THE CLINICAL EVALUATION: PROFESSIONAL COMPETENCIES AND ELEMENTS TO CONSIDER FOR USING DSM-5 FOR SUBSTANCE USE AND CO-OCCURRING DISORDERS

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ABOUT THE INSTRUCTOR

Diane Sherman is an organizational consultant and national trainer. She has worked in the substance abuse profession since 1975. In her consulting services, she has three specific areas of focus: coaching, consultation and continuing education. Dr. Sherman provides Executive Coaching for those persons seeking to maximize their leadership potential. She is a CARF surveyor and consultant for agencies seeking or maintaining national accreditation. Presently, she is responsible for monitoring substance abuse services for the Georgia Department of Juvenile Justice. Dr. Sherman also conducts continuing education opportunities with Brown University through the Northeast Addiction Transfer and Technology Center. Over her professional tenure, Diane has trained nationally for NAADAC, National Association of Drug Court Professionals, CARF, Southeast School of Addiction Studies, South Carolina Behavioral Health Services Association, Tennessee Advanced School on Addiction, and locally for Georgia Department of Human Resources, Georgia Council on Substance Abuse, and Georgia Addiction Counselors Association.

DSM-5 for Substance Use and Co-Occurring Disorders: Current Evidence and Diagnostic Developments

The DSM-5 diagnostic framework for substance use disorders described in this course represented a fundamental shift from the DSM-IV system of abuse and dependence to a single, severity-graded continuum. Since this course was written, research has validated key aspects of that restructuring while also identifying areas where the criteria require careful clinical interpretation, particularly the craving criterion, the severity classification system, and the growing challenge of diagnosing co-occurring disorders in populations with increasingly complex presentations.

A 2022 article in the Journal of Studies on Alcohol and Drugs documented the historical process by which the DSM-5 substance use disorder criteria were developed, which directly informs how practitioners should understand and apply the diagnostic framework taught in this course. The revision involved three major decisions: collapsing substance abuse and substance dependence into a single substance use disorder based on Item Response Theory analyses demonstrating that the abuse and dependence items can be ordered on a single latent dimension; adding the craving criterion despite debate about its statistical redundancy, for its conceptual importance and potential as a biomarker target; and incorporating gambling disorder as a behavioral addiction within the substance-related disorders chapter (Zachar et al., 2022). Understanding this decision history is practically valuable, because it explains why the current system works the way it does and why some aspects were included for clinical rather than purely statistical reasons. When a practitioner encounters a client whose presentation sits at the boundary between mild and moderate disorder, knowing that the severity thresholds were derived from dimensional analysis rather than arbitrary cutoffs can inform how confidently the clinician assigns a severity level and communicates it to the client.

The craving criterion, new to DSM-5 and a topic this course covers, has received direct empirical validation. A 2023 study of 588 adults tracked over 90 days found that baseline craving predicted subsequent substance use with odds ratios ranging from 4.2 for alcohol to 234.3 for heroin, and that including craving in the DSM-5 diagnosis improved its ability to predict future substance use compared to diagnoses made without it, with moderate craving showing stronger predictive power than severe craving (Shmulewitz et al., 2023). For the clinical evaluation competencies described in this course, this has direct implications: practitioners should not treat craving as a supplementary criterion. It is one of the most clinically informative items in the DSM-5 checklist, particularly for heroin and opioid use disorders where the odds ratio exceeded 200, and asking about it with the same rigor applied to tolerance, withdrawal, and loss of control captures information that predicts the client's immediate trajectory more powerfully than most other indicators.

The co-occurring disorders dimension of this course has grown more clinically urgent as the prevalence of dual diagnosis has increased. A 2022 study of 47,117 prison admissions in British Columbia documented that the proportion presenting with both mental health needs and substance use disorders rose markedly from 15 percent in 2009 to 32 percent in 2017, the proportion with any mental health or substance use need rose from 61 percent to 75 percent, and methamphetamine use increased nearly fivefold from 6 percent to 29 percent (Butler et al., 2022). For clinicians conducting DSM-5 evaluations, these trends mean that co-occurring disorder assessment is not a specialized add-on for complex cases but a baseline competency required for the majority of clients in many settings, applied with the expectation that most clients will meet criteria for more than one condition and that the

interaction between conditions affects treatment planning, prognosis, and risk.

