Standardized Assessments: Addressing Concurrent Disorders Using Clinical Formulations

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Agenda

- Review intake, admission data and standardized assessment
- Gather clinical information
- Link to admission/discharge criteria
- Create a formulation

Intake Form

- Guides Triage for Treatment
- Collection of General Information
  - Age, Gender, Referral Source, Client’s request for service,Treatment History,Medical/Psychiatric Information, Legal Status, Income Source, Present and Historical Substance use

Brett’s Intake Form

The data collection and hypothesis begins

Admission Data Form

- Identifies self referral or mandated
- Marital Status
- Education
- Presenting Issues
- Present Problem Substances

  Client’s perception
- Mental and Physical Health, including medications

Brett’s Admission Data Form

The research continues…..

Original Intent of the Standardized Assessment

- Raise clinical standards/Implement Best Practices
- Standardize choices of tools and language
- Move form measuring dependency level to measuring circumstances in client’s life

Original Intent

- Move from preference to based decisions
  (both client and counsellor)
- Match client to best destination based on info gathered and preference
- “Professionalize” treatment planning and remove philosophy-based referral practices

Original Intent

- Create and expectation that referrals should make sense- client/public/system
- Stepped care
- Motivational Interviewing as Best Practice
- Could be used for clinical evaluation/outcomes

Assessment Process

Influencing Factors:

- Counsellors approach/beliefs….

  Is it mandatory paperwork or a clinical opportunity to engage the client ?

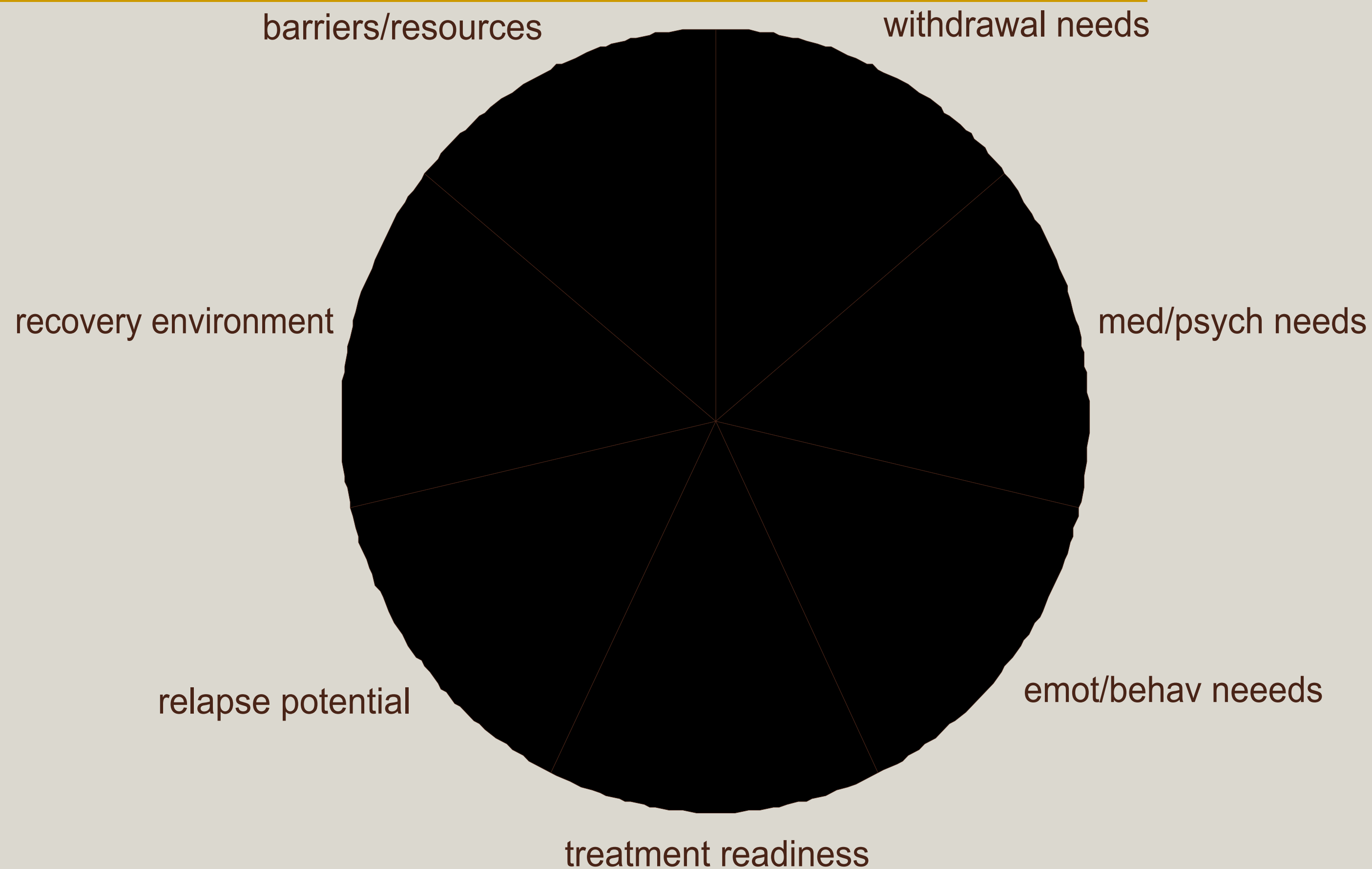
  Is it a static one time procedure or an ongoing fluid process?
- Client's physical/mental health

