—List B (cont’d)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Purpose</th>
<th>Clinical utility</th>
<th>Age of target population</th>
<th>Norms available</th>
<th>Referenced or documented psychometric properties</th>
<th>Options</th>
<th>Time</th>
<th>Training needed</th>
<th>Fee for use</th>
<th>Substance(s) if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>SADD</td>
<td>To measure alcohol dependence</td>
<td>To determine level of treatment &amp; goal planning</td>
<td>Adults</td>
<td>Yes, young male offenders</td>
<td>Reliability, validity</td>
<td>Paper and pencil self</td>
<td>Two-five mins</td>
<td>No</td>
<td>No</td>
<td>Alcohol</td>
</tr>
<tr>
<td>PESQ</td>
<td>To screen for substance abuse</td>
<td>To identify teenagers who should be referred for a more thorough assessment of their substance use</td>
<td>Adolescents</td>
<td>Yes, various samples</td>
<td>Internal consistency; content, criterion &amp; construct validity</td>
<td>Paper and pencil self</td>
<td>Five mins</td>
<td>No</td>
<td>Yes</td>
<td>Alcohol and other drugs</td>
</tr>
<tr>
<td>Guided Format for Consulting with Families</td>
<td>Identifies problematic substance use among all members; impact of substance use in life areas</td>
<td>Treatment &amp; goal planning</td>
<td>Families</td>
<td>No</td>
<td>Interview</td>
<td>Yes</td>
<td>No</td>
<td>Alcohol and other drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rosenberg Self-Esteem Scale</td>
<td>To measure self-esteem</td>
<td>Adults</td>
<td>Yes, general population</td>
<td>Reliability, validity</td>
<td>Paper and pencil, self</td>
<td>Five mins</td>
<td>Basic</td>
<td>No</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
Chapter 3

THE INTERVIEW PROCESS

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THE CORE ELEMENTS OF A GOOD INTERVIEW

Building on Chapter 2’s discussion of the specific features of a good assessment process, we will now outline the core elements of a good interview. Along the way, we will review some common clinical challenges that counsellors may experience during the process and provide some tips to use in clinical practice.

The core elements of a good interview include such things as:

1. **Motivational interviewing principles:**
   - Use counselling strategies that build rapport.
   - Use counselling strategies that reduce resistance.
   - Use counselling strategies that are client-centred.

2. **Doing the right thing at the right time:**
   - Use clinical judgment to determine when to use the tools in an interview.
   - Use interventions that are designed for the client’s stage of change.

3. **Using an appropriate mix of probing, data gathering and direction.**

4. **Using your clinical judgement:**
   - Should the tools be used for this individual?
   - Should the tools be used at this time?
   - Can the tools be used within the interview? Outside of the interview? As homework?

5. **Employing “best practices”:**
   - Use clinical standards that respect diversity.
   - Use clinical standards that are research-based and have clinical utility.

In Chapter 2, you read some clinical tips about things that will help your client feel comfortable with you in the context of a therapeutic relationship. The client needs to understand your role, its limitations and strengths and your relationship with other referral sources. The client also needs to develop an understanding of his or her own role in this equation.

All of the above factors, in conjunction with the style of your interview, the format, the purpose of the interview, and other elements such as the client’s personal circumstances, are the key elements to a positive interview experience.
Research indicates that “the way in which the therapist interacts with the client appears to be nearly as important as, or more important than, the specific approach or school of thought from which he or she operates. This suggests that therapist style, a variable often ignored in outcome research, is a major determinant of treatment success” (Miller & Rollnick, 1991, p. 4).

This manual will assist you to develop an interview style that promotes client engagement and encourages your client to attend further appointments, if that is appropriate to your role. There is an art to incorporating the use of structured tools into the interview. You have a complex task to build rapport, gather information and enhance client information within the structure of an interview.

**Clinical challenge**

**Question:** What do I do if my client is high or under the influence of alcohol?

**Discussion:** If your client is under the influence of substances, his impression of you may be coloured by his level of intoxication, as may your impression of him! Ensure that the first interview is not conducted while the client is too affected by intoxicants. And how does one define too intoxicated? When should an interview be rebooked, and what are the potential consequences? Several factors will need to be considered to answer these questions.

1. **The setting in which you work:** Your agency may have a policy about how and when staff are to proceed with an interview if the client is under the influence of substances. Policies will need to be developed for all substances. Training can be accessed about intoxication, about when substance use can interfere with participation, and about how to determine when the client is too intoxicated to proceed. The policies of the the setting in which you work, as well as the work to be accomplished, will determine the answer to this question.

   Some centres may have a policy to use a Breathalyzer on-site for determining alcohol intoxication. In such a case, clients would be required to provide a breath sample and the level of blood alcohol concentration would be a deciding factor in whether the interview proceeded or was rebooked.

   The level of a client’s impairment would determine whether the application of the tools would be meaningful or not. Agencies should focus on the level of impairment rather than on clients’ meeting expectations of “24 hours clean and sober” or “alcohol- and drug-free.”

2. **The drug used:** Clinical settings may have different policies about specific drug use. An agency may have a policy that clients must be abstinent from some drugs but that the assessment may proceed if the client is under the influence of other drugs. For example, medication used as prescribed would be allowed, but medication purchased on the street would be considered inappropriate. Keep in mind that a clinician may not realize that a client has taken a mood-altering drug if there are no behavioural or physical indications.

3. **The work to be done in the interview:** A screening or intake interview at a withdrawal management service would naturally proceed unless there were anticipated medical complications in withdrawal. In other clinical settings such as residential treatment or support an interview to gather data and other information would most likely be rebooked. An admission interview for any setting that requires abstinence would not normally proceed and the client would be referred to
the withdrawal management service or other appropriate resource.

Should the intoxicated client be unable to go ahead with the interview, the focus becomes the safety of the client as well as of the rest of the community. The client may need a referral to a withdrawal management service or emergency department, as appropriate.

4. The client’s ability to abstain or use moderately: Some clients may not be able to attend an appointment while abstinent, in which case some mutually agreeable terms need to be set, so that the client can attend the centre to access services. There are clinical strategies that can assist a client to reduce her use over time so that she eventually, or by some agreed-upon date, can attend appointments while drug-free.

INTERACTION WITH A PURPOSE

The initial interview may have several different priorities. You may need to address the immediate needs of the client and concentrate on building rapport. In addition, collecting assessment information is important, so that referrals can be made. The interview should have structure and be meaningful to the client. The structure of each assessment interview should be consistent from client to client within an agency so that the clinician can develop skill in probing for personal information in an empathetic manner. Both clinician and client need to be clear about the purpose of the interaction. It is to:

- conduct an objective assessment of substance use
- collect baseline data to be discussed
- examine the impact of substance use on a variety of life areas
- examine the client’s perception of risk, problems and consequences
- give the client an opportunity to clearly compare her substance use patterns and consequences to those of other clients in the clinical population and in the general public. This comparing is called norm referencing and the purpose is to increase the client’s information about what responsible use looks like.

The structured assessment interview allows the clinician to ensure that all necessary data is collected so that the client and the clinician can together develop treatment goals and determine next steps.

Clinical challenge

**Question:** Does using tools diminish the ability of the client and counsellor to establish rapport?

**Discussion:** There is a time and a place for the use of tools, and once you are comfortable with the administration of the tool and have enough practice, you will find you can maintain rapport during the administration of the tool.
Remember to:

• introduce the tool
• explain its purpose
• explain what it measures and what the two of you will do with the information!

Make sure that you have enough space to administer the tools and spread out the paperwork. It is a good idea to have a small table where you can lay out the materials and where you and your client can either look at the tools together or where the client can sit to complete the tools himself.

**Clinical tip**

*It is a good idea to practise administering the tools with a colleague or with your supervisor to develop a comfort level with the materials. It takes practice to handle the forms and explain them with ease, and to score and interpret them. Again, it’s important that you can fully explain the tools to the client, including why you are using them and why investing his time to carefully assess the issues will be helpful to the client.*

If you are not yet convinced about why the tools can assist you then you will not be able to engage the client and explain to him why the tools are helpful. A good assessor understands and believes in the process of assessment and is able to convey to the client the value in the process.

**CLIENT FEEDBACK**

The purpose of the assessment is to gather data so that you can give the client individualized feedback. You will share the results of the assessment with the client using a motivational framework, counselling strategies appropriate to her stage of change and with a view to reinforcing the responsibility of the client to decide upon next steps.

The client receives personalized information and sees the scores and interpretations of the assessment tools. This can be a very motivating experience for the client. You may share personalized feedback during the assessment or in a later session, depending on the setting in which the assessment takes place.

When feedback is individualized, it is more meaningful to the client because it is clinically relevant to the client personally. It is current information about her own patterns of use. Remember that clients may not be used to thinking about their use patterns in this way. They may be surprised to see the total scores. Clients who present in various stages of change are helped differentially by personalized feedback.

See Appendix B, “The importance of motivational interviewing,” for more on building an interview style using motivational interviewing approaches and about how personalized feedback helps a client stage by stage.
Clinical tip

During the interview:

- Take your time when sharing feedback.
- Speak clearly and do not use clinical jargon.
- Give the client a copy of the feedback or results to follow along with and explain how the session will go.
- Tell them they can stop and ask questions.
- Do not set yourself up as the expert. After each tool is explained, ask the client if they understand, have questions or wish to pause and reflect on how they are reacting.
- Watch body language and other non-verbal cues for signs of resistance, distress or relief. Use motivation-enhancing techniques such as probing, reflection and amplified reflection to elicit the client’s own reactions.
- Remember that your interpretation of the results will not be as important, relevant or powerful as the client’s own!

General information about other substance users, research, or your clinical experiences can only go so far to engage the client in decision-making. The other very important piece in this equation is to relate the client’s personal feedback and scores to relevant norms. Comparisons to other non-problem users, the population that your agency serves, or the system’s alumni can be very helpful ways to allow the client to process their use compared to others. Telling the client that they drink too much may not be as helpful as saying “your total number of drinks per week is about the average that the other clients of the addiction treatment system report.” This confirms to the client that they are in the right place for help.

Clinical challenge

You may wonder, “How can I be sure that my client is telling the truth?”

Clients will give accurate information if they feel safe. A client may decide not to give you “all” the information at this time, but he may wish to share more at a later time. At the beginning of an assessment interview it is wise to cover this by saying, “I hope you can be as honest as possible when answering questions. This is your process and it will be more helpful for you if you can give more information. I realize that it takes time to develop trust and that you may feel you have a lot at stake. If you wish to change or add any information later, please feel free to do so.”

Research shows that a self-report is generally valid as long as the client does not have a positive blood alcohol level at the time of the interview and has nothing to lose by telling the truth.
**Clinical challenge**

**Question:** "How do I encourage mandated clients to tell the truth when the truth could result in the loss of children, liberty, employment or welfare?" Clients will need to be fully informed of the limits of confidentiality.

**Discussion:** Inform clients fully of your obligation to report to family and children’s services. Inform them of their rights to confidentiality, informed consent and protection or advocacy.

It may be helpful to do a decisional balance so that they may decide the benefits and costs of telling you the whole story as opposed to bits and pieces.

A decisional balance is an exercise where you and the client map out the costs and benefits of both sides of an issue.

It is important to explain the importance of their input and how it is reflected in the results and interpretations. Some clients will be encouraged in knowing that an accurate assessment may show that they are drinking within acceptable standards or minimally beyond responsible use standards. The assessment may show that they do not actually have as much of a problem as they feared! Sometimes referral sources are mistaken in their interpretation that a client is substance-dependent. Sometimes the client has a history of bad decision-making or inappropriate lifestyle choices and it is assumed that a previous history of substance abuse or dependence means she is a drug abuser now.

You may be able to convince the client that it is in her interest in the long run to participate fully. Encourage your client to see that you cannot advocate on her behalf if you are not fully apprised of the situation.
Chapter 4

CLINICAL CHALLENGES WITH STANDARDIZED TOOLS

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INTRODUCTION

This section will discuss the unique clinical challenges found in the context of the implementation of the Standardized Assessment Tools, the largest initiative ever in the history of addiction treatment in Ontario. This section is designed to pay particular attention to some of the sectors that will be more challenged as they begin to use this standardized set of tools. This chapter will cover the specific clinical challenges found in:

- withdrawal management services
- community treatment services
- residential support services
- residential treatment settings.

It will cover the following issues:

- innovative delivery models
- time management.

CHALLENGES IN SPECIFIC TREATMENT SETTINGS

WITHDRAWAL MANAGEMENT SERVICES

This sector has not historically provided their clients with assessment services due to resource constraints, but many withdrawal management services (WMS) have developed protocols for other treatment settings to use space and assess residents of the WMS. Typically, the treatment setting that was likely to admit the client has provided the assessment service. Local planning decision-makers will need to evaluate whether this continues to make sense or whether there are other ways to meet the assessment needs of the WMS residents.

Communities may decide that the standardized assessment will be done by:

- WMS staff
- community treatment staff
- residential treatment staff
- the most common entry points in the community.

Each community has an implementation committee that must discuss and decide how to implement the administration of assessment tools in ways that make sense for the system, the clients and the staff. The implementation committee will have to consider the effect on resources for the protocols developed. The protocols must provide for appropriately educated and experienced clinical staff. This requires:
- training in the administration and interpretation of the tools
- training in the use of and a commitment to adhere to the Admission and Discharge Criteria
- best use of human resources in all clinical settings.

Frequently asked questions

Which tools must be administered at a WMS?

All clients who are thought to be “treatment ready” to participate in structured treatment must have all seven tools administered prior to referral to begin treatment.

All seven can be completed at the WMS or in conjunction with other service providers. This is what is meant by “stepped assessment.” The client may have several tools administered at the WMS and the rest in a community treatment setting. All of the seven tools must be administered prior to admission to treatment—it doesn’t matter where the tools are administered or by whom.

Much depends on the local planning decisions and the availability of the WMS staff to provide assessment services, their training and clinical ability. The seven tools can be administered on-site, if that is seen as appropriate. The WMS may only administer some of the tools to determine next steps in the referral process.

For example, if a client indicates he would like to talk to someone about change, a WMS staff could administer the Socrates, TEQ and the Health Screening Form to determine if he is in an appropriate stage from which to refer. The client may be homeless and be referred to a shelter with a date to attend the local community treatment centre for an assessment. The scores and results could be entered into DATIS and forwarded.

Or, if you are unsure about the client’s motivation and readiness for treatment, the WMS staff might administer the Socrates and TEQ. The scores on the subscales will provide information about his general readiness to enter treatment and the internal reasons for wanting to continue on in treatment. Client profiles on these tools may also provide clear information about the client’s disinterest in next steps. See the following chapters for more information about the utility of the tools to assist you in determining next steps.

If you are unsure about how much support the client feels he has prior to discharge, administer the PSS. The PSS will provide information about the client’s perceptions about the support that his family and friends provide. This information will assist you in deciding whether a stabilization phase is required or whether residential support services would assist the client while the balance of the assessment is completed.

Do all residents of the WMS get assessed?

No. As with all settings, certain clients will not be assessed at all. These include clients who are in the precontemplation stage or who require a period of stabilization. Withdrawal management services should examine their annual statistics (DATIS) to determine the percentage of clients who have traditionally been referred to treatment programs. All clients who are referred to treatment settings must have the tools completed prior to admission.
The pss predicts that some of their admissions will not be appropriate for the assessment process. This will need to be tracked so that valid estimates can be shared about the percentage of admissions that are treatment ready. Research indicates that approximately 20 per cent of clients tend to be in action stages and the actual percentage of clients who are treatment ready will impact on the workload at pss. In time, through the collection of assessment information and datis data, Ontario will have accurate information about the percentage of clients who are treatment ready in each of the service types.

What if the client wants to return home?

The client can be administered the socrates, teq, pss and Health Screening Form to determine next steps. If the client is precontemplative or wishes to discharge himself or herself against program advice, then follow policies and procedures and facilitate the discharge.

If a client wishes to discharge himself or herself prior to completing withdrawal, the tools need not be administered. The client needs to be detoxified in order to participate in the assessment process. Appropriate discharge supports might be recommended as per agency discharge policies.

Should we always administer certain tools?

It is a good idea to get some information about medical needs, so the Health Screening Form should be routinely administered. The socrates and teq may also be good standard practice at a wms to determine the general level of motivation and the specific internal values that the client has about changing the problem behaviour in question. The wms monitors withdrawal needs and symptoms and collects datis information on each client admission. This should obviously continue.

How will we decide what tools to administer?

This question must be answered in consultation with experts in the withdrawal management field and in consultation with our provincial planning associations.

COMMUNITY TREATMENT

In these settings, the use of assessment tools has been standard practice and the use of new tools should not present too much difficulty, as it is not a new clinical practice. Difficulties are more likely to be related to using different tools than have been the usual practice. It is reported that the tools take longer and some services have historically used briefer protocols and different tools altogether. The concept of “least intrusive interventions first” is also familiar in these settings.

What will need to be discussed at the implementation committee is service provision outside of the community treatment centre (ctc). In some communities it may be sensible to send the ctc staff into other settings like the wms to provide all assessment services. The staff may have to embrace more of an outreach model to deliver services and those services who have not had to deal with increased demands from the community may need to find efficiencies in service delivery models to accommodate additional requests for assistance from colleagues. All communities must carefully plan and evaluate strategies to see what works best.
Frequently asked questions

Must all the tools be administered to CTC clients if they stay at the CTC after assessment and are referred to internal programs?
Yes.

What about re-admissions?
Much of the decision will be based on the length of time since the last admission. Use all or some of the tools that will give you the information you need to update the client’s file. If the information will be clinically useful, use the tools.

RESIDENTIAL SUPPORT SERVICES

These settings will provide the stabilization period for appropriate clients. No tools will be mandatory for referrals to admit for stabilization to this sector. During the course of the interview, it may be apparent to you that the client needs a period of stabilization. There will be clients who require a stabilization period in a sober and structured environment while the assessment process is completed or before a treatment plan can be developed.

The following are indicators of the need for residential support:

• poor health
• emotional instability
• homelessness
• unsupportive or unsafe home environment
• psychiatric diagnosis needed.

This partial list is meant to illustrate potential situations or complications that might warrant a referral to a supportive recovery environment. Other potential referrals might be to shelters, safe environments for women and children or wherever the local addictions planning committee has indicated that stabilization should occur.

If a client is in need of stabilization “in order to be able to complete the tool package,” she should be referred prior to the assessment process. The assessment process may proceed over a longer period of time than usual to accommodate the special needs of the client. The Admission and Discharge Criteria allow for a stabilization period to interrupt or postpone the assessment process. The assessment can continue when the client is able.

Once the client and counsellor decide to continue with formalized assessment and treatment planning so that the client may enter treatment, all of the tools must be completed.
RESIDENTIAL TREATMENT

Clients will often be referred to residential treatment services after they have already been assessed elsewhere. It is likely that a good percentage of clients will arrive for intake interviews with the package completed or, ideally, the tools themselves, or the tracking summary and consent forms have been sent in advance by the referral source or can be accessed through DATIS.

Some residential treatment programs predict that more than 50 per cent of clients will already have been assessed using the standardized package, and so the use of standardized assessment tools will not affect their specific intake workload in regards to new assessment duties. If the residential treatment program is not identified as a point of entry to the continuum, based on the district implementation plan, this percentage may in fact be higher.

However, all residential staff that perform intake duties or assessment functions still need to know how to administer, score and interpret the tools as well as understand the Admission and Discharge Criteria.

Some residential programs may be designated as points of entry in the local district addiction treatment continuum by the implementation committee and as such would administer the Standardized Assessment Tool package and use the Admission and Discharge Criteria. They would provide assessments to determine where in the “system” the client should go next.

Some referral sources, for example, correctional services, probation officers and physicians, that routinely refer to residential treatment services will not be using the standardized assessment tools. A LHIN-funded agency has the responsibility to determine eligibility as per the Admission and Discharge Criteria, regardless of the referral source. All clients must fit the criteria for admission and must have the standardized tools package administered prior to admission. The residential treatment service will have to ensure that this occurs.

As with community treatment settings, it is expected that the residential treatment service will still want to determine suitability for their particular program. Residential programs have differences in program structure and staffing so client matching is essential. Residential programs will also want to determine if the client can be admitted without compromising the safety and security of the other clients and staff. The program will have liability issues for which they are responsible. It is assumed that the client would have an intake interview to ensure that the program fit is correct, both for the client and the program.

Some residential treatment programs in Ontario have specific intake forms that they ask referral sources to complete when a referral is made. These forms are often used for clinical programming that is unique to the residential program. The mandatory assessment tools are now the only tools that are required for the LHIN-funded programs to use to meet the Admission and Discharge Criteria. Additional forms, assessment tools and screening forms that individual treatment programs require would now need to be administered at the point of entry to that specific program. It would not be expected that referral sources fill in these additional forms. Exceptions to this would be medical history and clearance forms to be signed by physicians and so on.

There may be interest in developing a shared or common intake form that covers information related to intake decisions.
This form might include information about:

- history of violence towards self or others
- survivor history
- history of concurrent disorder
- identified barriers
- special needs
- literacy, language concerns
- diversity issues
- outstanding court dates and charges.

Residential programs and settings may use some or all of the tools at discharge to determine suitable referrals for clients who are leaving or graduating. The standardized assessment package is meant for use in both pre-treatment and post-treatment situations.

**MODELS FOR DELIVERING THE ASSESSMENT PACKAGE**

There are many ways to deliver the assessment tools. The tools can be administered:

- in one-to-one sessions
- in groups
- by clients themselves in the agency setting
- by clients themselves as homework between sessions.

The decision on which vehicle to use will depend on a variety of factors including:

- the experience of the clinician in group screening and assessments
- the setting in which the tools are to be administered
- the time allotted
- the demand for service and the available human resources
- the opinions of management and the front line staff about best practices models for intake and assessment.

Some addiction agencies have traditionally delivered intake, screening and assessment tools in group settings. It is effective, efficient and an expedient way in which to complete required paperwork. It is also a very effective way to engage clients. Other agencies have traditionally delivered assessment services on an individual basis only.
The standardized assessment package can be delivered in a variety of ways. Boards of directors, management, consumers and front line staff should ponder the best use of resources and the delivery models that suit the clinical setting. The decision to move to group modalities is often due to human resource implications and the demand for service. Group delivery models for intake, screening and assessment services are also valued for their effectiveness as well. Clients report satisfaction about the group experience in the evaluation surveys that are completed at the end of the group.

Details about the mandatory assessment tools were noted in Chapter 2, Table 3. The reader will see that some of the tools (DTCQ-8; Socrates; TEQ; PSS) can also be self-administered individually or in a group format. Some of the assessment tools lend themselves more readily to group sessions because they can be easily explained to a small group of five to eight persons and the clinician is available to answer questions and clarify concerns that participants may have. In Ontario, several agencies administer the TEQ, Socrates and PSS within group intake sessions. These three tools can also be given as homework assignments to clients for whom this would be appropriate.

This same table (List A) indicates that a trained clinical staff must administer several of the tools; they are not meant to be self-administered without access to a trained counsellor (DHQ; BASIS-32; Adverse Consequences).

The Health Screening Form also should not be self-administered without access to a counsellor, given the emotional aspects of some of the questions.

Keeping the above in mind, it is important to design an assessment process that meets the needs of the client, the agency and the staff. Waiting lists can be caused by administrative changes, such as DATIS, or by clinical improvements, such as a provincial initiative of this magnitude. Waiting lists can have an effect on client attendance and decrease motivation. Group models should be explored in settings where demand for service exceeds supply! A combination of individual sessions and group offerings can probably meet the needs of all involved. It will take creativity and openness to adapt to changes.

Several agency settings in Ontario administer all seven of the tools in a group setting once or twice per week. The client then attends a personalized feedback session the following week to receive the results of their assessment. These agencies have found that the weekly group meets the demand for service and decreases the waiting period.

Other agencies use a hybrid model where clients attend an intake group and complete the Socrates, TEQ and PSS. Then they are booked for an individual session to complete the initial assessment phase (DHQ; BASIS-32; DTCQ-8, Health Screening Form).

The model chosen and the process developed will be dependent on many factors as mentioned above. It is a wonderful opportunity for staff to discuss creative alternatives and to provide services in innovative ways.
CHAPTER 4: CLINICAL CHALLENGES WITH STANDARDIZED TOOLS

TIME MANAGEMENT

Quality assessment practices take time. Assessment is the foundation of quality treatment planning and referrals that meet the client’s needs. The use of standardized tools will benefit both client and counsellor as they provide rich information about strengths and needs. It is well worth the time it takes to increase the quality of care for Ontarians seeking assistance.

The administration of all the tools in the standardized tool package can take over an hour. Initially it may take much longer. This time frame applies to the administration, not the scoring, of all the tools, and does not include the time necessary to engage the client, build rapport and trust. Should the agency require the collection of additional assessment information, the assessment may take much longer. Agencies will need to examine their requirements for additional information and alter their practices to keep the assessment interview manageable.

The completion time suggested is a framework for planning. You are not expected to meet this as a clinical standard; it is merely a benchmark.

Counsellors may find the scoring of the tools too time consuming, so arrangements should be made to have an outside resource assist with scoring to give participants immediate feedback. Clients can be invited back for a feedback session with their personalized information.

Other factors may cause the interviews to be much longer. In order to accommodate other intake and assessment needs, the clinician must develop efficient time management practices. It takes longer to administer the entire package at first because there is a learning curve that can be steep. This is especially true for the clinician who is not used to using tools at all.

The first step in becoming skilled in the delivery of the tools is to read all manuals that accompany each tool and the available research. The rationale is to ensure that you can explain the value of each tool, the reason it was chosen for administration, the information that the tool will collect and how the tool was tested. This information may be of interest to some of your clients, and you will feel more confident if you can explain the tool in an appropriate way. The use of “research language” may not be appropriate for most clients, so you must be able to use understandable words and phrases to describe the tools and their utility.

You may choose to practise with a colleague or with the entire team. Dexterity in handling the tools will add to your confidence, and to the confidence of the client about your skills.

Make sure that you have all that you need to administer the tool. You may want to laminate sections of the manuals or handouts for the client’s reference. For example, along with the DHQ form, you will need:

- the 90-day window (more on this in Chapter 6)
- the DHQ manual to look up drug categories for reference
- the norms about substance use rates in the general population.
Time management pressures can come from a variety of sources including the setting in which you work, the demand for service from the community, human resource implications, as well as from other responsibilities you need to perform in the completion of your duties:

1. The setting in which you work will determine how long you have for an interview. Community treatment settings book one to two hours for assessments now. They will not have a huge adjustment to make to implement the standardized tool package. Withdrawal management services will have more difficulty managing the time it takes to administer the tools because shift changes further complicate this issue.

2. The demand for service from the community can increase the pressure that counsellors feel with regard to the time it takes to complete an assessment. Many services have waiting lists and report that they are under-resourced. Quality clinical practice includes a thorough assessment and the standardized tools are an integral part of this process.

3. Human resource implications are relevant concerns for all services, but they are particularly relevant for agencies that have not previously provided assessment services. An intake interview is not as time-consuming and the standardized assessment process is new to some agencies and, perhaps, will add additional work to already busy schedules. These concerns need to be discussed at the local planning level.

4. The purpose of the interview will also determine what kind of time pressures you experience. If you are doing an intake interview for a client being referred from another setting in the addiction treatment continuum, the tools will already be completed. If the package has not been completed for some reason, you will need to do so, unless there is some clinical reason why you should not.

5. The intake and assessment paradigm of the agency may make time management easier. There are some tools that can be administered in groups or can be individually self-administered. Using new assessment methods can also ease time pressures. Intake, screening and assessment procedures should be reviewed to make the process expedient.

6. The other information your agency collects may also increase the time required. Each agency should review their procedures for the collection of data and eliminate any duplication of information. Forms and protocols should be streamlined so that information is only collected once.

7. Client diversity can increase the time required to administer the assessment interview. Using interpreters and educating the client about substance use issues and concerns can increase the time required for the interview. Where necessary, it may be helpful to break the interviews into several brief sessions. The extra time it takes needs to be planned for by the counsellor and supported by the agency and the system so that everyone has access.

8. Psychological and emotional client states can make the interview longer or make the administration of tools more time-consuming. It may be sound clinical judgment to leave the tools for another session or to postpone the administration of the tool package to another time when the client is more stable. In these cases the counsellor may want to evaluate the client’s needs for stabilization, medical or psychiatric fragility and make appropriate referrals.

9. Direct service expectations may need to be adjusted as counsellors begin to administer some or all of the tools. Direct services are clinical expectations of face-to-face appointments. These are usually set at 50 to 60 per cent of clinical time spent in face-to-face clinical appointments. This can create time management pressures for staff that are trying to meet service standards.
In settings where the administration of any tool is new, there may be a need to discuss and alter other clinical expectations of clinical front line staff.

In settings where assessments have been provided historically, minor adjustments to caseloads will need to be made while staff becomes familiar with the administration of the package. Serious effects on the waiting lists of agencies should be discussed at local planning tables and adjustments made to staffing plans, protocols and so on.

**WORKING WITH RESISTANCE**

Resistance from the client can be difficult for both the clinician and the client. Resistance is not the *fault* of the client; it is a result of the interaction between the counsellor and client, the situation itself and the client’s previous experiences. It is the responsibility of the counsellor to examine the source of the resistance and to ensure that they are not adding fuel to the fire!

There are different types of resistance and specific strategies to deal with this issue in counselling. This section will briefly discuss how to minimize resistance and will discuss the counsellor’s role in the creation of resistance.

Appendix B, “The importance of motivational interviewing,” discusses the role of motivational interviewing in the reduction of resistance. There are many courses available in the community on motivational interviewing. It is advisable to take one or more to complement your work! Motivational interviewing is research-based and it is a powerful method of connecting to your client.

One will see more resistance in some stages than in others. The stage of precontemplation is the most obvious stage, because clients do not see the problem, and yet they are attending an addiction treatment centre for an interview that they do not wish to attend!

No wonder they are resistant!

Problem drinkers, randomly assigned to confrontational counselling showed much higher levels of resistance (arguing, changing the subject, interrupting, denying) than did those given a more client-centred motivational approach…..

Therapist behaviours associated with this approach [confrontation] have been shown to predict treatment failure, whereas accurate empathy—almost an exact opposite of hostile confrontation—is associated with successful outcomes.

These are quotes from William Miller and his colleagues, who developed an approach to dealing with resistance. This approach begins with the understanding that a client’s resistance may from the perception that he or she is being accused of something. Some people call this client reaction “denial” and try to confront denial with the facts as the clinician or family sees them. However, confrontation creates and exacerbates resistance. Labelling can cause resistance as well. Clients may agree that they have problems when they drink but strongly react to a label of “alcoholic” or “addict.”
Miller has developed motivational interviewing principles, which include “rolling with resistance.” Rolling with it means that counsellors do not address the resistance—they do not confront it, name it or try to correct it! They note it. They work with it and use it to explore the meaning of change and the fears of the client. What is causing the resistance?

- Is it anger or resentment?
- Have they been treated unfairly before?
- Is it fear?
- Is it embarrassment?
- Is it expectations about failure?
- What is the context in which resistance appears?
- What is the interaction between client and counsellor at the time?
- What is the client protecting?
- Did you play any role in creating or adding to it?

As Mark Twain said, “Habit is habit and cannot be flung out the window; it must be gently walked to the door.”

**Clinical tip**

*Remember when interviewing that the facts according to “others” will have little relevance to a client who is feeling resistance. The counsellor must try to understand that resistance is adaptive; it meets a need for the client. The counsellor has to understand this need. What is the concern expressed by the resistance?*

**Counselling Strategies**

Several counselling strategies have been found in Miller’s research to be very effective in minimizing resistance. A few of the techniques are illustrated below.

Client says: “I think you’re wrong!”

1. *Simple reflection*

   Counsellor responds with non-resistance. Counsellor says: “People have their own opinions and I respect that.”

2. *Amplified reflection*

   Counsellor responds using a slight exaggeration of exactly what the client said. Counsellor says: “You think I’m crazy for even suggesting it.”
3. **Double-sided reflection**

Counsellor acknowledges both sides of the client’s ambivalence. Counsellor says: “Even though you agree that change is a good idea right now, you don’t agree with the advice I’m giving.”

**Clinical tip**

*It is understood that prior to beginning assessment and counselling, the counsellor has explained the parameters of expected client behaviour and has indicated that threatening or hostile behaviour will not be tolerated in the treatment setting. Agencies should have clear policies that are explained to clients prior to beginning the initial interview. In a WMS setting, this dialogue may not take place until the client is sober or is able to understand the information.*

**SPECIAL CONSIDERATIONS**

When you are administering assessment tools, your clinical judgment will determine how to proceed. If clients are reacting with resistance it is probably a good idea to take a break or switch to another topic or task. Check with the client if moving along would suit her. Her resistance may be caused by any number of issues or concerns including time pressures, impatience to finish the appointment or a variety of good reasons. Clients may have juggled their schedule with home, work or school to attend the appointment or they may be tired. They may have physical or emotional concerns that would interfere with their ability to participate. It is wise to sort through any external causes of resistance such as personal worries, flat tires, parking problems, bus and train delays in schedules and so on, before one assumes that the source of the resistance is the administration of assessment tools.

If the client will not participate fully or is resistant to the point of disrupting the interview, the counsellor will have to act as per agency policy and terminate the interview or reschedule.

Under normal circumstances, if the assessment is not complete, the referral to treatment may not occur until the full set of tools is administered. Referrals would not normally proceed unless the assessment results could be used to map onto the Admission and Discharge Criteria.

If clinical judgment dictates that some or all of the tools should not be used, then referrals may proceed and the clinical judgment and exceptions are noted on the Tracking Form (to be discussed fully in Chapter 14).
WORKING WITH CLIENT PREFERENCE AND CHOICE

Counsellors may ask, “How can I manage to develop and implement an individualized treatment plan and work with client preferences, when the Admission and Discharge Criteria seem to be so prescriptive and I have seven mandatory tools to administer?”

These two needs are not diametrically opposed to one another!

The standardized tool package is grounded in client preference. It is the clients’ perceptions of their own functioning that are elicited in the basis-32, the Perceived Social Support survey, the socrates, the Adverse Consequences tool and the teq. The dhq is also based on self-report.

In Ontario, the importance of working with the client’s preferences and offering choice as a way to build or enhance motivation is considered best practices. The work of Annis, Sanchez-Craig, Miller and Rollnick, and Hester (Sanchez-Craig, 1993; Miller & Rollnick, 1991; Hester, 1995, 1989), to name only a few, has played a role in the development of Ontario’s best practices. Health Canada also recognizes the importance of these issues in their publications.

However, it is important to note that the client’s preferences may not always be supported by the results of the assessment. The tension between client preference and the Admission and Discharge Criteria will need to be resolved by the counsellor. The counsellor must sort through a number of factors to resolve any discrepancy between client preference and the results of the assessment. We will demonstrate this below with a hypothetical conversation between client and counsellor.

The Admission and Discharge Criteria have been developed to screen for general levels of motivation and the initial reasons for entering addiction treatment. The client’s perceptions of their own strengths and needs and the use of decision trees assist the clinician to build a treatment plan that is founded on those strengths and recognize that the client’s opinion of their needs is the best place to start. In addition, the counsellor starts by asking the client about other potential crises or situations that can influence the early phases of decision-making. As the Admission and Discharge Criteria ask,

- What does the client want?
- Is there a crisis?
- Does the client want help with housing, food, health care and other basic needs?
- Is the client at risk of withdrawal complications?
- Is the client at risk of relapse?

It will be prudent for the counsellor to address crisis situations pertaining to health and safety first. Basic needs such as shelter and food will also need to be addressed prior to assessment or treatment planning.
What happens when the counsellor and client see different needs after the assessment is complete?

Counsellors sometimes ask themselves, “Do I give the client what they want or what they need?” The answer is “Both,” but there may be a time frame on delivering both. One is probably a suitable starting place and the other the end result.

This question of want-versus-need sometimes presumes that clients cannot know what they need to do or need to change. The premise that the counsellor knows best is coloured by an attitude about clients that may damage the therapeutic relationship. The counsellor as expert is a dangerous paradigm.

A helpful paradigm is for the counsellor to be a guide who assists clients to discover what they need to do or what is available to them. It is sad but true that some clients do not have an awareness of what is available for them.

When counsellors are torn between what their client wants and what they need, they should ask themselves, “Am I imposing what I want on the client? Who wants this change more, the client or me? Who will have to live with the changes?” The answer is obvious and the plan of action is embedded in that answer. If the client is the creator of his own action plan, then the counsellor can skillfully steer him towards his choices through motivational interviewing, individualized treatment planning and an objective approach to accepting what the client knows about himself. The counsellor must give the client enough time to identify his needs. It is important not to rush the client in the decision-making process; it is not a foot race!

Remember that, by virtue of training and experience, you will certainly have a sense of what the client might do to solve problems related to substance misuse, abuse or dependence. It is what you are trained for! However, your clarity about the client’s issues need not be imposed on the client in order for him to see the need for change. It is important for you to facilitate the development of “client choice” or redirect his choices in some situations. For example, a client may not meet the Admission and Discharge Criteria for admission to a setting he is requesting. The counsellor will need to help the client work through any conflict that is caused.

The counsellor has experience at the helm, and teaches the client how to steer and feel in control of the ship at all times. When the client has safely landed at port, she will feel the necessary confidence in herself to be able to embark on the next leg of the journey.

Client preferences may not be as healthy as the counsellor might like, but it is important for the counsellor to accommodate the client’s opinion and to work to gently help the client to see the need to change behaviours. One of the goals of the Admission and Discharge Criteria is to make the best use of the most expensive resources on the addiction treatment continuum.

Keep in mind that the Admission and Discharge Criteria are designed to assist the counsellor in moving the client to the least intrusive intervention first, unless there are clinical reasons or personal circumstances that indicate a more intrusive choice of treatment. Under these special circumstances, the clinician can make a clinical exception. Such exceptions must be noted on the tracking summaries, which will be monitored within the agency and through the local system planning committee. Each local system planning committee should ideally share and compare rates of exceptions as part of its quality control function.

Should the counsellor advise the client that she meets the criteria for a more structured intervention (residential treatment) and the client indicates a preference to accept a lesser intervention (community day treatment), it is
appropriate for the counsellor to accommodate this client preference. Should the client prefer to go to residential treatment, but she does not meet the criteria, it is not appropriate to alter the treatment recommendations according to the criteria, and the client may not be referred or admitted.

The referral destination must not admit a client if she does not meet the admission criteria. The client would need to be redirected to a more appropriate resource.

In closing, the strengths and needs of the client are identified during the assessment process and the preferences of the client can be accommodated in a treatment plan, as long as the Admission and Discharge Criteria are met.

SAMPLE COUNSELLOR RESPONSE

In the following conversation, the client, Jacques, has come to the session following the assessment interview (a personalized feedback session) with a preconceived decision about where he will go for treatment. This decision is supported by Jacques’ referral source, who has also suggested that he needs the residential treatment.

Clinical information

• Jacques has been referred by Family and Children’s Services.
• He reports very heavy use of alcohol on a daily basis.
• He has been drinking heavily (12 standard drinks per day or more) for 10 years.
• Jacques has decided that he needs to abstain from alcohol.
• Assessment results confirm that alcohol is causing serious consequences and problems to personal health, emotional health and family relationships and Jacques agrees.
• Jacques has not been violent with his partner or children.
• He has not had previous treatment.
• He has stable employment, supportive family and a suitable home environment.
• He is off on sick leave for another week with support of his doctor and his employer.
• Jacques has attended the local withdrawal management service and has been abstinent for two weeks at the time the conversation below takes place.
• He is attending mutual aid group in community and reports some enjoyment of it.
• Some assessment tools were completed at the WMS, Jacques was discharged, and a referral was made for initial assessment and treatment planning. This phase of interaction has taken place and the conversation below is taking place as part of treatment planning and placement in programming.
• Jacques has knowledge of a local residential treatment service and is asking for a referral there, but he does not fit the criteria for residential support or treatment. He fits the criteria for community treatment.
Counsellor: Jacques, thanks for coming in today to discuss what you should do next. We can start by talking about how you've been since we last met, and then we can talk about the services that are available to you in the community. How does that sound?

Jacques: That sounds okay to me. I've been okay since last time. Thought about drinking, but I didn't do it. I went to a meeting instead. I've been thinking about doing this thing right, and I'd like to go to one of those programs you told me about.

Counsellor: I have examined all the assessment results and want to talk to you about what your thoughts are, as well as about the next steps that are available for you.

Jacques: I think it would be best for me to go to Program XYZ. I know some people from work who have gone there and my worker at Family and Children's Services says it's very good. They tell a lot of people to go there.

Counsellor: That XYZ program has a very good reputation, but the choice of which program you should go to is really based on exactly what you need at this time. You have been doing extremely well since you decided to stop drinking. Residential programs are actually reserved for people in Ontario who cannot meet their goals unless they go there.

Jacques, you actually might not need to go to that extreme in your treatment plan! From what I see, from what you have told me in your assessment, you are an example of someone with a lot of support right now.

Jacques: But I hear that it will be easier in the long run if I just do this thing the right way, bite the bullet and go there. I hear that in the long run I'd end up there anyway because I am a pretty heavy drinker.

Counsellor: You know, that's a very common misconception out there in the community. Most people really only know about a couple of programs in the community. There are actually quite a few different kinds of groups, sessions and alternatives out there. There isn't one program that fits everyone's needs.

One of the things that addiction treatment programs in Ontario do differently now is to look at all the areas of a person's life when creating a treatment plan. Then, you look and see what their strengths are, as well as what they need help with. Then together you pick a program or programs that will help them reach their goals. Your choices should be based on what the person is doing well, not just on his needs.

In your case, you have been abstinent for a couple of weeks now and although you are reporting some cravings, you have done very well. You also have a supportive family and a home where you can be abstinent. Some clients have homes where there is a lot of drinking going on and no one in their life is sober.

So in your situation, these are all things that you have going for you, in your corner, so to speak. It means that you have more chances of achieving your goals without the 24-hour structure that residential programs provide.

Jacques: So, are you saying that I don't need treatment? Because, if you are, I disagree with that!

Counsellor: Thanks for telling me how you feel. No, I am not saying that you do not need treatment or more formalized help. You have said that you think you need some help and I agree with you. I am saying that I think you can do this, make these changes without living away from your home.
The other bit of information that we look for, when doing an assessment, is to ask about previous treatment experiences and you have not been to treatment before. This means that we should try to find a solution that meets your needs that doesn't interrupt your life so much. You do not need to live away from your home, and you may be able to return to work while you continue to work on your abstinence goals.

To summarize, Jacques, here are your strengths. You are working, have a family that supports you, a home that is safe and sober and no previous treatment experiences. You have also been able to remain sober through the first couple of weeks, which is a really good sign! You are involved with a support group in the community and there are some other sessions and groups that we can refer you to in the evenings and on weekends.

You do have some needs. You need to continue with your support group and I can tell you about the other treatment that is appropriate for you, and you can choose from these options. There are community treatment sessions for relapse prevention and support groups. You can talk with a trained counsellor who can help you sort out your feelings about not drinking any more and who will monitor your progress. If you are struggling, then we may have to alter your plan. But we won’t do that unless you need it.

Here’s a way to think about it. If you had heart problems that could be helped by diet and exercise alone, wouldn’t it be inappropriate to recommend surgery? We need to save the surgery referrals for people who cannot survive without it; wouldn’t you agree?