The treatment implications of co-occurring diagnoses have been quantified. A 2025 meta-analysis of 13 primary studies confirmed that individuals with concurrent mental health and substance use disorders face approximately twice the risk of adverse outcomes such as relapse, emergency visits, rehospitalization, and mortality, with a pooled risk ratio of 1.71 (Scott & Gorey, 2025). A 2024 expert review of schizophrenia and comorbid substance use disorders noted that these patients face poor physical health, low medication adherence, high relapse and hospitalization rates, and increased mortality, and recommended combining pharmacological and psychosocial treatment within an integrated, multidisciplinary approach (Neyra et al., 2024). These findings reinforce that the diagnostic process is not merely a classification exercise but the foundation for treatment decisions with measurable consequences. An evaluation that accurately identifies co-occurring conditions enables integrated planning, while one that misses a co-occurring condition routes the client toward single-disorder treatment that the meta-analytic data associates with worse outcomes.

The quality of assessment instruments available for clinical evaluation has itself been evaluated. A 2023 systematic review of 73 brief, freely accessible self-report measures for substance use disorders found that only 19 percent achieved excellent psychometric ratings, 37 percent were rated good, and 44 percent adequate (Stewart et al., 2023). Practitioners must not only know how to administer screening and assessment instruments but also how to evaluate their psychometric properties and select tools appropriate for their specific population, recognizing that an instrument performing well in research may not maintain its reliability with a different demographic or in a different clinical context.

Why the Diagnosis Changed: The Logic of the DSM-5 Restructuring

To use the DSM-5 framework well, a clinician benefits from understanding not only what the criteria are but why they took their current form, because the reasoning explains both the strengths and the limits of the system. The central change, merging the DSM-IV categories of abuse and dependence into a single substance use disorder, was not a matter of committee preference but rested on a large empirical base. The work group's recommendation was grounded in consistent findings from over 200,000 study participants showing that the former abuse and dependence criteria do not mark two distinct conditions but instead fall along a single underlying dimension of severity (Hasin et al., 2013). In plain terms, the old distinction between abuse and dependence turned out not to describe two different things; it described milder and more severe points on one continuum.

Several specific criterion changes accompanied the merger, each with a rationale a clinician should know. The legal-problems criterion was dropped because it added little diagnostic information and functioned inconsistently across populations. The craving criterion was added to capture a clinically central feature of addiction that the older criteria did not directly represent. Withdrawal syndromes for cannabis and caffeine were recognized, tobacco use disorder criteria were aligned with those for other substances, and gambling disorder was moved into the same chapter as the substance-related disorders in recognition of its shared features as a behavioral addiction (Hasin et al., 2013).

For the practitioner, this history has a practical payoff beyond intellectual interest. It means the severity levels of mild, moderate, and severe are not arbitrary bands but points on a validated dimension, which lends confidence to the act of assigning severity. It also means that a client who would once have

been labeled with abuse and a client who would once have been labeled dependent are now understood as occupying different positions on the same continuum rather than as having categorically different conditions, a shift that changes how a clinician frames the diagnosis and discusses trajectory and prognosis with the client. Understanding the single-dimension model is the conceptual foundation on which the rest of competent DSM-5 evaluation rests.

The shift also resolved a practical problem that had troubled the older system, the so-called hierarchy between abuse and dependence. Under DSM-IV, abuse was implicitly treated as a milder, almost preliminary condition and dependence as the serious one, yet research showed this ordering did not hold: some abuse criteria, such as hazardous use, actually marked more severe problems than some dependence criteria. Collapsing the two into a single dimension and letting the number of criteria determine severity produced a more accurate ordering, in which severity is measured by how many features of the disorder are present rather than by which of two categories a person happened to fall into. For the practitioner, this means the old intuition that abuse is a way station on the road to dependence should be set aside, because the current framework does not describe two stations but a single continuous road along which a client can sit at any point.

It is worth noting what the merger did not change, because clinicians trained under the older system sometimes carry assumptions forward. The individual behaviors and consequences that constitute the criteria, tolerance, withdrawal, loss of control, continued use despite harm, and the rest, are largely the same features clinicians always assessed; what changed is how they are combined into a diagnosis and a severity level. A clinician who understood the older criteria is not starting over but re-learning how the same clinical observations map onto a single graded diagnosis, and appreciating that continuity makes the transition to confident DSM-5 practice less daunting than the reorganization of the manual might suggest.

How Reliable Is the Diagnosis?

A diagnosis is only as useful as its reliability, the degree to which two clinicians evaluating the same person reach the same conclusion, and honesty about reliability is part of competent practice. The DSM-5 field trials tested exactly this, having two clinicians independently evaluate the same patients across multiple academic sites. The results were mixed and worth knowing plainly: across the diagnoses with adequate samples, five fell in the very good range of test-retest agreement, nine in the good range, six in the questionable range, and three in the unacceptable range (Regier et al., 2013). Substance use disorders generally landed among the more reliable diagnoses, which is reassuring, but the overall picture is a reminder that psychiatric diagnosis is not a laboratory measurement and that reasonable clinicians can disagree.

