Core Function #1 screening

1

SCREENING definition:

The process by which a client is determined *appropriate* and *eligible* for admission to a particular program.

2

Screening is the process by which the counselor, the client, and available significant others review the current situation, symptoms, and other available information to determine the most appropriate initial course of action, given the client's needs and characteristics and the available resources within the community.

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Screening requires the counselor to consider a number of factors before deciding whether or not to schedule the potential client for intake and admission to the program. Each program has requirements detailing factors that make a potential client ***appropriate*** and ***eligible***. The concept of appropriateness refers to the ***level of care***. The following provides a number of factors to be considered regarding appropriateness.

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Appropriateness

- The potential client needs to present a possible alcohol or drug abuse problem with the abused substance… one that is treated in the program.
- The potential client's physical condition needs to be appropriate to the level of care provided within the program. Blindness, deafness, pregnancy, and other physical conditions might make a potential client inappropriate for a given program.
- A potential client needing detox would be inappropriate for an immediate admission to an outpatient program.

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- The success or failure of previous treatment efforts may make a program appropriate now. It would usually be inappropriate to admit a client for their first treatment experience into a relapse prevention program or to admit a potential client who left a detox program "Against Medical Advice" (AMA) to a halfway house.
- A potential client who is court-ordered to treatment should not be admitted to a completely voluntary program.
- A serious mental or medical illness may need to be addressed and stabilized before alcohol and/or drug abuse treatment is initiated.
- A male should not be admitted to a program treating, for instance, pregnant females (also an eligibility factor)

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Many counselors in the United States are using the American Society of Addictive Medicine (ASAM) to determine functioning in the ASAM six dimensions. How a client is assessed in each of the dimensions relates to a level of care needed for that client. The following table identifies the six dimensions:

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ASAM CRITERIA:

Level of Functioning Key

4: Indicates utmost severity; critical impairments in coping and functioning.
3: Serious issue or difficulty coping within a given dimension.
2: Moderate difficulty in functioning.
1: Mildly difficult issue or present minor signs and symptoms.
0: Non-issue or very low-risk issue.

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

Quality assessments that rate a client appropriately in each of the six Dimensions lends justification for the level of care then recommended at the end of an assessment. The Table below is merely a guide and there are so many considerations to be made when making a recommendation for a client's needs and level of care placement.

Level of Functioning	Level of Care
0: Non-issue or very low-risk issue.	None or Education
1: Mildly difficult issue or present minor signs and symptoms.	Mild - Outpatient
2: Moderate difficulty in functioning.	Moderate – Intensive Outpatient or Day Treatment
3: Serious issue or difficulty coping within a given dimension.	Serious – Short- or long-term Residential
4: Indicates utmost severity; critical impairments in coping and functioning.	Crisis – Seek immediate intervention

Keep in mind that the concept of eligibility most often refers to a client meeting certain demographic variable requirements. The following provides a number of factors to be considered regarding eligibility:

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- **Level 0.5:** Early intervention treatment
- **Level I:** Outpatient treatment
- **Level II:** Intensive outpatient/partial hospitalization treatment (subdivided into levels 2.1 and 2.5)
- **Level III:** Residential/inpatient treatment (subdivided into levels 3.1, 3.3, 3.5, and 3.7)
- **Level IV:** Medically managed intensive inpatient treatment

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Eligibility

- Age of the client: A 23-year-old male would not be eligible for admission to an adolescent program.
- Gender: A male would not be eligible for admission to a program treating only females.
- Place of residence: A resident of a neighboring county would not be eligible for admission to a program that is limited to treat only their own county residents.
- Legal status: A potential client would not be eligible for admission to an outpatient program when the person is currently (or about to be) incarcerated in prison.
- Veteran status: A non-veteran would not be eligible for admission to a VA hospital-based program.
- Income level: A potential client with no or little ability to pay for treatment would not be eligible for admission to a private practice outpatient program. A counselor would need to make an appropriate referral.
- Referral Source: A potential client seeking treatment independently would not be eligible for admission to a program that only accepts referrals from a specific source such as juvenile or adult probation office.