Jacques: Well, I just thought residential was what I needed. I guess we can talk about this other thing. I didn’t know that it would be all right for me to go back to work. What about my worker at Family and Children’s Services?

Counsellor: Leave that to me, I’ll speak to them about what is most appropriate for you, and I will go to bat for you if there are any problems with this, okay?

Jacques: Okay.

Counsellor: Now let’s talk more about how all this information is sitting with you. Where would you like to start?
Chapter 5

WORKING WITH CLINICAL EXAMPLES

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INTRODUCTION

We will now introduce two fictitious clients, Harry James and Joyce Smithers. Their case histories provide some clear information about the substance or substances they are using, as well as their stated goals.

The cases have not been written with the intention of tricking the reader. There are no hidden clues to find, nor mysteries to solve. (If these were your real clients, there might be additional information that you would need before you could proceed clinically.) The information below will help you interpret the results that emerge as we work through the assessment tools in Part 2 of the manual. In Chapter 14, “Putting it all together,” the information gathered through the tools will be analyzed and used to create a treatment plan for each client.

CASE STUDY: HARRY JAMES

Age: 65
Gender: Male
Partnered: Widowed for seven years
Vocational: Retired federal government employee
Dependents: Son serving in Canadian Armed Forces overseas—limited contact, no other living relatives
Accommodation: Lives in a boarding house
Legal: No prior or current legal issues
Assessment date: September 13 [this year]

Current status

Harry went to Emergency because he was having alcohol-induced seizures. He was hospitalized for three days and given Valium while he was in the hospital. He was discharged from the hospital to return to his home, with an appointment to go to a community treatment service in one week. He attended the appointment and participated in an assessment. At this assessment, Harry reported abstinence since his release from the hospital.

Harry lives in a boarding home that he does not like. There is a lot of drinking and fighting in the home among other residents. He has a history of multiple health problems and is currently taking the following medications:

- Nitro-Dur 0.8 patch (0.8 mg/hr; nitroglycerin for angina pain)
- Losec: 20 mg twice daily (omeprazole; medication to reduce gastric acid)

Harry indicated that he has vomited blood and has bloody stools, and seems to have indigestion after eating any meal. He takes Ensure three times daily to supplement his food intake.
Substance use history

• Before the age of 58, Harry would have two to three drinks weekly, but after a major car accident in which he was severely burned, he increased his use of alcohol.

• His wife died in the accident.

• A friend suggested he use alcohol to help him sleep.

• He is drinking 26 ounces (750 mL) of vodka daily (about 17 standard drinks).

• He drinks in a bar to be around people.

• He has experienced blackouts during the last two years.

• His recent hospitalization for seizures is a first-time occurrence.

• Harry is a non-smoker.

While he was in hospital recovering from severe burns from the car accident at age 58, he became dependent on morphine. He was given a prescription for pain medications but did not use the prescription. After discharge from the hospital 16 months later, he said he experienced tremors, sleep disturbance and night terrors.

His relationship with his son was never very close, but since he got out of the hospital and his alcohol use increased, he has had very little contact.

Previous treatment

• Attended a 21-day abstinence-based residential program but did not complete it.

• Three admissions to the withdrawal management service over the past three years.

• Community treatment with a physician for grief issues, injuries from fire and death of wife.

• Ongoing medical tests because of his severe injuries and gastric problems.

Client’s stated concerns and intentions

• Harry is concerned about his health, and he is unhappy with his accommodation.
CASE STUDY: JOYCE SMITHERS

Age: 31  
Gender: Female  
Partnered: Separated for five years  
Vocational: Not employed outside home, receiving Ontario Works (welfare) prior to admission to withdrawal management service  
Dependents: Two children in foster care for last 30 days  
Accommodation: None  
Legal: No charges pending, no recent convictions, not on probation/parole  
Assessment date: September 13 [this year]

Current status

Client has referred herself to the withdrawal management service and has been there for five days. She has not yet completed detoxification. The assessment tools have been administered in the wms. The client is interested in pursuing referrals.

Joyce has just given up her apartment and has no fixed address. Her belongings have been moved into a friend's basement.

The assessment was completed at the wms and the results show the following:

Substance use history

- Daily drinking for last five years prior to admission to wms (three to five drinks per weekday and 10 to 12 per day on weekends).
- Alcohol is the drug of choice and Joyce usually drinks wine.
- Joyce smokes a large package of cigarettes per day.
- Joyce tried a variety of drugs as a youth (pot, lsd, mushrooms) but has not used these drugs in the last 10 years. Joyce has been using cocaine for the last year on weekends prior to this admission to the wms. She reports she will snort coke on Friday and Saturday evenings (at least three times per night).
- Joyce last used cocaine four days ago and drank alcohol the day before she admitted herself to the wms.

Previous treatment

- Attended community treatment six years ago for alcohol and cocaine problems and was abstinent for three months after graduation and then relapsed to alcohol. After another nine months, she began to use cocaine again.
- Joyce has attended 12-step meetings in the past and liked the social aspect of the meetings.
Other issues of concern

• Joyce was sexually assaulted as a teenager but has never received counselling for this issue.
• She reports feelings of depression and hopelessness.
• Her children are in care of Family and Children’s Services and have been temporarily placed in a foster home. The children were taken into custody because Joyce was intoxicated and a neighbour called the CAS.

Client’s stated concerns and intentions

• Joyce states that she is interested in abstaining from all substances.
• She wants her kids back but is afraid that she cannot stay sober.
• She will go back on Ontario Works after treatment.
• She wants to find appropriate shelter for herself and her children.
• She is interested in returning to school to get her Grade 12.
• Joyce reports feeling angry sometimes and is concerned about the source of her anger.
• She is very concerned about her relapse potential.
• Joyce does not enjoy self-help groups that are co-ed.
• She reports that she has had a lot of indigestion and has had some problems with her bowels recently.
• Joyce saw her doctor two months ago. The physician is not aware of her drinking. She was prescribed an antidepressant and has been taking it as prescribed.
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Using the ADAT Tools and Forms

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Chapter 6
THE PSYCHOACTIVE DRUG HISTORY QUESTIONNAIRE

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DESCRIPTION AND PURPOSE

The Psychoactive Drug History Questionnaire (DHQ) was designed to provide information on the quantity and frequency of substance use specifically by drug category. It was designed to measure the patterns and frequency of psychoactive drugs only. Medications that are not psychoactive are reported on the Health Screening Form (discussed in Chapter 13) and not on the DHQ.

The counsellor can use the DHQ to gather information about the clients’ use of substances by type, using 13 different DATIS categories (e.g., “alcohol,” “cannabis” and “hallucinogens”). The form includes space to record the exact amount of each substance consumed within two time frames:

- in the last 12 months
- in the last 90 days.

The DHQ focuses on the following areas of strengths and needs:

- levels of intoxication and withdrawal needs
- relapse potential.

Clinical tip

*In keeping with a stepwise approach to care, the counsellor will be evaluating throughout the assessment interview, “How much information do I need to determine the next steps?” You may find you have enough information after administering one tool, or you may find you need to go through the entire assessment package.*

The DHQ gives information about current and recent use patterns only. It is a quantity and frequency measure for the last year. With clients with a long history of use, you may need to collect more historical data to fully explore the impact of their substance use over time. For example, they may have made changes in recent years and you won’t know if you only ask about the last 12 months. This other data may include age of onset of use, the first drugs used, drugs of preference and other relevant facts. Counsellors may have other intake or data collection forms where they can note this historical information.
CHAPTER 6: THE PSYCHOACTIVE DRUG HISTORY QUESTIONNAIRE

INTENDED POPULATION

The research on this instrument indicates that it is appropriate for use with adults and youth, males and females.

ADMINISTRATION

This instrument is not intended to be given to the client as a homework assignment. It should be administered with the assistance of a counsellor trained to administer the tool in groups or in individual sessions. Some clients might be able to do more of the work independently, but the counsellor should be available to answer questions and assist the client to explore her drug use patterns. Issues that might need explanation include the definitions of the drug categories and what constitutes a standard drink. As well, the counsellor and client may discuss the street names for or characteristics of different drugs, to help identify those the client is using or has in the past. For example, the client may take a medication because she knows it helps her “nerves,” but she may not be able to identify it by its brand name, Valium.

While administering the tools, the counsellor should also be watching for nonverbal signs and body language that indicate areas of concern to the client that the counsellor would like to come back to later. Along the way, the interview process provides the opportunity to educate the client about concepts and issues such as:

- tolerance
- harm reduction
- the continuum of use, misuse, abuse and dependence
- withdrawal symptoms
- the dangers of intoxication to health.

The counsellor also has the opportunity to affirm and support the client for changes made, amounts reduced and so on. There is an opportunity to evaluate the client’s use of each drug separately. The client may be struggling with one or more drugs but using yet another as prescribed, or within safer limits.

PREPARING TO USE THE DHQ

To administer this tool, you will need the following items at your fingertips:

- a calendar with the 90-day window highlighted for your and the client’s reference
- Appendix E, “Psychoactive Drug Classes for use in Completing the DHQ,”
- Appendix F, “Drug use by adults surveyed in Canada”
- Appendix G, “Guidelines for quantifying drug use on a typical substance-using day”
- a calculator to do averages for standard drink equivalencies.
It may be helpful for you to look at the Psychoactive Drug History Questionnaire as you read this section. You may consult the sample copies for Harry and Joyce at the end of this chapter. Blank forms for the ADAT tools are available to course participants at http://www.camh.net/Publications/Resources_for_Professionals/ADAT/.

The Psychoactive Drug History Questionnaire has 14 rows, each about a drug category. Together you and your client will go methodically through each drug category to explore the client’s specific use patterns.

You can start by filling in the first two columns (use in last 12 months and in the last 90 days) for each of the categories on the questionnaire. Then, for those drug categories that the client reports as used, you go back and collect the information for the remaining three columns: the client’s reported last use; the dosage or typical amount used during the last 90 days; and your clinical comments, including notes on historical use.

Clinical tip

The counsellor has to be prepared! To administer the DHQ, the counsellor needs to be familiar with drug categories and able to explain their effect on the central nervous system. As well, the interviewer needs to understand the potential side effects, withdrawal symptoms and impact of intoxication on the body. Courses in pharmacology are available throughout the province and as part of best practice counsellors are encouraged to keep their training in this area up to date.

THE 90-DAY WINDOW

The DHQ uses a “90-day window” as the period of time for recent use. This period starts 90 days prior to the day before the interview. For example, if you are interviewing on a Monday, the 90-day period ends on Sunday, the previous day, and you count back 90 days from that to mark the beginning of the period. The reason for not marking the 90 days from the day of the interview is that the day is not over and the client might use before the day ends.

A 90-day period can also be used for purposes of follow-up and outcome evaluation. After treatment, programs could contact clients to inquire about patterns of use or abstinence “in the last 90 days.” Questions asked in this way may give a more accurate picture of how the client is doing. To illustrate, if you ask the client, “Have you used a substance?” he or she will answer yes or no, which does not reflect how recent use compares with the pre-treatment picture. Capturing use patterns over a 90-day period will provide a much more accurate overview of reduced use, problem use or periods of abstinence.

Use a calendar to find the beginning and end of the 90-day period and highlight it on the calendar for the client. Write the dates of the period at the bottom of the DHQ in the space provided.
Calendars that you can print out to use at the interview are available free online at www.timeanddate.com. You can laminate the calendar and then use a dry-erase marker to highlight the 90-day window and marker dates, so that the calendar can be used again later.

IDENTIFYING MARKERS

As you show the client the calendar, reflect on the period it spans and relate it to him or her. Do the 90 days correspond with any of the following:

- school?
- a school break?
- time when the kids were home?
- statutory holidays?
- summer vacation?
- a trip?
- family celebrations?
- cultural celebrations?

The above list contains examples of the kinds of life experiences that encourage memory and are called markers. Counsellors find that clients can remember far more than they imagine when markers are used to prompt memory. Some protocols, such as the Timeline FollowBack Method (TLFB), use a year calendar as well as a 90-day calendar. During the assessment, the client and counsellor highlight the time period they are talking about, and can tie it to markers that prompt memory.

Other common markers that may prompt more descriptive reports on patterns of substance use include:

- use patterns on paydays
- common abstinent days
- weekend versus weekday patterns
- celebrations such as weddings and parties
- holiday weekends
- vacations
- seasonal sporting activities
- attending sporting events.
EXPLORING USE PATTERNS

Going through all of the drugs first, row by row, and getting a sense of which drugs have been used at all, in the last 12 months or ever in the past (prior to the last 12 months), is helpful before you move to use patterns in the last 90 days. Using the DHQ this way, you establish first which drugs are used or have ever been used, and then focus on the categories with “yes” responses to collect the rest of the information relating to use within the 90-day period.

You can use sortable index cards to help make the interview process more interactive (for example, with youth) and to give the client a participatory role (and something to do to reduce stress or nervousness). Put the names of each drug category, with examples and street names, on individual cards (for example, “Hallucinogen” = LSD = acid).

Begin by simply asking the client to say “yes” or “no” when you say the drug category. Encourage the client to ask for other names or common slang to understand the drug category as you go through the categories/cards. Note his or her responses as you go along.

If you are using cards, ask the client to sort them into two piles: drugs they have used in the last 12 months, and drugs they have not used during the year.

The client may also sort them into one pile for drugs they have used prior to the 12-month period, and one pile for drugs they have never used.

Next, move to the column that asks about drug use in the last 90 days. You will ask the client to refer to the 90-day window highlighted on the calendar, so that the client knows the exact range of time you are exploring.

With cards, you would again have the client sort the cards into two piles, this time for the drugs they have used during this period.

How the columns are filled out, and the cards sorted, will give you some interesting information. The columns/piles may be exactly the same for the two time periods. Or, they may be quite different, perhaps showing a progression from drug to drug that shows that the situation has been getting more serious or dangerous. Or, the information may reveal an improvement in use patterns that shows that the client has been consciously making changes to decrease harm.

Clinical tip

Using cards to sort through the drug categories and the drug names within the categories adds an interactive dimension to the interview process and can be particularly appropriate for work with certain clients, for example, youth or individuals with attention deficit disorder. As well, the card piles offer an illustration of the client’s use in ways that checkboxes on a form cannot. Imagine the visual power of a client handing back two cards naming the drugs she used this week, and the entire pile for what she used a year ago.
While some clients use different drugs in different ways (e.g., some in a dependent way, some sporadically), other clients may use all drugs in exactly the same way. A client may have a very specific preference for a particular drug in a category (e.g., crack), or a preference for drugs within a particular category (e.g., amphetamines and cocaine and crack); or they may use a wide variety of drugs from different categories (e.g., cocaine, alcohol and hallucinogens). As counsellor and client work through the categories and then the individual drugs named, a picture of the individual client’s use patterns and preferences will emerge.

When complete, the DHQ quantifies the specific drug used and records the frequency with which the drug is administered or taken by the client. The DHQ uses a standardized measure of alcohol or drug “equivalencies,” which the counsellor and client use to talk about standard drinks, numbers of pills, lines or injections. The section “Quantifying use,” below, will discuss this topic in more detail.

In addition, the counsellor and client will explore:

- how long it has been since the client last used each separate drug category
- the number of times the client typically administers each drug when using
- changes in the client’s drug use patterns in the last year and in the last 90 days
- the dosage or amount and name of and mode of administration for each drug, using standardized equivalencies
- drugs that the client is no longer using or has never used
- drugs that the client has been prescribed that are psychoactive but that the client is using as prescribed.

There is a coding format at the foot of the DHQ form for the interviewer to use when filling in the column “How long since last use?” The codes are:

- 1 = < 24 hours (i.e., client has used within the last 24 hours)
- 2 = 1–3 days (i.e., client has used within the last three days)
- 3 = within last week (i.e., client has used within the last seven days)
- 4 = within last month (client has used within the last 30 to 31 days)
- 5 = more than a month ago (client last used more than 30 to 31 days ago)

All of this information helps the counsellor determine the approximate level of intoxication that the client reaches, how often he or she reaches it, and whether there is danger in withdrawal (remember the seven areas of client strengths and needs). This tool will also assist you in determining the client’s level of relapse potential. If the client is physically dependent on a substance, he or she may use it again to ease or to avert withdrawal symptoms.
Clinical tip

In quantifying drug use, some information may illustrate a client’s strengths and needs better than others. For instance, it may be more meaningful to measure the amount of time or money a client spends to use, than to quantify the actual weight or amount of drug he or she uses.

See “Quantifying use” and the “Clinical Challenges” later in this chapter for more on how to evaluate and look for patterns in the information you gather during the DHQ interview.

QUANTIFYING USE

The Psychoactive Drug History Questionnaire uses standardized measures and equivalencies, such as the number of standard drinks or the number of times the user administers the drug to themselves.

This method of quantifying use is a significant change in Ontario because counsellors are accustomed to asking the client how much of the substance they use in terms of weight (grams, ounces, pounds) or cost (dollars). However, the familiar practice can be ineffective.

The problem with asking the cost of drugs is that it doesn’t help the counsellor or the client evaluate whether the client’s use is a problem. It may give you good information about the client’s financial picture. Is the client spending beyond what he or she can afford? Is the client dealing to keep costs down? What does it tell you about the client who can afford to use drugs? However, this kind of information does not tell you how much is too much. The dollar value of the drug may be high because of the laws of supply and demand (basic economic theory)—but the user may be paying more and actually using less than last month! The dollar value is therefore not a good way to quantify use patterns.

The other problem with asking about how much and quantifying the number of grams or ounces per day or week is that you may not know what a gram of, say, hash looks like. How many times can a user get high on a gram of hash?

• Is it a lot?
• Is it enough for a day or a week?
• Could it last a month?

The DHQ quantifies drug use in terms of the number of times that a drug is administered each time the user uses it. So when the user reports smoking 10 to 12 joints a day, this gives you some specific information about how much effort the client makes each day to smoke pot. It will tell you how many times he or she gets high over the course of the day. This information is more meaningful to both of you than is a report of “half an ounce of pot per day.”

When measuring substance use, you will get used to thinking in terms of:

• the number of joints (pot, hash, oil)
• the number of pills (note the dosage in comments section)
• the number of lines snorted (coke)
• the number of pipes or bowls (crack, hash)
• the number of injections per day (heroin, cocaine)
• the number of standard drinks.

When measuring alcohol use, take the alcohol level of the drinks into account. For instance, a case of 24 beers does not count as 24 drinks if it is light beer. A light beer of 4 per cent alcohol is equal to about 0.8 of a standard drink. On the other hand, a case of 24 bottles of beer with 10 per cent alcohol by volume is also not 24 drinks; it is equal to 48 standard drinks. Also, although officially Canadians use metric measures, in common use we tend to refer to alcohol volume in ounces. You may need to use both measurement systems! A conversion chart can help you to work out equivalencies.

Clinical tip

Remember that the size of the drink and the percentage of alcohol by volume are both factors in determining the number of standard drinks. If you use the following formula, a drink is a drink is a drink!

12 ounces of 5% beer = 5 ounces of 12% wine = 1½ ounces of 40% liquor

• If the size or volume of the drink increases, it is more than a standard drink.
• If the percentage of alcohol in the drink is higher, it is more than one drink.

WORKING WITH THE STANDARD DRINK FORMULA

If the concept of standard drink equivalencies is new to you, you can use the formula in the clinical tip above for reference. Work out the equivalencies in the following five questions and check them against the answers in the footnote below.*

1. Three ounces of 40 per cent liquor is equal to:
   a. 1 standard drink
   b. 2 standard drinks
   c. 3 standard drinks

2. Ten ounces of 12 per cent wine is equal to:
   a. 1 standard drink
   b. 2 standard drinks
   c. 3 standard drinks

*Answers: 1: b, 2: b, 3: c, 4: b, 5: c.
3. Twelve beers (12 ounces each) of 10 per cent beer is equal to:
   a. 12 standard drinks
   b. 18 standard drinks
   c. 24 standard drinks

4. How many standard drinks (approximately) in a large can (25 ounces) that is 5 per cent alcohol?
   a. 1 drink
   b. 2 drinks
   c. 3 drinks

5. One large can (25 ounces) of 10 per cent beer is equal approximately to:
   a. 2 standard drinks
   b. 3 standard drinks
   c. 4 standard drinks

**INTERPRETATION USING THE ADMISSION AND DISCHARGE CRITERIA**

What does all the information you have collected in the DHQ mean? How does one generate a clinical profile from recent patterns of use? As with all of the ADAT tools, you and the client need to gather all of the information before either of you comes to any conclusions. What do you know about the client that can help you and the client determine next steps?

The DHQ measures two areas of client strengths and needs:

1. **Levels of intoxication and withdrawal needs**
   - How high is the client getting?
   - Does the client need to be monitored to safely withdraw?
   - How much monitoring does the client need?
   - How has the client decreased harm on his or her own?
   - Has the client had periods of abstinence or reduced use?
   - What drugs has the client successfully quit in the past?
   - Has the client had withdrawal symptoms when reducing or stopping use?
2. Relapse potential

- What is the client’s personal history of relapse?
- What has the client done in the past to end a relapse?
- Is the client aware of relapse signals and symptoms?
- How much structure does the client need to avoid relapse?
- How many days has the client used in the last 12 months? in the last 90 days? Daily use may be more predictive of relapse.

Look at the first “bubble” in the Admission and Discharge Criteria. It asks you to assess for appropriate level and intensity of withdrawal management services.

What do you know about your client so far in terms of his or her need for withdrawal management? Answers to the following questions will assist you:

- When did the client last use a drug?
- How much did the client use?
- Do the substances the client uses warrant medical attention when the user is in withdrawal?
- What withdrawal symptoms has the client had in the past?
- Has the client had complications in withdrawal in the past?
- Is the client medically fragile? Will withdrawal be medically complicated? Does the client need to see a doctor?

The next bubble directs you to look for information relating to levels of intoxication and withdrawal needs, which point to the client’s need for stabilization services.

Answers to the following questions will assist you:

- Does the client have somewhere safe to go for the post-withdrawal period?
- If the client is currently abstinent or meeting reduced consumption goals, does he or she have an environment to go to that will support this?

The DHQ will provide the information necessary to answer the questions in the bubbles. Ask for additional information as required. The client’s perspective about his or her own needs will be vital. As you continue to collect pertinent information through the administration of the other tools, the picture will usually become clearer. There may be clinical exceptions and the counsellor may work with very complicated clients. The counsellor should use discretion in these cases in working with the needs of the client and the Admission and Discharge Criteria.
CLINICAL CHALLENGES

Remember that younger clients may know only the street names of a drug and you will need to help them learn about the proper names or categories. It is an opportunity to educate the client as you administer the tool. Some clients may bring in a pill that can be looked up in the *Compendium of Pharmaceuticals and Specialties* (CPS). The client may only be able to describe the effect and may not know the name of the drug; this style of drug-taking behaviour has inherent risks and so should be noted. Write in the proper name of the drug in the last category “Other psychoactive drugs” and note that the client takes a drug he or she cannot name.

Clients taking drugs that have been prescribed for them by their doctors may not remember their dosage of medication. You may need to ask clients to bring in their medications to the next appointment so that you can copy down the name and dosage. You may need to make sure the client knows that you will not confiscate their drugs. If they are unwilling to bring the drugs in, you may ask them to call you and spell the name of the drug and give the information to you over the phone.

Note the changes in the substance use in the last 12 months and 90 days. Is the client using more, less or the same? Have some drugs increased when others have decreased? Has the use of all substances increased in the last 90 days, or have they all decreased? Are there any drugs that the client has not been using at all in the last 90 days? What has the client been doing to accomplish this? This information will give the client and counsellor a sense of the strengths that the client brings to the interview. Whatever it is that is helping the client change his or her behaviour can be used to accomplish treatment goals for any other drugs as well.

Think of the following examples:

- A client has used alcohol daily in the first nine months of the 12-month period that you are discussing. In the last 90 days, the client has used for two days each week (2 out of 7 days). What would you note about the client’s use? What additional questions would you ask? This is a significant reduction in the client’s substance use in the last 90 days.

- A client reports use of heroin only in the last two months but previously had been using several other substances daily. What would you want to know about this change in pattern?

Historical information about age of first use, first drugs used, and periods of abstinence may also be important to the development of a treatment plan and could be recorded elsewhere in the client file. Significant periods of abstinence and other achieved treatment goals will also be noteworthy. Relapse experiences will also factor into treatment planning. An optional form called “The Clinical Profile Form” is in Chapter 14, “Putting it all together.” This form is used by some agencies to assist in the creation of a clinical profile, as well as to gather all of the information into one place for the file. Feel free to use it to assist you with your learning.

The DHQ provides a wonderful opportunity to educate the client about how their substance use relates to others’. The “norm referencing” of their alcohol and/or other drug use patterns can be very helpful to the client in determining next steps. You can compare the client’s substance use to that of the population of users who seek help at your agency, as well as that of the general population of non-problem users.
The client may be interested to know, for instance, that:

- although they may, say, drink just like all their friends, they are drinking above safe standards in terms of physical health
- their consumption rates are generally higher than most users
- about 15 to 20 per cent of the population does not use alcohol at all, and so an impression that “everyone drinks” is not necessarily so, and that the rates of non-use are much higher for other substances. This information can help you make the case that there are plenty of new non-using friends out there waiting.

Clients want to know how they measure up and will let you know how interested they are in finding out about others’ use. These facts, given in an objective and non-judgmental manner, can be very important to the client’s decision-making:

- There is evidence that shows simple advice can effect behaviour change, and that it is perhaps more effective for those trying to change smoking and excessive drinking behaviours than for those trying to make changes to eating or exercise behaviours.
- The appropriateness of a harm reduction goal for an individual client cannot be determined by looking at the results from any single tool, but will depend on the client’s overall history, patterns of use, progression of use and other substance use–related information obtained from the other tools.

**CLINICAL EXAMPLES**

**HARRY’S LIFE**

Information collected in the DHQ provides evidence that Harry has personal strengths that will help with treatment planning. When a client’s personal strengths are pointed out to him or her by the counsellor, the client will feel supported and affirmed.

Harry has fairly limited experience with substances, which is typical given his age. His primary problem substance is alcohol and he has reported using it daily for both time periods used in the DHQ. Harry has been drinking a fairly consistent amount on a daily basis, and realistically this pattern has only stopped because he had a seizure and went to the emergency department of his local hospital. Harry was admitted and has not used alcohol since.

The DHQ gives information about the potential for Harry to experience withdrawal symptoms, which are evident in Harry’s self-report as was relapse potential, which is high because of the frequency with which Harry has used alcohol since being released from hospital after his car accident. He has used alcohol daily in a predictable fashion in terms of amount. However, on a positive note, he has maintained abstinence since his seizure.

The DHQ might give some indications about the benefits of using alcohol for the client (e.g., Harry says he uses alcohol “to assist with sleep problems”). The DHQ will identify the precipitating factors in use, but the primary value of the information gathered is to look at the withdrawal needs and relapse potential for the client.
dependency on alcohol or other substances can be a flag for the counsellor in terms of how much support the client will need medically and emotionally to withdraw from substances.

Harry has been drinking 17 standard drinks daily for years and is going to feel withdrawal symptoms once abstinent. He may feel the effects of post acute withdrawal for some time and take some time to feel well.

The only other drug that Harry reports he has used in the last 90 days is Valium, which was administered in the hospital to assist him with the seizures and the withdrawal symptoms he was experiencing. The counsellor must fill in this category, although the drug had not been misused and was very limited in the duration of use.

It is noteworthy that after the car accident, Harry was dependent on morphine, given to him to deal with the pain of healing after being severely burned. Despite physical dependency, Harry did not fill the prescription that was given to him to continue use. Accordingly, on the DHQ, you would fill in the “No” column for opioid use in both the last 12 months and the last 90 days but also record his “historical involvement with the drug.” In this way, you can capture information on several levels using the tool. Harry’s experience in withdrawal from morphine and his decision to not continue use can be discussed in later sessions to see what Harry can take from that experience to use now.

From the DHQ, it appears Harry’s risk of relapse is high, given that he is only recently sober, is not feeling well and has been physically dependent on alcohol.

Harry was a social drinker prior to the accident, information that should be interpreted as another of his strengths, because it means that in Harry’s life so far he has been a non-problem drinker for more years than he has been a problem drinker. There may be strategies that he has used before that he can redeploy to assist him in his treatment goals as the assessment unfolds and the treatment plan is generated.

Harry has also remained abstinent from this substance since his release, and given the level of dependency that one would assume with his consumption profile, this new period of abstinence is a very positive sign. Other information gathered from later tools would give the counsellor a stronger picture of Harry’s relapse potential.

The counsellor may be getting some signals about the reasons that Harry might have developed an alcohol problem after the accident, his wife’s death and his injuries. The counsellor will begin to develop the clinical profile for Harry as the rest of the tools are administered and discussed.

Harry’s case information and scores illustrate the issues that may play a role in understanding the substance abuse of older persons and their specific needs. See Appendix C: “Resources” for places you can go for more information on alcohol and other drug use by older persons.
Sample counsellor response

Here are some comments that the counsellor might make while sharing the assessment results with Harry:

Harry, the purpose of filling in a tool like this is to get some accurate information about the amount of alcohol or other drugs that you have been using. Now we know that your concerns are about alcohol and you have not used other drugs except as prescribed by your doctor. Shall I go over the results of this with you?

Harry, the DHQ shows us, from what you’ve told me, you are drinking about 17 drinks each day [counsellor explains briefly about standard drink equivalencies]. I need to tell you that 17 drinks is a lot of alcohol for anyone’s body in one day. Over time some health effects could be felt. What have you noticed?

You also have said that you are concerned about your health, and what I should tell you is that you may be right to be concerned. Seventeen drinks each day can hurt your body. Did you tell me that you’ve been having some troubles with your digestion [counsellor waits for affirmative]? This amount each day could be what is making you feel unwell. You were smart to decide to check it out further. What else would you like to know?

Harry, I’d like to point out a couple of things to you that strike me as extremely positive. The DHQ tells us that you do not smoke. Good for you! You also have only been drinking 17 drinks per day for the last seven years or so, and you have more history as someone that we would call a “social drinker.” This means that you have used alcohol as an adult in ways that did not cause problems for you for the greater part of your adult life. This means you have not always used alcohol as much as you do now.

The other thing that is positive is that when you were released from the hospital after the accident, you had been taking morphine for a long time and you just quit it the day you were discharged to go home. This means that you have accomplished goals when you set your mind to it. Tell me what you did then to deal with the physical effects of not using.

JOYCE’S LIFE

Joyce reports current use of both alcohol and cocaine in the 12-month and 90-day columns. She also reports historical use of the same substances prior to her first experience with treatment. In addition she is smoking cigarettes and taking an antidepressant prescribed by her doctor.

Clinical tip

In order to calculate the number of standard drinks, the counsellor must work with the client to decide on a specific number of drinks on weekdays and weekends. If the client says, “I drink three to five drinks,” do not simply split the difference between three and five. Work with the client to find out if it is more often three or more often five. In order to get the standard drink equivalency, you will decide on a whole number to represent the number of drinks for each day of the week and then multiply by the days and divide by the number of days that they actually use. Remember that if the client never drinks on Thursdays, there are six days in the week to divide the total by, not seven!
Joyce says that she has five drinks on each weekday ($5 \times 5 = 25$ drinks) and 12 drinks on each weekend day ($12 \times 2 = 24$ drinks), for a total of 49 drinks over seven days, which on average is seven standard drinks per day.

It is important to note in the comments column the exact number of drinks and patterns, and so on. Whole numbers need to go in the columns for a typical amount on each day.

Joyce has reported that she uses alcohol differently on weekdays and weekends. As her responses show, Joyce’s consumption increases on the weekend, and the counsellor will want to ask Joyce whether this is planned or coincidental. That is, is her pattern unrelated to any conscious effort or is she actually planning and thinking about her drinking? Is Joyce trying to drink less on the weekdays and if so, for what reason? What does she do to successfully limit her consumption?

It is possible that Joyce could answer these questions in a variety of ways and her answer will shape the clinical profile in terms of her consumption pattern and relapse potential. The counsellor may find any of the following issues in Joyce’s response:

- Joyce purposely purchases less on the weekdays.
- Joyce does not want to get too intoxicated during the week because her kids are home.
- Joyce may start drinking after the kids are in bed and so she cannot consume as many drinks.
- Joyce may start drinking earlier in the day on the weekends.
- She may not be able to afford to drink that many drinks on weekdays and would if she could afford to.

These questions and the variety of responses that are possible will give the counsellor a lot of good information to help shape the treatment plan. For example, if Joyce is drinking less on purpose during the week, the information may give the counsellor a sense of the control that Joyce has over how much she drinks, and that she can successfully plan for drinking less and stick to her goal.

On the other hand, Joyce may indicate that she would like to drink much more than she does. She may drink all five drinks in two hours or may drink in the mornings. All of these details are necessary to get an accurate picture of Joyce.

Joyce reports that she snorts cocaine on the weekends and again, the counsellor will need some additional information about Joyce’s patterns of use, preferences and habits. It would appear, based on her self-report, that Joyce’s historical use of cocaine and relapse to the use of this drug was a contributing factor in the dissolution of her marriage.

Joyce’s use of tobacco can be discussed in terms of her long- and short-term goals. While some clients make plans to change the use of all substances in the short term, some do not want to attempt to quit tobacco at the same time.

Joyce’s use of antidepressants is described as “used as prescribed” in the case history. However, the counsellor must remember that she has not actually taken it as prescribed, because one is not supposed to drink alcohol while
taking antidepressants. She has been compliant in taking her medication but has not taken it as prescribed! The dosage and length of time that the client has taken the prescription should also be noted.

Joyce’s case history tells us that she has had a period of abstinence after her last experience with treatment, but she has not been abstinent for her current drugs of choice in the last year. This history reveals fairly predictable patterns of use and may indicate that she has a high relapse potential. Some client statements in the interview and case study also indicate that Joyce is concerned about her ability to stay abstinent.

Although Joyce has not used other drugs and she has not used other drugs in the last 12 months, it is appropriate to record that there was some historical use as a youth.

**Sample counsellor response**

Here is what the counsellor might say to Joyce:

> Joyce, the DHQ shows us that you have been using alcohol or cocaine or both almost every day for the last year. You’ve made a good decision to come in and talk about the changes you might like to make. Tell me about how you came to this decision.

> Your use patterns tell me that you have probably been feeling a lot of withdrawal symptoms. Tell me what you have been doing to cope with how you feel physically. What helps you through this?

> When we spoke about your use patterns, you told me you were worried about relapse and you wondered whether you could achieve your treatment goals. Tell me how you maintained abstinence after treatment a couple of years ago. Is there anything that you learned from that experience that you can duplicate or avoid?
# PSYCHOACTIVE DRUG HISTORY QUESTIONNAIRE

Program #____________________ Client Name Harry James  Counsellor: __________________________ Date __________________________

<table>
<thead>
<tr>
<th>DRUG TYPE</th>
<th>Used in Past 12 Months?</th>
<th># of days used in past 90 days</th>
<th>How Long Since Last Drug Use? (see codes below)</th>
<th>Typical Amount on Each Day of Use in the Last 90 Days*</th>
<th>Clinical comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) NONE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>X [ ] [ ] [ ] [ ]</td>
<td></td>
<td>80</td>
<td>4</td>
<td>17 Social drinker to age 57. Alcohol use escalated following car accident when wife was killed. Current use = 17 standard drinks daily x 5.5 years. Alcohol seizures started 1 week ago.</td>
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<tr>
<td>(3) COCAINE/CRACK: coke</td>
<td>[ ] X [ ] [ ] [ ]</td>
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<td></td>
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</tr>
<tr>
<td>(4) AMPHETAMINES/OTHER STIMULANTS</td>
<td>[ ] X [ ] [ ] [ ]</td>
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<td></td>
</tr>
<tr>
<td>(5) CANNABIS: hash, weed, grass, pot, marijuana</td>
<td>[ ] X [ ] [ ] [ ]</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6) BENZODIAZEPINES</td>
<td>X [ ] [ ] [ ] [ ]</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>Given benzodiazepines in hospital for seizures last week for 3 days.</td>
</tr>
<tr>
<td>(7) BARBITURATES</td>
<td>X [ ] [ ] [ ] [ ]</td>
<td></td>
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<tr>
<td>(8) HEROIN/OPIUM</td>
<td>X [ ] [ ] [ ] [ ]</td>
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<tr>
<td>(9) PRESCRIPTION OPIOIDS</td>
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How Long Since Last Used: 1=<=24 hour  2=1-3 days  3=within last week  4=within last month  5=more than a month ago
# PSYCHOACTIVE DRUG HISTORY QUESTIONNAIRE (CONT’D)

Program # ___________________ Client Name_ Harry James ___________ Counsellor: ___________________________ Date_ September 13 [include year] ___________

<table>
<thead>
<tr>
<th>DRUG TYPE</th>
<th>Used in Past 12 Months?</th>
<th># of days used in past 90 days</th>
<th>How Long Since Last Drug Use? (see codes below)</th>
<th>Typical Amount on Each Day of Use in the Last 90 Days*</th>
<th>Clinical comments (e.g. drug name, dosage, patterns, periods of abstinence, used only as prescribed, length of use, age of first use, etc.)</th>
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<tr>
<td>(10) OVER-THE-COUNTER CODEINE PREPARATIONS</td>
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</tr>
<tr>
<td>(11) HALLUCINOGENS</td>
<td>✔</td>
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<tr>
<td>(12) GLUE/OTHER INHALANTS</td>
<td>✔</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(13) TOBACCO</td>
<td>✔</td>
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<tr>
<td>(14) OTHER PSYCHOACTIVE DRUGS</td>
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</table>

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* See Guidelines for Describing “Amount” of Each Drug Use

90 DAY WINDOW: START DATE (dd/mm/yyyy) _________________ END DATE (Yesterday) (dd/mm/yyyy) _________________

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# PSYCHOACTIVE DRUG HISTORY QUESTIONNAIRE

Program #  
Client Name  Joyce Smithers  
Counsellor:  
Date  September 13 [include year]  

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<thead>
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</thead>
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<tr>
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<td>Yes 1  No 2  Refused 8  Missing 9</td>
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<tr>
<td>(2) ALCOHOL: Beer/liquor/wine</td>
<td>❑ ☐ ☐ ☐</td>
<td>85</td>
<td>3</td>
<td>7</td>
<td>Joyce drinks 5 drinks weeknights and 12 drinks on each day of the weekend for an average of 7 SD. She prefers wine. Abstinent 5 days. Some previous treatment 6 months ago - abstinent for 3 months following treatment.</td>
</tr>
<tr>
<td>(3) COCAINE/CRACK: coke</td>
<td>❑ ☐ ☐ ☐</td>
<td>26</td>
<td>3</td>
<td>3</td>
<td>Snorts 3 times per evening each weekend night. Uses every Friday and Saturday night, intranasal. Used coke 6 years ago, attended treatment, abstinent from coke for one year following treatment.</td>
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<tr>
<td>(4) AMPHETAMINES/OTHER STIMULANTS</td>
<td>☐ ❑ ☐ ☐</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>(5) CANNABIS: hash, weed, grass, pot, marijuana</td>
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<td></td>
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</tr>
<tr>
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</tr>
<tr>
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### PSYCHOACTIVE DRUG HISTORY QUESTIONNAIRE (CONT’D)

**Program #**

**Client Name**  Joyce Smithers  

**Counsellor:**  

**Date**  September 13 [include year]

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<thead>
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<th>DRUG TYPE</th>
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<th># of days used in past 90 days</th>
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<th>Typical Amount on Each Day of Use in the Last 90 Days*</th>
<th>Clinical comments (e.g. drug name, dosage, patterns, periods of abstinence, used only as prescribed, length of use, age of first use, etc.)</th>
</tr>
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<tbody>
<tr>
<td>(9) PRESCRIPTION OPIOIDS</td>
<td>☐ ☑ ☐ ☐</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>(10) OVER-THE-COUNTER CODEINE PREPARATIONS</td>
<td>☐ ☑ ☐ ☐</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(11) HALLUCINOGENS</td>
<td>☐ ☑ ☐ ☐</td>
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<td></td>
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</tr>
<tr>
<td>(12) GLUE/OTHER INHALANTS</td>
<td>☐ ☑ ☐ ☐</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(13) TOBACCO</td>
<td>☑ ☐ ☐ ☐</td>
<td>90</td>
<td>1</td>
<td>25</td>
<td>Smokes large pack each day</td>
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<tr>
<td>(14) OTHER PSYCHOACTIVE DRUGS</td>
<td>☑ ☐ ☐ ☐</td>
<td>60</td>
<td>1</td>
<td>1</td>
<td>Effexor - antidepressant. Taking tablet as prescribed, 225 mg per day. Used a variety of drugs as a youth (pot, LSD, mushrooms), but none of these in last 10 years.</td>
</tr>
</tbody>
</table>

How Long Since Last Used: 1=<24 hour  2=1-3 days  3=within last week  4=within last month  5=more than a month ago

* See Guidelines for Describing “Amount” of Each Drug Use

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Chapter 7
THE ADVERSE CONSEQUENCES OF SUBSTANCE USE QUESTIONNAIRE

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DESCRIPTION AND PURPOSE

The Adverse Consequences of Substance Use tool focuses on determining the negative impact of the client’s substance use over a range of life areas. It acts as a filter to separate the adverse consequences directly related to substance use from the life problems in general that the client may be experiencing.

Clients frequently have difficulty linking life problems to their substance use. This tool helps them to sort through their life problems and, in their own voice, identify and acknowledge the problems that are directly associated with their substance use.

This tool collects information related to three areas of client strengths and needs:

- medical or psychiatric needs
- emotional or behavioural needs
- barriers and resources.

INTENDED POPULATION

This tool can be used with all clients (adults and adolescents) able to participate in an assessment.

ADMINISTRATION

Ideally this tool should be administered by the clinician within the structure of the assessment interview.

The tool records the adverse consequences in eight life areas:

a. Problems with physical health
b. Blackouts or memory problems
c. Mood and personality changes
d. Problems in relationships
e. Abusive behaviour towards others
f. School or work problems

g. Legal problems

h. Financial problems.

The counsellor begins by explaining the purpose of the tool to the client, stressing that only those negative consequences that are directly related to substance use should be identified.

Each life area has a measure of severity from 0 to 2 or 0 to 3, but the tool is not scored. Each life area is examined on its own. Each life area begins with the question, “As a result of your substance use, have you experienced . . . ?” This question is written at the top of the first page.

The counsellor frames the question to determine if problems have occurred “ever” in the client’s life, and, more specifically, within the “past 90 days.” If the counsellor and client have already completed the DHQ, the client will be familiar with reviewing the past 90 days.

The counsellor reads over each life area question with the client and engages her in discussion about specific problems, for example, when the problems occurred, how they affected the client’s life, the client’s own perception of the seriousness of the problem and if and how she has dealt with the problem.

The client determines the level of severity from the coded categories. On the form, code only the most severe level of consequences for each area. Thus, each column should only have one box marked for each life area in the “ever” column and in the “past 90 days” column. Different levels of severity may be coded for the two time periods. For example, a problem could have been very severe a few years ago but not have been a problem in the last 90 days.

If a client refuses to answer a question, the code to enter is 8. Code 9 is used for information that is missing (because either the counsellor forgot to ask the question or the client was unable to answer it).