Reliability improves markedly when clinicians use a structured instrument rather than unstructured clinical impression. The Psychiatric Research Interview for Substance and Mental Disorders, a clinician-administered instrument designed specifically for substance-using populations, was tested for DSM-5 in a sample of 565 substance users each interviewed twice by different clinicians. Agreement for most substance use disorder diagnoses was substantial to excellent, with kappa values from 0.63 to 0.94, graded severity showed intraclass correlations from 0.74 to 0.99, and the craving criterion reached excellent reliability for heroin at kappa 0.84 to 0.95 (Hasin et al., 2020). The single factor that most predicted disagreement between clinicians was disorder severity, with milder cases proving less reliable

to diagnose, which fits intuition: the boundary between no disorder and a mild disorder is inherently fuzzier than the diagnosis of a severe one.

For the practitioner, these findings carry two lessons. First, the diagnostic reliability that this course's competencies aim at is achievable, but it depends on systematic assessment rather than impression, which is a strong argument for using structured or semi-structured tools and for asking about every criterion explicitly rather than inferring. Second, the clinician should hold mild and boundary-line diagnoses with appropriate humility, recognizing that these are exactly the cases where two competent evaluators are most likely to differ and where a second look, additional information, or reassessment over time is most valuable.

It helps to understand why reliability varies as it does, because the pattern is not random. Diagnoses anchored in concrete, observable, countable features tend to be more reliable than those that depend on subjective interpretation of a client's internal state, and substance use disorders, built largely on discrete behaviors and consequences, benefit from this. The criteria ask about identifiable events, using more than intended, failing to fulfill obligations, experiencing withdrawal, that a client can report and a clinician can corroborate, which makes them more reliably assessed than, say, the subtle distinctions among mood or personality conditions. This is one reason substance use disorders sit among the more reliable diagnoses in the field trials, and it is an encouragement to the clinician that careful, concrete assessment genuinely can produce dependable conclusions.

Reliability is also something the clinician can actively improve rather than merely inherit from the criteria. Asking about each criterion explicitly and in the client's own terms, anchoring questions to specific time frames and concrete examples, corroborating with collateral information and records where available, and documenting the specific findings that support each criterion all raise the consistency of the resulting diagnosis. The gap between the reliability of unstructured impression and that of structured assessment is, in effect, the gap that these habits close, and adopting them is how a clinician moves from diagnoses that vary with the evaluator toward diagnoses that would hold up if a colleague conducted the same evaluation. This is the practical meaning of diagnostic competence, and it is largely a matter of disciplined method rather than special talent.

The Severity Continuum and the Problem of Low Thresholds

The DSM-5 defines a substance use disorder by the presence of at least two of eleven criteria, with severity graded as mild for two or three criteria, moderate for four or five, and severe for six or more. This low threshold of two criteria has drawn substantive criticism that a competent evaluator should understand, because it bears directly on the risk of over-diagnosis. Using data from a large national survey, one analysis found that the two-criterion DSM-5 threshold for alcohol use disorder produced a lifetime prevalence of 38.2 percent and a one-year prevalence of 12.4 percent, whereas a stricter set of criteria designed to capture genuine harmful dysfunction yielded a lifetime prevalence of 6.7 percent and a one-year prevalence of 2.3 percent (Wakefield & Schmitz, 2015). The stricter criteria aligned better with external validators such as treatment use, symptom count, and family history, and eliminated roughly 83 percent of a group of transient adolescent drinkers who met the DSM-5 threshold but did not appear to have a genuine disorder.

This does not mean the DSM-5 diagnosis is wrong, but it does mean the low threshold captures a

wide range, from mild, possibly transient problems to severe, entrenched disorders, and that the label of mild substance use disorder should be applied and communicated with care. For the practitioner, the implication is not to abandon the criteria but to weight severity heavily in interpretation and treatment planning. A client meeting exactly two criteria and a client meeting nine both carry a diagnosis of substance use disorder, but they present fundamentally different clinical pictures and warrant fundamentally different responses, and collapsing that difference by attending only to the presence or absence of the diagnosis wastes the very information the severity scale was designed to provide.