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SCREENING TOOLS:

ASAM: American Society of Addictive Medicine (6 dimensions)

AUDIT: Alcohol Use Disorders Identification Test (10 questions)

AUDIT –C: Shortened version of the AUDIT (only 3 questions)

CAGE: Cut down, Annoyed, Guilty, Eye-opener (4 questions)

CAGE- AID: Cut down, Annoyed, Guilty, Eye-opener – Adapted to Include Drugs

TWEAK: Tolerance, Worried, Eye-opener, Amnesia, K/C Cut down

(see attached handouts of screening tools)

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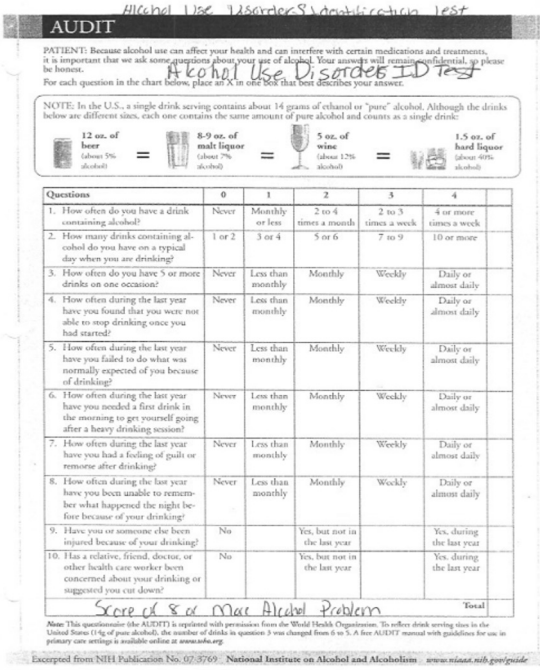


Alcohol Use Disorders Identification Test

AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.
For each question in the chart below, place an X in one box that best describes your answer.

Alcohol Use Disorders ID Test

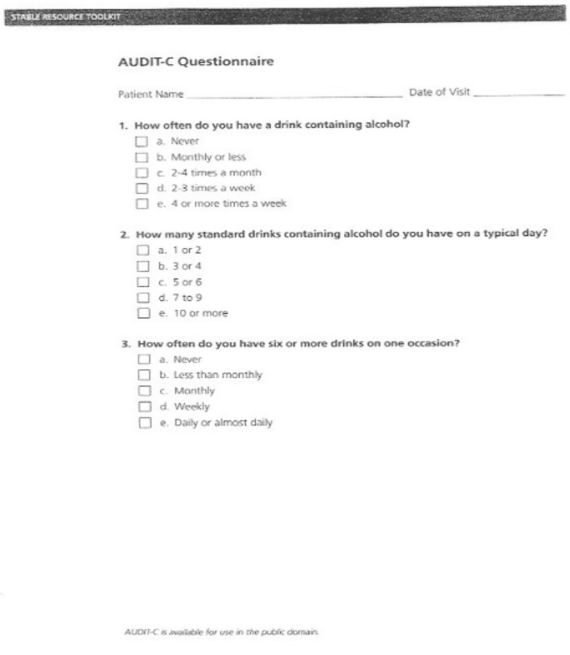
NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:

12 oz. of beer (about 5% alcohol) = 8-9 oz. of malt liquor (about 7% alcohol) = 5 oz. of wine (about 12% alcohol) = 1.5 oz. of hard liquor (about 40% alcohol)

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
Score of 8 or More Alcohol Problem						Total

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14 g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at www.who.org.

Excerpted from NIH Publication No. 07-3769 National Institute on Alcohol and Alcoholism www.niaaa.nih.gov/guide



STABLE RESOURCE TOOLKIT

AUDIT-C Questionnaire

Patient Name _____ Date of Visit _____

1. **How often do you have a drink containing alcohol?**
   - ☐ a. Never
   - ☐ b. Monthly or less
   - ☐ c. 2-4 times a month
   - ☐ d. 2-3 times a week
   - ☐ e. 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
   - ☐ a. 1 or 2
   - ☐ b. 3 or 4
   - ☐ c. 5 or 6
   - ☐ d. 7 to 9
   - ☐ e. 10 or more

3. **How often do you have six or more drinks on one occasion?**
   - ☐ a. Never
   - ☐ b. Less than monthly
   - ☐ c. Monthly
   - ☐ d. Weekly
   - ☐ e. Daily or almost daily

AUDIT-C is available for use in the public domain.