The counsellor uses the “Clinical Comments” section to record additional clinical information.

EXAMINING THE EIGHT LIFE AREAS

The next section assumes that you are the counsellor administering the tool. Let’s examine the eight life areas for tips to remember when administering the instrument.

A. Problems with physical health

Any problems with physical health that are directly related to substance use should be recorded here. It is sometimes difficult for the client to ascertain whether or not health problems are related to substance use. Ask if a medical professional indicated that substance use played a part in the medical problem. Use your clinical judgment. Substance abuse affects most organs and systems in the body; however, not every health problem should be listed here. For example, if the client has a thyroid problem or arthritis, it is not likely related to substance abuse. Pay particular attention to liver disease, some cancers (such as mouth, tongue, esophageal), circulatory or respiratory problems, accidents, falls or burns.
The information in parentheses on the form advises you to include overdose and diagnosed neurological damage, but to exclude neurological problems, such as blackouts, memory and confusion, because these problems are addressed in section (b).

You next determine the severity of the problem. If the problem was self-identified or identified by a concerned person, mark it as 1; if the client received a warning about his substance use from a health professional, mark it as 2; if the client received medical treatment for the condition, mark it as 3.

B. Blackouts or memory problems

This life area focuses on the impact of substance use on cognition. It looks specifically at blackouts, memory problems, forgetting, confusion and difficulty thinking. Again, these effects should be directly related to substance abuse. To help determine this relationship, ask if these events occurred primarily around the use of substances.

The number of occurrences of these events is used to code a level of severity.

C. Mood and personality changes

This life area examines the impact of alcohol and drug use on mood and personality. Mood and personality changes should be significant to be considered adverse. A minor mood change related to early withdrawal (for example, being irritable) wouldn’t be relevant here. You could frame the question: “Do you or others with you notice that you seem to be a different person when you have been using?”

Level of severity is rated by determining whether the impact is minor—the consequences are not serious enough to affect daily functioning—or major—consequences are serious and impact daily functioning, for example, the client may have missed work because of substance use, or been unable to look after herself.

D. Problems in relationships

This life area reviews the impact of substance use on relationships. Ask the client if relationships have been lost or damaged as a result of his using. Ask if family or friends have ever commented on his substance use and then began to treat him differently.

Some clients will need to distinguish between different relationships. Frequently their relationship with their family of origin is starkly different from their relationship with their immediate family (partner or spouse and children) and therefore their substance use has had a different impact on each family group. Similarly, a client’s substance use may have an impact on his family that is quite different from the impact on his friends. His use may have had major negative consequences with the family, but not with his friends, who have similar consumption levels and don’t view his use as problematic. If the impact of the client’s substance use varies significantly among the family he grew up with, his immediate family (partners and children) and his friends, the counsellor should add another column alongside the existing column and label each column with the name of the group it reflects.

Level of severity is rated as minor or major.
E. Abusive behaviour towards others

This tool records if the client becomes verbally or physically abusive to others when she is using. Note the instruction at the top of the form—“note only the most severe level of consequences . . . .” For the purposes of this tool, physical abuse is rated as more severe than verbal abuse, though it is recognized that verbal abuse also can have serious consequences. Therefore, if both verbal abuse and physical abuse have occurred, use the code for physical abuse, 2. Record the nature and extent of the abuse in the Comments column.

F. School or work problems

Some clients or clinicians prefer to look at school and work problems separately because they may be quite different from each other. In this case, the counsellor may create and label a second column.

Note the new rating category of 7, which means “not applicable”; that is, the client is not in school and not working. For these clients the “past 90 days” would be rated as 7; for most clients, the “ever” column can be completed.

G. Legal problems

Substance-related legal problems are coded as “charged only” and “convicted.” Legal problems could be crimes committed under the influence of substances or crimes committed to pay for drugs. It is helpful to ask if the client was using when charges were laid.

H. Financial problems

Financial problems directly due to substance use are recorded as minor or major. Financial problems are not solely related to the cost of the substances themselves but could include other costs associated with use, for example, fines, medical costs, repair of property and time off work.

SCORING AND INTERPRETATION USING THE ADMISSION AND DISCHARGE CRITERIA

The information that this tool gathers on three areas of client strengths and needs—medical or psychiatric, emotional or behavioural, and barriers and resources—provides the counsellor with a snapshot of the client’s understanding of the link between his or her substance use and the circumstances that have led the client to an assessment. Later in this chapter, discussion of the data for Harry and Joyce will illustrate how this instrument is particularly useful in exploring these three areas of strengths and needs.

The information gathered adds to the body of knowledge the counsellor is building with each successive tool during the assessment. On its own, and in concert with the other tools, the Adverse Consequences tool helps the counsellor apply the Admission and Discharge Criteria to determine the referrals and treatment that would be most appropriate for a particular client.
CLIENT STRENGTHS AND NEEDS

The information collected in this tool allows the counsellor to fully explore the consequences of substance use from the client’s perspective and will allow the counsellor and client to determine together what level of services will be required. If a client is successfully making links between use and consequences in life areas, he or she may be ready for treatment and the Admission and Discharge criteria will be easier to apply. If the client is not yet linking behaviour and consequences or does not see the linkages between substance use and the impact on his or her life, then a referral for community treatment can be made and motivational interviewing sessions can assist the client to make these linkages. Motivational interviewing can help the client become treatment-ready. The clinical examples of Harry and Joyce later in the chapter will help to illustrate how the Adverse Consequences tool makes that information available to us and how we can interpret with the client what the next steps might be.

MOTIVATIONAL INTERVIEWING

Because this tool focuses clearly on adverse consequences of substance use, and pulls together major life areas that could be affected, it is a pivotal tool for motivational interviewing.

After you have finished administering the tool, it is helpful to provide a summary to the client of your report. This summary provides an opportunity for you and the client to clarify anything that is unclear or missing or to ask for more detail.

Summarizing is an effective motivational tool because it gathers together all of the negative consequences of using drugs over a number of life areas and compares any problems experienced in the past (“ever”) with those being experienced currently (“past 90 days”).

This assessment may be the first time the client has viewed the information in this way and she may feel overwhelmed. An emotional response (expressed through words, tears or body language) to the pattern, type or number of negative consequences is one of the processes of change. It is an acknowledgement that the client is not content with the situation. This unease or conflict within, which has been created by exploring negative consequences, is the mechanism to “tip the balance,” that is, to have the client come to understand that the positive rewards of substance use are outweighed by the negative consequences.

Clinical tip

The Adverse Consequences of Substance Use interview provides the ideal vehicle for “tipping the balance.” It gives the clinician a method to review major life areas. The client responds, and the counsellor then works with the client to clarify responses. Articulating the negative consequences of using themselves, rather than being told them by someone else, allows the client to truly “hear” the negative consequences. Clients remember far more of what they say in the counselling session than of what the counsellor relays to them.
TREATMENT PLANNING

This instrument is a valuable treatment-planning tool. It outlines life areas that may need further investigation and can initiate with the client a discussion of possible referrals.

It presents a picture of the client’s barriers and resources, which can be very useful for treatment planning. The client may have problems or responsibilities in other life areas (for example, family and legal issues) that he needs to attend to before entering addiction treatment.

Clinical tip

A non-judgmental approach can go a long way toward helping the client feel comfortable talking about the negative consequences of substance use. Believing that the client can be truthful and honest in examining these factors helps the client to be just that. By being non-judgmental and by not reacting to the seriousness of some of the consequences, the counsellor creates an environment in which the client feels safe to expand on those consequences.

Make sure the client understands at the start that the discussion revolves around only those adverse consequences that are directly related to substance abuse. Give an example to illustrate the difference. Clarifying this point at the beginning is far preferable to correcting the client at each life area.

For clients at precontemplation or contemplation stages of change, remember to “tip the balance” (see Appendix B: “The importance of motivational interviewing” for more information and clinical tips). This is a very effective motivational technique for moving the client to the next stage of change.

If a client for some reason does not want to talk about a particular life area, let it go. The client may not be able to reveal all of the negative consequences in one session.

Pay close attention to the client’s reactions during the interview. If the client is overwhelmed by the information that is emerging, it is important not to simply move on to the next tool in the assessment. Take some time to discuss the client’s thoughts and feelings in a sensitive and empathic way. Acknowledge that the process must be difficult for the client.

When using the Admission and Discharge Criteria, refer to your notes in the Comments section on this tool and to the life areas affected by the client’s substance use, to confirm your clinical decisions.
CLINICAL EXAMPLES

HARRY’S LIFE

Administration

Harry was not aware that many of the problems occurring in his life were associated with his alcohol abuse. Therefore, the counsellor needed to use probing questions and discuss with Harry what each life area meant in terms of how it could be affected by substance use. Remember that Harry is a late onset substance abuser; for most of his life drinking was not problematic and therefore he is accustomed to viewing his drinking as non-problematic.

Let’s examine Harry’s responses for each life area.

A. Problems with physical health

Harry has had a great deal of hospital and medical care in the past seven years following his very serious car accident, in which his wife died and he suffered major burns. He therefore views his current medical complications as stemming from the accident. His admission to hospital for alcohol-related seizures was the first time Harry began to realize that his alcohol use was having serious consequences on his health. Although he had gastrointestinal bleeding over the past several years, and his specialist had advised him to cut down on his drinking, he hadn't realized the causal relationship between his health and his drinking. He remains ambivalent about it; he just can't believe it. In discussing the link between Harry’s drinking and his physical health, the counsellor needed to provide some information about the kinds of health problems that might be associated with substance use. Mentioning that heavy use of alcohol could cause damage to the stomach lining and result in internal bleeding twigs with Harry. He begins to see that his stomach and digestive problems may be a result of his drinking, although, at this point, he is reluctant to accept it. The two clear indicators of physical health problems are the alcohol-related seizures (which Harry recognizes were caused by his drinking) and the gastrointestinal bleeding over the past several years (which gives Harry a glimmer of realization that his drinking may be affecting his digestive tract). Clearly, “ever” and “past 90 days” each receive a 3 for severity.

B. Blackouts or memory problems

When the counsellor asked Harry about his memory and his ability to think clearly, he responded that his memory was poor and that he had not been able to think clearly for some time. However, he attributes these cognitive difficulties to his age. He says that many of the people he drinks with also have these problems. By discussing the concept of blackouts (asking if there were times when he couldn't remember what had happened when he had been drinking) and indicating that drinking has a profound affect on a person’s ability to think clearly, the counsellor helps Harry to realize that, over the past two years, blackouts and confusion have become a way of life for him. He has definitely had blackouts on more than five occasions.
C. Mood and personality changes

Harry has not reported any problems in this area.

D. Problems in relationships

Harry indicated that he had lost most of his friends after the car accident. He reports that at first they had been very supportive, but gradually they stopped dropping by. Harry was so grieved by the death of his wife and his physical injuries that he never called his friends.

He reports that he had never had a close relationship with his son; however, when he began drinking heavily and his standard of living went down to the point that he was living in a substandard boarding house, his son ceased to have any contact with him. Harry never hears from him and is not sure that his son even has his latest address or phone number. Because he is now totally estranged from his son, partly due to his drinking, the relationship area is marked as “major.”

E. Abusive behaviour towards others

Harry has reported no problems with abusive behaviour.

F. School or work problems

Harry is not currently working or in school, so the “past 90 days” column is coded as not applicable (“N/A”). Because he only began to have problems subsequent to his employment days and did not abuse substances while in school, the “ever” column is coded as 0 (none).

G. Legal problems

Harry has not reported any legal problems.

H. Financial problems

This was a difficult area to complete with Harry, because he saw his financial problems as stemming from the car accident. At that point, he had to quit his job as a federal government employee. Although he received a disability pension, he feels his reduction in salary led to his gradual necessity to sell the house. He sold it for much less than it was worth, because over the years since the accident, the house had greatly deteriorated and the interior was dirty and neglected. He also had failed to pay his taxes. He estimated how much he spent per week at a bar and on alcohol consumed at home. He agreed to mark this area as having a minor problem. He is not, at this point, able to see that his drinking was partly to blame for the lost revenue from the house and for other financial losses that he incurred when his alcohol use affected his ability to pay attention to other areas of his life.
Sample counsellor response

At the end of administering this tool, the counsellor might say something like this:

_Harry, you’ve had an awful lot of very serious difficulties in your life over the past seven years. I can see why you followed your friend’s advice and began drinking to get a break from everything that had happened to you. By completing this form, you were able to gradually separate out the negative things that have been happening in your life that are partially due to your alcohol use. Some of this may be new to you. You may be surprised to see how much alcohol has been affecting your life. Let me just summarize the life areas that we marked as having been affected by your alcohol use._

_**First of all, your physical health has been seriously affected; you just spent three days in hospital due to alcohol-related seizures, and you’ve had some internal bleeding over the past several years that, prior to our discussion today, you didn’t realize could be caused by your drinking.**_

_Your ability to think and remember things has been seriously affected by your drinking; you were surprised, when you thought it over, to see how many times you had a blackout over the past two years; you’ve lost contact completely with your son partially due to your alcohol use, you don’t have any close friends, which you did prior to the car accident; and you indicated that your alcohol use has affected your finances, although you don’t see it as a major cause of your financial problems._

_This adds up to quite a list of negative consequences. How are you feeling at this point about our discussion of how alcohol has affected your life? It must be difficult for you to think about all this._

In response, Harry might get quite emotional. He might say something like drinking was the only way he could cope with the car accident; he didn’t realize it was so bad; he feels terrible about how things have turned out. At this point, the counsellor should not rush to administer the next tool. It is important to allow Harry the opportunity to experience these realizations, as it may be the turning point for him; it may result in “tipping the balance.” In fact, the counsellor may spend the rest of the appointment talking about the summary and the impact of alcohol on Harry’s life. Harry may need time to think about this new information and new realizations. The counsellor needs to give Harry the time and opportunity to discuss how he is feeling.
JOYCE’S LIFE

Administration

Joyce is very aware that her substance use has had major negative consequences in other life areas. She went to the withdrawal management service on her own. Rather than using this tool to “tip the balance” for Joyce, it can be used to reinforce her decision to seek treatment.

Let’s look at how Joyce responded.

A. Problems with physical health

Joyce identified a recent problem with indigestion that she believes may be caused by her substance use. At this point or, during the completion of the Health Screening Form, the counsellor might want to ask if her family doctor is aware of her substance use, and if she would feel comfortable talking to her family doctor about her stomach problems, and her belief that they may be related to her use. As her physical health concern is self-identified, both the “ever” column and the “past 90 days” column would be marked with a 1.

B. Blackouts or memory problems

Joyce reported no cognitive problems.

C. Mood and personality changes

Joyce reports feeling depressed much of the time and really angry some of the time. She feels that her moods are unpredictable. She has been taking antidepressants prescribed by her family physician for the last two months. Because she is using every day, it is difficult to ascertain if these mood changes are related to her substance use. Because she is managing to carry on with her daily life, the impact of her substance use on her mood and personality would be scored as minor impairment.

D. Problems in relationships

Use of alcohol and other drugs was a major factor in Joyce’s break up with her partner and the loss of her children to the Children’s Aid Society (cas). In fact, a neighbour had reported her to cas when she was intoxicated one weekend. After some discussion, Joyce also reported the loss of some friendships due to her use. This took some exploration and discussion of why she has lost contact with her closest friends. The adverse consequences in this life area would be scored as “major,” because Joyce has lost both friendships and her partner due to her substance use.

E. Abusive behaviour towards others

Joyce indicated that she became verbally abusive when she was drinking or using cocaine. It was while using that she “told her spouse exactly what she thought of him,” and she also reports having little patience with the kids, yelling at them to the point that they run to their rooms. Joyce reports that she is very quiet and unable to assert herself when she is sober. This item would be marked with a 1, for verbal abuse.
F. School or work problems

Joyce experimented with a variety of drugs as a youth. She realizes that drug use contributed to her poor grades and dropping out of school. She wants to complete her Grade 12. A score of 1 would therefore be entered in the “Ever” column, and 7 in the “Past 90 Days” column, because she is currently unemployed and not in school.

G. Legal problems

Joyce reported no legal problems.

H. Financial problems

Joyce reported having real financial hardships, and feeling very guilty about spending money on alcohol and other drugs when it should have been spent on the kids. She has had to give up her apartment due to financial hardship. The adverse consequences in this area would be recorded as major problems, due to her inability to retain a place to live.

Joyce is quite aware that her alcohol and drug use have negatively affected her life. This became clear to her when she experienced the loss of her children.

Sample counsellor response

Joyce does not need as long a summary as Harry because she is already in the preparation or action stage of change. In fact, at this point the counsellor would not want to emphasize the negative consequences too much or Joyce might feel overwhelmed and helpless to make changes. In this case, it would be helpful for the counsellor to simply review what was said:

Joyce, you’ve indicated that your substance use has affected a number of life areas.

Your partner and your children are no longer in your life, you’ve lost friends due to your use, you say you become verbally abusive to your family and your moods are unpredictable when you are using, you’ve spent money on alcohol and other drugs that you could have really used for living expenses, and, in fact, had to give up your apartment, and you are beginning to wonder if you are developing some health problems due to your use.

You also said that your poor grades and dropping out of high school was due to your drug use.

You’re very aware how substance use has negatively affected your life in many life areas. You have come to a difficult and brave realization, and I respect you for looking at how you can change your situation.
### ADVERSE CONSEQUENCES OF SUBSTANCE USE: SAMPLE FORMS

**Program #**

**Client Name**  Harry James

**Counsellor:**

**Date** September 13 [include year]

(Note to Assessment Therapist: Code only the most severe level of consequences for each problem.)

As a result of your substance use, have you experienced:

<table>
<thead>
<tr>
<th></th>
<th>Ever</th>
<th>Past 90 Days</th>
<th>Clinical Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a. Problems with your physical health (including overdose but</strong></td>
<td>![ ]</td>
<td>0 0</td>
<td>If Ever, When:</td>
</tr>
<tr>
<td><strong>not neurological problems unless neurological damage has been</strong></td>
<td>![ ]</td>
<td>1 1</td>
<td>- Gastrointestinal bleeding x several years</td>
</tr>
<tr>
<td><strong>diagnosed)</strong></td>
<td>![ ]</td>
<td>2 2</td>
<td>- Recent alcohol-related seizures</td>
</tr>
<tr>
<td>0 none</td>
<td>![ ]</td>
<td>3 3</td>
<td>- Hospitalized for 3 days for seizures</td>
</tr>
<tr>
<td>1 self-identified/other person concerned</td>
<td>![ ]</td>
<td>8 8</td>
<td>- First time for seizures</td>
</tr>
<tr>
<td>2 health care professional’s health warning</td>
<td>![ ]</td>
<td>9 9</td>
<td></td>
</tr>
<tr>
<td>3 medical treatment for physical problem (illness or accident)</td>
<td>![ ]</td>
<td>8 8</td>
<td></td>
</tr>
<tr>
<td>related to substance use</td>
<td>![ ]</td>
<td>9 9</td>
<td></td>
</tr>
<tr>
<td><strong>b. Blackouts or memory problems, forgetting, confusion,</strong></td>
<td>![ ]</td>
<td>0 0</td>
<td>If Ever, When:</td>
</tr>
<tr>
<td><strong>difficulty thinking</strong></td>
<td>![ ]</td>
<td>1 1</td>
<td>- For the last two years</td>
</tr>
<tr>
<td>0 none</td>
<td>![ ]</td>
<td>2 2</td>
<td></td>
</tr>
<tr>
<td>1 5 or fewer occasions</td>
<td>![ ]</td>
<td>8 8</td>
<td></td>
</tr>
<tr>
<td>2 more than 5 occasions</td>
<td>![ ]</td>
<td>9 9</td>
<td></td>
</tr>
<tr>
<td><strong>c. Mood changes, personality changes, substance-related</strong></td>
<td>![ ]</td>
<td>0 0</td>
<td>If Ever, When:</td>
</tr>
<tr>
<td><strong>psychoses, flashbacks when using</strong></td>
<td>![ ]</td>
<td>1 1</td>
<td>- No contact with son for last several years</td>
</tr>
<tr>
<td>0 none</td>
<td>![ ]</td>
<td>2 2</td>
<td></td>
</tr>
<tr>
<td>1 minor (impairment had no serious consequences on daily</td>
<td>![ ]</td>
<td>8 8</td>
<td></td>
</tr>
<tr>
<td>functioning)</td>
<td>![ ]</td>
<td>9 9</td>
<td></td>
</tr>
<tr>
<td>2 major (impairment had adverse on daily functioning)</td>
<td>![ ]</td>
<td>8 8</td>
<td></td>
</tr>
<tr>
<td><strong>d. Problems in relationships (including friendships, family</strong></td>
<td>![ ]</td>
<td>0 0</td>
<td>If Ever, When:</td>
</tr>
<tr>
<td><strong>of origin, partner/spouse, etc.)</strong></td>
<td>![ ]</td>
<td>1 1</td>
<td>- No contact with son for last several years</td>
</tr>
<tr>
<td>0 none</td>
<td>![ ]</td>
<td>2 2</td>
<td></td>
</tr>
<tr>
<td>1 minor (strains and arguments)</td>
<td>![ ]</td>
<td>8 8</td>
<td></td>
</tr>
<tr>
<td>2 major (relationship broken off or about to be broken)</td>
<td>![ ]</td>
<td>9 9</td>
<td></td>
</tr>
</tbody>
</table>

*Continued on next page.*
**ADVERSE CONSEQUENCES OF SUBSTANCE USE (CONT’D)**

Program # ___________________________ Client Name _Harry James_

Counsellor: ___________________________ Date _September 13 [include year]_

(Note to Assessment Therapist: Code only the most severe level of consequences for each problem.)

As a result of your substance use, have you experienced:

<table>
<thead>
<tr>
<th></th>
<th>Ever</th>
<th>Past 90 Days</th>
<th>Clinical Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>e. Emotional/physical abuse of others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0  been neither verbally or physically abusive when using</td>
<td>x</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1  been verbally abusive when using</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2  been physically abusive when using</td>
<td>8</td>
<td>8</td>
<td>If Ever, When:</td>
</tr>
<tr>
<td>f. School or work problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0  none</td>
<td>x</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1  performance affected (loss of time from work or school, or reduced work/school capacity, turning in school assignments late or not at all, assignments of poor quality or supervisor/teacher complained)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>2  loss of job threatened, or actual loss of job/ expelled from school threatened or actual</td>
<td>8</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>7  n/a – no job and not in school</td>
<td>9</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>g. Legal problems (substance-related charges)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0  none</td>
<td>x</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1  charged only (case pending or dropped)</td>
<td>1</td>
<td>1</td>
<td>If Ever, When:</td>
</tr>
<tr>
<td>2  convicted</td>
<td>8</td>
<td>8</td>
<td>- None</td>
</tr>
<tr>
<td>h. Financial problems (DUE TO SUBSTANCE USE)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0  none</td>
<td>x</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1  minor (spending too much)</td>
<td>1</td>
<td>1</td>
<td>If Ever, When:</td>
</tr>
<tr>
<td>2  major (substance use associated with significant loss of income, etc.)</td>
<td>8</td>
<td>8</td>
<td>- Harry lives in boarding house as a result of finances/spending</td>
</tr>
</tbody>
</table>

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As a result of your substance use, have you experienced:

<table>
<thead>
<tr>
<th>Problem Description</th>
<th>Ever</th>
<th>Past 90 Days</th>
<th>Clinical Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems with your physical health (including overdose but not neurological problems unless neurological damage has been diagnosed)</td>
<td><img src="1" alt="0" /></td>
<td><img src="1" alt="0" /></td>
<td>If Ever, When: Joyce does not report severe adverse consequences associated with use of substances but thinks problems with indigestion etc might be related.</td>
</tr>
<tr>
<td>0 none</td>
<td><img src="1" alt="1" /></td>
<td><img src="1" alt="1" /></td>
<td>If Ever, When: No reports of blackouts, memory problems.</td>
</tr>
<tr>
<td>1 self-identified/other person concerned</td>
<td><img src="2" alt="2" /></td>
<td><img src="2" alt="2" /></td>
<td>If Ever, When: No reports of blackouts, memory problems.</td>
</tr>
<tr>
<td>2 health care professional’s health warning</td>
<td><img src="8" alt="8" /></td>
<td><img src="8" alt="8" /></td>
<td>If Ever, When: No reports of blackouts, memory problems.</td>
</tr>
<tr>
<td>3 medical treatment for physical problem (illness or accident) related to substance use</td>
<td><img src="9" alt="9" /></td>
<td><img src="9" alt="9" /></td>
<td>If Ever, When: No reports of blackouts, memory problems.</td>
</tr>
<tr>
<td>Blackouts or memory problems, forgetting, confusion, difficulty thinking</td>
<td><img src="X" alt="X" /></td>
<td><img src="X" alt="X" /></td>
<td>If Ever, When: No reports of blackouts, memory problems.</td>
</tr>
<tr>
<td>0 none</td>
<td><img src="1" alt="1" /></td>
<td><img src="1" alt="1" /></td>
<td>If Ever, When: No reports of blackouts, memory problems.</td>
</tr>
<tr>
<td>1 5 or fewer occasions</td>
<td><img src="2" alt="2" /></td>
<td><img src="2" alt="2" /></td>
<td>If Ever, When: No reports of blackouts, memory problems.</td>
</tr>
<tr>
<td>2 more than 5 occasions</td>
<td><img src="8" alt="8" /></td>
<td><img src="8" alt="8" /></td>
<td>If Ever, When: No reports of blackouts, memory problems.</td>
</tr>
<tr>
<td>Mood changes, personality changes, substance-related psychoses, flashbacks when using</td>
<td><img src="X" alt="X" /></td>
<td><img src="X" alt="X" /></td>
<td>If Ever, When: Joyce reports feeling really angry sometimes, irritable with kids, unpredictable moods, depression (taking antidepressants).</td>
</tr>
<tr>
<td>0 none</td>
<td><img src="1" alt="1" /></td>
<td><img src="1" alt="1" /></td>
<td>If Ever, When: Joyce reports feeling really angry sometimes, irritable with kids, unpredictable moods, depression (taking antidepressants).</td>
</tr>
<tr>
<td>1 minor (impairment had no serious consequences on daily functioning)</td>
<td><img src="2" alt="2" /></td>
<td><img src="2" alt="2" /></td>
<td>If Ever, When: Joyce reports feeling really angry sometimes, irritable with kids, unpredictable moods, depression (taking antidepressants).</td>
</tr>
<tr>
<td>2 major (impairment had adverse on daily functioning)</td>
<td><img src="8" alt="8" /></td>
<td><img src="8" alt="8" /></td>
<td>If Ever, When: Joyce reports feeling really angry sometimes, irritable with kids, unpredictable moods, depression (taking antidepressants).</td>
</tr>
<tr>
<td>Problems in relationships (including friendships, family of origin, partner/spouse, etc.)</td>
<td><img src="X" alt="X" /></td>
<td><img src="X" alt="X" /></td>
<td>If Ever, When: Joyce has lost some friendships and partner left due to coke use. Joyce is worried about her relationship with kids after she regains custody. Loss of kids directly tied to substance use.</td>
</tr>
<tr>
<td>0 none</td>
<td><img src="1" alt="1" /></td>
<td><img src="1" alt="1" /></td>
<td>If Ever, When: Joyce has lost some friendships and partner left due to coke use. Joyce is worried about her relationship with kids after she regains custody. Loss of kids directly tied to substance use.</td>
</tr>
<tr>
<td>1 minor (strains and arguments)</td>
<td><img src="2" alt="2" /></td>
<td><img src="2" alt="2" /></td>
<td>If Ever, When: Joyce has lost some friendships and partner left due to coke use. Joyce is worried about her relationship with kids after she regains custody. Loss of kids directly tied to substance use.</td>
</tr>
<tr>
<td>2 major (relationship broken off or about to be broken)</td>
<td><img src="8" alt="8" /></td>
<td><img src="8" alt="8" /></td>
<td>If Ever, When: Joyce has lost some friendships and partner left due to coke use. Joyce is worried about her relationship with kids after she regains custody. Loss of kids directly tied to substance use.</td>
</tr>
</tbody>
</table>

Continued on next page.
### ADVERSE CONSEQUENCES OF SUBSTANCE USE (CONT’D)

Program #  
Client Name _Joyce Smithers_

Counsellor:  
Date _September 13 [include year]_

(Note to Assessment Therapist: Code only the most severe level of consequences for each problem.)

As a result of your substance use, have you experienced:

<table>
<thead>
<tr>
<th>(8 = Refused, 9 = Missing)</th>
<th>Ever</th>
<th>Past 90 Days</th>
<th>Clinical Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>e. Emotional/physical abuse of others</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>If Ever, When:</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Used to verbally fight with spouse when using. Had little patience with kids and would yell at them when using or hung over.</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>f. School or work problems</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>If Ever, When:</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Joyce did not complete high school and attributes this to her drug use as a teenager. She wants to complete grade 12. She is currently unemployed and not in school.</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>7</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td><strong>g. Legal problems (substance-related charges)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>If Ever, When:</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td>- None</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>h. Financial problems (DUE TO SUBSTANCE USE)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>If Ever, When:</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td>Joyce knows she spends too much money on alcohol and drugs. She has given up her apartment due to financial hardship.</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
Chapter 8

THE SOCRATES

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DESCRIPTION AND PURPOSE

The socrates provides information on client strengths and needs in the areas of treatment readiness. The name implies the area being measured: Stages of Change Readiness and Treatment Eagerness Scale.

This tool is designed to give a general measure of the motivation of problem drinkers and drug users to enter treatment.

Longer versions of this tool were first developed and tested. Success in the first studies prompted the development of a brief 19-item version. This 19-item version is used in Ontario’s standardized assessment package.

The addiction treatment field continues to attempt to measure the “stage of change” in which the client presents. Prochaska, Norcross and DiClemente outlined six stages in their Stages of Change model (1994), which is applicable to many behaviours. The stages are:

1. Precontemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance
6. Termination.

These stages are discussed in some detail in Appendix B: “The importance of motivational interviewing.”

The 19-item version of the socrates tool does not determine the client’s specific “stage of change” but provides scores on three scales—Recognition, Ambivalence and Taking steps—which measure the client’s general level of motivation:

1. Recognition: This scale provides information about the client’s level of awareness or consciousness of and acknowledgement of the link between substance use and current problems.
2. Ambivalence: This scale provides information about whether the client is certain or uncertain that he or she has or doesn’t have a problem. The scores are neither good nor bad; they simply indicate the amount of energy the client is spending in thinking about the change process or in debating the pros and cons of change.
3. Taking steps: This scale considers evidence that a client is starting to take steps, or has already taken some steps, to change behaviour.
The counsellor uses the Socrates as a starting point in the overall discussion with the client about his or her motivation for change. It is a useful exercise in early discussions about next steps and the client’s options for treatment. It also affects clinical decisions about appropriate referrals.

When the client becomes involved in clinical treatment, subsequent administrations of the Socrates can show the impact of clinical interventions, through changes on the three scales.

**INTENDED POPULATION**

Problem drinkers have become the intended population for the Socrates, although the original research premise was that it would be designed for “heavy drinkers.” This instrument has been tested in the United States for both males and females, across several cultural groups, including Hispanic, White, Non-Hispanic, Black and Native American.

The Socrates is not intended for use with youth under the age of 19. It is appropriate for adults aged 19 and up.

This version of the Socrates was used in Project MATCH in the United States as part of that project’s pretreatment assessment battery in 1993. Project MATCH followed 1,726 adult men and women who were entering various types of treatment. The tool compares the client’s raw scores to the scores of the original Project MATCH participants. Note that individual scores are therefore being ranked as low, medium or high relative to people already presenting for treatment.

**ADMINISTRATION**

There are two forms, one for alcohol (8A) and one for other drugs (8D). The counsellor must complete the 8A and at least one copy of the 8D if the client is using alcohol and one or more other drugs. For the purposes of the standardized assessment package, it is suggested that the counsellor assess for the top three drugs of concern (from among the drug categories defined by DATIS, listed on the Dhq as well as in DATIS), if the use of the substances is relevant to the assessment and time permits.

Each drug should be measured separately so that the counsellor can identify the levels of motivation for each substance used, as well as the interplay among them.

This tool can be given to the client to self-administer if this is appropriate. The counsellor must determine if issues such as culture, diversity, language and literacy may impact on self-administration. The forms can be used as homework assignments, and can be used in groups or individual sessions.
The counsellor will:

- Explain the purpose of the tool, the importance of the feedback and mutual exploration of the meaning of the three scales.
- Explain that there are two versions, one for alcohol and one for other drugs.
- Give the client a copy of the tool and go over the instructions.
- Explain that the questions pertain to “right now” and ask the client to fully use the five answers and the full range of their feelings to the extremes of strongly agree and strongly disagree. Ask them to read each question carefully. Encourage them to ask for clarification or assistance as necessary and assure them that there are no right or wrong answers.

**SCORING AND INTERPRETATION**

When the client has finished with the tool, the counsellor transfers the answers the client has circled to the scoring sheet for both 8A and 8D and then totals the columns to get one number for each of the three scales. There is a range of scores within which the client’s total must fall. For example, recognition scores will fall between 7 and 35. These are called “raw scores.”

The raw scores for each scale can then be placed on the profile sheet that has the comparison decile scores from Project MATCH. In this way, you will be able to rank your client’s raw score to the decile scores of participants who were seeking treatment.

You will circle the corresponding decile score that relates to the raw score. For example, on the recognition scale, a raw score of 29 is equal to a decile score of “30 or Low.” This means that your client’s score relates to what was evaluated as a low level of recognition for participants in Project MATCH. It is understood that clients entering treatment will have a variety of levels of awareness of the links between problems and substance use.

It is important to look at the whole client and not just the scores. When scores don’t seem to fit the client, you may need to ask about the client’s comfort with the test, other factors that might distract the client or any causes of distress that may have interfered. The counsellor may say, “How does this fit for you? Does it seem accurate?” These questions can be an effective method to encourage more discussion. Another approach might be, “How are you feeling as you see the scores?”

It is also important to examine the individual answers and not just the totals. For example, a client may have a lower recognition score, but she or he may have answered “strongly agree” to “Sometimes I wonder if I am an alcoholic.”

You should have a score for **Recognition**, **Ambivalence** and **Taking steps** for each form administered.

With the scores in hand, the counsellor should have a good picture of the client’s general level of motivation to make changes, take steps and implement change. Additional information gathered at the interview will assist the
counsellor in determining treatment readiness. Treatment readiness may be affected by outside factors such as work stress, responsibilities of caring for others, fear of change and previous failed treatment attempts. Chapter 10 discusses the Treatment Entry Questionnaire (TEQ), which also measures the internal or external reasons that the client is seeking treatment. The Socrates scores and TEQ scales go together very nicely.

WHAT IS AMBIVALENCE?

Do not be afraid of ambivalence! Ambivalence does not mean that the client is not ready to change, nor does it mean that the client will not change. Ambivalence is concrete evidence of the ongoing struggle between the pros and cons of change. Ambivalence ebbs and flows throughout treatment and can resurface in the face of setbacks or as the client moves from one stage to another and gets closer to change.

The ambivalence that we can measure gives us hope clinically, because it means that the client is aware of the benefits of change as well as the costs. Many clients enter treatment and then withdraw prematurely because they see for the first time the costs of change! Resolving ambivalence must be completed prior to beginning treatment or the treatment can end up being postponed, delayed or even abandoned if the client becomes frightened or disheartened.

Many researchers and clinicians discuss the decisional balance involved in behaviour change. The “decisional balance” exercise is a clinical tool that can be used to illustrate, in a tangible way, the hopes and fears that co-exist within any person contemplating such change. In this exercise, the counsellor and client together develop a list of the costs and benefits of change as well as the pros and cons of the status quo, using a table or grid like the one below.

<table>
<thead>
<tr>
<th>Status Quo</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs</td>
<td>In this space, the client lists the costs of not reducing substance use or abstaining.</td>
</tr>
<tr>
<td>Benefits</td>
<td>In this space, the client lists the benefits of continued use of substances.</td>
</tr>
</tbody>
</table>

The decisional balance exercise can be used to begin the preliminary thinking about next steps in treatment or to identify the current struggles in giving up or reducing the use of substances, or it can be used to measure the client’s progress in thinking about the costs and benefits.

Remember that the benefits of quitting substances or reducing use remain constant as clients move to preparation and action stages. The client may have always been aware of the benefits of quitting. It is the reducing of the costs of change over time that makes change easier to discuss and act upon.
WHAT ABOUT THE ABSENCE OF AMBIVALENCE?

When we see low scores on ambivalence, it may mean that the client has worked through the pros and cons of change and is ready to proceed, or it may mean that the client has decided not to change and has no ambivalence about that! The first example is a client in the preparation or action stage, while the second example is of a client in precontemplation. A low score may also mean that the client is clear about needing to make changes but has so many things going on that he is unclear about where to start.

This is a crucial difference in how we currently view ambivalence in the addiction treatment field. The client who says “I want to, but I do not want to” from session to session, or even within the same session, is not ready for treatment planning or referrals; he needs motivational interviewing sessions.

Once a client is in treatment, the resurgence of old feelings of ambivalence can also be dealt with through motivational interviewing. See Appendix B: “The importance of motivational interviewing” for further discussion.

Clients who continuously become distracted with ambivalence may need to work through the issues at a slower pace. They may be telling you that things are moving too fast or that the treatment goals are not right for them. They may not have worked through what they are giving up when they reduce their use or choose abstinence. Both the counsellor and the client often overlook the benefits of substance use. It is important to fully examine the positive health or emotional effects that substances provide for the client. It is important not to focus prematurely on all the benefits of behaviour change and miss other essential information.

Eugene Tinelli, MD, PhD, suggests in his article “The Health-Oriented Substance Use Interview” that “we have become sophisticated in our substance use assessments, but most of us share a bias toward a pathological view of substance abuse that leads us to miss essential information and an opportunity to increase our rapport with clients” (2000). He goes on to say that even though we have stage-oriented models and motivational and skill-enhancing techniques to help people move through these stages, “The fundamental health question on which most individual psychoactive drug use is based is rarely asked.” This question is, “How does . . . your drug . . . of choice work for you in a healthy way?” This question assumes, says Tinelli, that substance abuse was acquired not for pathological reasons, but for reasons of health, for example, to initially ease shyness or depression or to cope with stress.

It is understood that although the benefits of use keep the person using initially, the costs bring them to formal addiction programs once use moves into abuse and dependence.

THE SOCRATES AND THE ADMISSION AND DISCHARGE CRITERIA

The Admission and Discharge Criteria differentiate between the stages of change. For example, those clients demonstrating ambivalence or resistance—that is, those in the precontemplation or contemplation stage and not yet ready for treatment—should not enter the treatment system except to receive motivation-enhancing sessions. Each local implementation committee will decide which agencies provide this service.
The criteria challenge the counsellor to distinguish between treatment and housing as well as between crisis management and treatment readiness. If the client is in crisis and needs shelter, food or a safe environment, the criteria require that the counsellor see to these needs first, or refer the client to an agency that will. If the client is in crisis due to withdrawal management needs, then a referral is made and later the standardized assessment tools will help determine next steps. Treatment programs must be reserved for clients who are treatment-ready!

The socrates tool will give the counsellor and client an initial sense of whether the client is currently prepared and ready to move into the next steps. Additional assessment information will make decisions easier in terms of treatment planning.

**WHAT DO THE SCORES MEAN?**

The scores will give the counsellor information about whether the client scored low, average or high relative to people already seeking treatment for alcohol and drug problems. The researchers give the following general interpretation guidelines for the socrates—8 (A or D) scores.

**RECOGNITION**

High scorers directly acknowledge that they are having problems related to their drug use. They tend to express a desire for change and perceive that harm will come if they do not change.

Low scorers deny that alcohol or other drugs are causing them any serious problems, reject diagnostic labels such as “alcoholic,” “problem drinker” or “addict,” and do not express a desire for change.

**AMBIVALENCE**

There are questions in the socrates that ask the client if they “wonder” about whether they are:

- a problem drinker or drug user
- an alcoholic or drug addict.

These questions are designed to measure ambivalence, as clients who are still wondering will be ambivalent at this time. Clients who do not “wonder” already know that they “are” or definitely “are not” problem drinkers or addicts.

High scorers say they sometimes “wonder” if they are in control of their use or are using too much, are hurting other people or are alcoholic or drug addicted. High scores reflect uncertainty. High scores may also indicate some openness to reflection, as is expected in the contemplation stage.
Low scorers say they “do not wonder” if they drink or use too much or are in control, hurting others, or are an addict or alcoholic. A person can be low on ambivalence because they “know” their substance use is causing problems (look for higher recognition scores) or they “know” that they do not have drinking or drug problems (lower recognition scores).

Thus a low Ambivalence score should be interpreted in relation to the Recognition score.

**TAKING STEPS**

High scorers report they are already doing things to make a positive change in their drinking and may have experienced some success in this regard. High scores are predictive of successful change.

Low scorers report that they are not currently doing things to change their drinking and have not made recent changes. It is important to point out to low-scoring clients that they have already taken the first step by attending the session or participating in the administration of some assessment tools. The counsellor must offer affirmation and encouragement in an effort to move these clients toward the next stage of change.

---

**Clinical tips**

Some counsellors worry that the SOCRATES does not place the client in a stage of change exactly. Remember that the scores on the three scales, as well as each score in relation to the other scales, will give you an individualized profile of each client. The Treatment Entry Questionnaire will give you information about the internal and external motivators for seeking help.

Scores on ambivalence must always be interpreted in relation to recognition scores. Keep in mind that low ambivalence can be positively affiliated with both:

- low recognition levels and
- high recognition levels.

The language of the SOCRATES can be problematic. The counsellor needs to explain to the client that the words “alcoholic” and “problem drinker” are used in the forms and that they are sometimes seen as either too much of a label or not enough of one! If the client is a member of a 12-step group such as Alcoholics Anonymous, she may prefer the language of “alcoholic,” and this preference should be acknowledged and honoured. Likewise, if the client prefers another term, assure her that you will go with her choice, and then use that term.

The forms use “I wonder” as the verb in the questions about whether the client thinks he is a problem drinker or alcoholic. The client might want to disagree with “I wonder,” because he is past “wondering” and now feels sure that he is an alcoholic or problem drinker. Explain to the client that he should disagree with the “wonder” questions if that feels like the most appropriate response.
If the form has been copied to be a two-sided form, the counsellor must remind the client to turn the form over and complete the other side.

Some clients will be able to transfer their own scores. The counsellor has to decide when this level of involvement is appropriate, and for which clients. Group sessions, where participants assist each other and the facilitator can walk the entire group through the process step by step, may make this easier.

Remember that the feedback session is very important in the role that the counsellor plays to increase motivation. The counsellor has the opportunity to affirm the steps that the client has taken and support the client’s level of recognition. If the scores are in fact lower than ideal for treatment planning, the counsellor should assure the client of the counsellor’s role in helping them move ahead. The counsellor uses the information from the assessment to encourage the client about appropriate next steps.

**CLINICAL EXAMPLES**

**HARRY’S LIFE**

**8A—Alcohol**

Harry has not used any other drugs and so only the 8A is administered. The counsellor needs to incorporate the three subscales into the overall profile of the client. Each subscale score is significant, but in this case, the individual answers to the Socrates are very interesting for Harry. Although his three subscale scores are fairly low to medium (Recognition = 23; Ambivalence = 15; Taking steps = 9), Harry has some concerns, as expressed in some of his answers (questions 2, 3, 7, 10 and 12). When we examine Harry’s answers, we see that he does have awareness and is thinking about the changes he is making, even though they are quite recent.