Assessment Process

What are we looking for?

- Patterns
- Priorities
- Inconsistencies
- Themes

Mapping Onto the Admission Discharge Criteria



Mapping Onto the Admission/Discharge Criteria

- Drug History Questionnaire

Intoxication/Withdrawal Needs, Relapse Potential and Psycho/Social History

- Adverse Consequences

Medical/Psychiatric, Emotional/Behavioural Barriers and Resources, Psycho/Social History

- Socrates

Treatment Readiness

Mapping Onto the Admission/Discharge Criteria

- Drug Taking Confidence Questionnaire

Relapse Potential

- Treatment Entry Questionnaire

Treatment Readiness

- Basis 32

Medical/Psychiatric, Emotional/Behavioural, Recovery Environment and Barriers/ Resources

Mapping Onto the Admission/Discharge Criteria

- Perceived Social Supports

Recovery Environment

- Health Screening

Psycho/Social History and all other areas

Assessment to Formulation

- Gather information to inform treatment using admission/discharge criteria
- How will the client be best supported within the addictions treatment system?

Formulations

- Can link the assessment to treatment approaches
- Create hypothesis to construct treatment
- Collect new information as it is presented
- Continually evaluated and reassessed

Formulations

Assessment	Case Formulation and Diagnosis	Treatment Planning and Informed Consent	Treatment

Client Name: ____________________

Date: ____________________

Counsellor:

GENERAL INFO: Age, sex, marital status, living arrangements, source of income, referral source, consents, medication, substance of choice, legal history	Intake, Admission Data, Health Screening	
STABILIZATION NEEDS: Physical health, psychiatric needs, emotional, behavioral needs, risk potential, suicidality	Health screening, DHQ, DTCQ, Basis-32, Adverse Cons., MMS, Lynx screening	
PSYCHOSOCIAL HISTORY: Family history (include history of mental illness/substance use), trauma, education, employment, spiritual beliefs, cultural beliefs, current relationships, major life roles, attachment	Genogram, Admission Data, Intake, Health Screening, Perceived Social Support	

MENTAL HEALTH: diagnosis, past and present, prescription meds, history of past counselling/therapy, coping skills (maladaptive)	Intake, Admission Data, Health Screening, Basis 32, MMS, Lynx Screening	
<u>SUBSTANCE USE/GAMBLING:</u> History of use (pattern, frequency), substance of choice, age of onset (significance?), stage of change, coping skills (maladaptive), periods of abstinence, previous Tx, goals	DHQ, Admission Data, Socrates, Basis 32, DTCQ, Tx Entry	
CONCLUDED THERAPEUTIC APPROACH:		