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CAGE Questionnaire

- Have you ever felt you should **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?

Scoring:

Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

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Developed by Dr. John Ewing, founding Director of the Bowles Center for Alcohol Studies, University of North Carolina at Cahpel Hill, CAGE is an internationally used assessment instrument for identifying alcoholics. It is particularly popular with primary care givers. CAGE has been translated into several languages.

The CAGE questions can be used in the clinical setting using informal phrasing. It has been demonstrated that they are most effective when used as part of a general health history and should NOT be preceded by questions about how much or how frequently the patient drinks (see "Alcoholism: The Keys to the CAGE" by DL Steinweg and H Worth; American Journal of Medicine 94: 520-523, May 1993.

The exact wording that can be used in research studies can be found in: JA Ewing "Detecting Alcoholism: The CAGE Questionaire" JAMA 252: 1905-1907, 1984. Researchers and clinicians who are publishing studies using the CAGE Questionaire should cite the above reference. No other permission is necessary unless it is used in any profit-making endeavor in which case this Center would require to negotiate a payment.

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

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

Score: __ /4

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

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

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TWEAK

		Points
1.A	How many drinks does it take before you begin to feel the first effects of alcohol? (3 or more drinks = 2 points) *or*	____
1.B	How many drinks does it take before the alcohol makes you fall asleep or pass out. If you never pass out , what is the largest number of drinks that you have? [Tolerance] (5 or more drinks = 2 points)	
2.	Have your friends or relatives worried about your drinking in the past year? (yes = 1 point) [Worried]	____
3.	Do you sometimes take a drink in the morning when you first get up? (yes = 1 point) [Eye-opener]	
4.	Are there times when you drink and afterwards can't remember what you said or did? (yes = 1 point) [Amnesia]	____
5.	Do you sometimes feel the need to cut down on your drinking? (yes = 1 point) [K/C Cut down]	____
	Score	____

A score of three of more is considered positive for alcoholism/heavy drinking.

Reference: Chan AWK; Pristach EA; Welte JW; Russell M. Use of the TWEAK test in screening for alcoholism/heavy drinking in three populations. *Alcoholism: Clinical and Experimental Research* 17(6): 1188-1192, 1993. (30 refs.)

Bibliography on TWEAK.

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A key outcome of SCREENING is to “screen out” a person before a scheduled appointment when knowing that the client is not eligible or appropriate for that program. A successful screening saves the client a trip to the program and saves everyone’s time.

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A potential client’s feelings may range from one extreme of hope and expectation to the other extreme of severe negative emotions of anger and fear, or feelings may be neutral. As a counselor at the other end of the phone, all the empathy, motivational interviewing skills and engagement skills are needed to assist a client during the screening process. Connections begin with this initial contact. First impressions are important.

It is important at all times for the counselor to conduct him or herself in a professional manner. First impressions, including verbal and non-verbal communications, are very important.

Motivational interviewing skills can be used here during the Screening process to enhance motivation for change. In the business world it would be all about “customer service”. The person conducting the screening needs to be the “Greatest Salesman in the World” and relate with empathy and clarity to each potential client.

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Most often the initial screening is conducted over the phone. A competent counselor will listen to what the potential client is saying, ask clarifying or probing questions, and, as appropriate, direct questions. A counselor needs to use appropriate diagnostic criteria to determine whether a potential client's alcohol or drug use constitutes abuse. Through the initial phone interview a counselor solicits specific examples of how the potential client's use of alcohol or other drugs has become dysfunctional or a focus of concern for self or significant others. It is a mini-assessment with a more thorough assessment completed upon admission.

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A competent counselor/coach will know how to:

- Evaluate psychological, social, and physiological signs and symptoms of alcohol and other drug use and abuse.
- Determine the client's appropriateness for admission or referral
- Determine the client's eligibility for admission or referral.
- Identify any coexisting conditions (medical, psychiatric, physical, etc.) that indicate the need for additional professional assessment and/or services.
- Adhere to applicable laws, regulations, and agency policies governing alcohol and other drug abuse services.

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