This is very early in the treatment process for Harry, and it makes sense that he has not yet made a lot of changes and is lower on recognition. Once Harry has met with a counsellor a few more times, he should start to make the links between areas of his life that are problematic and his drinking. The cause and effect of abusing alcohol should become apparent as Harry spends more time being sober. The counsellor will be trying to assist Harry in making these links between his current problems and his use of alcohol.

It makes sense that Harry reports he is not yet making changes, as realistically he has only been admitted to the hospital and attended only one scheduled appointment, one week later! Perhaps Harry is a realist and does not want to misrepresent what has actually transpired to date.

Numerous publications and Web sites discuss issues of particular relevance to older adults and substance use. For example, best practice protocols recognize that older adults may or may not identify with labels such as “alcoholic” or “problem drinker.” For more information, see Appendix C, “Resources.”
Let’s look at each of the subscales.

**Recognition**

Recognition is 23. This indicates a very low level of recognition between Harry’s use of substances and his problems overall, as compared with others entering treatment. Harry has only recently attended the hospital, so he may not have spent much time thinking about the links and relationships between drinking and his problems. Harry does say that he is concerned about his health. He says he thinks that his problems will get worse (# 3). Harry acknowledges problems and harm associated with drinking. This is very positive for the client. There are a lot of reasons to feel hopeful for Harry when one looks at his responses on the Socrates. The counsellor can assist him with making the links he will need to understand his use and to plan for his treatment goals.

**Ambivalence**

Ambivalence is 15. This is a medium score compared with others entering treatment. Remember that Harry is worried about his health and the recent seizures may have frightened him. He seems to be “sure” that he has problems. It may be that his perceptions about his health have caused him to accurately assess the impact of his alcohol use. Harry seems to be a little ambivalent about what he needs to do. Remember that Harry is early in his recovery. Ambivalence scores should always be understood in the context of the recognition score.

Clients will have low ambivalence when they know they have problems or, conversely, when they know they do not!

**Taking steps**

Taking steps is also low at 9 and this makes perfect sense given the timing of the assessment appointment and the recent discharge from the hospital. Harry’s decision to be abstinent is very new and he accurately portrays the amount of work that has been done to date. This subscale will be higher once Harry has been abstinent for a longer period of time.

**Sample counsellor response**

Here are some examples of what the counsellor might say to Harry when discussing the scores:

*Harry, your scores show us that you are early on in your understanding of the role that alcohol has played with your health. You’ve had quite a scare but you are still working out the feelings about change in your head and in your heart. Does that make sense to you?*

*Your period of abstinence is relatively new and I want you to know that you have done really well so far in getting and staying sober! This might be why you have answered the questions about the changes you have made in a way to get a lower score. You are just starting out, what do you make of that?*

*I want to commend you for the period of abstinence you now have. Although your scores show that you are early on in terms of making changes to your drinking, I’d like to know what you did over the last week to stay sober. Tell me about the strategies you used.*
JOYCE’S LIFE

8A—Alcohol

Joyce has filled in both an 8A and 8D form because she has involvement with alcohol and other drugs.

Recognition

Joyce has a medium level of recognition (33) when it comes to her use of alcohol. She has seen the relationship between her use and problems that she is experiencing in her life. Look at her individual answers to questions 1, 3, 7, 12, 15 and 17.

Ambivalence

Joyce gets 19 on this scale, which indicates very high ambivalence about change with alcohol. This does not necessarily mean that Joyce does not want to change and in fact this probably means that Joyce is struggling with the pros and cons of change. It means that she is struggling with the reality of the costs and benefits of staying the same as well as those of changing. This is an active struggle for clients and the SOCRATES gives a view of that struggle. Ambivalence can be very high just as clients are about to embark on the treatment plan, or once it has started. This situation is not uncommon and does not mean the plan should be abandoned. It means that the client needs to continue to work on the treatment plan and goals and to discuss openly the struggle and fears that they feel. Their ambivalence may be based on previous attempts to quit that they will view as failures. They may feel hopeless and afraid to let their family and friends down.

Taking steps

Joyce has a very low score on Taking steps (24). She has been in the withdrawal management centre for five days and is newly abstinent. Her score is an accurate reflection of what she has actually done to date. Examine her answers to questions 4, 5, 8 and 9. Joyce is aware that this is very early in her recovery period and the counsellor must note that she has been through this process before. This is a more honest appraisal at this point of what she has actually done so far.

8D—Cocaine

Joyce’s scores on the three subscales for drugs are very similar. She has slightly higher recognition about her cocaine use and this may be related to the substance itself and the attitudes that clients and the general population have about illegal drugs. Joyce may have a sense that this drug has contributed to a lot of her problems. Joyce does report that her use of cocaine contributed to the break-up of her marriage. The Adverse Consequences information fits nicely with this new information from the SOCRATES.

Clients may need to get information and spend time discussing the impact of each drug on their lives in order to see more clearly the relationship between use and problems or consequences. Joyce’s individual answers are also important and the counsellor can discuss the feelings behind the answers in future sessions.
Joyce’s general level of motivation seems appropriate and her awareness of the problems she has is accurate. She has just lost her children as a direct result of her drug use. She will have a lot of feelings about this situation and may feel very apprehensive at this time. She may also be a bit “stuck” due to the absence of any counselling related to her past sexual abuse.

Sample counsellor response

Here are some ways that the counsellor could discuss Joyce’s scores:

Joyce, let’s talk about what these scores might mean. You have a bit of an advantage here because you have had treatment before and so you know what to expect. It’s a lot of work to make this commitment and stick to it, isn’t it?

Joyce, your recognition scores are in the middle of the pack here, you probably are starting a little higher than others because you have done some work on this before, you know, linking the role that alcohol and coke play in creating problems. What do you make of that?

Joyce, it seems that you are having some feelings about changing your drinking and drug habits. The ambivalence score can show us a few different things. In your case it may be showing us that although you have decided to make these changes, you are having some thoughts about how hard it might be or whether you can do it. Does that seem right? What feelings are you having?
### PERSONAL DRINKING QUESTIONNAIRE (SOCRATES 8A)

Program # _______________ Client Name ____________

Counsellor: ____________________________________________________________________________ Date __________ [include year]

**Instructions:** Please read the following statements carefully. Each one describes a way that you might (or might not) feel about your drinking. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it right now. Please circle one and only one number for each statement.

<table>
<thead>
<tr>
<th></th>
<th>NO! Strongly disagree</th>
<th>No Disagree</th>
<th>? Undecided or unsure</th>
<th>Yes Agree</th>
<th>YES! Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I really want to make changes in my drinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>Sometimes I wonder if I am an alcoholic.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>If I don’t change my drinking soon, my problems are going to get worse.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
</tr>
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<td>4.</td>
<td>I have already started making changes in my drinking.</td>
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<td>4</td>
</tr>
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<td>9.</td>
<td>I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern.</td>
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<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>I have serious problems with drinking.</td>
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<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

*Continued on next page.*
**PERSONAL DRINKING QUESTIONNAIRE (SOCRATES 8A) (CONT’D)**

<table>
<thead>
<tr>
<th>Statement</th>
<th>NO! Strongly disagree</th>
<th>No Disagree</th>
<th>Undecided or unsure</th>
<th>Yes Agree</th>
<th>YES! Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Sometimes I wonder if I am in control of my drinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
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<td>12. My drinking is causing a lot of harm.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I am actively doing things now to cut down or stop drinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. I want help to keep from going back to the drinking problems that I had before.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. I know I have a drinking problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. There are times when I wonder if I am drinking too much.</td>
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<td>18. I am working hard to change my drinking.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. I have made some changes in my drinking, and I want some help to keep me from going back to the way I used to drink.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
SOCRATES SCORING FORM—19-ITEM VERSION 8.A

Transfer the client’s answers from questionnaire.

<table>
<thead>
<tr>
<th>Recognition</th>
<th>Ambivalence</th>
<th>Taking steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Totals: Re 23 Am 15 Ts 9
Possible range: 7–35 4–20 8–40
**SOCRATES PROFILE SHEET—19-ITEM VERSIONS 8.0**

Program # ___________________ Client Name ___________________  
Counsellor: ___________________ Date ___________________

**Instructions:** From the socrates Scoring Form (19-item version) transfer the total scale scores into the empty boxes at the bottom of the Profile Sheet. Then for each scale, circle the same value above it to determine the decile range.

<table>
<thead>
<tr>
<th>Decile scores</th>
<th>Recognition</th>
<th>Ambivalence</th>
<th>Taking steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 Very High</td>
<td>19–20</td>
<td></td>
<td>39–40</td>
</tr>
<tr>
<td>80</td>
<td>18</td>
<td></td>
<td>37–38</td>
</tr>
<tr>
<td>70 High</td>
<td>35</td>
<td>17</td>
<td>36</td>
</tr>
<tr>
<td>60</td>
<td>34</td>
<td>16</td>
<td>34–35</td>
</tr>
<tr>
<td>50 Medium</td>
<td>32–33</td>
<td>15</td>
<td>33</td>
</tr>
<tr>
<td>40</td>
<td>31</td>
<td>14</td>
<td>31–32</td>
</tr>
<tr>
<td>30 Low</td>
<td>29–30</td>
<td>12–13</td>
<td>30</td>
</tr>
<tr>
<td>20</td>
<td>27–28</td>
<td>9–11</td>
<td>26–29</td>
</tr>
<tr>
<td>10 Very Low</td>
<td>7–26</td>
<td>4–8</td>
<td>8–25</td>
</tr>
<tr>
<td>Raw scores (from Scoring Sheet)</td>
<td>Re = 23</td>
<td>Am = 15</td>
<td>Ts = 9</td>
</tr>
</tbody>
</table>
**PERSONAL DRINKING QUESTIONNAIRE (SOCRATES 8A)**

Program # __________________________ Client Name_ Joyce Smithers

Counsellor: __________________________ Date_ September 13 [include year]

**Instructions:** Please read the following statements carefully. Each one describes a way that you might (or might not) feel about your drinking. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it right now. Please circle one and only one number for each statement.

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<th>No! Strongly disagree</th>
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<th>Undecided or unsure</th>
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<tr>
<td>1. I really want to make changes in my drinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Sometimes I wonder if I am an alcoholic.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. If I don’t change my drinking soon, my problems are going to get worse.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I have already started making changes in my drinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I was drinking too much at one time, but I’ve managed to change my drinking.</td>
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<td>6. Sometimes I wonder if my drinking is hurting other people.</td>
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<td>5</td>
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<td>7. I am a problem drinker.</td>
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<tr>
<td>8. I’m not just thinking about changing my drinking, I’m already doing something about it.</td>
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<td>9. I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern.</td>
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<td>4</td>
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<tr>
<td>10. I have serious problems with drinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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</tbody>
</table>

*Continued on next page.*
### PERSONAL DRINKING QUESTIONNAIRE (SOCRATES 8A) (CONT’D)

**Program #**

**Client Name** Joyce Smithers

**Counsellor:**

**Date** September 13 [include year]

**Instructions:** Please read the following statements carefully. Each one describes a way that you might (or might not) feel about your drinking. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it right now. Please circle one and only one number for each statement.

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<tr>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>11. Sometimes I wonder if I am in control of my drinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. My drinking is causing a lot of harm.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I am actively doing things now to cut down or stop drinking.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. I want help to keep from going back to the drinking problems that I had before.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. I know I have a drinking problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. There are times when I wonder if I am drinking too much.</td>
<td>1</td>
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<tr>
<td>17. I am an alcoholic.</td>
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<td>5</td>
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<tr>
<td>18. I am working hard to change my drinking.</td>
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<td>4</td>
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</tr>
<tr>
<td>19. I have made some changes in my drinking, and I want some help to keep me from going back to the way I used to drink.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
### PERSONAL DRUG USE QUESTIONNAIRE (SOCRATES 8D)

**Program #** __________  **Client Name** Joyce Smithers  
**Counsellor:** _____________________________________________________________________________  **Date** September 13 [include year]

**Instructions:** Please read the following statements carefully. Each one describes a way that you might (or might not) feel about your drug use. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it right now. Please circle one and only one number for each statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>NO! Strongly disagree</th>
<th>No Disagree</th>
<th>? Undecided or unsure</th>
<th>Yes Agree</th>
<th>YES! Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I really want to make changes in my use of drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Sometimes I wonder if I am an addict.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. If I don’t change my drug use soon, my problems are going to get worse.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I have already started making some changes in my use of drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I was using drugs too much at one time, but I’ve managed to change that.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<td>6. Sometimes I wonder if my drug use is hurting other people.</td>
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<td>2</td>
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<td>4</td>
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<tr>
<td>7. I have a drug problem.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I’m not just thinking about changing my drug use, I’m already doing something about it.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I have already changed my drug use, and I am looking for ways to keep from slipping back to my old pattern.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I have serious problems with drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

*Continued on next page.*
### PERSONAL DRUG USE QUESTIONNAIRE (SOCRATES 8D) (CONT’D)

**Program #**

**Client Name**  Joyce Smithers

**Counsellor:**

**Date**  September 13 [include year]

**Instructions:** Please read the following statements carefully. Each one describes a way that you might (or might not) feel about your drug use. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it right now. Please circle one and only one number for each statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Sometimes I wonder if I am in control of my drug use.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. My drug use is causing a lot of harm.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I am actively doing things now to cut down or stop my use of drugs.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. I want help to keep from going back to the drug problems that I had before.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. I know that I have a drug problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
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<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. I am a drug addict.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. I am working hard to change my drug use.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. I have made some changes in my drug use, and I want some help to keep from going back to the way I used before.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Complete one Scoring Form and one Profile Sheet for each questionnaire a client completes. For example, if a client completed an 8A and two 8Ds, fill out three Scoring Forms and three Profile Sheets, making sure to identify the 8D drugs. In our fictitious case, Joyce Smithers completed an 8A plus an 8D for cocaine, so her counsellor completes two Scoring Forms and two Profile Sheets. If you like, you may add a column to the Scoring Form and Profile Sheet for each drug listed, as we have done in these samples.
## SOCRATES PROFILE SHEET—19-ITEM VERSIONS 8.0

Program #: ___  
Client Name: Joyce Smithers

Counsellor: ____________________________  
Date: September 13 [include year]

**Instructions:** From the SOCRATES Scoring Form (19-item version) transfer the total scale scores into the empty boxes at the bottom of the Profile Sheet. Then for each scale, circle the same value above it to determine the decile range.

<table>
<thead>
<tr>
<th>Decile scores</th>
<th>Recognition</th>
<th>Ambivalence</th>
<th>Taking steps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8A</td>
<td>8D</td>
<td>8A</td>
</tr>
<tr>
<td>80</td>
<td></td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>70 High</td>
<td>35</td>
<td>35</td>
<td>17</td>
</tr>
<tr>
<td>60</td>
<td>34</td>
<td>34</td>
<td>16</td>
</tr>
<tr>
<td>50 Medium</td>
<td>32–33</td>
<td>32–33</td>
<td>15</td>
</tr>
<tr>
<td>40</td>
<td>31</td>
<td>31</td>
<td>14</td>
</tr>
<tr>
<td>30 Low</td>
<td>29–30</td>
<td>29–30</td>
<td>12–13</td>
</tr>
<tr>
<td>10 Very Low</td>
<td>7–26</td>
<td>7–26</td>
<td>4–8</td>
</tr>
<tr>
<td>Raw scores</td>
<td>Re = 33</td>
<td>Re = 35</td>
<td>Am = 19</td>
</tr>
</tbody>
</table>

(from Scoring Sheet)
Chapter 9

THE TREATMENT ENTRY QUESTIONNAIRE

Description and purpose ................................................................. 144
Intended population ........................................................................... 144
Administration .................................................................................. 145
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DESCRIPTION AND PURPOSE

The Treatment Entry Questionnaire (TEQ) is a very simple tool that provides very rich information in the measurement of the “treatment readiness” area of the client’s strengths and needs.

This instrument is designed to measure a different aspect of motivation than the Socrates or other tools that measure the “levels of motivation” that the client demonstrates when entering treatment. Designed by Wild (1995), the questionnaire looks at the reasons a client has for entering treatment, rather than at a client’s general motivation to change behaviour. Clients may have the same level of motivation at entry but be attending treatment for very different reasons. For example, one client may be attending because of a personal decision based on her recognition of the relationship between her substance use and other problems in her life. Another may be attending because his employer is concerned about his substance use and the client wishes to keep his job.

The TEQ is based on self-determination theory (Deci & Ryan, 1987). Self-determination theory defines motivation in relation to the reasons clients engage in activities rather than to the amount of energy they expend, the stage of change in which they present or their sense of self-efficacy.

The TEQ looks at three measures of motivation:

1. *Internal positive:* The degree to which the client identifies personally with the positive value of behaviour change.

2. *Internal negative:* The degree to which the client identifies with what will happen negatively if he or she does not change.

3. *External coercion:* The degree to which the client’s attendance is due to an external referral or identified pressure or ultimatum.

“Self-determination theory defines motivation in relation to the reasons why people engage in activities, rather than the amount of energy that they expend, the stage of change they are in, or their sense of self-efficacy. A large body of research shows that, in comparison with external and introjected reasons for engaging in behaviour, there will be a positive outcome for clients who identify with the inherent positive value of behaviour change.” (Wild, 1995)

INTENDED POPULATION

This tool may be self-administered by clients over the age of 18. If more appropriate (for example, if the client has special needs or requests help), the counsellor may administer the TEQ. The TEQ may also be used as a homework assignment.
ADMINISTRATION

The client fills in his or her response to 12 statements. The counsellor should encourage the client to fully use the seven possible responses, which range from “strongly disagree” (1) to “strongly agree” (7). The counsellor needs to assure the client that there are no right or wrong answers.

SCORING

When the questionnaire is completed, the counsellor scores the responses by grouping them into three scales, as described earlier:

1. *Internal positive:* Add responses to statements 1, 4, 8 and 10 for a total out of 28.
2. *Internal negative:* Add responses to statements 5, 7 and 11 for a total out of 21.
3. *External coercion:* Add responses to statements 3, 6, 9 and 12 for a total out of 28.

Note that statement 2 is *omitted* from the scoring, for the reason that it contributes to more than one scale and so can’t be applied to any single scale (Wild, 1995).

The totals for each of the scales should be placed in the appropriate place on the scoring sheet and the findings interpreted for the client in a personalized feedback session.

INTERPRETATION USING THE ADMISSION AND DISCHARGE CRITERIA

The client is asked to choose a response that matches his or her level of agreement to the 12 statements. Clients are asked to indicate how they would feel if they did or did not change behaviour, and about their belief systems and personal choices and values about treatment.

It is important that no one view the findings as “exclusionary.” Counsellors should assure their clients that they will not be denied treatment because they are attending “for the wrong reasons.” There are no right or wrong reasons. If clients are attending to avoid legal consequences or to regain custody of their dependents, those are acceptable places to start their initial assessment and treatment.

External forces may be the primary reason that a client initiates contact with assessment and treatment services but the counsellor’s role will be to assist the client to terminate treatment with a more internal positive focus if at all possible.

Behaviour change can successfully occur for a myriad of reasons. When asked, some clients know exactly why they changed behaviour, while others say, “I just did it, I don’t know why.” Some say, “Initially it was because I had to, but in time I liked the changes and the way I felt.” Some say, “I didn’t want to get in any more trouble or I didn’t want to lose my job.”
The TEQ allows frank discussion of the starting places for engagement. External forces and pressures can be very motivating, at least at the outset! Long-lasting behaviour change does require a lot of energy and commitment, but research indicates that relapse rates are lower for clients who have been in treatment. Indeed, relapse rates may be lower than has been traditionally thought in addiction treatment (McLellan et al., 2000, p. 1693). There is a continued need for more research about relapse in health care so that we can reduce the stigma associated with relapse in addictions.

When interpreting scores, be aware that some clients will not receive the entire assessment package. In some clinical settings, the TEQ might be administered as well as the SOCRATES to determine the internal reasons for seeking assistance as well as the general level of motivation. The scores would then help the counsellor and client discuss next steps. For example, in such a setting, a client whose score on the TEQ indicates external coercion as the primary motivation for entering treatment, and whose scores on the SOCRATES are low on the recognition and ambivalence scales, would not receive the rest of the standardized assessment package. A client with these scores might be under threat of legal sanctions, workplace discipline or loss of employment, and it is important that each community accommodate these clients in some meaningful way. For example, clients could be referred to community treatment or residential support environments where they could receive one or more motivational counselling sessions on-site or in another program, while they determine next steps.

**Clinical tip**

Keep in mind when working with clients that any motivation for change is okay to start with. The counsellor’s job is to help the client give even the smallest spark for change the support it needs to grow. Remember that each individual may have a different motivation for change and that all reasons should be respected.

**CLINICAL CHALLENGES**

It can be very challenging to work with clients who must attend for services but who clearly do not intend to change or do any treatment planning. They are primarily motivated to avoid consequences imposed by a third party. The mandate of each agency may need to be examined through a local planning process to determine if the agency is a suitable destination. One expedient way to deliver services is through the use of group sessions. Groups can be designed to offer brief interventions or education sessions to accommodate the referrals, give the clients an opportunity to receive an intervention, but not bog down the system by providing services to those who may not intend to change.

The Admission and Discharge Criteria allow the client and counsellor to choose more appropriate services and levels of treatment for externally coerced clients. These services would primarily be located within community treatment settings, where the costs of treatment would be lower while the service assists the client with appropriate decisions.
Clients who are externally coerced to attend treatment often benefit from as many choices as possible, given that they feel they do not have any choices! Externally referred clients may also be resistant or hostile about their attendance. William Miller’s research on motivation shows that one of the ways to reduce resistance is to offer a menu of options. The options depend on the results of the assessment tools. Clients who are treatment-ready and appropriate for referrals to treatment might be able to choose from different programs.

Clients may be offered a variety of ways to proceed to the next level of clinical interaction. For example, after an intake group, clients in the precontemplation stage and on probation or parole could be invited to choose from the following options:

- to make an appointment on the spot for the next time
- to choose an appointment time that suits their schedules or preferred days or times
- to call in at a later time to make an appointment
- to think about it for a while and reconnect later
- to ask their referral source if they have to continue.

Some clients may have higher scores for two different scales. For example, they may have high scores in:

- Both external coercion and internal positive: These clients are not only mandated to attend but know on some deeper level that they should change and may want to! To flip it around, on some level they want to attend, even though the decision appears to be involuntary. They may remark that they always knew they’d have to make a change.

- Both internal positive and internal negative: These clients are aware of both the benefits and costs that go with changing or not changing their behaviour.

- Both internal negative and external coercion: These clients are afraid of the negative consequences of not following through. They are externally coerced to attend and do not want to experience the consequences if they do not attend. They do not score high on internal positive. This indicates that they do not personally value behaviour change. These will be the clients that do not want to attend and yet never miss a session!

Clients who have a high score only on the external coercion scale and who have low scores on both the internal positive and the internal negative scales are clients who have to attend but do not want to. They are likely to book appointments, not attend, and rebook chronically. They follow through on scheduling but can manage to never attend.
CLINICAL EXAMPLES

HARRY’S LIFE

1. Internal positive

Harry has a low score on the internal positive scale (8 out of 28). The low score means that Harry does not yet identify strongly with the positive values of change and the good that can come from it. Harry is motivated to seek and attend treatment interviews for other reasons, as you will see below. A look at Harry’s individual answers on the TEQ reveals that Harry does have concerns about his drinking. However, his response to the first statement indicates he strongly disagrees with the concept of getting some help. He says he does not want to make changes with his life (#4), but he disagrees that he has been pressured into getting treatment (#6).

2. Internal negative

Harry’s score is high, 17 out of a possible 21. This score shows that his decision to continue with treatment is motivated by fear or worry. Harry is worried about what will happen if he does not change his drinking! It would appear as well that Harry has some very real concerns about his physical health. The case history notes that Harry has several serious physical health issues and Harry has honestly reported these concerns. Harry has had an alcohol-related seizure and this has probably been a frightening experience. He has problems with his bowels and with his digestive tract. He is probably feeling very unwell at this time after his recent withdrawal from alcohol.

These internal negative factors may be the initial reasons that Harry follows through with appointments and a treatment plan. These are solid reasons and the counsellor needs to work with the client’s stated concerns. In time the other values and attitudes about positive behaviour change may take effect.

Harry is likely to follow through because of his worries about his health. When the client is motivated by health concerns, the counsellor can build on these concerns to enhance and build other sources of motivation as well.

3. External coercion

Harry’s score (6 out of 28) indicate that he is not motivated by external coercion. Although he has low recognition scores as witnessed on the SOCRATES, he has probably come to treatment because he is concerned about his health. Harry has been out of the hospital for a week, but he has remained abstinent. He has attended the next appointment; he also had medium levels of ambivalence on the SOCRATES. The TEQ scores are useful in understanding Harry’s reasons for taking the next step.

Sample counsellor response

Here are some comments that the counsellor might make:

Harry, your scores seem to tell us that you are worrying about the things that might happen to your health if you don’t change. Does that seem accurate? Tell me more about the things you are worrying about.
We know you are here of your own accord, no one is making you come. That's why this score is so low [counsellor points to the external coercion score]. You've just made up your own mind, is that right?

This score shows that you are worried about the negative things that might happen if you do not change, does that seem right to you? Tell me more.

JOYCE’S LIFE

1. Internal positive

Joyce’s TEQ scores indicate that she identifies more with the positive values of behaviour change than with the negative. Her score on the internal positive statements is 26 out of 28, and this relatively high score represents strong positive internal values about change.

2. Internal negative

Joyce’s score is 8 out of 21 on the internal negative scale. If you look at the statements and responses that relate to the score, you see that 5, 7 and 11 are related to shame and guilt. Some experienced clinicians note that women, more so than men, often feel a disproportionate amount of shame and guilt in treatment or counselling generally, and that it is important during treatment to sort out these feelings and how they relate to the women’s life experiences. For example, Joyce may feel extraordinary amounts of guilt related to the loss of her children. Joyce also has a previous attempt at abstinence that she was not able to sustain, and that relapse may have fuelled more guilt, because clients often blame themselves for relapse.

Joyce is also depressed, which may influence how she views the changes that she must make. Her antidepressants may not be as helpful to her as they could be, given her use of alcohol and other drugs.

3. External coercion

Joyce may feel some pressure to do something about her substance use because she is involved with the Children's Aid Society, but it appears that external coercion is not a major factor in her seeking treatment, given her low external coercion score of 6 out of 28.

Sample counsellor response

Here are some examples of what the counsellor can say about Joyce’s scores:

Joyce, your scores on the TEQ confirm what you have been saying in our interview. You know it is time to make changes and you believe that changes in your alcohol use and cocaine use will improve your life. See, here [counsellor points to the internal positive score] your score is very high. This is a very positive way to start!

We both know that you are aware of the pressure on you right now from the CAS. You also want things to be different for you and your kids. This score [counsellor indicates the external coercion score] shows that the pressure from CAS is not the only reason that you are choosing to change right now. Tell me more about what this all means to you.
TREATMENT ENTRY QUESTIONNAIRE: SAMPLE FORMS

TREATMENT ENTRY QUESTIONNAIRE

Program #
Client Name: Harry James
Counsellor: ________________________________ Date: September 13 [include year]

Instructions: Please indicate whether you agree or disagree with each of the following statements by placing the number that best reflects your own personal opinion in the blank provided. Remember, there are no right or wrong answers, and your responses are completely confidential.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I decided to enter a program because I was interested in getting help.</td>
<td>2</td>
</tr>
<tr>
<td>2. I decided to enter a program because I won't like myself very much unless my substance abuse problem is under control.</td>
<td>5</td>
</tr>
<tr>
<td>3. If I remain in treatment it will probably be because others will be angry with me if I don’t.</td>
<td>1</td>
</tr>
<tr>
<td>4. I decided to enter a program because I really want to make some changes in my life.</td>
<td>2</td>
</tr>
<tr>
<td>5. I plan to go through with treatment because I'll be ashamed of myself if I don’t.</td>
<td>6</td>
</tr>
<tr>
<td>6. The reason I am in treatment is because other people have pressured me into being here.</td>
<td>1</td>
</tr>
<tr>
<td>7. If I remain in treatment it will probably be because I’ll feel like a failure if I don’t.</td>
<td>5</td>
</tr>
<tr>
<td>8. I decided to enter a program because it feels important for me personally to deal with my substance abuse problem.</td>
<td>2</td>
</tr>
<tr>
<td>9. I have agreed to follow a treatment program because I will get in trouble with my friends and family if I don’t follow all the guidelines.</td>
<td>2</td>
</tr>
<tr>
<td>10. I plan to go through with a treatment program because not abusing alcohol and drugs is a choice I really want to make.</td>
<td>2</td>
</tr>
<tr>
<td>11. If I remain in treatment it will probably be because I’ll feel very bad about myself if I don’t.</td>
<td>6</td>
</tr>
<tr>
<td>12. I have agreed to follow a treatment program because I was pressured to come.</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scoring Sheet</th>
</tr>
</thead>
<tbody>
<tr>
<td>I (Internal Positive)</td>
</tr>
<tr>
<td>II (Internal Negative)</td>
</tr>
<tr>
<td>III (External Coercion)</td>
</tr>
</tbody>
</table>

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TREATMENT ENTRY QUESTIONNAIRE

Program # ___________ Client Name Joyce Smithers
Counsellor: ___________________________ Date September 13 [include year]
Instructions: Please indicate whether you agree or disagree with each of the following statements by placing the number that best reflects your own personal opinion in the blank provided. Remember, there are no right or wrong answers, and your responses are completely confidential.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I decided to enter a program because I was interested in getting help.</td>
<td>7</td>
</tr>
<tr>
<td>2. I decided to enter a program because I won’t like myself very much unless my substance abuse problem is under control.</td>
<td>6</td>
</tr>
<tr>
<td>3. If I remain in treatment it will probably be because others will be angry with me if I don’t.</td>
<td>1</td>
</tr>
<tr>
<td>4. I decided to enter a program because I really want to make some changes in my life.</td>
<td>7</td>
</tr>
<tr>
<td>5. I plan to go through with treatment because I’ll be ashamed of myself if I don’t.</td>
<td>3</td>
</tr>
<tr>
<td>6. The reason I am in treatment is because other people have pressured me into being here.</td>
<td>1</td>
</tr>
<tr>
<td>7. If I remain in treatment it will probably be because I’ll feel like a failure if I don’t.</td>
<td>2</td>
</tr>
<tr>
<td>8. I decided to enter a program because it feels important for me personally to deal with my substance abuse problem.</td>
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</tr>
<tr>
<td>12. I have agreed to follow a treatment program because I was pressured to come.</td>
<td>2</td>
</tr>
</tbody>
</table>

Scoring Sheet

| I | Internal Positive 26/28 Questions 1, 4, 8 and 10 are added. |
| II | Internal Negative 8/21 Questions 5, 7 and 11 are added. |
| III | External Coercion 6/28 Questions 3, 6, 9 and 12 are added. |

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Chapter 10

THE DRUG-TAKING CONFIDENCE QUESTIONNAIRE (DTCQ-8)

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DESCRIPTION AND PURPOSE

With respect to addictive behaviours, an important component of self-efficacy is a person's perception of his or her ability to resist alcohol or drugs. The Drug-Taking Confidence Questionnaire (dtcq-8) measures the client's confidence in his or her abilities to cope in situations that are high-risk for substance use. The tool yields information about client strengths and needs in the area of relapse potential.

The tool allows for exploration of a client’s relapse potential by not only identifying potential high-risk situations for that person, but also by exploring his or her level of confidence in being able to cope with a particular high-risk situation.

BACKGROUND

The dtcq-8 (Sklar & Turner, 1999) is based on the work of Bandura (1977, 1995), who advanced the concept of self-efficacy—a person's belief in his or her ability to succeed in a particular situation—and on the work of Marlatt and Gordon (1985). Marlatt and Gordon interviewed adult substance abusers who had experienced a relapse. Their study found that virtually all relapses could be grouped into eight categories of risk.

The original Drug-Taking Confidence Questionnaire had 50 questions designed to assess clients' confidence in their ability to cope in high-risk situations for substance use (Annis & Martin, 1985; Annis et al., 1987). Another tool, the Situational Confidence Questionnaire (Annis & Graham, 1988), assessed clients' confidence levels in the eight high-risk situations Marlatt and Gordon had identified, using 39 items specifically about alcohol use.

The dtcq-8 was developed to be a reliable and valid brief measure of coping self-efficacy for substance users to serve the needs of clinicians and researchers who desire a global measure of a client’s confidence across high-risk situations (Sklar & Turner, 1999). Briefer than the dtcq-50, the tool’s eight questions each capture one of the high-risk situations identified by Marlatt and Gordon. (If a particular area among the eight needs further exploration, the counsellor is encouraged to use the full tool.) The dtcq-8 has separate questionnaires, one for alcohol use, and one for other drug use.

THE EIGHT CATEGORIES

The eight high-risk situations that Marlatt and Gordon identified (1985) as high-risk for relapse fall into two major classes of situations:

- personal states
- situations involving other people.
The category “personal states” refers to internal states, both physical and emotional (thoughts and feelings). It includes five situations:

1. Unpleasant emotions.
2. Physical discomfort.
3. Pleasant emotions.
4. Testing personal control.
5. Urges and temptations.

The other category, “Situations involving other people,” refers to challenging situations that involve others:

1. Conflict with others.
2. Social pressure to drink.
3. Pleasant times with others.

Some people find one class of situations more challenging than the other.

**INTENDED POPULATION**

This assessment tool is appropriate for adults.

**ADMINISTRATION**

The DTCQ tool has separate questionnaires for alcohol and other drugs. During the assessment, up to three substances can be recorded on separate forms. The drug types are:

- alcohol
- cannabis
- cocaine
- hallucinogens
- heroin
- sedatives
- hypnotics
- solvents
- stimulants
- tranquilizers
- other narcotics.

If the substances of concern are drugs, the DTCQ-8 for Drugs provides a line for the counsellor to insert the name of the drug.

The instructions at the top of the page direct the counsellor to ask the client to “imagine yourself as you are right now in each of these situations.”

The sentence that precedes each of the statements is shown just above the rating scales. Clients say to themselves, “I would be able to resist the urge to drink heavily if I [were in such and such a situation]” and then choose the level of their confidence for this statement. It is the client who defines “heavy” drinking. The form for drugs asks the client to rate his or her confidence in the statement, “I would be able to resist the urge to use [the name of the drug, as filled out by the counsellor].”

The rating scales from 0 per cent to 100 per cent. The low end represents “not at all confident” in being able to resist the urge to drink/use. The high end represents being “very confident” of one’s ability to resist the urge. Incremental increases of 20 per cent create six points among which to choose.

Specific guidelines are given on the form to assist the client in determining the level of confidence. The counsellor needs to review these instructions with the client beforehand. For example, the instructions specify, “If you are more unconfident than confident, circle 40 to indicate that you are only 40 per cent confident that you could resist the urge to use.”

**SCORING**

When the client has completed the questionnaire, the counsellor calculates the “Global Self-Efficacy Score.” To arrive at the score, the counsellor adds the percentages recorded for the eight scales and then divides the total by eight to yield an average level of confidence, expressed as a percentage. The counsellor then writes this global score in the space provided at the foot of the form. This number represents the average level of confidence the client has across all categories of risk. Remember that if one scale is very high or very low compared to the other scales, it can skew the average score, so that the average appears higher or lower than it otherwise would be.

Next, the counsellor takes the confidence scores for the eight items and puts them on the DTCQ-8 graph. The items along the x-axis on the graph correspond to each question. Thus, the percentage score for the first question is entered in the space for “Item 1, Unpleasant emotions” and so on. Item 9 is the space for the Global Self-Efficacy Score.

To create a bar for each item, the counsellor shades in the area between 0 and the percentage scored. Each item should be viewed separately, not as part of a sequence, so the counsellor should be careful not to connect the items to one another when making the bars. The scores are not related to one another.
INTERPRETATION USING THE ADMISSION AND DISCHARGE CRITERIA

Remember that a higher score means more confidence for the client. Thus, high scores (80 per cent and above) indicate that the client believes he can cope in these situations. Low scores (0 to 20 per cent) indicate that the client believes that the situation would likely put him at risk of relapse.

High self-efficacy is related to positive outcomes, that is, the more confident someone is that she can cope with a high-risk situation, the more likely she will succeed in avoiding relapse and additional consequences. In fact, improved self-efficacy is a positive outcome of treatment.

This tool gives the clinician a wonderful opportunity to discuss the client’s individualized risk of relapse. Many clients have never connected a relapse or risk of relapse with a particular situation or set of circumstances. They believe the relapse “just happened.” For many clients, the value of this tool is that they can now see that in some situations they are relatively safe, while in other situations they are at much greater risk to use.

The tool is also particularly helpful to the clinician, especially in working with clients who have not developed the skill of analyzing their thoughts, feelings and behaviour. An open-ended question such as, “When are you at greatest risk of relapse?” may be very difficult to answer for a client who has never considered the concept of situation-specific relapse. This tool provides a list of situations that have been determined through research with clients who have relapsed to be high-risk, and asks the client to respond to them. The client does not have to start from scratch, trying to construct his or her own high-risk situations.

With this tool, not only can clinicians identify a personalized profile of high-risk situations for the individual client, but can also record the client’s level of confidence in each risk situation. The questionnaire yields rich clinical information about the risk of relapse that the counsellor can then discuss with the client.

Let’s examine how to interpret different profiles on the graphs.

GENERALIZED LOW SCORES IN MOST AREAS

This profile indicates that substance use is playing a major role in the client’s life. There are virtually no situations in which the client feels safe. This is a client who is always on the verge of relapse, and who may be “white-knuckling” sobriety because of the great risk she feels in most situations.

When discussing this profile with the client, do not present it with alarm. Many clients are relieved that this profile reflects how they are actually feeling and presents their substance use from a perspective they can truly understand.

For treatment planning purposes, this profile indicates that the client needs a lot of support and structure. Examining her Perceived Social Support scores (discussed in Chapter 12) is important, as is looking at her DHQ (Chapter 6) for strategies that she has used successfully in the past to achieve periods of abstinence, reduce use or increase control.
This client could manage with community treatment (e.g., attending a community day or evening treatment program), if she has sufficient support and structure in her life (for example, through attending mutual-aid groups or strong support from family or friends). Another client with this profile but lacking support in the community would need to attend residential treatment.

Of course, the counsellor would review the full information using the Admission and Discharge Criteria before deciding on next steps in the formulation of a treatment plan.

**GENERALIZED HIGH SCORES IN MOST AREAS**

A client who scores 80 per cent or more in most areas is very confident that he will not relapse in almost any situation. This, of course, may be found with a client who has worked through a treatment plan and practised new skills to the point where he has become comfortable in high-risk situations. Results like these can be extremely rewarding for someone who has really worked hard on recovery. It is something tangible to show that his life has changed and that his hard work is paying off.

Be cautious, however, when you see this type of profile from a client completing intensive treatment. Sometimes after treatment the client is feeling so good about himself that he believes that getting back into the daily routine of life, without the support of intensive treatment, will be easy. It is important to discuss the “rose-coloured glasses” effect, and to caution the client to proceed slowly and with care in high-risk situations.

**LOW SCORES PRIMARILY IN PERSONAL STATES**

Low scores that appear primarily over the first five items reflect a person's struggle in dealing with internal states, both physical and emotional. It is extremely important for this person to pay attention to the routines of sleep, nutrition, exercise and relaxation to minimize her physical discomfort and stress. The counsellor should discuss with the client strategies she can use to deal with urges and temptations during treatment. As well, it’s important to work with the client to identify her specific high-risk situations within these categories, along with some possible game plans to deal with them.

**LOW SCORES PRIMARILY IN SITUATIONS INVOLVING OTHER PEOPLE**

Low scores that appear primarily over the last three items reflect a person’s struggle in dealing with others. This person usually says that he is fine when people leave him alone, but around certain people, he is at risk.

If this client participates in community treatment, it is important to discuss how he might handle these situations while he moves into early recovery. His scores on this tool suggest he would benefit from residential treatment because of the grave risk of relapse that association with others poses.

These scores are also important information for the treatment facility to use in relapse prevention work.
LOW SCORES PRIMARILY IN NEGATIVE SITUATIONS

Items 1 (unpleasant emotions), 2 (physical discomfort), 5 (urges/temptations) and 6 (conflict with others) all describe negative situations. You will see that some clients are fine when life is stable and pleasant but cannot cope without substances when negative circumstances arise. Often, these people have learned to use substances to deal with negative situations and lack other, more functional coping strategies to deal with negative happenings in life. Again, this is rich information for treatment services to have in order to tailor relapse prevention planning to individual needs.

LOW SCORES PRIMARILY IN POSITIVE SITUATIONS

Items 3 (pleasant emotions), 4 (testing personal control), 7 (social pressure) and 8 (pleasant times) all reflect situations that are positive. For some clients, their low scores appear mostly in positive situations. It is often more difficult for these clients to discern that they have a problem with substances. They may work hard, recognize and cope with negative situations, but when positive events happen in their lives, they resort to substance abuse. Remember that many major life events that are positive (e.g., partnering, birth of a child, job promotion) can also be fraught with stress. From the perspective of a person looking in, the events appear to be ones to celebrate, but from the perspective of the person experiencing these major changes in life, the stress level over these positive events may be more than she can handle. Change, both negative and positive, elicits stress.

Another avenue to explore with the person whose scores cluster around positive situations is whether she is the type of person who likes to party and spends much of her time socializing with others, and who also may use drugs to excess. This person may have gradually built up a high tolerance using drugs over the years because of the frequency of using drugs with others. It is essential when working with clients with this score profile to thoroughly explain the concept of tolerance—to compare their use many years ago to their current use, and to discuss the risk of overdose when tolerance is reduced.

TREATMENT PLANNING USING THE DTCQ-8 RESULTS

Initial assessment

The counsellor needs to provide sufficient interpretation of the DTCQ-8 results to the client and other members of the treatment team so that the information can be used to develop the most appropriate treatment plan.

For some clients, the Global Self-Efficacy Score is all they need to understand their risk of relapse. In this case, the counsellor would apply the global score to those of the Admission and Discharge Criteria that specify risk of relapse as a determining factor.

For other clients, considering risk of relapse as a situation-specific phenomenon is a new way of thinking. With these clients, it might be helpful to go into more detail when discussing the results of the DTCQ-8. This may be the first time a client has thought about relapse as a process she or he is able to comprehend and perhaps grapple with.
in treatment. Understanding more about personal high-risk situations may be a motivating factor for a client to enter treatment.

**Treatment service**

The results of the DTQ-8 can also be used by the treatment service to provide greater detail for an in-house treatment plan for the individual participating in treatment. The more detailed interpretations of the clinical profiles are useful in order to focus relapse prevention work on an individual client’s specific high-risk scenarios.

**Clinical tips**

- **Introduce the tool to the client by explaining how it was developed.** You could say, “This assessment tool helps to figure out the situations in your life in which you might be at risk of using or using heavily. Researchers asked a large number of people with alcohol and drug problems to describe the situations in which they relapsed. They found that almost all of the situations fell into eight categories. This questionnaire asks you how confident you are that you could resist using heavily in these eight situations. It measures your level of confidence in coping with these eight areas.”

- **Ensure that the client understands that the higher the score, the more self-confident he is that he could handle the situation without drinking or using drugs as a coping mechanism.**
**CLINICAL EXAMPLES**

**HARRY’S LIFE**

Harry did not score above 20 per cent on any of the eight items and his Global Self-Efficacy Score was 10 per cent. Harry has a “generalized low profile,” which illustrates that alcohol plays a major role in Harry’s life, meaning that he is at risk of relapse most of the time.

This result makes sense given the conditions of Harry’s life. He lives in a boarding house where heavy drinking is the norm. He drinks in bars to meet and socialize with people. He indicates that he has no friends and is estranged from his only son.

In talking to Harry about this profile, it is important that the counsellor not present it as doom and gloom but instead use a factual but empathetic style. The counsellor can explain that the results verify, as did the Adverse Consequences of Substance Use questionnaire (Chapter 7), that alcohol is playing a major role in Harry’s life, and that it has permeated most of his living situations. In fact, in virtually all situations, Harry is at high risk of relapse. This information will likely not surprise Harry. It will help him to understand why he has such strong cravings and how much of his life is consumed with alcohol use. This information can be used during treatment planning to ensure Harry has the structure and supports he needs to tackle his substance abuse should he decide to do so.

**JOYCE’S LIFE**

Joyce completed two DTQ-8s, one for alcohol and one for cocaine.

For alcohol, Joyce has a Global Self-Efficacy Score of 33 per cent, which means that overall she is confident only one-third of the time that she would not drink heavily in these risk situations. Her lowest scores are in the first five situations, which are those dealing with “personal states.” Considering the circumstances of Joyce’s life, this makes sense. She is a single parent living on limited financial means with no employment. She has lost her children because of her drug use and is feeling depressed and hopeless. She is somewhat more confident about resisting use when she is socializing with friends, but she scores a high level of confidence only in one item—celebrating with a friend.

On her DTQ-8 for cocaine, her scores indicate that she is at very high risk of relapse, with a Global Self-Efficacy Score of 10 per cent. She is at high risk across all eight situations.

Joyce had realized that she was at high risk of relapse and as a result entered a residential withdrawal management service. Her awareness of her risk of relapse and her decision to come to withdrawal management are strengths that the counsellor should affirm.
### DTCQ-8: SAMPLE FORMS

**DTCQ-8 FOR ALCOHOL**

**SHORTENED VERSION OF THE DRUG-TAKING CONFIDENCE QUESTIONNAIRE**

Program #  
Client Name: Harry James

Counsellor:  
Date: September 13 [include year]

Listed below are a number of situations or events in which some people experience an alcohol problem.

*Imagine yourself as you are right now* in each of these situations. Indicate on the scale provided how confident you are that you will be able to resist the urge to drink heavily in that situation.

Circle 100 if you are 100% confident right now that you could resist the urge to drink heavily, 80 if you are 80% confident; 60 if you are 60% confident. If you are more unconfident than confident, circle 40 to indicate that you are only 40% confident that you could resist the urge to drink heavily; 20 for 20% confident; 0 if you have no confidence at all about that situation.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Not at all confident</th>
<th>20</th>
<th>40</th>
<th>60</th>
<th>80</th>
<th>100</th>
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</thead>
<tbody>
<tr>
<td>1. If I were angry at the way things had turned out.</td>
<td>0</td>
<td>20</td>
<td>40</td>
<td>60</td>
<td>80</td>
<td>100</td>
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<tr>
<td>2. If I had trouble sleeping.</td>
<td>0</td>
<td>20</td>
<td>40</td>
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<td>100</td>
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<tr>
<td>3. If I remembered something good that had happened.</td>
<td>0</td>
<td>20</td>
<td>40</td>
<td>60</td>
<td>80</td>
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<tr>
<td>4. If I wanted to find out whether I could take a drink occasionally</td>
<td>0</td>
<td>20</td>
<td>40</td>
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<tr>
<td>without getting hooked.</td>
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<tr>
<td>5. If I unexpectedly found some booze or happened to see something</td>
<td>0</td>
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<tr>
<td>that reminded me of drinking.</td>
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<tr>
<td>6. If other people treated me unfairly or interfered with my plans.</td>
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<td>7. If I were out with friends and they kept suggesting we go somewhere</td>
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<td>and drink.</td>
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<td>8. If I wanted to celebrate with a friend.</td>
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**Office Use Only:**  
Global Self-Efficacy Score: 80 or 10 %

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* This form is administered separately for the primary problem substance and the secondary problem substance.
**DTCQ-8 FOR ALCOHOL**

Program # ___________ Client Name ___________ Counsellor: ___________________ Date ___________

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<table>
<thead>
<tr>
<th>Unpleasant Emotions</th>
<th>Physical Discomfort</th>
<th>Pleasant Emotions</th>
<th>Testing Personal Control</th>
<th>Urges/Temptations</th>
<th>Conflict with Others</th>
<th>Social Pressure to Drink</th>
<th>Pleasant Times With Others</th>
<th>Global Self-Efficacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1</td>
<td>Item 2</td>
<td>Item 3</td>
<td>Item 4</td>
<td>Item 5</td>
<td>Item 6</td>
<td>Item 7</td>
<td>Item 8</td>
<td>Item 9</td>
</tr>
</tbody>
</table>
DTCQ-8 FOR ALCOHOL*

SHORTENED VERSION OF THE DRUG-TAKING CONFIDENCE QUESTIONNAIRE

Program # ___________________ Client Name Joyce Smithers
Counsellor: ___________________________ Date September 13 [include year]

Listed below are a number of situations or events in which some people experience an alcohol problem.

Imagine yourself as you are right now in each of these situations. Indicate on the scale provided how confident you are that you will be able to resist the urge to drink heavily in that situation.

Circle 100 if you are 100% confident right now that you could resist the urge to drink heavily, 80 if you are 80% confident; 60 if you are 60% confident. If you are more unconfident than confident, circle 40 to indicate that you are only 40% confident that you could resist the urge to drink heavily; 20 for 20% confident; 0 if you have no confidence at all about that situation.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Not at all confident</th>
<th>Very confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If I were angry at the way things had turned out.</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>2. If I had trouble sleeping.</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>3. If I remembered something good that had happened.</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>4. If I wanted to find out whether I could take a drink occasionally</td>
<td>0</td>
<td>60</td>
</tr>
<tr>
<td>without getting hooked.</td>
<td></td>
<td>80</td>
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<tr>
<td>5. If I unexpectedly found some booze or happened to see something</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>that reminded me of drinking.</td>
<td></td>
<td>60</td>
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<tr>
<td>6. If other people treated me unfairly or interfered with my plans.</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>7. If I were out with friends and they kept suggesting we go</td>
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<tr>
<td>somewhere and drink.</td>
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<td>80</td>
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<tr>
<td>8. If I wanted to celebrate with a friend.</td>
<td>0</td>
<td>20</td>
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<td></td>
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</tbody>
</table>

Office Use Only: Global Self-Efficacy Score: 260 or 32.5 (round up to 33) %

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* This form is administered separately for the primary problem substance and the secondary problem substance.
<table>
<thead>
<tr>
<th>Item</th>
<th>Confidence Level %</th>
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<tbody>
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</tbody>
</table>

**DTQ-8 FOR ALCOHOL**

**Client Name:** Joyce Smithers

**Counsellor:**

**Program #:**

**Date:** September 13 [include year]

**Confidence Level %**

**Adapted from:** CAMH's Drug Taking Confidence Questionnaire (DTQ-8) 2014

**For Alcohol**

**Unpleasant Emotions**

1. Physical Discomfort
2. Conflict with Others
3. Social Pressure to Drink

**Pleasant Emotions**

4. Testing Personal Control
5. Urges/Temptations
6. Pleasant Emotions With Others

**Global Self-Efficacy**

7. Pleasure Times With Others

**Additional Notes:**

Joyce Smithers started the program on September 13, 2014. She has progressed well, showing a high level of confidence in her ability to manage alcohol-related situations. She has reported a significant reduction in urges and temptations, and a marked increase in personal control. She has also enjoyed pleasant times with others, which has contributed to her overall confidence. The counsellor notes her dedication and the positive changes she has made. The program continues to focus on reinforcing these behaviors and identifying areas for further improvement.

**Program #**

**Date:** September 13 [include year]

**Confidence Level %**

**Adapted from:** CAMH’s Drug Taking Confidence Questionnaire (DTQ-8) 2014

**For Alcohol**

**Unpleasant Emotions**

1. Physical Discomfort
2. Conflict with Others
3. Social Pressure to Drink

**Pleasant Emotions**

4. Testing Personal Control
5. Urges/Temptations
6. Pleasant Emotions With Others

**Global Self-Efficacy**

7. Pleasure Times With Others

**Additional Notes:**

Joyce Smithers started the program on September 13, 2014. She has progressed well, showing a high level of confidence in her ability to manage alcohol-related situations. She has reported a significant reduction in urges and temptations, and a marked increase in personal control. She has also enjoyed pleasant times with others, which has contributed to her overall confidence. The counsellor notes her dedication and the positive changes she has made. The program continues to focus on reinforcing these behaviors and identifying areas for further improvement.

**Program #**

**Date:** September 13 [include year]

**Confidence Level %**

**Adapted from:** CAMH’s Drug Taking Confidence Questionnaire (DTQ-8) 2014

**For Alcohol**

**Unpleasant Emotions**

1. Physical Discomfort
2. Conflict with Others
3. Social Pressure to Drink

**Pleasant Emotions**

4. Testing Personal Control
5. Urges/Temptations
6. Pleasant Emotions With Others

**Global Self-Efficacy**

7. Pleasure Times With Others

**Additional Notes:**

Joyce Smithers started the program on September 13, 2014. She has progressed well, showing a high level of confidence in her ability to manage alcohol-related situations. She has reported a significant reduction in urges and temptations, and a marked increase in personal control. She has also enjoyed pleasant times with others, which has contributed to her overall confidence. The counsellor notes her dedication and the positive changes she has made. The program continues to focus on reinforcing these behaviors and identifying areas for further improvement.
SHORTENED VERSION OF THE DRUG-TAKING CONFIDENCE QUESTIONNAIRE

Program # ____________________________ Client Name Joyce Smithers
Counsellor: ____________________________ Date September 13 [include year]

Listed below are a number of situations or events in which some people experience a drug use problem.

Imagine yourself as you are right now in each of these situations. Indicate on the scale provided how confident you are that you will be able to resist the urge to use cocaine in that situation.

Circle 100 if you are 100% confident right now that you could resist the urge to use cocaine; 80 if you are 80% confident; 60 if you are 60% confident. If you are more unconfident than confident, circle 40 to indicate that you are only 40% confident that you could resist the urge to use cocaine; 20 for 20% confident; 0 if you have no confidence at all about that situation.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Not at all confident</th>
<th>Very confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If I were angry at the way things had turned out.</td>
<td>0</td>
<td>20  40  60  80  100</td>
</tr>
<tr>
<td>2. If I had trouble sleeping.</td>
<td>0</td>
<td>20  40  60  80  100</td>
</tr>
<tr>
<td>3. If I remembered something good that had happened.</td>
<td>0</td>
<td>20  40  60  80  100</td>
</tr>
<tr>
<td>4. If I wanted to find out whether I could use cocaine occasionally without getting hooked.</td>
<td>0</td>
<td>20  40  60  80  100</td>
</tr>
<tr>
<td>5. If I unexpectedly found some cocaine or happened to see something that reminded me of cocaine.</td>
<td>0</td>
<td>20  40  60  80  100</td>
</tr>
<tr>
<td>6. If other people treated me unfairly or interfered with my plans.</td>
<td>0</td>
<td>20  40  60  80  100</td>
</tr>
<tr>
<td>7. If I were out with friends and they kept suggesting we go somewhere and use cocaine.</td>
<td>0</td>
<td>20  40  60  80  100</td>
</tr>
<tr>
<td>8. If I wanted to celebrate with a friend.</td>
<td>0</td>
<td>20  40  60  80  100</td>
</tr>
</tbody>
</table>

Office Use Only: Global Self-Efficacy Score: 80 or 10 %

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* This form is administered separately for the primary problem substance and the secondary problem substance.
# Chapter 10: The Drug-Taking Confidence Questionnaire (DTCQ-8)

**DTCQ-8 FOR DRUGS**

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<th>Urges/ Temptations</th>
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Program # ____________ Client Name ____________ Counsellor: __________________________ Date __________________ [include year]
### Chapter 11

**THE BEHAVIOUR AND SYMPTOM IDENTIFICATION SCALE (BASIS-32)**

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DESCRIPTION AND PURPOSE

The **BASIS-32** is a 32-item questionnaire in which clients self-report their degree of difficulty with mental health symptoms and daily functioning over the previous seven days. It measures the client’s own perceptions of his or her difficulty with symptoms and functioning on a day-to-day basis.

The **BASIS-32** provides a lot of information pertaining to client strengths and needs. It contributes to these four areas:

- Medical and psychiatric
- Emotional and behavioural
- Recovery environment
- Barriers and resources

This questionnaire is used to determine if mental health problems and problems with daily living might serve as barriers to entering the addiction treatment system. It identifies mental health problem areas that may need to be considered in the development of a treatment plan.

The McLean **BASIS-32** Instruction Manual (Eisen & Cahill) describes this tool in more depth. Contact McLean Hospital directly for more information about the manual (http://www.basissurvey.org/contact/).

INTENDED POPULATION

This tool was originally developed with psychiatric in-patients (Eisen et al., 1994), but has also been validated with outpatients seeking treatment for mental health problems (Eisen, Wilcox et. al., 1999). It is appropriate for both adults and adolescents. It is used extensively in outcome assessment of mental health problems (Eisen, Leff et. al., 1999).

ADMINISTRATION

The questionnaire can be completed by the client with instructions or administered by the counsellor within the interview session. Eisen (1995) looked at the impact on clients of the two modes of administration and concluded that most clients were able to complete the questionnaire on their own but preferred that the survey be administered through an interview, if they were given a choice.
Begin by going over the instructions at the top of the survey. Tell the client that this form lists areas of life in which some people experience difficulties.

Then ask the client to rate each question using the scale on the form. It is helpful to put the ratings on an index card to give to the client. Point out that the scale starts with 0, which represents having no difficulty in that area, and increases to 4, which indicates extreme difficulty.

Direct the client to fill in the box with the answer that best describes how much difficulty she has been having in each area during the past week. Emphasize that the time period is only the past week.

Make sure to mention that if the client is having no difficulty, she should score the item as zero. As well, a zero should be entered if the question does not apply to the client. Ask the client not to leave any questions blank.

Review the first couple of questions with the client. Read the line above the questions, “In the past week, how much difficulty have you been having in the area of . . .” with the specific item, for example, item 1 would be “In the past week, how much difficulty have you been having in the area of managing day-to-day life.” Then read out the examples that illustrate the particular item—for item 1, these would be getting places on time, handling money, making everyday decisions.

Ask the client to ask you if she doesn’t understand any of the words or statements.

For further clarification and examples of each item, see Appendix D: “BASIS-32: Item clarification and elaboration.” Ensure you read this list over so that you gain a better understanding of the meaning of the categories and can answer any questions the client may have.

If you are not scoring the questionnaire until later and the client is leaving your agency, take a glance at the response to question 18, “suicidal feelings or behaviour.” Because the survey’s questions pertain to feelings and behaviour during the past week, make sure you scan this item before the client leaves to ensure that the client is safe.

**SCORING**

Scoring the BASIS-32 yields five subscale scores:

1. Relation to self/others
2. Daily living/role functioning
3. Depression/anxiety
4. Impulsive/addictive
5. Psychosis.
The counsellor then determines the total average score.

Before you begin scoring, first check that there are responses to all the questions. If more than five are missing, the instrument is not valid and should not be used. Speak to the client about the missing answers and see if he needs information or other assistance.

The scoring procedure is rather complicated, but if you get frustrated with it, keep in mind how much information you are gaining through the process. If math was not your best subject, get someone to help you.

Use the basis-32 Scoring Sheet. Transpose each of the individual item scores into the appropriate space. For example, under the column “Relation to self/others,” the subscale is formed from the responses to items 7, 8, 10, 11, 12, 14 and 15.

All questions are directly transposed with the exception of the second item under “Daily living/role functioning.” The score for the item “Role” is determined by looking at the responses to questions 2, 3 and 4, and picking the highest score out of the three questions. These questions pertain to the primary roles of household responsibilities, work and school. The highest score out of these three areas represents “role.”

Once you have completed transposing the scores, next refer to the five subscale columns (ignoring for now the basis-32 Average). Add the scores under each column and enter the total. The “# of items” refers to the number of items that you just added. For example, if all questions were completed under “Relation to self/others,” you would enter 7. If one question were missing, you would enter 6. The first two columns have 7 items if they are all filled in; the next two columns have 6 items; and the last has 4 items.

Calculate the average for each subscale score by dividing the total by the number of items. Round off the average to one decimal point. The scores will range from 0 to 4. If your score is greater than 4 or a negative number, check your math or get someone else to check it.

Now it’s time to calculate the average score. First, resist the urge to add up the totals of the five subscales. This won’t work. Instead, go back to the original questionnaire and add up all 32 items. The five subscales cover only 30 items because two were omitted when the score for “Role” was calculated. Divide by 32 if all questions were completed.

Enter the averages onto the graph. Shade in the area between the score and 0 to create a bar graph for each item. Do not connect the scores from one item to another. Each item should be viewed separately, not within a sequence.

The basis-32 Overall Score gives a general measure of overall mental health problems.
CHAPTER 11: THE BEHAVIOUR AND SYMPTOM IDENTIFICATION SCALE (BASIS-32)

INTERPRETATION USING THE ADMISSION AND DISCHARGE CRITERIA

INTERPRETING THE SCORES

The BASIS-32 provides a lot of information pertaining to client strengths and needs, but remember this information reflects client functioning only over the past week.

If the client scores 2 (moderate difficulty) or above on the subscales, it is helpful to further explore the area with the client. If the questionnaire was administered shortly after detoxification, re-administer the questionnaire in one week, as the change can be significant.

TALKING TO THE CLIENT ABOUT THE SUBSCALES

Relation to self/others

This subscale measures the client’s perceived level of difficulty in being an independent functioning person, who knows the direction in life she or he is taking. As well, it measures the level of difficulty in relationships and getting along with others. When sharing the results with the client, you could say, for example, “Your score suggests that you are having some difficulty knowing who you are and where you’re going in life and relating to others in your life.” Then you could give examples from the client’s responses to the questions included in that subscale, reviewing the highest scores. You could say, “For example, in question 14 you indicated that you have quite a bit of difficulty with goals or direction in your life. Can you tell me more about that?”

Daily living/role functioning

This subscale measures the level of difficulty the client has in living day-to-day. It looks at such items as making everyday decisions, household responsibilities, school and work, use of leisure time, autonomy, and level of satisfaction with life. When reviewing this area with the client, you could say, “Your score in this area suggests you are having difficulty managing your day-to-day life, taking care of yourself and doing everyday chores. For example, you said you had quite a bit of difficulty in . . . [refer to responses]. Could you tell me more about that?”

Depression/anxiety

This subscale measures the level of difficulty the client has in dealing with depression and anxiety. If appropriate, define the meaning of depression and anxiety, and try to normalize it so the client is not frightened. In discussing the results with the client, ask if the client has a history of depression or anxiety, if he has spoken to anyone else about it, if he was on medication. If the client is on medication, ask if he has skipped any doses due to substance use. Pay close attention to question 18 to ensure client safety.

This subscale can be elevated by withdrawal symptoms. If the client has a high score on this subscale, re-administer the tool in one week to see if the measure has improved.

If the client has a history of depression or anxiety or has felt that way for some time, ask him to make an appointment with his family doctor or a mental health professional to be screened for clinical depression or anxiety.
Impulsive/addictive

This subscale measures the level of difficulty the client is having with mood swings, compulsive behaviour, substance use, anger, impulsive or reckless behaviour. Use language that is appropriate to the client that she can understand and that is not alarming. This subscale is not a measure of addiction, instead it focuses on behaviours that fall under impulse control. In providing feedback on the client’s score, you could say, “This score suggests you may be having a problem because of doing things impulsively, having mood swings, feeling angry and so on [based on individual client scores].” If the only two items that scored high in this subscale are the two substance use questions, discuss the difficulty with substance use rather than impulsivity.

Psychosis

This subscale measures the level of difficulty the client is having dealing with psychotic symptoms, that is, disturbing thoughts, audio and visual hallucinations, and bizarre behaviour.

A psychotic reaction may occur as a result of withdrawal from certain drugs (e.g., amphetamines). Try to determine if the client has been feeling this way for some time or if these feelings and behaviour are primarily related to substance abuse.

Ask the client if she has been diagnosed with a mental health problem in the past or, if she has been hospitalized for a mental health problem. You may be able to identify mental health specialists with whom you could consult, with the client’s consent.

If the client has high scores on this subscale, with her consent, it is important to contact her family doctor, psychiatrist or mental health worker.

DEVELOPING A TREATMENT PLAN

Those clients not already connected with mental health services who score above 2 on one or more subscales may need a referral to a mental health specialist for assessment. Use the Admission and Discharge Criteria (Appendix A) for guidance in making this decision.

For clients with a concurrent disorder, it is best to provide integrated treatment (Health Canada, 1999, 2002); that is, care that will provide both mental health and substance abuse treatment either under one roof or in a collaborative relationship between a mental health service and a substance abuse service. The type of treatment would depend on the mental health diagnosis and the particular circumstances of the individual client.

For clients with substance abuse and serious mental illness, it is preferable to provide integrated treatment focusing on psychosocial rehabilitation in the community, rather than highly structured residential treatment (Health Canada, 2002). It is important to link closely with local mental health services and Assertive Community Treatment (ACT) teams. Many of these teams are staffed with concurrent disorder specialists.
It is imperative that only those clients who really require a specialized residential program for concurrent disorders are referred to these scarce resources. If a client with a concurrent disorder has met the criteria for residential treatment, then see the guidelines on distinguishing between clients who require specialized residential treatment for concurrent disorders and those who could attend a non-specialized residential program.

**CLINICAL EXAMPLES**

**HARRY’S LIFE**

Harry’s basis-32 Average Score is 2.25, which means overall he is having moderate difficulty with mental health concerns. He is having “quite a bit of difficulty” in daily living skills and with depression and anxiety. In relation to self and others, he is having “moderate to quite a bit of difficulty.” For each subscale, the counsellor looks back at his individual responses that are rated as “extreme difficulty” to help frame feedback.

**Sample counsellor response**

In talking to Harry about his scores, the counsellor tries to word the subscales in simpler language. For example:

*Harry, overall this questionnaire shows that you are having moderate difficulty in coping with life’s demands. You can see here [counsellor points to the graph] that you scored very high in daily living skills. You reported having extreme difficulty managing your day-to-day life and managing household responsibilities like shopping, cooking and cleaning.*

*You also said you have extreme difficulty dealing with your leisure time and that you lack interest in doing things.*

*You can see that you also scored high in the area of depression or anxiety. You reported extreme difficulty with depression, hopelessness and feelings of loneliness.*

*It sounds as if you’re really having a difficult time right now just getting through each day.*

The counsellor waits for Harry’s response and then discusses what his day-to-day life is like for him, as well as whether the responses reflect specifically the last week (basically, since the recent hospitalization) or if this has been the situation for some time.

The counsellor then notes:

*You also scored between moderate and quite a bit of difficulty in the area we call relation to self and others. In this area you reported feeling bad about yourself, lacking goals or direction in your life, and being unable to feel close to others. This suggests that you’re not feeling very good about yourself or your relationship with other people.*

The counsellor talks to Harry about how he is feeling about himself and his relationships with others.
If the feedback session with Harry is about one week after he completed the assessment tools, the counsellor may ask him to complete the basis-32 again for the most recent week, because Harry has been abstinent since his hospitalization and one more week of sobriety may result in reduced scores. This information is further feedback for Harry and will be valuable during treatment planning (which will be discussed in Chapter 14).

JOYCE’S LIFE

Joyce’s basis-32 average score is 1.5 indicating that overall she is not having major mental health concerns. The only subscale above 2 is depression or anxiety (score of 2.8), which is approaching “quite a bit of difficulty.” Joyce has been taking antidepressants as prescribed by her family physician for the past two months. However, she was drinking daily, apart from the past five days, and snorting cocaine. Her family physician is unaware of her substance abuse. It is imperative that the counsellor contact Joyce’s family physician (with Joyce’s consent) to advise him or her about Joyce’s substance abuse in an effort to determine if Joyce has clinical depression.

On Joyce’s individual responses, she scored 4 or “extreme difficulty” with adjusting to major life stresses, relationship with family members, isolation or feelings of loneliness, depression/hopelessness, drinking alcoholic beverages, and feeling satisfaction with your life.

Given Joyce’s current life situation, these scores make sense. The counsellor will find it helpful to talk to Joyce about the questions she reported as “extreme difficulty” to get a better sense of how she is coping with the current problems in her life. The counsellor also tells her that many people in her situation feel this way in early recovery and assures her that she has taken important first steps.
THE BASIS-32: SAMPLE FORMS

BASIS-32—HARRY JAMES’S SURVEY AND SCORING INFORMATION

BASIS-32™ (BEHAVIOUR AND SYMPTOM IDENTIFICATION SCALE)

Program # __________________________ Client Name  Harry James
Counsellor: ____________________________ Date  September 13 [include year]

Instructions to Respondent: Below is a list of problems and areas of life functioning in which some people experience difficulties. Using the scale below, fill in the box with the answer that best describes how much difficulty you have been having in each area DURING THE PAST WEEK.

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<thead>
<tr>
<th>Scoring Sheet</th>
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<tbody>
<tr>
<td>0</td>
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<td>1</td>
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<td>2</td>
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<tr>
<td>3</td>
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<tr>
<td>4</td>
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</tbody>
</table>

Please do not leave any questions blank. If there is an area that you consider to be inapplicable, indicate that it is 0 = No Difficulty.

<table>
<thead>
<tr>
<th>IN THE PAST WEEK, how much difficulty have you been having in the area of:</th>
<th>Item #</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Managing day-to-day life. (For example, getting places on time, handling money, making everyday decisions)</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>2. Household responsibilities. (For example, shopping, cooking, laundry, cleaning, other chores)</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>3. Work. (For example, completing tasks, performance level, finding/keeping a job)</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>4. School. (For example, academic performance, completing assignments, attendance)</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>5. Leisure time or recreational activities</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>6. Adjusting to major life stresses. (For example, separation, divorce, moving, new job, new school, a death)</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>7. Relationships with family members</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>8. Getting along with people outside of the family</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>9. Isolation or feelings of loneliness</td>
<td>9</td>
<td>4</td>
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<tr>
<td>10. Being able to feel close to others</td>
<td>10</td>
<td>4</td>
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<tr>
<td>11. Being realistic about yourself or others</td>
<td>11</td>
<td>0</td>
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<tr>
<td>12. Recognizing and expressing emotions appropriately</td>
<td>12</td>
<td>1</td>
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<tr>
<td>13. Developing independence, autonomy</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>14. Goals or direction in life</td>
<td>14</td>
<td>4</td>
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### BASIS-32™ (BEHAVIOUR AND SYMPTOM IDENTIFICATION SCALE) (CON’T)

Program # ___________________ Client Name Harry James

Counsellor: ___________________ Date September 13 [include year]

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<td>3</td>
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</tbody>
</table>

Please do not leave any questions blank. If there is an area that you consider to be inapplicable, indicate that it is 0 = No Difficulty.

<table>
<thead>
<tr>
<th>IN THE PAST WEEK, how much difficulty have you been having in the area of:</th>
<th>Item #</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Lack of self-confidence, feeling bad about yourself</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>16. Apathy, lack of interest in things</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>17. Depression, hopelessness</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>18. Suicidal feelings or behaviour</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>19. Physical symptoms. (For example, headaches, aches and pains, sleep disturbance, stomach aches, dizziness)</td>
<td>19</td>
<td>4</td>
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<tr>
<td>20. Fear, anxiety, or panic</td>
<td>20</td>
<td>2</td>
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<tr>
<td>21. Confusion, concentration, memory</td>
<td>21</td>
<td>4</td>
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<tr>
<td>22. Disturbing or unreal thoughts or beliefs</td>
<td>22</td>
<td>0</td>
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<td>23. Hearing voices, seeing things</td>
<td>23</td>
<td>0</td>
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<tr>
<td>24. Manic, bizarre behaviour</td>
<td>24</td>
<td>0</td>
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<td>25. Mood swings, unstable moods</td>
<td>25</td>
<td>1</td>
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<td>26. Uncontrollable, compulsive behaviour. (For example, eating disorder, hand-washing, hurting yourself)</td>
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<td>1</td>
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<tr>
<td>27. Sexual activity or preoccupation</td>
<td>27</td>
<td>1</td>
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<tr>
<td>28. Drinking alcoholic beverages</td>
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<td>4</td>
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<tr>
<td>29. Taking illegal drugs, misusing drugs</td>
<td>29</td>
<td>1</td>
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<tr>
<td>30. Controlling temper, outbursts of anger, violence</td>
<td>30</td>
<td>1</td>
</tr>
<tr>
<td>31. Impulsive, illegal, or reckless behaviour</td>
<td>31</td>
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<tr>
<td>32. Feeling satisfaction with your life</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>Total</td>
<td>25</td>
<td>Total</td>
<td>20</td>
<td>Total</td>
<td>7</td>
<td>Total</td>
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<td>Sum total 72</td>
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<td># of items</td>
<td>6</td>
<td># of items</td>
<td>4</td>
<td>Item total 32</td>
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<tr>
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<td>2.71</td>
<td>Average</td>
<td>3.57</td>
<td>Average</td>
<td>3.33</td>
<td>Average</td>
<td>1.17</td>
<td>Average</td>
<td>.25</td>
<td>Total average 2.25</td>
</tr>
</tbody>
</table>

Note: Number of items = Number of completed items
Average = Column total/number of items
Total average (basis-32 average) = Sum total of all totals (include items 2, 3, 4)/Total number of completed items

* ROLE = The highest rated item of 2, 3, 4. Do not include the scores of the two other items.
**BASIS-32™ CLIENT PROFILE**

**BASIS-32 SUBSCALES AND OVERALL SCORE**

<table>
<thead>
<tr>
<th>Program #</th>
<th>Client Name</th>
<th>Harry James</th>
<th>Counsellor:</th>
<th>Date</th>
<th>September 13 [include year]</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Score</th>
<th>Subscale 1</th>
<th>Subscale 2</th>
<th>Subscale 3</th>
<th>Subscale 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme Difficulty</td>
<td>4</td>
<td>3.57</td>
<td>3.33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quite a Bit of Difficulty</td>
<td>3</td>
<td>2.71</td>
<td></td>
<td></td>
<td>2.25</td>
</tr>
<tr>
<td>Moderate Difficulty</td>
<td>2</td>
<td></td>
<td>1.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Little Difficulty</td>
<td>1</td>
<td></td>
<td>.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Difficulty</td>
<td>0</td>
<td>Relation to self/others</td>
<td>Daily living skills</td>
<td>Depression/ anxiety</td>
<td>Impulsive/ addictive</td>
</tr>
</tbody>
</table>
BASIS-32—JOYCE SMITHERS’ SURVEY AND SCORING INFORMATION

**BASIS-32™ (BEHAVIOUR AND SYMPTOM IDENTIFICATION SCALE)**

Program # ___________________________ Client Name Joyce Smithers

Counsellor: __________________________ Date September 13 [include year]

**Instructions to Respondent:** Below is a list of problems and areas of life functioning in which some people experience difficulties. Using the scale below, fill in the box with the answer that best describes how much difficulty you have been having in each area during the past week.

<table>
<thead>
<tr>
<th>Scoring Sheet</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
</tbody>
</table>

Please do not leave any questions blank. If there is an area that you consider to be inapplicable, indicate that it is 0 = No Difficulty.

<table>
<thead>
<tr>
<th>IN THE PAST WEEK, HOW MUCH DIFFICULTY HAVE YOU BEEN HAVING IN THE AREA OF:</th>
<th>Item #</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Managing day-to-day life. (For example, getting places on time, handling money, making everyday decisions)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. Household responsibilities. (For example, shopping, cooking, laundry, cleaning, other chores)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3. Work. (For example, completing tasks, performance level, finding/keeping a job)</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>4. School. (For example, academic performance, completing assignments, attendance)</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>5. Leisure time or recreational activities</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>6. Adjusting to major life stresses. (For example, separation, divorce, moving, new job, new school, a death)</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>7. Relationships with family members</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>8. Getting along with people outside of the family</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>9. Isolation or feelings of loneliness</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>10. Being able to feel close to others</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>11. Being realistic about yourself or others</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>12. Recognizing and expressing emotions appropriately</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>13. Developing independence, autonomy</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>14. Goals or direction in life</td>
<td>14</td>
<td>1</td>
</tr>
</tbody>
</table>

*Continued on next page.*
# BASIS-32™ (BEHAVIOUR AND SYMPTOM IDENTIFICATION SCALE) (CONT’D)

<table>
<thead>
<tr>
<th>Scoring Sheet</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
</tbody>
</table>

### Please do not leave any questions blank. If there is an area that you consider to be inapplicable, indicate that it is 0 = No Difficulty.

**IN THE PAST WEEK, how much difficulty have you been having in the area of:**

<table>
<thead>
<tr>
<th>Item #</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Lack of self-confidence, feeling bad about yourself</td>
<td>3</td>
</tr>
<tr>
<td>16. Apathy, lack of interest in things</td>
<td>1</td>
</tr>
<tr>
<td>17. Depression, hopelessness</td>
<td>4</td>
</tr>
<tr>
<td>18. Suicidal feelings or behaviour</td>
<td>2</td>
</tr>
<tr>
<td>19. Physical symptoms. (For example, headaches, aches and pains, sleep disturbance, stomach aches, dizziness)</td>
<td>1</td>
</tr>
<tr>
<td>20. Fear, anxiety, or panic</td>
<td>2</td>
</tr>
<tr>
<td>21. Confusion, concentration, memory</td>
<td>0</td>
</tr>
<tr>
<td>22. Disturbing or unreal thoughts or beliefs</td>
<td>0</td>
</tr>
<tr>
<td>23. Hearing voices, seeing things</td>
<td>0</td>
</tr>
<tr>
<td>24. Manic, bizarre behaviour</td>
<td>0</td>
</tr>
<tr>
<td>25. Mood swings, unstable moods</td>
<td>2</td>
</tr>
<tr>
<td>26. Uncontrollable, compulsive behaviour. (For example, eating disorder, hand-washing, hurting yourself)</td>
<td>0</td>
</tr>
<tr>
<td>27. Sexual activity or preoccupation</td>
<td>0</td>
</tr>
<tr>
<td>28. Drinking alcoholic beverages</td>
<td>4</td>
</tr>
<tr>
<td>29. Taking illegal drugs, misusing drugs</td>
<td>0</td>
</tr>
<tr>
<td>30. Controlling temper, outbursts of anger, violence</td>
<td>1</td>
</tr>
<tr>
<td>31. Impulsive, illegal, or reckless behaviour</td>
<td>0</td>
</tr>
<tr>
<td>32. Feeling satisfaction with your life</td>
<td>4</td>
</tr>
</tbody>
</table>

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## BASIS-32™ SCORING SHEET

Program # __________ Client Name: Joyce Smithers ___________ Counsellor: __________________________ Date: September 13 [include year]

<table>
<thead>
<tr>
<th>Relation to self/others</th>
<th>Daily living</th>
<th>Depression/anxiety</th>
<th>Impulsive/addictive</th>
<th>Psychosis</th>
<th>BASIS-32 average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item</td>
<td>Score</td>
<td>Item</td>
<td>Score</td>
<td>Item</td>
<td>Score</td>
</tr>
<tr>
<td>7.</td>
<td>4</td>
<td>1.</td>
<td>2</td>
<td>6.</td>
<td>4</td>
</tr>
<tr>
<td>8.</td>
<td>2</td>
<td>ROLE*</td>
<td>2</td>
<td>9.</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>2</td>
<td>5.</td>
<td>2</td>
<td>17.</td>
<td>4</td>
</tr>
<tr>
<td>11.</td>
<td>0</td>
<td>13.</td>
<td>0</td>
<td>18.</td>
<td>2</td>
</tr>
<tr>
<td>12.</td>
<td>0</td>
<td>16.</td>
<td>1</td>
<td>19.</td>
<td>1</td>
</tr>
<tr>
<td>14.</td>
<td>1</td>
<td>21.</td>
<td>0</td>
<td>20.</td>
<td>2</td>
</tr>
<tr>
<td>15.</td>
<td>3</td>
<td>32.</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>Total</td>
<td>11</td>
<td>Total</td>
<td>17</td>
</tr>
<tr>
<td># of items</td>
<td>7</td>
<td># of items</td>
<td>7</td>
<td># of items</td>
<td>6</td>
</tr>
<tr>
<td>Average</td>
<td>1.71</td>
<td>Average</td>
<td>1.57</td>
<td>Average</td>
<td>2.83</td>
</tr>
</tbody>
</table>

**Note:**
- Number of items = Number of completed items
- Average = Column total/number of items
- Total average (basis-32 average) = Sum total of all totals (include items 2, 3, 4)/Total number of completed items

* ROLE = The highest rated item of 2, 3, 4. Do not include the scores of the two other items.
BASIS-32—JOYCE SMITHERS’ SURVEY AND SCORING INFORMATION (CONT’D)

**BASIS-32™ CLIENT PROFILE**

**BASIS-32 SUBSCALES AND OVERALL SCORE**

<table>
<thead>
<tr>
<th>Program #</th>
<th>Client Name</th>
<th>Joyce Smithers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counsellor:</td>
<td>Date</td>
<td>September 13 [include year]</td>
</tr>
<tr>
<td>Extreme Difficulty</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Quite a Bit of Difficulty</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Moderate Difficulty</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Little Difficulty</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No Difficulty</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relation to self/others</th>
<th>Daily living skills</th>
<th>Depression/anxiety</th>
<th>Impulsive/addictive</th>
<th>Psychosis</th>
<th>BASIS-32 overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.71</td>
<td>1.57</td>
<td>2.83</td>
<td>1.16</td>
<td>1.46</td>
<td>0</td>
</tr>
</tbody>
</table>
Chapter 12

THE PERCEIVED SOCIAL SUPPORT TOOL

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**DESCRIPTION AND PURPOSE**

The Perceived Social Support (pss) tool is a 14-item tool that separates social support into “family” and “friends,” asking the client seven questions about the support they perceive from each group. The Perceived Social Support tool measures aspects of the recovery environment, which is one of the seven areas of strengths and needs.

Research tells us that general social support contributes to positive outcomes in treatment. It can influence well being and indirectly affect alcohol involvement (Longabaugh & Beattie, 1985; Beattie et al., 1993). It is evident that the assessment of social support is an important facet of pre-treatment assessment.

The pss is a very brief tool that measures the client’s perception of social support from family and friends. Each of the items on the tool is a statement about social support that the client is asked to respond to with “yes,” “no” or “don’t know.”

**INTENDED POPULATION**

The pss can be used for both men and women but is intended only for adults over the age of 18. It can be administered by a counsellor during the interview, self-administered by the client or used as a homework assignment. It is short and easily explained, and works well in group settings as well as in individual sessions.

**ADMINISTRATION**

**DURING AN INTERVIEW**

If the counsellor and client are filling in the pss together during the interview, the counsellor should begin by explaining the tool, to let the client know its purpose and how its information is useful to the assessment process. The counsellor then encourages the client to answer with his own opinion about the amount of support he feels he has from family and friends. If the client cannot answer “yes” or “no,” he should be encouraged to check “don’t know.”

The counsellor should explain that the answers and scores will be discussed together and that the client can ask for clarification or share their impressions at that time.

**SELF-ADMINISTRATION**

If the client is going to fill out the form on her own, the counsellor should explain to her first the purpose of the tool and give her an opportunity to ask questions about any item that is not clear (this is especially important if the client is taking it home to do).
The counsellor needs to explain that the answers and scores will be discussed in a later session and that the client will have an opportunity to ask for clarification or share impressions at that time.

**SCORING**

The scoring key indicates the answers that will result in one mark each. If the client chooses all seven answers, then the maximum score is 7 out of 7. The scoring is developed so that there are two “no”s that result in a mark each, so five “yes” answers and two “no” answers will produce the maximum score.

The questions that should be marked “no” to get a point are 2 and 7. The entire scoring key is:

- Item 1: Yes
- Item 2: No
- Item 3: Yes
- Item 4: Yes
- Item 5: Yes
- Item 6: Yes
- Item 7: No

As appropriate, either counsellor or client can add up the answers that fit into the scoring key and get a total for each section with a score out of 7.

**INTERPRETATION USING THE ADMISSION AND DISCHARGE CRITERIA**

The higher the score out of seven, the more perceived social support!

Remember that the client’s perception of what support looks and feels like may be very different from the counsellor’s. It is their perception of support that is being measured. Clinically, the counsellor may question how much support there really is for this client and might hope that more support could be developed and fostered in their personal lives. However, it is amazing to see how well clients do if they perceive that they have support, even though the nature of their support is different than the counsellor might wish for them.

The Admission and Discharge Criteria look for stability and safety in the recovery environment as evidenced by support from family and friends on many levels, including an emotional level. The tool asks about moral and emotional support provided by family and friends.
ADMISSION CRITERIA

The criteria assume that clients with high social support and access to people who care about their emotional well-being will need less structure in the treatment environment. Clients with greater social support will do better in community treatment settings. Clients who do not have support at home or in the community can also do well in community treatment settings but will need more formalized support networks. A client should not automatically be referred to residential support or treatment because he does not have social support networks. Much will depend on the environment in which he lives and the support for his treatment goal in the home environment.

There are exceptions to this, and the counsellor’s clinical judgment will determine the level and intensity of treatment, based on the support needs of the client and the assessment results. The standardized assessment package and Admission and Discharge Criteria are not “precise guidelines.” There are clear principles and expectations, but the role of clinical judgment may occasionally indicate a bypass of the usual criteria.

Again, reflecting on the research quoted at the beginning of this chapter, one can see that those who need more recovery support should have access to it, and that those who have support elsewhere can probably benefit from less structure in their treatment plan.

DISCHARGE CRITERIA

Social support levels are also important in the development of discharge plans. The level of support can be screened again, prior to discharge, to determine how much support the client needs post treatment. Some clients will need to access structured environments, such as residential support, in the early days of their post treatment experience. Other clients will have homes and social networks to which they can return.

CLINICAL CHALLENGES

One of the clinical challenges this tool presents is the that sometimes, after a client has finished this tool, she may feel she has a lot of social support from family and friends, but you may question whether her friends and family will really be able to provide that support.

Some clients live in environments where there is a lot of alcohol and drug use and these may not be ideal environments for them to return to. As well, clients may overestimate their ability to “handle” the drinking and drugging that may go on around them after discharge. You may need to motivate these clients to reach out for more formalized support from the treatment system.

Another challenge counsellors face is the situation where the client has no support and no illusions about the situation. Their scores on the pss could be 0 out of 7, on each scale. It is difficult to affirm the client’s feelings and be positive about how much better life will be once he or she is not experiencing these problems, when you and the client both know that the client is starting out with no social or family network to draw support from.
This knowledge can be very traumatizing for the client. Formalized self-help networks can be a way for people to begin to make new friendships and networks for support. Some clients feel that these are the most important connections, as their peers in self-help really know what they are experiencing. Sometimes families may be supportive, but they really do not know what the client is experiencing; others going through the same stages and processes can provide valuable support.

The amount of structure that a client needs (i.e., day treatment or residential support) may not be available in your community or there may be a waiting list. This can be a difficult treatment planning issue. Sometimes creative treatment plans can identify other potential sources of support, such as classes, professional networks, volunteer groups and associations.

**CLINICAL EXAMPLES**

**HARRY’S LIFE**

Harry’s perception of his support from family is accurate and the counsellor will need to help Harry build support into his life through the treatment plan. In all, Harry scores his support from family as 0 out of 7. He has stated in his interview that he has no contact with his son and he has accurately noted in item 2 that other people are closer to their families than he is. At this point, the counsellor probably does not have much information about the extended family, and may want to make a note to ask Harry more about his family situation later. His relationship with his son can also be explored later, when the counsellor is prepared to introduce the topic and when Harry has indicated that issues of a more personal nature can be discussed.

Harry ranks his support from friends also as 0 out of 7. His associates are likely those who live in his boarding home and perhaps those who drink in the bar that Harry frequents. Harry may, it is hoped, develop supportive relationships in the near future, perhaps through attending counselling groups, by meeting new peers who are non-users and through support or mutual aid groups or self-help.

Harry accurately feels that he does not have a lot of support. At a later date, when it is appropriate, the counsellor can explore with him his friendships and social life prior to the accident. This issue (social support through social activities) will be important in relation to the maintenance of Harry’s treatment goals.

**Sample counsellor response**

Here are some clinical comments the counsellor might share with Harry:

*Harry, from the information you have shared with me and the scores on this tool, I see that you’ve lost contact with your family over the last few years. Tell me how you feel about that?*

*Harry, from the PSS scores, it appears that most of your friends are the people at the boarding house and in the bar you go to. You seem to recognize that you are not getting the support that you might like. Tell me how you can change this?*
Harry, your thoughts about support and your friends prompt me to ask you, would you be interested in hearing about some of the support groups that meet in our community?

JOYCE’S LIFE

Joyce sees herself as having a fair amount of support from family and friends. She scores her family support as 4 out of 7, and her friends’ support as 6 out of 7. It may take some further exploration and discussion to understand how her friends support her. The counsellor can explore with Joyce how her friends and family support her, how often she sees them and in what context.

Joyce has stored her belongings with some friends, and she may have a group of friends who will really support her after treatment and in obtaining custody of her children.

Joyce will need to explore how many of her friends are substance users versus abusers, and what the impact of their continued use will be on her own treatment plans. Again, these discussions can take place later, after Joyce is stabilized and has a little more experience with sobriety.

Sample counsellor response

Here are some things the counsellor might say to Joyce:

Joyce, your scores on the PSS show that you feel you have a good level of support from your family and friends. Tell me about how they have been supporting you in your decision to stop drinking and taking cocaine.

Joyce, can you share with me how you will get the support you need from family and friends? You have been to treatment before, and you know what it takes to achieve your goals. Tell me who has been there for you in the past.
**THE PSS: SAMPLE FORMS**

**PERCEIVED SOCIAL SUPPORT**

Program # ______________ Client Name: Harry James

Counsellor: ______________________________ Date: September 13 [include year]

**Directions:** The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with family or friends. For each statement there are three possible answers. Yes, No, Don’t Know. Please check the answer you choose for each item.

<table>
<thead>
<tr>
<th>Family Items</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>My family gives me the moral support I need.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Most other people are closer to their family than I am.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I rely on my family for emotional support.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>My family and I are very open about what we think about things.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>My family is sensitive to my personal needs.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Members of my family are good at helping me solve problems.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>I wish my family were much different.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Family Score** 0 out of 7

<table>
<thead>
<tr>
<th>Friends Items</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>My friends give me the moral support I need.</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Most other people are closer to their friends than I am.</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>I rely on my friends for emotional support.</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>My friends and I are very open about what we think about things.</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>My friends are sensitive to my personal needs.</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>My friends are good at helping me solve problems.</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>I wish my friends were much different.</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

**Total Friends Score** 0 out of 7

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## PERCEIVED SOCIAL SUPPORT

**Program #** ________________  
**Client Name** Joyce Smithers  
**Counsellor:** ______________________________________  
**Date** ____________________________________________________________________________

**Directions:** The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with family or friends. For each statement there are three possible answers. Yes, No, Don’t Know. **Please check** the answer you choose for each item.

<table>
<thead>
<tr>
<th>Family Items</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>My family gives me the moral support I need.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most other people are closer to their family than I am.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I rely on my family for emotional support.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My family and I are very open about what we think about things.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>My family is sensitive to my personal needs.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members of my family are good at helping me solve problems.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>I wish my family were much different.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**Total Family Score** 4 out of 7

<table>
<thead>
<tr>
<th>Friends Items</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>My friends give me the moral support I need.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most other people are closer to their friends than I am.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>I rely on my friends for emotional support.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My friends and I are very open about what we think about things.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My friends are sensitive to my personal needs.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>My friends are good at helping me solve problems.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I wish my friends were much different.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**Total Friends Score** 6 out of 7

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Chapter 13

THE HEALTH SCREENING FORM

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The Health Screening Form: Sample forms ............................. 197
DESCRIPTION AND PURPOSE

The Health Screening Form is a brief recording form for current and historical physical and mental health problems that might require referral to a medical or mental health professional or that might interfere with the client participating in addictions treatment. It also tracks all other medication the client is taking that is not psychoactive.

ADMINISTRATION

The Health Screening Form presents an opportunity to educate the client about the physical effects of substance abuse and harm reduction strategies.

If you administer this form near the end of the assessment process, you will already have an idea of some of the physical and mental health areas of concern to the client. For example, the Adverse Consequences of Substance Use tool addresses adverse physical effects related to substance use, as well as significant mood and personality changes related to substance use. As well, the BASIS-32 gives some indicators of mental health functioning, which you can follow up on with this form.

Because this form asks for personal and sensitive information, remember to let clients know they do not have to answer any questions they are not comfortable about.

Section A deals with acute medical concerns that require immediate attention. For example, a client may come to an appointment in acute withdrawal requiring medical attention. Or, a client may present with other health problems that should be dealt with as soon as possible, for example, a client may report vomiting blood or have a badly infected needle site.

Section B records recent contact with medical professionals, including family physicians and any other medical or mental health specialists.

Current medications that are not mood-altering are also recorded here.

Clinical tips

Below are a few tips to assist in asking clients about their use of medications.

- Ask the client to make a list of all medications prescribed by a doctor. If the client is seeing more than one doctor, ask the client to list all medications prescribed by all physicians.

- Ask the client to list the name of the drug and the dosage, if possible, and how many times a day the medication should be taken. Ask the client how often she is actually taking the medication. Is it as prescribed?
• It can also be helpful to ask the client why he is taking the medication. This can help to clarify which drug the client is actually taking, if there is any confusion. For example, in one case, a client reported use of Zantac to help him sleep, when in fact he had confused the drug with Xanax. Another example would be a client who said that her doctor had given her something to, say, settle her nervous stomach and the drug turned out to be a benzodiazepine.

• Sometimes clients cannot remember the name of the medications they are taking. Ask them to either bring the containers in at the next appointment (making it clear they will not be confiscated) or to make a list of their medications at home to bring with them to the next appointment. Or you could arrange to call the client at home when he can read the names and dosages to you over the phone.

• Clients are sometimes taking over-the-counter medications on a regular basis. These should also be recorded here. Again, ask why the client is using an over-the-counter medication on a regular basis. One client reported using Tylenol 1s as a sleeping aid and had been using them for years.

Section C on the Health Screening Form lists physical diseases and symptoms that are sometimes associated with substance abuse; record any health problems or concerns about these problems. For some clients, you can present the list to the client to check off, ensuring beforehand that the client knows she can ask you questions about any terms she is not familiar with, and that she knows that both actual health problems and concerns should be recorded. Or, read out the list to the client, adding further explanation as you proceed down the list. You could start with a comment such as, “I’m going to read you a rather lengthy list of health problems. Please let me know if you have any of these health problems, or if you have any concerns about any health problems on this list.” If a client indicates that she has concerns, discuss the nature of the concerns, whether she has discussed them with a professional, whether the concerns were treated, and if they are causing any current problems.

Depending on your interviewing style, you might want to regroup the items on the list. For example, you could start with physical health problems, and then move to more sensitive material such as abuse trauma and infectious diseases.

In the area of infectious diseases, ask the client if he has any concerns about HIV or hepatitis. Ensure that you ask clients who are injecting drugs if they have any concerns or are interested in anonymous testing.

Sexually transmitted diseases (STDs) were once called venereal diseases, and include such diseases as gonorrhea, syphilis, chlamydia, and genital herpes. There are more than 20 sexually transmitted diseases. Although it is sexually transmitted, HIV is included in the section on infectious diseases rather than in this section because sharing needles is a major means of transmitting the virus. When asking about sexually transmitted diseases, ask if the client has any concerns about chlamydia, gonorrhea or syphilis or is concerned about the risk of her partner or partners having an STD.

You should have some information at your agency about infectious diseases and STDs and know where to refer the client for information, testing or counselling.
CLINICAL EXAMPLES

HARRY’S LIFE

Harry clearly has serious medical problems that require medical monitoring. Harry is continuing to have medical tests and needs to be medically stabilized before entering addiction treatment, if he decides to do so. His hospitalization for alcohol-related seizures has likely been discussed with him prior to gathering health screening information; for example, during the review of “Problems with physical health” within the Adverse Consequences of Substance Use tool.

In Part C of the Health Screening Form, Harry checked off history of seizures/epilepsy, heart disease (angina pain) and stomach problems (vomiting blood, bloody stools). At this point, it might be helpful to talk to Harry about the physical effects of heavy drinking. This is an opportunity to summarize the effects of drinking on Harry’s physical health. This is the one area over which Harry had expressed considerable concern.

JOYCE’S LIFE

Joyce went to her family physician two months ago, reporting that she was feeling depressed and anxious. Her physician is not aware of her substance use. She was prescribed an antidepressant, which she has been taking “as prescribed.” She was unaware that she should not drink or use cocaine while taking an antidepressant. At this point, it is important to ask Joyce if she would feel comfortable talking to her doctor about her substance use or if she would give consent for you to talk with her doctor. Given her regular substance use and her current life circumstances, her depression may be situational and not require an antidepressant. It is important for either Joyce or you to have a discussion with her doctor about the best approach to treating her depression at this time.

Joyce was sexually assaulted as a teenager by a person she thought was a good friend. She did not lay charges and has tried to pretend it was “no big deal.” She has never discussed it with anyone or received counselling. Joyce also reports feeling angry but does not understand the source of her anger.

Joyce is beginning to have indigestion and bowel problems. These symptoms have not been discussed with her doctor.

The primary focus of discussion with Joyce over her Health Screening Form is the need to talk to her doctor about her substance use and how that relates to her feelings of depression and anxiety and her recent stomach problems.
THE HEALTH SCREENING FORM: SAMPLE FORMS

HEALTH SCREENING FORM

Program # __________________________ Client Name Harry James

Counsellor: ____________________________________________________________ Date __________________________

A. Acute Medical Problems

Are there acute medical complications that may require referral to emergency/hospital for immediate medical assessment?

☐ Yes ________________________________________________________________

☒ No ________________________________________________________________

MEDICAL PROBLEMS THAT MAY REQUIRE MEDICAL ASSESSMENT

B. Medical History

When did you last see a physician? Who is your physician?

Harry has been in regular contact with his own physician, Dr. Smith, since his car accident several years ago.

Had a physical within last 30 days. Reports some other problems with upper and lower gastrointestinal tract.

Most recently he was admitted to Emergency with alcohol-related seizures. One week ago, he was in hospital with seizures, and was released to his own home.

Are you currently in any type of treatment or counselling for emotional or mental health problems?

Is there a threat of harm to self or others?

Harry is depressed and has thought about suicide recently. He reports moderate difficulties in this area. He has not had any counselling in regards to death of wife

Have you had any hospitalizations in the last year? For what reasons?

As noted above, recently admitted for seizures related to alcohol use. No other admissions.

List all current medications (dosage).

Nitro-Dur patch 0.8

Losec 20 mg 2x daily

Ensure 3x daily

Continued on next page.
HEALTH SCREENING FORM (CONT’D)

Program # ____________________ Client Name  Harry James

Counsellor: __________________________________________ Date  September 13 [include year]

C. Health Screening

Check all indicated and note concerns:

☒ unmanaged diabetes
☒ history of seizures/epilepsy
☐ cancer
☒ eating disorders (bulimia, anorexia, under/over eating)  Harry has not been eating well, is taking Ensure.
☒ heart disease (angina pain)
☐ blood pressure problems
☐ liver disease (hepatitis-cirrhosis)
☐ kidney disease
☐ jaundice
☐ menstrual/menopausal difficulties
☐ possible pregnancy
☐ pancreatitis
☐ physical or sexual abuse
☐ emotional/verbal abuse
☐ recent untreated injuries
☐ risk of infectious diseases __________________________________________

☒ sexually transmitted diseases (syphilis, gonorrhea, chlamydia, herpes)
☐ lice/scabies
☒ stomach problems (ulcers, gastritis)
☐ tuberculosis
☐ head injury
☐ other

Clinical Notes/Referrals Needed:

Prior to hospitalization, Harry was vomiting blood, had blood in stools, ongoing tests are required from accident/burns. Medical monitoring required.

________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________

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HEALTH SCREENING FORM

Program # ____________________________ Client Name Joyce Smithers
Counsellor: ___________________________________________ Date September 13 [include year]

A. Acute Medical Problems
Are there acute medical complications that may require referral to emergency/hospital for immediate medical assessment?
☐ Yes __________________________________________
☒ No __________________________________________

MEDICAL PROBLEMS THAT MAY REQUIRE MEDICAL ASSESSMENT

B. Medical History
When did you last see a physician? Who is your physician?

Joyce last saw her doctor two months ago, when she was given the prescription for antidepressants. Dr. Jones is her doctor and Joyce will bring address and phone number for next appointment.

Are you currently in any type of treatment or counselling for emotional or mental health problems?
Is there a threat of harm to self or others?
Depression and anxiety present, doctor has prescribed medication. No threat to self or others. Has been sexually assaulted in past—no counselling for this trauma to date.

Have you had any hospitalizations in the last year? For what reasons?
No injuries or hospital admissions.

List all current medications (dosage).
Joyce is prescribed Effexor, an antidepressant, and she takes it as prescribed, but has continued to drink while taking the medication. The dosage is 225 mg per day, oral dose.

Continued on next page.
C. Health Screening

Check all indicated and note concerns:

☐ unmanaged diabetes
☐ history of seizures/epilepsy
☐ cancer
☐ eating disorders (bulimia, anorexia, under/over eating)
☐ heart disease (angina pain)
☐ blood pressure problems
☐ liver disease (hepatitis-cirrhosis)
☐ kidney disease
☐ jaundice
☐ menstrual/menopausal difficulties
☐ possible pregnancy
☐ pancreatitis
☐ physical or sexual abuse
☐ emotional/verbal abuse
☐ recent untreated injuries
☐ risk of infectious diseases

☐ sexually transmitted diseases (syphilis, gonorrhea, chlamydia, herpes)
☐ lice/scabies
☐ stomach problems (ulcers, gastritis)
☐ tuberculosis
☐ head injury
☐ other

Clinical Notes/Referrals Needed:

Joyce’s physician is unaware of her substance use and because she’s taking an antidepressant this is a concern. The doctor needs to be informed.
Chapter 14

PUTTING IT ALL TOGETHER

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DESCRIPTION AND PURPOSE

This chapter describes how to construct a clinical profile for Harry and Joyce by interpreting the results of the assessment and mapping out the Admission and Discharge Criteria to determine the most appropriate service or services in the addictions treatment system for these clients, given their individual strengths and needs. The counsellor uses the Tracking Summary and the Clinical Profile forms to put together all the information from the tools and forms completed during the assessment interview process with the client.

The Tracking Summary is a required form and should move with the client through the treatment system. The Tracking Summary is the one document that must be transmitted—with the client’s consent—to the referral destination. However, many programs find the entire core package of tools helpful in learning more about the client and creating a more detailed treatment plan. The Clinical Profile Form is optional, but can be very useful because it provides a way to deliver the information from the entire core package to these programs in a condensed format while providing a more contextual description of the client’s circumstances.

This chapter includes a completed Tracking Summary and Clinical Profile Form for each of the fictitious clients we have been following, Harry James and Joyce Smithers. You will want to refer to these as you read the following analysis, which reviews the Admission and Discharge Criteria, using the assessment results for Harry and Joyce. For counsellors not familiar with the Criteria, it is helpful to start with the four “assessment” bubbles, as we do in this chapter.

We will begin with the analysis of Harry James’s results.

ANALYZING HARRY’S NEEDS AND STRENGTHS

ASSESSING THE NEED FOR WITHDRAWAL MANAGEMENT SERVICES

Harry has spent three days in hospital and has maintained abstinence for 10 days in total. Although he does not look or feel well, he does not need further withdrawal management services. He does, however, need to know that if he has strong cravings or does relapse, these services are available for him. He has been in wms three times in the past and at least is familiar with the safe supportive environment. He should be reminded that he could phone the wms for supportive counselling during the night.
ASSESSING THE NEED FOR STABILIZATION SERVICES

Let’s review the criteria on the decision tree “Assessing the client’s need for stabilization services.”

1. **Is ready to explore change options:** Harry is beginning to realize his drinking is causing problems, especially with his physical health. His scores on the SOCRATES were low in recognition, but medium in ambivalence, which means that he is at least considering the possibility that his drinking is problematic. Completing the Adverse Consequences of Substance Use tool helped Harry to see the major negative impact that drinking is having on his life. As Harry was a social drinker for most of his life, it is more difficult for him to see drinking as a major problem. He is just at the beginning of being ready to explore change options.

2. **Is using prescribed psychiatric or protective medication appropriately:** This criterion is not applicable for Harry.

3. **Is eating appropriately:** This is a major problem for Harry, given his gastric problems and his difficulty with daily living skills (as noted on the Health Screening Form and BASIS-32). Harry is definitely having difficulty eating appropriately.

4. **Has the stamina to manage daily living activities:** The BASIS-32 shows that Harry has quite a bit of difficulty managing day-to-day living activities. He also scored high on depression, which contributes to the difficulty in managing daily living activities.

5. **Is able to comprehend or understand information:** Harry can understand information but cannot concentrate for too long. He tires easily.

6. **Memory has returned:** Harry’s memory is not good. He still becomes confused and does not remember recent events. The Adverse Consequences tool indicates he has had blackouts and memory problems or confusion for the last two years.

7. **Is physically well enough to participate in treatment:** The DHQ and Health Screening Form show that Harry is not physically well enough to participate in treatment.

Harry does not meet most of the criteria and therefore would be referred for stabilization. Harry needs time for his health to improve. He needs a service that will provide support in areas of daily living to ensure he eats and sleeps well and attends medical appointments. He is not ready to attend structured treatment at this time.

ASSESSING THE NEED FOR MEDICAL OR PSYCHIATRIC SERVICES

Harry is having difficulty with depression and is undergoing medical testing in regard to his gastric problems, and he has angina. However, he is already receiving medical care. In this case, you would likely consult with the health professionals working with Harry to determine the level of participation Harry could handle should he decide to enter the structured addiction treatment system.
NEXT STEPS

At this point in the assessment there are two options as next steps:

- **Option 1**: If Harry’s community has an older person’s outreach program, home visits could be integrated with other home care services to provide the basic services that would help Harry to become more physically and cognitively healthy.

- **Option 2**: Harry could be referred to residential supportive services for stabilization.

In considering option 2, we now turn to the fourth “assessment” bubble.

ASSESSING THE NEED FOR RESIDENTIAL SUPPORTIVE SERVICES

Let’s review the criteria on the decision tree “Assessing the client’s need for residential supportive services.”

1. *Is living in a situation where there is no drinking or drug use and/or pressure to use substances*: Harry’s boarding house, where heavy drinking and fighting are common occurrences, is not a safe environment.

2. *Is living in a situation where he or she is not at risk of violence or abuse*: Although Harry tries not to associate with other boarding house residents, he has been robbed a couple of times and is at some risk of violence.

3. *Has a fixed address*: Harry has a fixed, unsafe residence.

4. *Has a supportive person in current living situation or social network*: As we know from the Perceived Social Support form, Harry has no friends or family he can count on.

5. *Has the personal support or resources to manage while awaiting treatment or between program hours*: Harry does not meet this criterion.

6. *Is at low risk of relapse*: The Drug-Taking Confidence questionnaire shows Harry is at high risk of relapse across all situations.

7. *Has a stable living environment while addressing longer-term goals*: Harry’s home environment offers no support and is in fact unsafe so cannot be considered stable.

Harry does not meet most criteria and therefore, would a referral to level 1 residential supportive treatment services would be appropriate. Harry did attend a residential treatment program in the past, which he did not complete. It would be helpful to explain to Harry that although he would need to be abstinent, the focus of this service is to help him get well, rather than to participate in structured addictions treatment. Given Harry’s concern for his health, he might accept this referral.
As Harry stabilizes either at the community treatment level or at a residential supportive service, depending on what is available in his community and on what Harry decides, his counsellor could use motivational strategies to see if Harry might eventually attend treatment or continue to receive residential supportive services following stabilization. Once Harry is stabilized, some of the tools (e.g., DTCQ-8, BASIS-32, Socrates) could be re-administered to see if there are changes in his functioning and to again apply the Admission and Discharge Criteria, with the aim of determining the most appropriate service in the addictions treatment system for him at that time.
### Program # ___________________________ Client Name  Harry James

<table>
<thead>
<tr>
<th>Date completed (dd/mm/yyyy)</th>
<th>Tool</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>13/09/[yr]</td>
<td>Drug History Questionnaire</td>
<td>Late onset drinker following car accident in which wife died &amp; Harry badly burned. Drinking 17 sdr x 5.5 yrs. Alcohol-related seizures 1 wk. ago. Used morphine after accident—did not use after hospitalization.</td>
</tr>
<tr>
<td></td>
<td>Adverse Consequences</td>
<td>Physical health—GI bleeding, alcohol-related seizures, blackouts, no contact with son, no friends, living in heavy drinking boarding house.</td>
</tr>
</tbody>
</table>

#### SOCRATES

<table>
<thead>
<tr>
<th></th>
<th>Alcohol</th>
<th>Drug*</th>
<th>Drug*</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition</td>
<td>23</td>
<td></td>
<td></td>
<td>Very low recognition</td>
</tr>
<tr>
<td>Ambivalence</td>
<td>15</td>
<td></td>
<td></td>
<td>Medium ambivalence</td>
</tr>
<tr>
<td>Taking steps</td>
<td>9</td>
<td></td>
<td></td>
<td>Very low taking steps</td>
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</tbody>
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#### DTCQ-8

<table>
<thead>
<tr>
<th></th>
<th>Alcohol</th>
<th>Drug*</th>
<th>Drug*</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unpleasant emotions</td>
<td>20</td>
<td></td>
<td></td>
<td>Generalized low profile. Alcohol playing a major role in Harry’s life – high risk of relapse across all situations.</td>
</tr>
<tr>
<td>Physical discomfort</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pleasant emotions</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testing personal control</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urges/temptations</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflict with others</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social pressure</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pleasant times</td>
<td>20</td>
<td></td>
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<td></td>
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<tr>
<td>Global scores</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>10</td>
<td></td>
<td></td>
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#### Treatment Entry Questionnaire

<table>
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<th>Alcohol</th>
<th>Drug*</th>
<th>Drug*</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal positive</td>
<td>8/28</td>
<td></td>
<td></td>
<td>Worried about effects of drinking on his health</td>
</tr>
<tr>
<td>Internal negative</td>
<td>17/21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External coercion</td>
<td>6/28</td>
<td></td>
<td></td>
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</tbody>
</table>

#### BASIS-32

<table>
<thead>
<tr>
<th></th>
<th>Alcohol</th>
<th>Drug*</th>
<th>Drug*</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relation to self/others</td>
<td>2.71</td>
<td></td>
<td></td>
<td>Quite a bit of difficulty with daily living skills and depression Moderate difficulty with relation to self/others and with overall score.</td>
</tr>
<tr>
<td>Daily living/role functioning</td>
<td>3.57</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression/addictive</td>
<td>3.33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impulsive/anxiety</td>
<td>1.17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosis</td>
<td>.25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall score</td>
<td>2.25</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Note: List drug that has been assessed in “Comments” column. If more than two drugs, use a separate sheet.

Continued on next page.
SAMPLE FORMS: HARRY JAMES’S TRACKING SUMMARY AND CLIENT PROFILE FORM (CONT’D)

ADMISSION AND DISCHARGE REFERRAL AND DECISION TRACKING SUMMARY (CONT’D)

<table>
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<tr>
<th>Date completed Tool</th>
<th>Perceived Social Support</th>
<th>Family</th>
<th>Friends</th>
<th>0/7</th>
<th>0/7</th>
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</thead>
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<td>Friends</td>
<td>0/7</td>
<td>0/7</td>
<td>Estranged from son, no friends.</td>
</tr>
</tbody>
</table>

Concerns from Health Screening Form:
Harry was involved in a serious car accident 7 yrs. ago—his wife died and he was severely burned. Alcohol-related seizure one week ago, hospitalized for three days. Harry has been vomiting blood, and has bloody stools, involved in ongoing tests over gastrointestinal problems. He has angina and he has a Nitro-Dur patch. Harry has not been eating well and is taking Ensure.

Admission and Discharge Guidelines Recommended
(check all that apply)

| Withdrawal management services | Y X | N | |
| Stabilization services | Y X | N | At a residential support service. |
| Option 1 | Community treatment services | Y X | N | Communities that have an older person’s outreach program could provide community treatment services. |
| Medical/psychiatric services | Y N | X | |
| Residential treatment services | Y N | X | |
| Option 2 | Residential support services | Y X | N | Residential Support Services. |

If guidelines were not followed, why not?

Clinical notes (If more space needed insert third page):
Harry requires a period of stabilization to improve his health. He is interested in working on his health problems. Harry has two options:

1. Communities that have an older person’s outreach program could provide community treatment in the home integrated with other home care services.
2. Harry could attend residential support services. He would benefit from the focus on daily living skills and support.

Counsellor signature: ____________________________ Date ____________________________
I. Using information gathered in interviews and referencing tools administered, briefly describe the client’s strengths and needs below:

• **Acute Intoxication and Withdrawal Needs** *(Health Screening Form, DHQ, Adverse Consequences)*
  Harry was in hospital for 3 days for alcohol-related seizures. He was discharged to home with an appointment at community treatment in one week. Harry has abstained from alcohol for 10 days. He reports not drinking because he feels so ill. Harry has not had a seizure since out of hospital.

• **Medical/Psychiatric Needs** *(Health Screening Form, BASIS-32, Adverse Consequences)*
  Harry is undergoing further medical testing re his gastric problems (vomiting blood, bloody stools). He is currently not eating much. He also has angina. Harry clearly requires medical monitoring and is not medically stable to attend treatment at this time. Harry is having quite a bit of difficulty with depression as shown on the BASIS-32. Although he received some counseling from his G.P. regarding his wife’s death in the accident, he has been feeling depressed since the accident.

• **Emotional/Behavioural Needs** *(Health Screening Form, Adverse Consequences, BASIS-32)*
  Harry is having quite a bit of difficulty in daily living skills. Harry has been feeling too sick to look after household responsibilities and, as a result, has not been eating well for some time, his hygiene has been problematic for some time, and he has not been taking care of any day-to-day responsibilities, such as banking.

• **Treatment Readiness** *(SOCRATES, TEQ)*
  High internal negative score on TEQ—Harry is worried about the effect of continuing to drink on his health. He has very low recognition compared with others entering treatment. He does have medium ambivalence, which is a positive sign that Harry is questioning the effect of his drinking on his life. He indicates that he wants to stop abusing alcohol, but does not want to give it up completely.

• **Relapse Potential** *(DHQ, DTCDQ-8)*
  Generalized low profile on the DTCDQ. Harry is at high risk of relapse across all situations. For the past 5.5 years, alcohol has played a major role in Harry’s life. However, for most of his life he was a social drinker. He also has been able to abstain for 10 days.

• **Recovery Environment/Supports** *(BASIS-32, PSS)*
  Estranged from son—has not contacted son in one year. Has no friends. Used to have good friends prior to the accident. Goes to bars to socialize.

• **Barriers/Resources** *(Health Screening Form, Adverse Consequences, BASIS-32)*
  Harry’s poor health is a barrier to attending treatment. He is medically fragile and it may take some time before he feels better.
HAS THE CLIENT HAD PREVIOUS TREATMENT?

Describ date and type attended, outcome, client's preferences:

Attended a 21-day abstinence based residential program three years ago, but he did not complete the program and resumed drinking immediately. He has three admissions to WMS over the past six years. He refused referrals for treatment each time.

DESCRIBE QUANTITY/FREQUENCY PATTERNS OF SUBSTANCE USE PRIOR TO THE PAST 12 MONTHS. IS PATTERN ABOUT THE SAME, IMPROVED, DETERIORATED?

Harry was a social drinker for most of his life, prior to the accident seven years ago. His drinking gradually increased over the years.

IS THERE EVIDENCE OF PROBLEM GAMBLING?

How does client wish to proceed (i.e., readiness for treatment/stage of change)? Describe changes in above prior to the past 12 months: Is pattern about the same, improved, deteriorated?

IS THERE EVIDENCE OF ANY OTHER CLINICAL ISSUES THAT WILL MAKE THE CLIENT'S TREATMENT GOALS MORE DIFFICULT TO ATTAIN? ISSUES MIGHT INCLUDE SUCH THINGS AS FAMILY OF ORIGIN, TRAUMA, LOSS ETC. IF YES, DESCRIBE BELOW.

Issues of grief and loss from the car accident in which he was seriously burned and his wife died are immense for Harry. Loss of contact with his son, his only living family member, is also a difficult issue.

IN YOUR CLINICAL OPINION, FROM YOUR OBSERVATIONS, INTERVIEWS, OTHER COLLATERAL INFORMATION AND CLIENT REPORT, WHAT IMPACT HAS SUBSTANCE ABUSE HAD ON OTHER LIFE AREAS?

<table>
<thead>
<tr>
<th>Area</th>
<th>Family</th>
<th>Dependents</th>
<th>Accommodation</th>
<th>Work</th>
<th>School</th>
<th>Leisure</th>
<th>Legal</th>
<th>Health</th>
</tr>
</thead>
<tbody>
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<td>Low</td>
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<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>Serious</td>
<td>N/A</td>
<td></td>
<td>Moderate</td>
<td>Serious</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

24-HOUR ACCESS TO STAFF IS IMPERATIVE FOR HARRY GIVEN HIS INABILITY TO COPE WITH DAILY LIVING SKILLS AND TASKS. HIS CURRENT RESIDENCE IS NOT SAFE, NOR IS THERE A SUPPORTIVE PERSON TO ASSIST HIM WITH DAILY LIVING ACTIVITIES.
VIII. Are there acute health issues, unmanaged medical issues or concerns that could interfere with referrals at this time? If yes, please comment.

YES  NO

Ongoing medical tests for gastric problems including vomiting blood and bloody stools.

IX. Mapping onto Admission and Discharge Criteria: Using the information gathered from tools and interviews, refer to the “Admission Decision Tree” in the Admission and Discharge Criteria document and address the four concerns below:

Does the client need any or all of the following?

1. Withdrawal management services:
   - Community WMS
   - Residential WMS
   - Level I
   - Level II
   - Level III

2. Stabilization:

   YES  NO

   Harry meets most of the criteria for stabilization services. Given Harry’s need for support around daily living activities, a referral to residential supportive services would likely be appropriate.

3. Medical/psychiatric services:

   YES  NO

   Ongoing tests for gastric problems. Does not require further referrals.

4. Residential support:

   YES  NO

   Harry meets most of the criteria for residential supportive treatment. He needs time to stabilize and improve his health. Given the emphasis on support and health rather than structured treatment, Harry has accepted this referral.

Other Comments:

Following stabilization, some of the assessment tools could be re-administered to see if Harry has improved and to assist in working through the criteria to see where Harry might access further services from the system.
We now move on to relating Joyce Smithers’s results to the Admission and Discharge Criteria. A completed Tracking Form and Client Profile Form for Joyce are at the end of the chapter.

ANALYZING JOYCE’S NEEDS AND STRENGTHS

ASSESSING THE NEED FOR WITHDRAWAL MANAGEMENT SERVICES

First, let’s look at how the Admission and Discharge Criteria were used to decide if Joyce was appropriate for withdrawal management services. The information that could be reviewed against the criteria were supplied by a DHQ and Health Screening Form administered when Joyce came to the WMS, along with the standard intake information.

The DHQ provided a drug history, identified current and historical periods of abstinence and led to a discussion of Joyce’s current situation.

Joyce has been trying to quit substances on her own for the last month, since her children were removed from her home. Because of financial problems, she has given up her apartment and now is living with drug-using friends, while she attempts to get her life together. She has been able to quit for a day or two at a time, but then resumes drinking and coke use. She was abstinent for one day and was struggling with her withdrawal when she decided to self-refer to the WMS.

The Health Screening Form revealed that she did not require referral for acute medical complications or potential medical complications (which completes “Assessing the client for appropriate level/intensity of withdrawal management services, Part 1.”).

Although it is recognized that most communities do not have the option of community withdrawal management services, let’s pretend that the community in which Joyce lives does have that option, so that we can review the criteria in the decision tree “Assessing the client for appropriate level/intensity of withdrawal management services, Part II.” The criteria on this tree help to determine whether a client should be referred to community WMS or residential WMS.

Because community WMS is the least intrusive intervention, let’s examine those criteria first (on the right side of the tree). Joyce has no fixed address, therefore she does not have a safe, supportive environment, and she does not have a support person who could provide monitoring and support throughout her withdrawal (she is living with drug-using friends). Therefore, she does not meet the criteria for community withdrawal management.

Looking at the criteria on the left of this tree, we see Joyce meets two of the upper criteria (requires a protected setting to be able to abstain and would benefit from a supportive group atmosphere) and meets all of the criteria in the lower part of the bubble. Joyce is a good candidate for a residential WMS.

We now move on to the rest of the assessment, administered on-site in the WMS five days after Joyce arrived.
ASSESSING THE NEED FOR STABILIZATION SERVICES

As with Harry, we review the criteria on the decision tree “Assessing the client’s need for stabilization services.”

1. *Is ready to explore change options:* The SOCRATES and the Treatment Entry Questionnaire are the two assessment tools that measure treatment readiness. In the SOCRATES, Joyce’s scores for recognition were at a medium level regarding her alcohol use and at a high level regarding her cocaine use, compared to the levels of clients entering treatment. These scores mean she is aware of the relationship between her substance use and problems that she is experiencing in her life. She has very high ambivalence, which indicates that Joyce is struggling between the pros and cons of change. This score is typical when someone begins to explore change options. Joyce scored high on the internal positive scale for the TEOQ, which shows that she identifies with the positive values of behaviour change. We can conclude that Joyce is ready to explore change options.

2. *Is using prescribed psychiatric or protective medication appropriately:* The Health Screening Form indicates that Joyce is taking an antidepressant and taking it as prescribed (apart from using other psychoactive substances as well).

3. *Is eating appropriately:* The Health Screening Form collects information on eating disorders. At this point, the counsellor would likely have asked Joyce about her eating habits and also observed her eating habits in the WMS. Let’s conclude that Joyce, on the whole, eats appropriately.

4. *Has the stamina to manage daily living activities:* The BASIS-32 indicates that over the past week, Joyce has been having between a little and moderate difficulties with daily living skills. Remember that she has given up her apartment, has been bunking with friends and using alcohol and cocaine. At this point, it is unlikely that Joyce has the stamina to manage daily living activities.

The last three criteria, which focus on ability to comprehend and understand information, memory and physical health, would have been observed over the past five days at the WMS. Let’s conclude that Joyce meets all of these criteria.

The only criterion that Joyce does not meet is having the stamina to manage daily living activities. As she meets most criteria, we would not refer her for stabilization services.

ASSESSING THE NEED FOR MEDICAL OR PSYCHIATRIC SERVICES

It is important to read the information at the top of the largest bubble on the decision tree “Assessing the client’s need for medical/psychiatric services.” We are using these criteria to determine if the client has “at least one of the following problems at a level serious enough to interfere with addiction treatment and is not currently under medical/psychiatric care.” Both the Health Screening Form and the BASIS-32 are critical to reviewing the medical and psychiatric criteria.
Joyce does not have medical complications that would interfere with addictions treatment. She scored between “moderate” and “quite a bit of difficulty” with depression or anxiety over the past week. She has been to see her doctor about her feelings of depression and has been taking an antidepressant for two months. This level of depression would not interfere with addictions treatment and she has contact with the medical profession. Therefore, she would not require a referral for medical or psychiatric assessment. However, as mentioned in the Health Screening section, it would be helpful, with Joyce’s consent, to contact her family doctor to discuss her use of substances and how they may be contributing to her depression.

ASSESSING THE NEED FOR RESIDENTIAL SUPPORTIVE SERVICES

As we did with Harry, we review the criteria on the decision tree “Assessing the client’s need for residential supportive services.”

Joyce does not meet the following criteria:

- living in a situation where there is no drinking or other drug use or pressure to use substances
- has a fixed address
- has a supportive person in current living situation or social network (discussion during the PSS interview)
- has the personal support or resources to manage while awaiting treatment or between program hours
- is at low risk of relapse (Joyce’s dTCQ-8 shows she is at high risk of relapse for both alcohol and cocaine)
- has a stable environment while addressing longer-term goals.

Joyce clearly requires residential support services while she is awaiting treatment. Depending on what services are available in her community or district, she could access these services by remaining at the WMS until she can get into residential treatment (if the waiting period is short), or by living at a residential supportive treatment service and getting community day treatment.

ASSESSING THE NEED FOR TREATMENT SERVICES

It is now time to assess for the appropriate level and intensity of treatment services for Joyce. In her treatment plan, Joyce indicated that she wants to abstain from cocaine and from alcohol, and that she wants to go to treatment before getting her children back from Children’s Aid Society.

Look at the “Assessing the client for appropriate level/intensity of treatment service” decision tree. Note in the top paragraph that we should first determine if Joyce could achieve her treatment goals through community treatment services.

Now look at the top left box in the tree. We have worked out a treatment plan with Joyce, she is committed at this point to accessing treatment, and has already begun actively working on goals for change by self-referring to the
wms and attending self-help meetings while she is staying there. We conclude “yes,” and move to the criteria in
the box below:

1. Can achieve treatment goals without 24-hour access to staff and peer support: The crucial phrase in this
criterion is “24-hour access to support.” Could Joyce manage on her own with intermittent support?
The DHQ shows that Joyce has been drinking daily for five years, since her separation from her partner.
Six years ago, she attended community treatment and was able to abstain from alcohol for three months
and from coke for one year. Given that she has tried to abstain on her own over the last month and only
managed one or two days, and she has no fixed address, it is not likely that intermittent support would
suffice. As well, her DTCQ-8 shows she is at high risk of relapse for both cocaine and alcohol.

2. Requires less intensive assistance to develop and practise life skills: On the basis of her
score between little to moderate difficulty in daily living skills. She is currently having problems with self-management of her
addiction, but she is living in a tenuous environment, which makes maintaining abstinence more difficult.
This is likely an area in which Joyce could manage with less intensive assistance.

3. Has adequate social support/social stability and/or a manageable lifestyle: Given Joyce’s current living
situation with using friends, she has little social stability. Discussion of her family and friends following
administration of the PSS reveals that she does not have a close friend or family member who could
support her early recovery. Her family lives far away, although they support her by telephone. She
considers her friends to be true friends, but they are all currently using and provide “off and on again”
support for her attempts at sobriety.

4. Has the resources to attend regularly scheduled treatment appointments: Joyce could attend regularly scheduled
appointments, because she does not have other commitments such as child care or employment.
However, given her high risk of relapse (DTCQ-8) and her current inability to maintain any length of
sobriety (DHQ), she does not have the internal resources to keep appointments. It would be unrealistic to
expect her to do so.

Joyce does not meet either of the last two criteria. Joyce does not meet the criteria for community treatment
services on their own. Joyce clearly needs a facility with 24-hour supports, which could either be a residential
treatment service, or, as described earlier, a supportive treatment facility from which she could attend day
treatment at a community setting.

ASSESSING THE LEVEL AND INTENSITY OF RESIDENTIAL TREATMENT SERVICES

The decision tree “Assessing clients in residential treatment” provides the criteria to ascertain if someone needs
specialized medical or psychiatric treatment:

- client has had a relapse serious enough to affect ability to participate in residential treatment
- client’s medical/psychiatric problems intensify and client is no longer able to participate in residential
treatment
- client has identified a serious emotional/behavioural problem.

From the three criteria, it is clear that Joyce does not require specialized medical or psychiatric treatment.
MATCHING JOYCE TO THE RIGHT TREATMENT

There are several gender-sensitive issues to consider in making a referral for structured treatment for Joyce. She is a single parent; she struggles with poverty; she was sexually abused as a teen and never received counselling; she is angry a lot and can’t sort out the source of the anger. Joyce needs to attend a women’s treatment program. She herself states that she prefers to work through her recovery with other women. Joyce needs to work with staff who have the sensitivity and skills to help Joyce deal with many gender-specific issues and to create a community reintegration plan that takes these into account.

NEXT STEPS

Joyce has two possibilities that would best match her current strengths and needs:

- Option 1: Entering a women’s residential treatment program, especially one that provides access to abuse counselling.
- Option 2: Accessing a women’s residential support service, while attending a community day treatment program that is specifically for women or that has a gender specific component.
# ADMISSION AND DISCHARGE REFERRAL AND DECISION TRACKING SUMMARY

<table>
<thead>
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<th>Program #</th>
<th>Client Name: Joyce Smithers</th>
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<tbody>
<tr>
<td>Counsellor:</td>
<td>Date: September 13 [include year]</td>
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<table>
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<th>Date completed (dd/mm/yyyy)</th>
<th>Tool</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>13/09/[yr]</td>
<td>Drug History Questionnaire</td>
<td>Drinks 5 sdd weekday; 7 sdd weekends x 5 yrs. Intransanal cocaine on weekends. Taking antidepressant. Community TX 6 yrs ago—3 mos. abst. from alc; one yr. from cocaine.</td>
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<tr>
<td></td>
<td>Adverse Consequences</td>
<td>Self-reported physical health problems (indigestion). Feels depressed and angry a lot; lost partner 5 yrs. ago because of coke use; lost children to cas 2 mos. ago, verbally abusive when using, dropped out of school; financial problems.</td>
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<table>
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<th>Drug †</th>
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<td></td>
<td>Impulsive/addictive</td>
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<td></td>
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<td>Psychosis</td>
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<td>Overall score</td>
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</table>

* Note: List drug that has been assessed in “Comments” column. If more than two drugs, use a separate sheet. Continued on next page.
### ADMISSION AND DISCHARGE REFERRAL AND DECISION TRACKING SUMMARY (CONT’D)

<table>
<thead>
<tr>
<th>Date completed (dd/mm/yyyy)</th>
<th>Tool</th>
<th>Family Support</th>
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<tbody>
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<td>13/09/[yr]</td>
<td>Perceived Social Support</td>
<td>Family Friends</td>
<td>4/7 6/7</td>
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</table>

**Concerns from Health Screening Form:**
Joyce saw her doctor 2 mos. ago and was given an antidepressant. G.P. not aware of substance use. Joyce has signed consent for her G.P. to be contacted to discuss substance use. Sexually assaulted in adolescence—no counselling for this trauma to date. Reports indigestion and bowel problems lately self-identified. Feels angry a lot and cannot pinpoint source of anger.

**Admission and Discharge Guidelines Recommended**

<table>
<thead>
<tr>
<th>Admission and Discharge Guidelines Recommended (check all that apply)</th>
<th>Referral Suggested (name agencies)</th>
<th>Accepted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withdrawal management services</td>
<td>Currently at wms—has been there for five days.</td>
<td>Y N N</td>
</tr>
<tr>
<td>Stabilization services</td>
<td></td>
<td>Y N N</td>
</tr>
<tr>
<td>Community treatment service</td>
<td>See Residential Support Services.</td>
<td>Y N N</td>
</tr>
<tr>
<td>Medical/psychiatric services</td>
<td></td>
<td>Y N N</td>
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<tr>
<td><strong>Option 1 Residential treatment services</strong></td>
<td></td>
<td>Y N N</td>
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<tr>
<td><strong>Option 2 Residential support services</strong></td>
<td>Residential Support Services.</td>
<td>Y N N</td>
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</table>

**If guidelines were not followed, why not?**

**Clinical notes (if more space needed insert third page):**
Although Joyce is ambivalent about seeking treatment, she actually is more concerned about her chances of maintaining abstinence once she completes treatment given the number of life challenges she has to cope with. She will have to find accommodation for herself and her children, look after her children as a single parent, attend workfare, and try not to associate with drug using friends. Her ambivalence is appropriate. Following residential treatment or residential support services/day treatment, she will need a solid community plan for support as she re-establishes herself in the community.

Counsellor signature: ___________________________________________ Date ____________________
I. Using information gathered in interviews and referencing tools administered, briefly describe the client’s strengths and needs below:

• **Acute Intoxication and Withdrawal Needs (Health Screening Form, DHQ, Adverse Consequences)**
  Joyce self-referred for w.m. She has been in residential w.m.s for 5 days. DHQ indicates Joyce withdrawing from alcohol and cocaine. Drinking 7 S.D.D. (5 on weekdays, 12 weekends); intranasal cocaine use weekends (3 x’s each night). No history of seizures.
  Gave up her apartment; living with drug using friends. Does not have a safe environment to return to.
  DTCQ-8 shows high risk of relapse for both substances.

• **Medical/Psychiatric Needs (Health Screening Form, BASIS-32, Adverse Consequences)**
  Health Screening Form and Adverse Consequences indicate Joyce is healthy apart from recent indigestion and bowel problems.
  Past two months, taking antidepressant as prescribed by G.P. who does not know about her substance use. Scored high on depression/anxiety scale.

• **Emotional/Behavioural Needs (Health Screening Form, Adverse Consequences, BASIS-32)**
  Feeling angry a lot, is unaware of source of anger.
  Sexually assaulted as a teenager—has never received counselling re this trauma.
  Verbally abusive when using.
  Wants kids back, but afraid she won’t be able to maintain sobriety.
  Reports feelings of depression/hopelessness.

• **Treatment Readiness (Socrates, TEQ)**
  High internal positive score on TEQ—interested in attending treatment.
  Recognition higher for cocaine than alcohol; high ambivalence for both alcohol & drugs; very low in taking steps; but ready to attend treatment.

• **Relapse Potential (DHQ, DTCQ-8)**
  Maintained 3 mos. abstinence from alcohol; one year from cocaine following community treatment six years ago.
  Very high risk of relapse for cocaine (10% global score on DTCQ); high risk of relapse for alcohol in personal states—less so for situations involving others.

• **Recovery Environment/Supports (BASIS-32, PSS)**
  Family is supportive, but do not live in this area.
  Good friends, but currently friends do not understand why Joyce is abstaining and still offer her drugs.
SAMPLE FORMS: JOYCE SMITHERS’ TRACKING SUMMARY AND CLIENT PROFILE FORM (CONT’D)

CLIENT PROFILE FORM (CONT’D)

Program # ___________________ Client Name Joyce Smithers
Counsellor: ___________________ Date, September 13 [include year]

- Barriers/Resources (Health Screening Form, Adverse Consequences, BASIS-32)
  Made a decision not to get kids back until she completes treatment.
  Issue of relation between depression and substance abuse needs to be sorted out—consultation with G.P.
  Need solid community plan for returning to community reintegration—needs a case manager who is
  involved in discharge planning from the treatment program.
  Has been able to abstain up to one year in the past.

II. Has client had previous treatment? ___________________
   YES NO
   Describe date and type attended, outcome, client’s preferences:
   Six years ago attended a community treatment program. Abstained from alcohol for 3 mos. and from
   cocaine for one year. As unable to abstain for more than one to two days and does not have her own
   residence, does not believe community treatment would work this time; feels she needs residential
   treatment.

III. Describe quantity/frequency patterns of substance use prior to the past 12 months. Is pattern Is pattern about the same,
   improved, deteriorated?
   Six years ago—alcohol consumption was less—only drank on weekends; cocaine use was heavier then.
   Alcohol consumption gradually increased from weekends to daily. Although cocaine use is less than
   before, Joyce believes it will be more difficult to give it up this time.

IV. Is there evidence of problem gambling? ___________________
   YES NO
   How does client wish to proceed (i.e., readiness for treatment/stage of change)? Describe changes in above prior to
   the past 12 months: Is pattern about the same improved, deteriorated?

V. Is there evidence of any other clinical issues that will make the client’s treatment goals more difficult to attain? Issues might
   include such things as family of origin, trauma, loss etc. If yes, describe below. YES NO
   Sexually assaulted as teenager—has received no counselling.
   Feels angry a lot and can’t pinpoint the source.
   May relapse if these issues not addressed.

VI. In your clinical opinion, from your observations, interviews, other collateral information and client report, what impact has
   substance abuse had on other life areas?

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<th>Serious</th>
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<td>Moderate</td>
<td>Serious</td>
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Client Profile Form (Cont’d)

Program # __________ Client Name Joyce Smithers

Counsellor: __________________________ Date: September 13 [include year]

VII. How much therapeutic structure (i.e., weekly appointments, residential milieu, 24-hour access to staff) will be needed for client to meet identified goals?

- 24-hour access to staff.
- Residential milieu likely helpful.

VIII. Are there acute health issues, unmanaged medical issues or concerns that could interfere with referrals at this time? If yes, please comment: YES NO

IX. Mapping onto Admission and Discharge Criteria: Using the information gathered from tools and interviews, refer to the “Admission Decision Tree” in the Admission and Discharge Criteria document and address the four concerns below:

Does the client need any or all of the following?

1. Withdrawal management services:
   - Community WMS
   - Residential WMS
   - Level I
   - Level II
   - Level III

2. Stabilization:
   YES NO
   The only criterion not met is having the stamina to manage daily living activities. Therefore, she does not meet the criteria for stabilization services.

3. Medical/psychiatric services:
   YES NO
   On antidepressant—seeing medical professional.

4. Residential support:
   YES NO

Joyce does not meet the following criteria:
- Living in a situation where there is no drinking/drug use and/or pressure to use substances
- Has a fixed address.
- Has a supportive person in current living situation or social network.
- Has the personal support or resources to manage while awaiting treatment or between program hours.
- Is at low risk of relapse.
- Has a stable environment, while addressing longer-term goals.

Other Comments:

There are two possibilities for Joyce to access treatment:

Attending a day treatment program while living in a residential support service. Given gender-specific issues, a program that addresses women’s issues would be preferable.

Attending a women’s residential program, especially one that provides access to abuse counselling.
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Appendix A

ADMISSION AND DISCHARGE CRITERIA*

September 2000

Ontario Substance Abuse Bureau

Ontario Addiction Services Advisory Council

* Publisher’s note: Appendix A contains the original text of Ontario’s Admission and Discharge Criteria as published in 2000. Obvious typographical errors have been corrected and cross-references within the figures have been edited to reflect the appendix’s pagination and to enable electronic linking and navigation.
The Ontario Substance Abuse Bureau (OSAB) gratefully acknowledges the hard work and commitment of the members of the Joint Working Group of the Ontario Addiction Services Advisory Council, who completed the task of developing the Admission and Discharge Criteria. The Joint Working Group was created when the Admission and Discharge Criteria Working Group and the Models of Intake and Assessment Working Group merged.

OSAB wishes to thank and acknowledge the members of the Joint Working Group:

- **Bernie Boyle**, Alcohol and Drug Recovery Association
- **Anne Bowlby**, Ontario Substance Abuse Bureau
- **Lorraine Chapman**, Withdrawal Management Association
- **Pam Gardiner**, Residential Addiction Intervention Services of Ontario
- **Linda James**, Addiction Intervention Association
- **Linda Sibley-Bowers**, Assessment and Outpatient Managers' Coordinating Committee
- **Gail Schmidt**, Centre for Addiction and Mental Health
- **Ian Stewart**, Assessment and Outpatient Managers' Coordination Committee
- **Nancy Usher**, Residential Addiction Services of Ontario
- **Susan Vincent**, Drug and Alcohol Registry of Treatment
- **Peter Welch**, Ontario Federation of Community Mental Health and Addiction Programs
- **Paul Welsh**, Youth Managers’ Coordinating Group
- **Steve Pierce**, Ontario Substance Abuse Bureau
- **Christine Bois**, Centre for Addiction and Mental Health
- **Jill MacArthur**, Assessment and Outpatient Managers’ Coordinating Committee
- **John Scott**, Assessment and Outpatient Managers’ Coordinating Committee

OSAB wishes to express a special thank you to Virginia Carver, for her significant contribution to the development of the material and for her initial leadership of the project.

A number of drafts of this document were distributed to the addiction field during its development, and to all those who provided feedback and comments, OSAB wishes to thank you for your contributions.
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1. BACKGROUND/CONTEXT

1.1 WHY DOES ONTARIO NEED ADMISSION AND DISCHARGE CRITERIA?

In the past, addiction treatment services across Ontario were using different criteria to admit and discharge clients, and to refer them to treatment services. With different criteria, clients could receive very different service referrals in different parts of the province. In some cases, client referrals were based more on available services, longstanding relationships between agencies and habit than on client need. Over the past two years, a number of agencies and organizations started to work together to develop standard Admission and Discharge Criteria. The Ministry of Health and the Ontario Addiction Services Advisory Council (OASAC) have worked with representatives of addiction service agencies to develop standardized admission and discharge criteria* that addiction staff across the province can use to guide their practice. The criteria are designed to put the client first, and encourage addiction agencies to focus on meeting client needs, rather than fitting clients to available services.†

1.2 KEY PRINCIPLES

The criteria are based on several key principles:

- The addiction treatment service system exists to meet the needs of people with addictions, who are clients of the system rather than clients of individual agencies.
- Addiction treatment service agencies, through a coordinated and integrated network of services, will meet each client’s individual needs, rather than try to fit clients into predetermined services.
- The addiction treatment service system will reflect and use best practices. Clients will receive an appropriate level of assessment that is individualized and tailored to the client’s needs, recognizes the importance of previous assessment information, and avoids duplication.
- Clients will be offered the least intrusive intervention that is most likely to help them regain their health.
- Clients will be referred to residential medical/psychiatric treatment services only when they have serious psychiatric and/or medical problems and require specialized treatment in a multidisciplinary setting.
- Addiction treatment service agencies will adopt a stepped approach to care, placing clients in the least intrusive intervention that will meet their needs, and then helping them to move easily through the system, as their needs change.
- Clients will be continually assessed/reassessed throughout their treatment to ensure that the services they receive match their needs.
- Services can be provided in a variety of settings (including outside the addiction treatment system).
- Addiction treatment services will be coordinated and avoid unnecessary duplication.

* The Ministry of Health and the Ontario Addiction Services Advisory Council (OASAC) have also developed standard definitions for addiction treatment services, which are included in this document, and a standard assessment package, available separately.
† For information about the location and availability of addiction treatment services, contact the Drug and Alcohol Registry of Treatment (DART), 1-800-565-8603, or the Ontario Problem Gambling Helpline (OPGH) 1-888-230-3505.
• Addiction treatment agencies will develop common protocols and agreements to ensure that clients can move easily between different levels and intensities of service.

1.3 WHAT WILL THE CRITERIA DO?

The admission and discharge criteria are designed to help agencies determine the level, intensity and type of services that clients need throughout their treatment. By applying these criteria, agencies will be able to help clients move through the system, based on their changing needs, rather than prescribed lengths of time in service. For example, clients in a residential service who achieve their treatment goals and meet certain criteria could be referred to a community treatment service, while clients who need more time in residential services will stay longer. Clients in community services who achieve their treatment goals and meet certain criteria may be offered a less demanding treatment schedule. On the other hand, clients in a community treatment service who meet the criteria for more intensive support to manage their addiction might be referred to a residential treatment service. This approach, which focuses on ensuring clients receive appropriate services, should lead to a more cost-effective, streamlined, efficient system, which is better able to meet client needs.

Unlike past criteria used for admission and discharge, these criteria:

• differentiate between treatment and housing needs. (They make the assumption that many clients can make the required changes with community treatment services while living at home, while some may need both community treatment services and residential support services, and others will need residential treatment services.)

• include a preparation/stabilization phase (which can occur in different settings) that allows clients to address issues that might interfere with their treatment.

The criteria do not include referral to mutual-aid/self-help services because clients may participate in these programs regardless of the level of service they attend or require.

1.4 USING THE CRITERIA: THE ROLE OF CLINICAL JUDGEMENT

The main goals of the criteria are to promote a client-focused, stepped approach to addiction treatment, and to encourage clinicians to think about their practice and how they make admission and referral decisions. This document lays out a series of questions that clinicians can use to help ensure that clients receive the help they need and are referred appropriately.

The criteria should not be applied—or admission, discharge and referral decisions made—regardless of all other factors. There will always be exceptions. Clinicians should consider:

• geographical or other barriers, which may make it necessary to refer clients to a different level/intensity of service than indicated by the criteria.

• client choice—a client may refuse the proposed level/intensity of service and request a less intensive one.
Clinicians are also encouraged to use their clinical judgement when applying these criteria. However, whenever clinicians make an admission or referral decision different from the one indicated by the criteria, they should be encouraged to explain the rationale for their decision, and to include the explanation in the client’s file.

*Note:* At this stage in their development, the criteria are broad and may not be specific enough to guide all clinical decisions with youth, older adults or members of culturally diverse groups. When using the criteria with these clients, clinicians are encouraged to use their clinical judgement.

### 2. SERVICE DEFINITIONS

With a new approach to addiction treatment services (i.e., client-focused, stepped approach to care) comes new language and understanding. To ensure some consistency in how the addiction treatment system refers to services, the Ministry of Health and the Ontario Addiction Services Advisory Council have developed some standard service definitions.

#### 2.1 INTRODUCTION

To report, monitor, plan, evaluate and provide services to clients, all stakeholders in the addiction treatment system should agree on and use the same standard service definitions. The same definitions should—and will—be used by the Substance Abuse Bureau for provincial rationalization, when allocating resources and in monitoring service utilization. Service providers and planners within local systems will be able to use these definitions during the planning stage and when admitting and discharging clients. DART will use these definitions for agency reporting and when providing information about the availability of treatment services to the public and professionals.

In keeping with efforts to take a client-centred approach to substance abuse and gambling treatment and related services, the terms “community” and “residential” are used throughout this document to refer to where the client lives while accessing a service. These terms are not intended to imply anything about the agency or service provider, such as location, sponsorship or philosophy.

#### 2.2 DEFINITION OF A TREATMENT SERVICE

A “service” refers to a broad category of specialized addiction treatment or support that constitutes part of the continuum of care. A treatment service is comprised of programs consisting of specific activities or clinical modalities (e.g., relapse prevention, psychotherapy, family therapy, pharmacotherapy, motivational interviewing, social skills training, crisis management).

One of the specific goals of the provincial rationalization project is to increase the number and range of “services” provided by organizations involved in addiction treatment (i.e., to encourage multi-functional agencies). Currently, treatment “services” exist in different organizational contexts. Some services operate within an independent free-standing agency. In other instances, the treatment service may be provided by a larger organization such as a public health unit or a hospital. In still other instances, a treatment service provides particular activities that are grouped into specific programs (e.g., a family intervention program, a guided self-change program, and a relapse prevention program).
While it is beyond the purpose and scope of this report to define the various organizational contexts in which treatment services exist, there will be a subsequent need to define common reporting units for OSAB, or DART, and perhaps other information systems. This process will be initiated and monitored by the OSAB using, for example, OSAB numbers or DART reporting numbers. Each reporting unit will provide one or more of the services defined in the next section.

2.3 CATEGORIES OF SERVICE

Entry

Activities and decision-making steps, which underlie the process by which someone obtains information about and/or enters the addiction treatment system. Includes:

- **Inquiry contact** (a request for information about agency programs, the treatment system, or other issues, made by a person from the community, a staff member from another agency, or another professional)
- **Intake** (contact with a person to determine whether he or she is eligible for agency services, to register the client into the agency, and to orient the client to services available at the agency)
- **Screening** (a brief process that collects information in only enough detail to determine the client’s immediate needs and to provide direction for next steps in the assessment/treatment process. The screening process can also provide information to clients, which assists clients in clarifying their own position regarding next steps. Screening may occur in an individual or group format.)

The various activities in entry services may occur by telephone, Internet, or face to face, and may be conducted in one session or more, in one or more locations, and individually or in a group.

INITIAL ASSESSMENT/TREATMENT PLANNING SERVICES

The **initial assessment** is a process involving mutual investigation or exploration that provides the clinician with more detailed information for the purpose of determining specific client needs, goals, characteristics, problems and/or stage of change. Assessments vary in length according to the client’s situation, and comprehensive assessments may be reserved for clients with more complicated histories and problems. This assessment forms the basis for initial treatment planning, a process of negotiation based on feedback from the assessment results, the client’s strengths, prioritized problem areas, clinician judgement, client preferences and readiness for change, and the identification of potential barriers to treatment entry. This culminates in the development of a clear plan of action, including referrals as appropriate.

CASE MANAGEMENT SERVICES

A process which includes the designation of a primary worker whose responsibilities include the ongoing assessment of the client and his/her problems, ongoing adjustment of the treatment plan, linking to and coordination of required services, monitoring and support, developing and implementing the discharge plan, and advocating for the client. Case management services are offered regardless where the individual is in the system.
COMMUNITY TREATMENT SERVICES

One- to two-hour sessions in group or individual format, typically once a week or less often, while the client resides elsewhere in the community. Community counselling/treatment includes brief intervention, lifestyle and personal counselling to assist the individual to develop skills to manage substance abuse/gambling and related problems, and/or maintain and enhance treatment goals. Such activities as relapse prevention, guided self-change, family intervention, follow-up and aftercare are included here. Care may be provided with or without medical/psychiatric treatment. Frequency and length of sessions may vary depending on client need and program format. May be offered in a variety of settings including outreach to the client’s home, school, an addiction agency or other service setting. Outreach includes activities such as early intervention but not prevention, education, or public relations activities.

COMMUNITY MEDICAL/PSYCHIATRIC TREATMENT SERVICES

A specific non-residential service to meet the needs of individuals with concurrent disorders. This service may be offered either through a structured day/evening program or through community treatment. These services are usually part of broader hospital services and employ physicians, nurses, and staff specializing in the treatment of concurrent disorders.

COMMUNITY DAY/EVENING TREATMENT SERVICES

A structured, scheduled program of treatment activities typically provided five days or evenings per week (e.g., three to four hours per day) while the client resides at home or in another setting, including residential supportive treatment services, to assist the individual to develop skills to manage substance abuse/gambling and related problems.

RESIDENTIAL TREATMENT SERVICES

A structured, scheduled program of treatment and/or rehabilitation activities provided while the client resides in-house, to assist clients to develop and practise the skills to manage substance use and related problems. In addition to the scheduled program activities, clients have 24-hour access to support and the residential treatment milieu.

RESIDENTIAL MEDICAL/PSYCHIATRIC TREATMENT SERVICES

A structured, scheduled program of addictions treatment and/or rehabilitation activities provided for clients whose biomedical, emotional and/or behavioural problems are severe enough to require individualized medical/psychiatric care, while the client resides in-house. The treatment and/or rehabilitation is intended to assist the individual in stabilizing and managing his/her medical/psychiatric problems, while also addressing the addiction problem per se, or to allow for referral to appropriate substance abuse/gambling treatment. In addition to the scheduled program of addictions treatment and rehabilitation activities clients have 24-hour access to support and the residential treatment milieu.
RESIDENTIAL SUPPORTIVE TREATMENT SERVICES*

There are two levels of residential supportive treatment services:

Level I

- Housing and related recovery/support services, such as lifestyle counselling, coaching for activities of daily living, community reintegration, vocational counselling and mutual aid, provided to clients who require a stable, supportive environment prior to, during, or following treatment, which is accessed elsewhere.

Level II

- Housing/accommodation in alcohol/drug-free setting. Addiction services are not offered on-site or as part of the housing service.

WITHDRAWAL MANAGEMENT SERVICES

Assistance with voluntary withdrawal from alcohol and/or other drugs to clients who are under the influence of these substances and/or in withdrawal or otherwise in crisis directly related to these substances. Care may be provided with or without the aid of drug therapy and/or other medical interventions. Additional support such as discharge planning and early recovery education is provided.

Services may be provided as community (non-residential) or residential:

- With community withdrawal management services, clients may be simultaneously accessing residential support services, or they may be residing in their home, the home of a significant other or in another community setting, supervised or unsupervised.

- With residential withdrawal management services, care is provided in a withdrawal management (detox) centre, or on an inpatient basis in a hospital.

The following three levels of service apply to both community and residential withdrawal management services. Clients at all levels who are not taking any medication are considered/assessed for admission.

Level I

- Client symptoms can be safely monitored by staff who are not medically trained.
- Intensity/severity of symptoms can be managed, as required, with medical consultation being provided by a physician/after-hours clinic/health centre/hospital emergency department.
- Client/staff ratios do not permit high intensity symptom monitoring.
- In consultation with a physician, if necessary, consider/assess individuals for admission who are taking the following types of medication:
  - Medications for medical problems

---

* Based on feedback on the draft criteria, the name of this service definition has been revised, but the definition itself has not.
- Medications for diagnosed psychiatric problems
- Pain medications only for acute injuries or recent surgery

**Level II**
- Client symptoms can be safely monitored by staff who are not medically trained.
- Intensity/severity of symptoms can be managed, as required, with medical consultation being provided by a physician/after-hours clinic/health centre/hospital emergency department.
- Routine medical consultation and sufficient staff resources are available to consider management of the following medications/situations:
  - All medications as listed in Level I
  - Clients on methadone
  - Clients being tapered from benzodiazepines or narcotics

**Level III**
- Client symptoms require monitoring by medically trained staff.
- Medical consultation and staff are available on a constant basis to monitor and manage the following medications/situations:
  - All medications as listed in Level I
  - Circumstances as listed in Level II
  - Medically assisted withdrawal

### 3. CLIENT STRENGTHS AND NEEDS

This section describes the seven categories of client strengths and needs that should be used to assess client functioning and match a client to the services described above.

#### 3.1 ACUTE INTOXICATION AND WITHDRAWAL NEEDS

*The client’s ability to function related to use of and withdrawal from substances.*

Does the client have intoxication/withdrawal management needs?

Clients who have recently used substances and may be intoxicated or in withdrawal should be assessed for their need for withdrawal management services. These needs will be considered mainly when clients first enter the system, but should also be reviewed when a client relapses or has any change in his/her withdrawal management needs.

The criteria are designed to help clinicians assess the level of intervention required. The criteria reinforce the fact that a client’s need for withdrawal management services may be complicated by medical problems or needs. For example, is the client stable enough psychiatrically or physically to participate in a withdrawal management service? Is the client using any prescribed medication appropriately?
3.2 MEDICAL/PSYCHIATRIC NEEDS

*Any signs or symptoms of medical/psychiatric problems.*

Does the client have any current acute or chronic medical or psychiatric problems that would interfere with his/her ability to participate in addiction treatment? Does he/she need medical/psychiatric care?

Clients who have medical or psychiatric issues should be assessed for their need for medical or psychiatric services, or for their need for addiction treatment services that can be adapted to their needs. For example, clients who have medical problems may not have the stamina or physical energy to take part in a structured treatment service or may need more support than most services provide. Clients who have psychiatric problems—such as depression, anxiety, thought disorders, problems with memory or concentration or suicidal thoughts—may also be unable to participate in a service until these problems are treated, and the clients are stable.

3.3 EMOTIONAL/BEHAVIOURAL NEEDS

*The client’s ability to function in terms of life skills, problem solving, coping skills and self management.*

Does the client have any difficulty with the basic activities of daily living, such as getting up, getting dressed, basic hygiene, getting meals or getting to appointments on time?

Clients’ ability to manage daily activities should be assessed to determine the level/intensity of treatment services and supports they may need. Clients who have good life or problem-solving skills—or only a few life problems—will likely need less intense services (e.g., weekly community treatment services), while those with complex life problems may need residential services.

A client’s progress in developing life skills will also be a key factor in helping him or her move through the system.

3.4 TREATMENT READINESS

*The client’s readiness to change their substance use or other aspects of his/her life.*

Is the client ready to make a change?

Clients will be at different stages of readiness to deal with their substance use, or with other problems in their lives that may trigger substance use. Clients’ willingness to make a change should be assessed to help determine the appropriate level/intensity of service required to help them make the change. People who are highly motivated will likely need less intense services. People who are not yet ready to change may need motivational counselling and other supports. The assessment questions are based on the framework developed by Prochaska and DiClemente. A client’s readiness for change should also be reassessed if the client has trouble maintaining agreed-upon treatment goals and when the client is being discharged, to help determine whether the client needs other supports or services.
3.5 RELAPSE POTENTIAL

*The client's potential to resume substance use (if the client is abstinent) or to relapse from agreed-upon treatment goals.*

Is the client likely to relapse? What level/intensity of service does the client need to maintain his/her treatment goals?

Clients should be assessed for their potential to relapse. A better understanding of the clients’ recent history of use and the strategies they use to avoid substance use will help clinicians determine the level of support they may need to avoid relapse. For example, someone who has been able to be abstinent for a week or longer and has appropriate support may be a candidate for day/evening treatment. On the other hand, someone who has been using steadily over the past one to three months, who has not been able to abstain for any length of time, and who has strong cravings may need residential support services.

During the course of addiction treatment, clinicians can use clients’ relapse potential, along with a consideration of the clients’ strengths and needs, to determine whether the clients are ready to move on in the system as well as the supports they may require.

3.6 RECOVERY ENVIRONMENT/SUPPORTS

*The level of support and safety available to the client.*

What support does the client have in his/her environment? Is there problem drinking or drug use? Does the client feel pressure to use? Is the client safe? Does the client have supportive family and friends?

Clients should be assessed for the ability of their environment to provide the safety and support they may need to recover. Clients who have supportive environments are likely to need less intensive services, while those in unsafe environments may need more intensive residential treatment services or residential supportive treatment services to be able to participate in treatment.

In assessing clients for their ability to move to a less intensive service or to be discharged from addiction treatment, clinicians should review their environment and determine whether they will have the supports to maintain their health and avoid relapse. If environment continues to be an issue, then the clinician can identify other services and supports that the client may need.

3.7 BARRIERS AND RESOURCES

*The barriers/commitments that may prevent a client from participating in treatment, and the resources the client has or needs to be able to attend scheduled treatment.*

Does the client have any barriers or commitments that may keep him or her from participating in treatment? What resources does the client need to be able to attend treatment? Clients should be assessed for other
responsibilities or issues in their lives that may keep them from attending treatment. For example, do they have medical or other appointments they have to attend? Do they have access to transportation or do they have enough money for transportation? Is childcare or are other family commitments or responsibilities an issue?

Are there legal factors (e.g., court appearance, jail sentence) that may prevent clients from attending treatment?

Is the client experiencing some kind of crisis and require support during the time before entering treatment? Clients may require support during a crisis at any time in any level of care or treatment.

These practical issues can have a direct impact on client care—particularly when clients first enter the addiction treatment system. However, they should also be reviewed whenever the client is ready to move to a different service in the system.

4. ADMISSION CRITERIA

This section contains a series of decision trees which reflect the seven categories of client strengths and needs. They are designed to summarize the criteria clinicians will use when working with clients. Clinicians can use the decision trees to help them make appropriate decisions about where to admit clients when they first enter the treatment system, and when to refer them to other services in the system.

All the decision trees are based on the principle that clients will be referred to the least intrusive service that can meet their needs.

4.1 HOW TO USE THE DECISION TREES

The admission decision tree is a guide to all the admission decision trees and how they relate to one another. For each client, clinicians will work through each series of questions, beginning with the initial screening/problem identification decision tree, and then working through the other decision trees that are appropriate.

Note: Not all admission decision trees will apply to every client. As noted earlier, clinicians will continue to use their clinical judgement in assessing, referring and discharging clients.

5. REFERRAL AND DISCHARGE CRITERIA

At each stage of treatment—whether it is in a withdrawal program, a stabilization program, a treatment program or residential supportive treatment program—clients should be continuously assessed to determine their need for other services and their readiness to move to the next stage of treatment. Clients will progress at different paces. For example, some will need more time than others in withdrawal and stabilization. Clients should be able to move easily from one service to another—either less intense or more intense—depending on their needs. Clinicians can use the criteria and decision trees in this section to help determine when a client needs to move within the system and when they may be ready for discharge. The discharge decision tree is a guide to all the discharge/referral decision trees and how they relate to one another. The other decision trees are specific to clients in a certain treatment service.
Admission decision tree

Initial screening/problem identification

- Assess for appropriate level/intensity of withdrawal management services.
- Assess for the need for stabilization services.
- Assess for the need for medical/psychiatric services.
- Assess for the need for residential support services.

Assess for appropriate level/intensity of treatment services.

Refer to appropriate level/intensity of community treatment.

Refer to appropriate level/intensity of residential treatment.
Initial screening/problem identification tree

What does the client want?

Is there a crisis?

Yes → Deal with crisis/safety needs.

Does the client want help with housing, food, health care and other basic needs?

Yes → Refer to the appropriate non-addiction agency/service in the community.

Is the client intoxicated or at risk of withdrawal complications?

Yes → Proceed to Assessing the client for appropriate level/intensity of withdrawal management services.

No → Proceed to Assessing the client’s need for stabilization services.

Is the client at risk for a relapse?

Yes → Proceed to Assessing the client’s need for stabilization services.

For information about treatment services available, call the Drug and Alcohol Registry of Treatment (DART) at 1-800-565-8603 or the Ontario Problem Gambling Hotline (OPHG) at 1-800-230-3505.
Assessing the client for appropriate level/intensity of withdrawal management services, part I

Assess for complex medical problems

Acute medical complications

If the client meets **one or more** of the following criteria...

- cannot be roused, is unconscious or semi-conscious, does not appear to be breathing or breathing is laboured OR
- is experiencing hallucinations, severe tremor or extreme agitation/confusion OR
- is an uncontrolled insulin-dependent diabetic OR
- is experiencing seizures (generalized, focal or status epilepticus) OR
- has a history of having more than one seizure at a time per episode OR
- is threatening harm to self or others OR
- is suspected of having taken an overdose

...then call emergency services or refer the client to a hospital for immediate medical assessment **before** continuing the assessment for appropriate withdrawal management service or sending the client home.

Potential medical complications

If the client meets **one or more** of the following criteria...

- has a previous history of severe withdrawal complications (e.g., DTs, hospital admissions for withdrawal, severe dehydration) OR
- is or suspects that she is pregnant OR
- has a prior history of withdrawal seizures OR
- requires medication for a chronic medical/psychiatric condition and does not have this medication readily accessible OR
- has a history of cardiac, respiratory or other severe medical problems
- has a recent history of head injury with loss of consciousness or other injury or trauma OR
- has history of intense drug usage (e.g., long-term use of benzodiazepines, combining alcohol and barbiturates) OR
- has severe vomiting or diarrhea and is at risk of dehydration from fluid loss OR
- is a medication-controlled diabetic who has not been eating regularly OR
- physical presentation does not match the
- information provided on substances taken

...then the client is at high risk for medical complications, and a medical consultation should be arranged as part of the referral to a withdrawal management service or making the decision to send the client home.

For consultation on the need for medical assessment, contact hospital emergency departments, physicians, withdrawal management centres or the CAMH Clinical Consultation Service at 1-800-720-2227.
Assessing the client for appropriate level/intensity of withdrawal management services, part II

Assess for complex medical problems

If the client meets at least one of the following criteria:
• requires 24-hour monitoring of withdrawal symptoms OR
• needs to remove himself/herself from the present environment and/or requires a protected setting to be able to abstain OR
• would benefit from a supportive group atmosphere
...AND the client meets all of the following criteria:
• requires the support of a withdrawal management setting AND
• exhibits behaviour that is suitable for a structured peer environment (e.g., not violent or abusive) AND
• is willing to manage without addictive medications but, if required, a physician is willing to collaborate with withdrawal according to WMAO (Withdrawal Management Association of Ontario) protocols

...then refer the client to a residential withdrawal management service.

If client meets all of the following criteria:
• exhibits non-violent emotions/behaviour AND
• has a safe, supportive environment where access to substances is restricted AND
• has made a choice to withdraw in a community setting AND
• has a support person who is educated about withdrawal symptoms and management, and who is able to provide monitoring and support AND
• can access 24-hour medical support and consultation AND
• has a plan in place for medically assisted withdrawal, if required

...then refer the client to a community withdrawal management program or service—if they are available in your community. If they are not available, refer the client to the closest residential withdrawal management service.

If client chooses not to participate in a formal withdrawal management service...

...then give client information about other services/resources, and suggest he/she see a physician.
Assessing the client’s need for stabilization services

Some clients may be over the acute stage of withdrawal but need a period of stabilization before they are able to participate in treatment. Others may not require withdrawal services but may still a period of stabilization before they are ready for treatment.

Does the client meet most of the following criteria?
• Is ready to explore change options
• Is using prescribed psychiatric or protective medication appropriately
• Is eating appropriately
• Has the stamina to manage daily living activities
• Is able to comprehend or understand information
• Memory has returned
• Is physically well enough to participate in treatment.

Yes

Refer the client to residential supportive treatment services or a community setting that can provide a period of stabilization and/or preparation for treatment such as motivational counselling (if available).

No

Proceed to Assessing the client for appropriate level/intensity of treatment service.
Assessing the client’s need for medical/psychiatric services

Serious medical or psychiatric problems can interfere with a client’s ability to participate in treatment and can occur at any time in the treatment process.

Is the client openly hostile or threatening harm (with intent) to themselves and/or others?

Yes

Call emergency services or a physician for immediate assessment.

No

Does the client have at least one of the following problems at a level serious enough to interfere with addiction treatment and is not currently under medical/psychiatric care?

- Is obviously showing major signs of clinical depression OR
- Is obviously anxious, nervous or agitated OR
- Has a history of causing harm to self or others OR
- Exhibits violent emotions/behaviour OR
- Exhibits paranoid thinking, thought disorders or has problems with reality testing OR
- Has trouble comprehending, concentrating or remembering OR
- Is having suicidal thoughts or threatening self harm OR
- Has a chronic or acute medical condition (e.g., liver, gastric, heart, cognitive) or psychiatric condition that requires attention before addiction treatment can begin OR
- Responses on the psychiatric screening tests indicate possible serious psychiatric problems.

Yes

Refer the client for medical/psychiatric assessment and/or work with client to develop plan to deal with medical/psychiatric problem.

No

Proceed to Assessing the client for appropriate level/intensity of treatment service.
Assessing the client’s need for residential supportive treatment services

Some clients may need residential supportive treatment services in order to facilitate participation in community treatment services or achieve their goals.

Does the client meet most of the following criteria?
- Is living in a situation where there is no drinking or drug use and/or pressure to use substances
- Is living in a situation where he/she is not at risk of violence or abuse
- Has a fixed address
- Has a supportive person in current living situation or social network
- Has the personal support or resources to manage while awaiting treatment or between program hours
- Is at low risk of relapse
- Has a stable living environment while
- Addressing longer-term goals

No

Refer to level I residential supportive treatment services or other housing options.

Yes

Assess the client’s need for level II residential supportive treatment services and for treatment services.
Assessing the client for appropriate level/intensity of treatment service

When assessing a client’s treatment service needs, look first at whether the client can achieve his/her treatment goals through community treatment services. Then determine what level/intensity of community treatment or residential treatment the client needs. In all cases, take into account client choice/preference and other factors that may prevent clients from participation in a certain level or intensity of service. When assessing a client, be aware that family members may also have treatment needs.

Is the client committed to a negotiated treatment plan, and actively working on goals for change?

Yes

No

Is the client willing to explore issues related to substance use?

Yes

No

Discharge with referral to other services/resources.

Refer to community treatment services.

Does the client meet all of the following criteria?

• Can achieve treatment goals without 24-hour access to staff and peer support AND

• Requires less intensive assistance to develop and practice life skills (e.g., social skills, self management, problem solving and community reintegration) AND

• Has adequate social support/social stability and/or a manageable lifestyle AND

• Has a supportive person in current living situation or social network AND

• Has the resources to attend regularly scheduled treatment appointments

OR meet either of these criteria?

• Exhibits behaviour that is not suitable for a structured peer environment (e.g., is violent or abusive)

• Has work or family commitments that make it difficult to attend a residential program

Yes

No

...then proceed to Assessing the client for appropriate level/intensity of residential treatment services.

...then proceed to Assessing the client for appropriate level/intensity of community treatment services.
Assessing the client for appropriate level/intensity of community treatment services

If the client meets some of the following criteria...

• is functioning in major life areas (i.e., has steady job, stable housing), despite some problematic use of substances
• has a relatively short history of substance abuse with some periods of maintaining goal choice
• assessment results indicate low level of dependency
• asks for the most minimal of treatment
• is employed, and taking time off work would affect employment
• needs to be at home for family commitments or other purposes
• must deal with other factors that would preclude daily attendance, such as legal issues, medical appointments, or an inability to pay transportation costs

If the client meets some of the following criteria...

• has a relatively long history of severe abuse and assessment results indicate a high level of dependency
• needs more than weekly contact to maintain treatment goals
• has had community treatment that was not successful
• substance use appears to be a priority in functioning, and has resulted in noted deficits in maintaining employment

Refer to community day/evening treatment services...

Unless client wants a less intense level of service, then...

Refer to community treatment services.
Assessing the client for appropriate level/intensity of residential treatment services

Does the client meet any of the following criteria?
• Has severe concurrent substance abuse and medical/psychiatric problems and needs a secure, monitored, specialized environment.
• Requires specialized treatment with 24-hour medical monitoring.
• Is unable to function in a community living group setting/structured peer environment.

Yes

Refer to medical/psychiatric residential treatment.

No

Refer to residential treatment.
Discharge decision tree

Ongoing assessment

Assessing clients in withdrawal management programs
Assessing clients in community treatment services
Assessing clients in day/evening treatment
Assessing clients in residential treatment
Assessing clients in residential support services

Refer to another level/intensity of service, or discharge with a treatment plan.
Assessing clients in withdrawal management programs

Assess for the potential to move to treatment services

When clients have completed withdrawal and are ready to make the transition to stabilization or treatment, refer them to the appropriate service based on their needs and preferences. (Note that some clients may need more time than others to withdraw or stabilize.) Use the following criteria (based on the seven categories of client strengths and needs) to determine the most appropriate service.

Common abstinence guidelines for admission to residential treatment services

<table>
<thead>
<tr>
<th>Substance</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>7</td>
</tr>
<tr>
<td>Cannabis</td>
<td>14</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>14</td>
</tr>
<tr>
<td>Cocaine</td>
<td>14</td>
</tr>
<tr>
<td>Narcotics</td>
<td>14</td>
</tr>
</tbody>
</table>

Does the client meet all of the following criteria?

- Is sufficiently withdrawn from substances.
- No longer needs monitoring for medical or psychiatric problems.
- Has no emerging medical or psychiatric issues.
- Is behaving appropriately.
- Is willing to consider treatment options.
- Is able to use strategies to prevent relapse over the short term.
- Has appropriate recovery environment and supports.
- Is able to keep scheduled treatment appointments.

Yes

 Proceed to Assessing the client for appropriate level/intensity of treatment.

No

Client should continue in the withdrawal management program.

Unless client is not interested in further assistance, then...

Discharge with referral to other services/resources.

Unless client has severe medical/psychiatric or behavioural problems, then...

Refer client for assessment and stabilization and/or admission to other, more appropriate services.

While client is waiting for entry to next treatment phase, ensure supports are in place.
Assessing clients in community treatment services

Assess for the potential to move to a less intensive level of service

Does the client meet all of the following criteria?
- Has developed sufficient skills to problem solve, self manage or cope with life issues AND
- Has developed, practised and has confidence in his/her relapse prevention strategies and skills AND
- Is actively working on addressing longer-term goals for change AND
- Has a supportive recovery environment AND
- Medical/psychiatric problems stabilized AND
- Is able to keep regularly scheduled appointments.

Yes

Transfer client to less intensive care.

No

Continue in community treatment services.

If client is not interested in further assistance, then...

Discharge with referral to other resources/services.

Assess for the need for a more intensive level of service

Does the client meet any of the following criteria?
- Has had a relapse serious enough to interfere with his/her ability to participate in community treatment OR
- Has developed more intense medical/psychiatric problems OR
- Has been unable to make progress in addressing his/her treatment goals with this level/intensity of service OR
- Requires specialized intervention for a serious emotional/behavioural problem OR
- His/her recovery environment/supports have deteriorated OR
- Has difficulty attending regularly scheduled appointments.

Yes

Refer to another level/intensity of care or to specialized intervention.

No

Continue in community treatment services.
Assessing clients in day/evening treatment services

Assess for the potential to move to a less intensive level of service

Does the client meet all of the following criteria?

- Has sufficiently resolved medical/psychiatric problems and can manage with less intense services AND
- Has sufficient skills to self manage, solve problems and cope with life with less than daily contact or support AND
- Is actively working on consolidating short term treatment goals and/or addressing longer term goals for change AND
- Is able to use strategies to maintain substance use goals with less than daily contact AND
- Has a supportive recovery environment AND
- Is capable of keeping regularly scheduled appointments

Assess for the need for continued service

Does the client meet any of the following criteria?

- Has had relapses serious enough to affect his/her ability to participate in day/evening treatment OR
- Medical/psychiatric problems have intensified to the point where he/she is no longer able to participate in day/evening treatment OR
- Has been unable to make progress in achieving treatment goals OR
- Environment/social supports have deteriorated significantly OR
- Has difficulty attending regularly scheduled appointments

Continue in day/evening treatment.

- If client is no longer interested, then...
- Discharge with referrals to other services/resources.

Refer to residential treatment services.

- If client is no longer interested, then...
- If client has identified a serious emotional/behavioural problem, then...
- Refer for specialized intervention.

Refer to a less intensive level of service.
Assessing clients in residential treatment

Assess for the potential to move to a less intensive level of service

Does the client meet all of the following criteria?

- Has sufficiently resolved medical/psychiatric problems and can manage without 24-hour structured peer environment/staff support AND
- Has developed sufficient coping and self-management skills to manage without 24 hour structured peer environment/staff support AND
- Is actively working on short-term and long-term treatment goals and can manage with less intense contact AND
- Is able to use strategies to prevent relapse without 24-hour structured peer environment/staff support AND
- Has a supportive recovery environment in place AND
- Has access to appropriate resources to maintain changes.

Yes

No

Continue at same level of treatment.

If client has commitments that affect his/her ability to stay in the program, then…

Refer to less intensive level of service.

Assess for the need for continued service

Does the client meet any of the following criteria?

- Has had a relapse serious enough to affect his/her ability to participate in residential treatment OR
- Medical/psychiatric problems intensify and he/she is no longer able to participate in residential treatment OR
- Has identified a serious emotional/behavioural problem.

Yes

No

Re-assess for another appropriate treatment. Refer to:

- Medical/psychiatric treatment
- Behavioural intervention
- Withdrawal management and stabilization.

If client is no longer interested, then…

Discharge with referrals to other services/resources.

If client is no longer interested, then…

If client is no longer interested, then…
Assessing clients in residential supportive treatment services

In the course of treatment, the client may need different levels of residential supportive treatment services, and may move from one level of support to another, or be discharged from residential supportive treatment service.

Clients in Level I

- Has there been some improvement?
- Is the client able to maintain personal and program goals?
- Has the client, at minimum, developed sufficient life skills to self-manage?
- Does the client have a fixed address or stable environment where there is no pressure to use substances?

Yes

Move client to Level II or consider discharge from residential supportive treatment service with a treatment plan.

No

Continue in Level I.

Clients in Level II

Does client meet most of the following criteria?
- Has developed sufficient life skills to manage activities of daily living.
- Has a personal support network and/or a supportive social network outside the residential support service.
- Is at low risk of relapse.
- Has a fixed address or a stable environment where there is no pressure to use substances.

Yes

Discharge from residential supportive treatment service, with a treatment plan.

No

Continue in Level II or assess for level/intensity of treatment.
Appendix B

THE IMPORTANCE OF MOTIVATIONAL INTERVIEWING

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INTRODUCTION

Motivational interviewing (MI) is a style of interaction that facilitates client involvement in decision-making. It is an appropriate interviewing style for every sector in the addiction treatment continuum of Ontario. It facilitates the client’s ownership of problems and responsibility to problem-solve. It assumes that clients have the right to make their own decisions and that it is their responsibility to initiate action and behaviour change. The role of the clinician is to facilitate this process and assist clients in a process of self-examination that leads to decision-making.

Motivational interviewing can be misunderstood to be an interviewing style that is only used in the “early” work done with the client. There are motivational interviewing strategies that pertain to each and every stage of client motivation. The research of William Miller and Stephen Rollnick (1991) found that resistance to change is increased by confrontation and that motivational interviewing actually decreases resistance. In addition, once resistance to change is decreased, the client is freed to move forward through the stages that all persons move through when addressing problem behaviours. Human behaviour is predictable when embracing the need to change. We do not want to do it!

Sometimes people avoid change even when it is obvious that they need to alter behaviour because it is unhealthy or dangerous (e.g., some people continue to smoke cigarettes even though they have chronic bronchitis). This avoidance of the obvious need to change is a common reaction to a problem.

Human beings choose this avoidance technique because change may appear to be too frightening or because it means that they must give up something that they enjoy or will miss. It takes practice to avoid the obvious and this is why behaviours become ingrained and are so hard to alter! Attachment to a behaviour looks and feels like resistance to the therapist. Resistance to change is mistakenly thought of as pathology or as a characteristic of substance users alone.

Resistance occurs naturally, it is the human condition to resist change, it is natural and it is normal. Motivational interviewing allows clients to explore their attachment to a harmful behaviour; it encourages them to examine and acknowledge the benefits or payoffs as well as the costs. When clients are ambivalent about change (in the contemplation stage, as we will discuss later) it just means that they see both the costs and benefits of change. It does not mean that they do not want to change; it means they are starting to see how hard it will be to change and they are starting to realize what they will have to give up as well as what they may have to gain!

**Clinical tip**

Close your eyes for a moment and think of something that you have changed about yourself in the past. How easy was it? Did you think about it for a while? How did you react to others who mentioned this problem to you? Did you ever defend your behaviour even though you knew deep down that you probably should change?
It is natural to fear change and defend the status quo. Our clients are not any different from us. Defending behaviour is merely a coping strategy that any of us might use at the same time as we acknowledge we have a problem.

See Appendix C, "Resources," for information on where to learn more about motivational interviewing counselling strategies.

An empathetic counsellor can emotionally identify with the client. They are objective, non-judgmental and demonstrate high levels of personal regard for the client.

This model is research- and evidence-based. It is portable across behaviours such as weight management, smoking cessation and substance abuse. The portability of the model, as well as its effectiveness, makes it one of the necessary staples in your tool box.

**MOTIVATIONAL INTERVIEWING AND THE STAGES OF CHANGE**

Prochaska et al. developed the “Stage of Change” theoretical model to help us understand behaviour change generally (1994). Motivational interviewing (mi) is a style of interviewing and can be adapted to work with clients in various stages of change (Prochaska et al., 1994). When counsellors understand the stages of change and use motivational interviewing, they have a very dynamic approach to facilitating change in clients.

There are specific strategies that are indicated for clients in each of the six stages of change. It is vital to know the client’s general stage of change in order to employ the correct motivational interviewing strategy. Clients in each specific stage of change require and will respond to an appropriate intervention that fits their view of why they have attended an interview for assessment or counselling. Many agencies in the province use specific screening and intake protocols to assess clients’ stage of change, in both individual and group sessions.

The stages are briefly defined below; please see the work of Prochaska et al. for further discussion (1994).

1. **PRECONTEMPLATION**

Clients do not intend to change at this time. They do not see a solution because they do not see a problem.

2. **CONTEMPLATION**

Clients see that there is a need to change but have not made any commitments about what to change or when.

3. **PREPARATION**

Clients are planning changes in the near future.
4. ACTION

Clients have recently made changes.

5. MAINTENANCE

Clients have made changes at least 60 days ago and are maintaining changes.

6. TERMINATION

Once clients have firmly established behavioural change into their lives, they move on to another specific stage of change that Prochaska et al. (1994) call “termination.” The client will determine whether he or she has in fact “terminated” treatment. This decision will be influenced by the client's own philosophy about change. Many who change through Alcoholics Anonymous and the 12 steps will not agree that they are in “termination”—they will feel that they are in maintenance instead, and that they are not “done with treatment.” The termination stage is a legitimate stage for some clients but not for others. The counsellor must help the client define this for themselves and make these decisions.

When we embrace the concept of providing different kinds of services to clients in different stages of change we can begin to understand how to use the Admission and Discharge Criteria.

For example, clients who are in precontemplation and contemplation stages need motivational interviewing to resolve ambivalence or resistance issues. They are not yet ready to think about behaviour change or are unsure of what they would like to do. They are not yet ready to do treatment planning. What would they plan to do? Treatment planning is actually an inappropriate intervention at this point.

Referrals to other places on the local continuum might need to wait until the client is ready to do this work. The client may need support during this time. The Admission and Discharge Criteria address these issues by asking the question, “What does the client need?” If the client is not going to be planning treatment, you do not need to provide assessment services (as per the Ministry of Health and Long-Term Care’s mandate) at this time, although the research indicates that the client may benefit from the personalized feedback that an assessment can provide (Miller & Rollnick, 1991). Some assessment tools can be administered, if the agency decides to do this, but the entire package is not mandatory.

This manual discusses the standardized assessment package for Ontario’s addiction programs. The standardized assessment package includes two tools that assess both the general level of readiness for treatment (Socrates) and the client’s internal and external motivation for attendance (Treatment Entry Questionnaire). These specific tools help provide important information to the client and to the clinician as they begin the treatment journey together.

Clients in the early stages of change need motivational interviewing to be encouraged to discuss pros and cons and costs and benefits so that they may begin to recognize the problems and consequences of substance use. When the client begins to make statements that reflect problem recognition and intentions to change, as well as optimism about changes, you receive cues to move ahead with initial assessment and treatment planning activities. The full
assessment package will provide the information required to take next steps to consider admission criteria and ascertain the most appropriate referral.

**Clinical tip**

_Think of something that you want to change now. What stage of change are you in? Refer to the definitions to confirm where you think you are. If you were to see a counsellor to help you with this problem, what approach would you prefer? How might you feel if the counsellor “told” you what you had to do? How might you feel if your counsellor let you move at your own speed and figure it out yourself?_

**THE PROCESSES OF CHANGE**

There are common elements that clients experience as they move from stage to stage. They are called the “processes of change” (Prochaska et al., 1994). There are 10 processes of change that occur as the client moves from stage one, precontemplation, to stage five, maintenance:

The first five pertain to the client’s experience of change:

1. **Consciousness-raising**: Increasing awareness and knowledge about one’s problem and oneself.
2. **Dramatic relief**: Becoming aware of the emotional impact of one’s behaviour or problem on oneself and on others.
3. **Environmental re-evaluation**: Becoming aware of the emotional relationship between one’s behaviour or problem and others who have or have not changed, or between one’s behaviour and certain environments.
4. **Social liberation**: Recognizing and accessing of social policies that support behaviour change (for example, non-smoking sections).
5. **Self-re-evaluation**: Assessing feelings and thoughts of self with respect to the problem.

The next five processes are associated with the actual behaviours involved in change:

6. **Stimulus (or “environmental”) control**: Avoiding stimuli—the cookie aisle in the grocery store if you are trying to change your diet, or wings night if you are trying to avoid drinking—that elicit problem behaviours.
7. **Helping relationships**: Enlisting help from others who care about behaviour change.
8. **Counter-conditioning (or “countering”)**: Learning and substituting healthy behaviours for problem ones.
9. **Reinforcement management (or “reward”)**: Building in a structure of positive consequences or rewards for change.
10. **Self-liberation (or “commitment”)**: Believing that one can change and choosing and committing to act.
These processes were found in the research produced by Prochaska, Norcross and DiClemente in their book *Changing for Good* (1994). When the researchers interviewed people who had successfully made changes with weight management and smoking cessation, they found that self-changers reported the same experiences that related to their success. The authors call these experiences and decisions “the processes of change.” This information is gathered from people who have successfully changed problem behaviours and it is important. It reinforces the belief that as counsellors, we should do the right thing with clients at the right time. We should address the process of change that relates to the actual stage that the client is in at the time of the interview!

**Clinical tip**

*Remember that precontemplators do not intend to change at this time. It is not that they do not see the solution; they do not see the problem! It is likely that they have been referred by another party to you. They are unlikely to self-refer.*

*Precontemplators may benefit from an assessment if this is your mandate. A full assessment can offer the precontemplator new meaning about their behaviours. For those who have not yet considered change, an assessment may tip the balance towards change. This makes good clinical sense and is practical in that it promotes the best use of the client’s time as well as yours.*

Although clients in the precontemplation stage can benefit from individualized motivational interviewing and assessment results, they do not need a mandatory assessment using the standardized assessment tool package. Each agency will need to examine time and human resource constraints and make a suitable decision.

Often, clients in the precontemplation stage will not see the relevance of discussing their use of substances because they do not intend to change their use patterns. An inappropriate intervention will cause or will increase resistance to your approach. Clients in the precontemplation stage need information, consciousness raising and dramatic relief.

Specific strategies are used with clients in the precontemplation stage to develop discrepancy between their situation at the time of the interview and where they want to be in the future. It is an opportunity to get them to talk about their use or the reason for their referral to you, but not to concentrate at this time on frequency or quantity of consumption. There is little reason to ask them about their perceptions of the impact of substance use on their life. Let’s now discuss what to do with clients in each specific stage.

**CLIENTS IN THE PRECONTtemplATION STAGE**

Clients in this stage need information and consciousness-raising. In your office, a precontemplator will give you a clear indication that he or she does not intend to change; he or she does not see a problem and is often attending an assessment at the request (implicit or explicit) of a third party. In some situations, a third party may mandate the client to attend treatment. The client and you are clearly in a dilemma in this scenario! The client does not see the problem and does not intend to change, yet you are expected to make a referral to treatment or admit the client to treatment programming. According to the Admission and Discharge Criteria, this client will not fit the
criteria for any treatment setting and should not be referred to treatment while in the stage of precontemplation. Precontemplators can be referred to a setting that provides motivational interviewing sessions. At a later point they can be re-assessed to determine the stage of change and be referred at that time.

Counsellors do not have to administer the standardized assessment tool package to precontemplators, but the section below talks about how personalized feedback does assist the precontemplator if time and resources permit.

Precontemplators do not seek information about the behaviour in question, and in fact think that others are overreacting or, are nagging them for no good reason. They are attending appointments purely to get others off their back or satisfy a mandate (Prochaska et al., 1994).

Personalized feedback that is norm referenced sends a powerful message to clients about how their use compares to others’. Many counsellors report that their clients say that they “drink like all my friends” or “just like my family does.” Many clients do not have a reference point for what “normal drinking” is. They compare their drinking to the consumption patterns around them and they see their own reflection. Personalized feedback about their drinking and the drinking habits of non-problem users, weekly and daily maximums, etc., may be very helpful to the client.

Your ability to provide information and raise awareness is enhanced by the objective assessment information. It is not your opinion that is shared, but rather the client’s self-report.

Assessment feedback provides an appraisal of patterns of consumption and about strengths and needs. You and the client can use the feedback to examine perceptions together to determine next steps.

CLIENTS IN THE CONTEMPLATION STAGE

Clients in the contemplation stage will be prepared to discuss the fact that they “might” need to change, but will be unclear about when or how. Specific counselling strategies can be used to elicit a commitment to move to preparation.

The client in this stage is unsure of how to do what they think they need to do. They probably have not picked a “quit date” or have not altered their behaviour in any way, but they are aware that they should change and have thought somewhat about it.

Prochaska, Norcross and DiClemente (1994) would suggest that clients in contemplation might read an article about their behaviour in a magazine, or talk about what they should do (that is, cut down, quit smoking or lose weight). They engage in conversation but have not yet formulated a plan. If they have in fact formulated a plan, they have not initiated it.

Personalized feedback helps clients in this stage by providing additional information that helps to elicit commitment from the clients by educating them about their problem or validating what they thought they should do differently.
Personalized feedback can confirm or enhance the motivation to change and the decision to move ahead to the next stage.

The assessment information and objective feedback session must be conducted using a motivational interviewing format. The five early strategies mentioned previously, as well as asking for the client’s comments, reflections and reactions to the feedback, create an atmosphere conducive to decision-making about behaviour change.

It is important to elicit and reflect the client’s own reactions to the feedback.

As well, your role is to offer clear and objective advice about the consumption patterns or the consequences that are evident in the client’s self-report.

Clinical challenge

Question: How do I know my client is in contemplation?

Discussion: An example of someone in contemplation might be a person who has bought new athletic shoes or joined a fitness club but hasn’t yet gone to work out.

They may say, “But I don’t have time.”

The client will understand that you have been listening and have a clear picture of her story in your head. Reflecting her own expressions of concern or statements about what she should do next will help her hear in her own words what her next step is. Clients will listen to what they themselves have to say and it will be more powerful than hearing you say it. You must give up the need to direct clients in regards to their next steps and instead help them find their own way.

Clinical tip

Objective, personalized feedback is:

Clear advice + A menu of options = Enhanced motivation to change!

Our own experiences are not always helpful to the client. Our path may have been similar but is not the client’s path necessarily. Be cautious about the decision to share your story. Examine your need to tell your story; is it for the client or for you? If it is for you, you should find a more appropriate time to work on you. However, sometimes the client is stuck and a personal touch can be very helpful by inspiring hope for the future. Evaluate each situation carefully and then decide. For example, non-smokers routinely tell smokers how they quit and why it worked. Are those experiences relevant? Can the smoker hear what made those experiences successful? How you changed may not motivate the client; it might make him feel less hopeful because clients often assume that as counsellors we change more easily or have “the inside edge” on making change less painful.
Clinical challenge

The counsellor may wonder, Should I share my own experiences to help reference the client’s decisions to norms?

Discussion: Personalized feedback can cause dramatic relief—remember the 10 processes of change (Prochaska et al., 1994). The client may experience an emotional charge about what they need to do next. For example, your client may relate his personalized feedback to another important person in his life who has changed, and your client’s motivation is then increased through identifying with another person who has also changed (Miller, 1991).

Your client may relate his personalized feedback to someone in his life who did not change and his motivation is then increased because he does not want to make the same choices.

The client may decide that what he has to lose is more important than what he gains by continued drug use.

The client may decide that short-term gain is not worth long-term pain.

The client will begin to recognize more “pros” to change and see fewer “cons.”

Clients can remain in the contemplation stage for a very long time (Prochaska et al., 1994). Research shows that this can be up to two years in duration. Ambivalence (defined as attachment to behaviour) is very common during this stage.

Ambivalence is good evidence of the struggle between the pros and cons of change. You should be excited when you detect ambivalence in your clients. It does not mean that clients are not serious about change; it is evidence that they are struggling and that their decision could go either way.

CLIENTS IN THE PREPARATION AND ACTION STAGES

Assessment feedback will assist the clients in this stage to make a decision to move ahead (preparation) or reaffirm their decisions to alter behaviour (action). Clients in these stages have experimented with new behaviours or have only recently started something new. This is a stage full of hope and promise and is very busy for client and counsellor.

Clients can use the personalized feedback to measure early signs of progress and evaluate how they are doing and feeling.

It is a clinical myth that clients in these stages do not need an assessment. The standardized assessment package will provide solid evidence for the client that will strengthen her commitment to change. The client may indicate that she “just wants to get on with it.” You should avoid rushing through assessment and feedback. There is no hurry and this is not a foot race! It is an opportunity to explore in some depth the reasons for change and the early strategies that the client has been using to accomplish her goals. You have the responsibility to make sure that the client has fully considered the pros and cons of change and has fully explored the costs and benefits of her decisions.
Clinical tip

The pros of change remain fairly constant over time—it is the cons of change that reduce and the behaviour change that becomes more manageable. Information about what change means or how it might feel to the client will be important at this time.

You will otherwise bear some responsibility for client decisions to leave treatment early. It is commonly felt that clinically it is hardest on the client when they leave treatment early. It is wise to slow the client down so that she carefully ponders the meaning and implications of behaviour change.

There is little reason to rush at this time and every reason to take the time to fully discuss and develop workable strategies for the client given her personal circumstances, strengths and needs. Once this work has been accomplished it is important to move ahead and strengthen commitment to change and move to maintenance.

CLIENTS IN THE MAINTENANCE STAGE

Clients can seek treatment for two separate reasons in this stage. They can be:

- seeking assistance after long-term behaviour change because they are feeling at risk of relapse
- seeking assistance post-treatment (after-care).

Clients who are leaving a particular treatment service type may not need the full standardized assessment package re-administered, but the clinician might re-administer some of the tools, depending on the clients’ personal circumstances, strengths and needs, to assist with a discharge plan. It would be appropriate to work through the Discharge Criteria to determine next steps and potential referrals for the client. The goal of personalized feedback is to maintain behaviour change through evaluating progress, setting new goals and re-evaluating any strategies that are not as effective as once assumed.

Clients who are relapse-prone may need all of the tools if they are to be referred to any treatment programs funded by MOHLTC.

The Drug-Taking Confidence Questionnaire (dtnco) is particularly effective at this time. Please see Chapter 10 for more about this instrument and to see sample forms.

CLIENTS IN RELAPSE

Clients may self-refer to treatment settings during or after a relapse. If the client has not had an assessment package administered prior to relapse, he must have the tools completed prior to a referral to treatment. If the client has recently been discharged from treatment, he may need some or all the tools re-administered to decide upon next steps.

If re-administering the tools would provide new clinical information, then the package of tools should be re-administered.
Appendix C

RESOURCES

The following list contains Web site addresses and information on other topics and tools of interest.

Addictions Ontario
www.addictionsontario.ca

Alcohol and Seniors
www.agingincanada.ca

Alcohol Policy Network of Ontario
www.apolnet.org

Canadian Centre on Substance Abuse
www.ccsa.ca

Centre for Addiction and Mental Health
  • Main site: www.camh.net
  • Publications index: http://www.camh.net/Publications/CAMH_Publications/index.html
  • Resources for professionals: http://www.camh.net/Publications/Resources_for_Professionals/index.html
  • Methadone: http://knowledgex.camh.net/amhspecialists/specialized_treatment/methadone_maintenance/Pages/resources.aspx
  • Journal of Gambling Issues: http://www.camh.net/egambling/
  • Healthy aging: http://www.camh.net/Publications/CAMH_Publications/healthy_aging_pubsindex.html
  • Working with older adults: http://www.camh.net/Publications/Resources_for_Professionals/Older_Adults/index.html
  • Working with families: http://www.camh.net/About_Addiction_Mental_Health/Child_Youth_Family_Resources/childyouthfam_healthprom.html
  • Working with youth: http://www.camh.net/Publications/CAMH/Publications/youth_pubsindex.html

ConnexOntario
www.connexontario.ca
Drug and Alcohol Registry of Treatment (DART)
www.dart.on.ca

Drug and Alcohol Treatment Information System (DATIS)
www.camh.net/datis

Health Canada

HIV/AIDS

Motivational interviewing
• www.motivationalinterview.org
• William R. Miller’s Web site: http://www.williamrmiller.net/

Ontario Federation of Community Mental Health and Addiction Programs
www.ofcmhap.on.ca

Other assessment tools:
• List B tools: http://knowledge.camh.net/amhspecialists/Screening_Assessment/assessment/adat/Pages/adat_license.aspx
• PESQ: available from Western Psychological Services, 12031 Wilshire Blvd., Los Angeles, California, 90025-1251; Credit card orders 1-800-648-8857; fax 310 478-7838

Project MATCH series, NIAAA (National Institute on Alcohol Abuse and Alcoholism)

Responsible Gambling Council of Ontario
SAMHSA (Substance Abuse and Mental Health Services Administration)

- Idaho RADAR Network Center’s Technical Assistance Publications (TAPS): [http://hs.boisestate.edu/RADAR/materials/taps.html](http://hs.boisestate.edu/RADAR/materials/taps.html)

Stages of Change model

[http://www.uri.edu/research/cprc/TTM/detailedoverview.htm](http://www.uri.edu/research/cprc/TTM/detailedoverview.htm)
1. **Managing day-to-day life**: Deciding what to wear, what to eat, using public transportation, self-care including dressing, bathing, etc.

2. **Household responsibilities**: Home management, child or elder care (if not done as paid employment), laundry, making bed, organizing clothing and personal possessions.

3. **Work**: Paid employment; if unemployed, efforts to find or keep a job, preparing resumes, handling interviews, managing rehab services, career groups or job training programs. Not applicable to those not needing or wanting to work.

4. **School**: High school, vocational or technical training, college or graduate school. Recreational classes, for example, piano lessons, self-improvement, should be included in #5 (leisure time, recreational activities).

5. **Leisure time**: Difficulty structuring free time or finding things to do, boredom. Leisure time activities include hobbies, social clubs, reading, jogging, sports, fitness, etc. Also includes recreational classes, for example, piano lessons, self-improvement, arts, etc.

6. **Adjusting to major life stresses**: Medical illness, job loss, financial or housing difficulties, victim of abuse, violence, or other crime, etc. Does not include the current hospitalization. If person has experienced no major stresses, item is not applicable and should be rated “0.” Adjustment to stressors should be considered during the past week. The stressors do not have to have occurred in the past week.

7. **Relationship with family members**: Relatives or long-term significant others. If relationships vary with different family members, patients should give their best estimate of family relationships overall.

8. **Getting along with people outside the family**: Roommates, friends, neighbours, supervisors, co-workers, teachers, boyfriend, girlfriend.

9. **Isolation, loneliness**: Subjective feelings of isolation or loneliness may be independent of actual degree of contact with others.

10. **Being able to feel close to others**: Feeling close (trusting, in harmony with, affectionate) to people you especially care about.

11. **Being realistic about yourself or others**: Having realistic expectations; e.g., not too high or too low regarding your own behaviour or that of others.
12. **Recognizing and expressing emotions appropriately**: Showing appropriate affect; recognizing, acknowledging affects such as sadness, anger, affection, etc.

13. **Developing independence, autonomy**: Feeling that you can take care of most things (financial, emotional, social) without being uncomfortably dependent on other people; feeling that you are in control of decisions about your life. Age, occupation and other factors may affect autonomy.

   This question asks about the degree to which lack of independence is problematic for the respondent.

14. **Goals or direction in life**: Knowing what you want to be doing in your life; working towards a goal.

15. **Lack of self-confidence, feeling bad about yourself**: Feeling that you are not a good, likable or worthwhile person; feeling stupid or incapable of accomplishing anything.

16. **Apathy, lack of interest in things**: Not caring about anything, not feeling like you want to do things that you usually enjoy.

17. **Depression, hopelessness**: Feeling depressed, sad, hopeless about the future, lack of pleasure in life.

18. **Suicidal feelings or behaviour**: Thinking about, planning, gesturing or attempting suicide by any means.

19. **Physical symptoms**: Difficulty should be rated regardless of etiology (e.g., medication side effects).

20. **Fear, anxiety, panic**: Nervousness, tension, jitters, agitation, fear of open spaces, heights, darkness, etc.

21. **Confusion, concentration, memory**: Difficulty understanding things, thinking clearly, remembering, maintaining focus on a task.

22. **Disturbing or unreal thoughts or beliefs**: Paranoid ideation (feeling as if you are being watched, poisoned, or that others can read your mind); delusions, for example, that your body is rotting, that you can fly, that a TV personality is speaking to you personally, etc.

23. **Hearing voices, seeing things**: Auditory or visual hallucinations; hearing messages or commands from a voice in one's head; seeing things that no one else can see.

24. **Manic, bizarre behaviour**: Racing thoughts, decreased need for sleep, increased talking, spending money, exaggerated sense of well-being; inappropriate behaviour including undressing in public, speaking incoherently to strangers; behaviour which others would generally consider very unusual or inappropriate.

25. **Mood swings, unstable moods**: Feeling happy one minute, sad the next; frequent emotional ups and downs, often unrelated to what is going on in your life at the time.

26. **Uncontrollable, compulsive behaviour**: Any behaviour that one feels compelled to frequently repeat including eating-disordered behaviour, checking, washing, gambling.

27. **Sexual activity or preoccupation**: Any sexual issue experienced as problematic (e.g., impotence, sexual addiction, fetishes, sexual identity confusion, etc.).

28. **Drinking alcoholic beverages**: Including difficulty dealing with urges, efforts to find alcohol.

29. **Taking illegal drugs, misusing drugs**: Any illegal substance of abuse (cocaine, heroin, crack, marijuana, etc.); misuse or overuse of prescription drugs (sedatives, stimulants, diet pills, anti-anxiety agents, etc.).

30. **Controlling temper, outbursts of anger, violence**: Screaming, throwing things, kicking, hitting, etc.
31. **Impulsive, illegal, or reckless behaviour**: Includes dangerous or illegal behaviour, for example, reckless driving, vandalism, assault, fraud, selling drugs, forging checks, etc.

32. **Feeling satisfaction with your life**: Happy with what you are doing, general sense of well-being.
Appendix E

PSYCHOACTIVE DRUG CLASSES FOR USE IN COMPLETING THE DHQ

<table>
<thead>
<tr>
<th>Drug category</th>
<th>Drug name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. None</td>
<td></td>
</tr>
<tr>
<td>2. Alcohol</td>
<td>beer, liquor, wine, liqueur, aftershave, mouthwash, vanilla extract</td>
</tr>
<tr>
<td>3. Cocaine</td>
<td>cocaine, crack/free base</td>
</tr>
<tr>
<td>4. Amphetamines/other stimulants</td>
<td>Speed, Crystal meth, Ice, Grit, Street stimulants = uppers, bennies, reds, white crosses, caffeine pills such as Wake-Ups, diet pills containing phenylpropanolamine or ephedrine, bronchodilators, Methylphenidate = Ritalin, Phentermine = Ionamin (yellow jackets), Fastin, Diethylpropion = Tenuate, Nobesine, Fenfluramine = Ponderal, Pondimin, Mazindol = Sanorex</td>
</tr>
<tr>
<td>5. Cannabis</td>
<td>marijuana, weed, pot, grass, hash, hash oil, hash honey</td>
</tr>
</tbody>
</table>
Psychoactive drug classes for use in completing the DHQ (cont’d)

<table>
<thead>
<tr>
<th>Drug category</th>
<th>Drug name</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Benzodiazepines</td>
<td></td>
</tr>
<tr>
<td>chlordiazepoxide</td>
<td>Librium, Novopoxide, Solum</td>
</tr>
<tr>
<td>diazepam</td>
<td>Valium, Vivol, Novodipam</td>
</tr>
<tr>
<td>alprazolam</td>
<td>Xanax</td>
</tr>
<tr>
<td>bromazepam</td>
<td>Lectopam</td>
</tr>
<tr>
<td>chlorazepate</td>
<td>Tranzene</td>
</tr>
<tr>
<td>clobazam</td>
<td>Frisium</td>
</tr>
<tr>
<td>clonazepam</td>
<td>Rivotril</td>
</tr>
<tr>
<td>flurazepam</td>
<td>Dalmane</td>
</tr>
<tr>
<td>ketazolam</td>
<td>Loftran</td>
</tr>
<tr>
<td>lorazepam</td>
<td>Apo-lorazepam, Ativan, Novolorazepam</td>
</tr>
<tr>
<td>midazolam</td>
<td>Versad</td>
</tr>
<tr>
<td>nitrazepam</td>
<td>Mogadon</td>
</tr>
<tr>
<td>oxazepam</td>
<td>Apo-oxazepam, Novoxapam, PMS oxazepam, Serax</td>
</tr>
<tr>
<td>triazolam</td>
<td>Halcion</td>
</tr>
<tr>
<td>temazepam</td>
<td>Restoril</td>
</tr>
<tr>
<td>7. Barbiturates</td>
<td></td>
</tr>
<tr>
<td>amobarbital</td>
<td>Amytal</td>
</tr>
<tr>
<td>pentobarbital</td>
<td>Nemutal</td>
</tr>
<tr>
<td>butalbital preparations</td>
<td>Fiorinal</td>
</tr>
<tr>
<td>amobarbital – secobarbital</td>
<td></td>
</tr>
<tr>
<td>phenobarbital secobarbital</td>
<td></td>
</tr>
<tr>
<td>butobarbital</td>
<td>Butisol</td>
</tr>
<tr>
<td>8. Heroin/opium</td>
<td></td>
</tr>
<tr>
<td>9. Prescription opioids</td>
<td></td>
</tr>
<tr>
<td>hydrocodone</td>
<td>Hycodan, Novahistex DH, Robidone, Tussionex</td>
</tr>
<tr>
<td>alfentanil</td>
<td>Alfenta</td>
</tr>
<tr>
<td>anileridine</td>
<td>Leritine</td>
</tr>
<tr>
<td>butorphanol</td>
<td>Stadol</td>
</tr>
</tbody>
</table>
Psychoactive drug classes for use in completing the DHQ (cont’d)

<table>
<thead>
<tr>
<th>Drug category</th>
<th>Drug name</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Prescription opioids (cont’d)</td>
<td>• codeine = Atasol 15, 30; Emprocet 30, 60; Exdol 14, 30; fiorinal C ¼, C ½; Omnitzus; Robitussin AC; Tylenol 2, 3, 4; 282, 282 MEP, 292</td>
</tr>
<tr>
<td></td>
<td>• fentanyl = Sublimaze</td>
</tr>
<tr>
<td></td>
<td>• hydromorphone = Dilaudid</td>
</tr>
<tr>
<td></td>
<td>• levorphan = Levo-Dromoran</td>
</tr>
<tr>
<td></td>
<td>• meperidine = Demoral</td>
</tr>
<tr>
<td></td>
<td>• methadone</td>
</tr>
<tr>
<td></td>
<td>• morphine = M.O.S., MS Contin, Statex</td>
</tr>
<tr>
<td></td>
<td>• nalbuphine = Nubain</td>
</tr>
<tr>
<td></td>
<td>• normethadone = Cophylac</td>
</tr>
<tr>
<td></td>
<td>• oxycodone = Endocet, Endodan, Oxycocet, Oxydodan, Oxydodan, Percodan, Percodan, Supeudol</td>
</tr>
<tr>
<td></td>
<td>• oxymorphone = Numorphan</td>
</tr>
<tr>
<td></td>
<td>• pentazocine = Talwin</td>
</tr>
<tr>
<td></td>
<td>• proproxyphene = Darvon-N, 642, 692</td>
</tr>
<tr>
<td></td>
<td>• sufentanil = Sufenta</td>
</tr>
<tr>
<td>10. Over-the-counter codeine preparations with up to 8 mg tablet or 20 mg/30 mL</td>
<td>• Tylenol 1 = 222</td>
</tr>
<tr>
<td></td>
<td>• AC&amp;C</td>
</tr>
<tr>
<td></td>
<td>• cough syrups with codeine</td>
</tr>
<tr>
<td>11. Hallucinogens</td>
<td>• LSD = acid, blotters</td>
</tr>
<tr>
<td></td>
<td>• psilocybin = shrooms, magic mushrooms</td>
</tr>
<tr>
<td></td>
<td>• MDMA = ecstasy</td>
</tr>
<tr>
<td></td>
<td>• STP/DOM</td>
</tr>
<tr>
<td></td>
<td>• TMA</td>
</tr>
<tr>
<td></td>
<td>• morning glory seeds = nutmeg</td>
</tr>
<tr>
<td></td>
<td>• mescaniline = Jimson Weed</td>
</tr>
<tr>
<td></td>
<td>• PCP = angel dust</td>
</tr>
<tr>
<td>12. Glue/other inhalants</td>
<td>• glue</td>
</tr>
<tr>
<td></td>
<td>• gasoline</td>
</tr>
</tbody>
</table>

APPENDIX E: PSYCHOACTIVE DRUG CLASSES FOR USE IN COMPLETING THE DHQ
## Psychoactive drug classes for use in completing the DHQ (cont’d)

<table>
<thead>
<tr>
<th>Drug category</th>
<th>Drug name</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Glue/other inhalants (cont’d)</td>
<td>• solvents</td>
</tr>
<tr>
<td></td>
<td>• aerosols</td>
</tr>
<tr>
<td></td>
<td>• PAM cooking spray</td>
</tr>
<tr>
<td></td>
<td>• Liquid Paper</td>
</tr>
<tr>
<td>13. Tobacco</td>
<td>• cigarettes</td>
</tr>
<tr>
<td></td>
<td>• chewing tobacco</td>
</tr>
<tr>
<td></td>
<td>• cigars</td>
</tr>
<tr>
<td></td>
<td>• smokeless tobacco</td>
</tr>
<tr>
<td></td>
<td>• Nicotine patch</td>
</tr>
<tr>
<td></td>
<td>• pipe</td>
</tr>
<tr>
<td>14. Other psychoactive drugs</td>
<td>• Anti-alcohol drugs = disulfiram (Antabuse), calcium carbimide (Temposil)</td>
</tr>
</tbody>
</table>

### Major tranquillizers/neuroleptics/antipsychotics

- chlorpromazine = Largactil
- haloperidol = Haldol
  - Clozapine, Droperidol, Flupenthixol, Fluphenazine, Fluspirilene, Loxapine, Mesoridazine, Methotrimeprazine, Pericyazine, Prochlorperazine, Promazine, Risperidone, Thiethylperazine, Thorproperazine, Thioridazine, Thiothizene, Trifluoperazine

### Antidepressants

- amitriptyline = Elavil, Etrafon, Levate, Novo-Triptyn, PMS-Levazine
- amoxapine = Asendin
- fluoxetine = Prozac
  - Clomipramine, Desipramine, Doxepin, Fluvoxamine, Imipramine, Isocarboxazid, Maprotiline, Moclobemide, Nortriptyline, Paroxetine, Phenelzine, Propritryptline, Sertraline, Tanyicypromine, Trazodone, Trimaprine

- Lithium
- Gravol
- Steroids
Appendix F

DRUG USE BY ADULTS SURVEYED IN CANADA

NUMBER OF DRINKS CONSUMED IN A WEEK BY ADULTS SURVEYED IN CANADA*

WHERE DOES YOUR DRINKING FIT IN?

Men

Women

Average number of drinks per week = 5.3

Average number of drinks per week = 2.0

Your average is: __________drinks/week

COCAINE OR CRACK USE BY ADULTS SURVEYED IN CANADA

WHERE DO YOU FIT IN?

Ever used

Current users
Appendix G

GUIDELINES FOR QUANTIFYING DRUG USE ON A TYPICAL SUBSTANCE-USING DAY

ALCOHOL = NUMBER OF STANDARD DRINKS ON A TYPICAL DRINKING DAY

One standard drink =

- 12 ounces of beer (5% alcohol)
- one pint of draft
- 5 ounces table wine
- two 8-ounce glasses of draft
- 1.5 ounces of liquor
- 3.5 ounces port or sherry

If daily drinking is reported, with increased number of drinks on the weekends, add up the total number of drinks in a week and divide by the number of days used:

- drinking 2 beers per day, Monday to Thursday = 8 drinks for 4 days
- drinking 12 beers per day, Friday and Saturday = 24 drinks for 2 days
- $8 + 24 = 32$ drinks divided by 6 days = 5 drinks per day

COCAINE (COKE, CRACK) = NUMBER OF LINES, PIPES OR INJECTIONS ON A TYPICAL DRUG-USING DAY

This is probably the most difficult drug to quantify. Record the number of times this drug was administered—either smoked, snorted or injected.
IV USERS

1. Ask how many times the client injects the drug per day.
2. Record the quantity used in the Comments section.

CLIENTS WHO SNORT

1. Ask how many lines the client snorts in a day.
2. Record the amount of cocaine used in the Comments section.

CRACK USERS

Light users

1. Ask how many pipes the client smokes in a day = the typical amount.
2. Record the amount of crack used in the Comments section.

Heavier users

1. Ask how many hours the client uses in a day (excluding time taken to find more drugs).
2. Multiply by 3 = typical amount.
3. Record the amount of crack used in the Comments section.

Example: If the client reports that crack was smoked over an eight-hour period, the typical amount would be 24 (8 x 3).

AMPHETAMINES/OTHER STIMULANTS—UPPERS, BENNIES REDS, SPEED, YELLOW JACKETS, CRYSTAL METH, RITALIN = NUMBER OF PILLS, LINES, INJECTIONS ON A TYPICAL DRUG-USING DAY

PILLS

1. Ask how many pills the client takes in a day.
2. Record the name of the drug and the quantity used in the Comments section.

CLIENTS WHO SNORT

1. Ask how many lines the client is usually snorting in a day.
2. Record the name of the drug and the quantity used in the Comments section.
IV DRUG USERS

1. Ask how many times the client is usually injecting in a day.
2. Record the name of the drug and the quantity used in the Comments section.

CANNABIS (MARIJUANA, GRASS, HASH, WEED) = NUMBER OF JOINTS, PIPES ON A TYPICAL DRUG-USING DAY

Conversion formula:
- Marijuana (pot): 1 ounce = 30 joints, 1 gram = 1 joint
- Hashish: 1 gram = 7 joints

Record in the Comments section:
1. How many joints are smoked at a time.
2. When those joints are smoked.

Some clients report daily use with increased frequency on the weekends. In these cases:

1. Add up the total number of joints.
2. Divide by the number of days of use.

Example:
- Smoked 1 joint every day Monday to Thursday = 4 joints for four days
- Smoked 6 joints Friday to Sunday = 18 joints for three days.
- $4 + 18 = 22$ joints divided by 7 days = 3 joints per day

3. Convert to joints.
4. Record in the Comments section.
BENZODIAZEPINES (TRANQUILIZERS, E.G., VALIUM, LIBRIUM, XANAX, ATIVAN) = NUMBER OF PILLS TAKEN ON A TYPICAL DRUG-USING DAY

Record in the Comments section:

1. The drug or drugs used.
2. Pattern of use.
3. Dosage.

BARBITURATES (SLEEPING PILLS, E.G., FIORINAL, TUINAL) = NUMBER OF PILLS TAKEN ON A TYPICAL DRUG-USING DAY

Record in the Comments section:

1. Drug or drugs used.
2. Pattern of use.
3. Dosage.

HEROIN/OPIUM (SMACK, JUNK) = NUMBER OF INJECTIONS, PIPES, LINES USED ON A TYPICAL DRUG-USING DAY

If the client injects:

1. Ask how many times the client is injecting in a day.
2. Record the quantity used in the Comments section.

If the client snorts:

1. Ask how many lines the client is using in a day.
2. Record the quantity used in the Comments section.

If the client smokes:

1. Ask how many pipes the client is smoking in a day.
2. Record the quantity used in the Comments section.
**PRESCRIPTION OPIOIDS (PERCODAN, DARVON, DEMEROL, TYLENOL 2, 3, 4, 282S, 292S) = NUMBER OF PILLS TAKEN ON A TYPICAL DRUG-USING DAY**

Record in the Comments section:

1. Drug or drugs used.
2. Pattern of use.
3. Dosage.

**OVER-THE-COUNTER CODEINE PREPARATIONS (222S, TYLENOL 1S, AC&C, COUGH SYRUPS WITH CODEINE) = NUMBER OF PILLS TAKEN ON A TYPICAL DRUG-USING DAY**

Record in the Comments section:

1. Drug or drugs used.
2. Pattern of use.
3. Dosage.

Note: Only code when it is abused, i.e., more than the recommended dose is taken.

**HALUCINOGENS (ECSTASY, ACID, LSD, MUSHROOMS, SHROOMS, MESCALINE) = NUMBER OF DISCRETE EPISODES OF USE ON A TYPICAL DRUG-USING DAY**

Example: If the client reported 3 hits of acid at one time, this would be a frequency of 1.

Record in the Comments section:

1. Drug or drugs used.
2. Quantity (i.e., 3 hits).

**GLUE/OTHER INHALANTS (GLUE, GASOLINE, LIQUID PAPER, PAM, PAINT) = NUMBER OF TUBES/EPISODES OF USE ON A TYPICAL DRUG-USING DAY**

Often, if the client uses over a period of time in the day, the typical amount will need to be estimated. As for crack, we can assume 3 uses per hour. So, if the client sniffed for a three-hour period, the typical amount would be 9.
TOBACCO = NUMBER OF CIGARETTES TYPICALLY SMOKED IN A DAY

OTHER PSYCHOACTIVE DRUGS (E.G., PROZAC, GRAVOL, STEROIDS, RUSH, LOCKER ROOM) = NUMBER OF PILLS TAKEN ON A TYPICAL DRUG-USING DAY

Record in the Comments section:

1. Drug or drugs used.
2. Pattern of use.
3. Dosage.

ODDITIES (SPEEDBALLS: COCAINE AND HEROIN) = TREAT AS TWO SEPARATE DRUGS

Record in the Comments section under both heroin and cocaine:

1. Frequency of use.
2. Typical amount.

Note: Make a note in the Comments section that heroin and cocaine were used together, especially if IV use.
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