The clinical evaluation this course teaches is therefore not complete when a diagnosis is assigned. The number of criteria met, which specific criteria they are, and the trajectory of the problem all carry information beyond the yes-or-no of the diagnosis, and a competent evaluation captures and communicates that fuller picture rather than reducing the client to a diagnostic category.

The way severity is communicated to the client also matters clinically, not just administratively. A client told simply that they have an alcohol use disorder may hear a heavier or lighter judgment than the diagnosis warrants, depending on their own associations with the word, whereas a client told they meet two of eleven criteria, at the mild end of a spectrum, receives information that is both more accurate and more actionable. For some clients, learning that their problem sits at the milder end can motivate early change before the disorder progresses; for others, understanding that they meet many criteria and sit at the severe end can cut through the minimization that sustains the problem. Using the severity information the DSM-5 provides to calibrate that conversation, rather than delivering an undifferentiated label, is part of turning the diagnosis into something therapeutically useful rather than merely classificatory.

Severity also interacts with the choice of treatment setting and intensity in ways the evaluation should anticipate. A mild disorder may respond to brief intervention and monitoring, while a severe disorder typically requires structured treatment and, for some substances, medication, and the criteria met during the evaluation are among the clearest signals of which level of care fits. This is the same matching logic that governs good treatment generally, applied at the diagnostic stage, and it is why an evaluation that records only the presence of a disorder, without grading its severity, has left on the table exactly the information most useful for deciding what to do next. The severity scale is not a bureaucratic refinement; it is a clinical instrument for matching intensity to need.

Severity assessment also intersects with the diagnostic evaluation of special populations in ways the clinician should anticipate, because the criteria can present differently across the lifespan and in particular circumstances. In adolescents, patterns of use that would signal an established disorder in an adult may reflect experimentation, developmental thresholds differ, and the social and school consequences that dominate a young person's presentation are weighted differently than the occupational consequences prominent in adults, so applying adult assumptions mechanically can mislead in either direction. In older adults, the criteria can be masked, because tolerance changes with age, physiological effects appear at lower quantities, and use may be attributed to medical conditions or interact with prescribed medications in ways that obscure the underlying disorder. A clinician alert to these developmental variations reads the same criteria with an eye to how they manifest in the particular person rather than applying a single template.

Pregnancy is another circumstance in which the diagnostic evaluation carries heightened stakes and heightened sensitivity, because the consequences of both the substance use and the diagnosis are magnified, and fear of legal or child-welfare consequences can suppress honest disclosure precisely

when accurate assessment matters most. A clinician evaluating a pregnant client must combine diagnostic rigor with an awareness of these pressures, creating enough safety for honest disclosure while gathering the information that accurate diagnosis and appropriate treatment require. In each of these special populations the DSM-5 criteria remain the framework, but competent evaluation means understanding how the criteria present in the specific population rather than assuming a uniform manifestation across every client.

The medical and physical dimension of the evaluation also deserves attention, because substance use disorders rarely occur in isolation from physical health, and the clinical evaluation is often where a serious medical consequence is first suspected. Heavy alcohol use carries implications for liver function, cognition, and withdrawal risk; injection drug use raises the possibility of blood-borne infection and endocarditis; stimulant use bears on cardiovascular health; and opioid use carries overdose risk that the evaluation should assess directly. While the counselor conducting a clinical evaluation is usually not the person who will treat these conditions, recognizing when a client's presentation warrants medical evaluation, and making the appropriate referral, is part of a competent assessment. A diagnostic evaluation that captures the psychiatric picture but overlooks a client visibly in need of medical attention has missed something the client's safety may depend on, and integrating this awareness into the evaluation is part of treating the whole person rather than only the diagnosis.

Withdrawal risk in particular is a safety judgment the evaluation should not defer, because for some substances withdrawal is not merely uncomfortable but dangerous. Alcohol and sedative withdrawal can produce seizures and delirium that are potentially fatal without medical management, and an evaluation that identifies significant physiological dependence on these substances should trigger consideration of medically supervised withdrawal rather than an assumption that the client can simply stop. Knowing which substances carry dangerous withdrawal, and asking the questions that reveal the level of physiological dependence, is therefore not only a diagnostic matter but a safety one, and it is a clear example of how the diagnostic evaluation this course teaches connects directly to decisions that protect the client's life.

Diagnostic Orphans and the Shifting Boundaries of Prevalence

One consequence of the move to a two-criterion threshold deserves particular attention because it reshaped who counts as having a disorder. Under DSM-IV, a person could endorse one or two dependence criteria without meeting the threshold for either abuse or dependence, and such people were known as diagnostic orphans, symptomatic but undiagnosed. Because DSM-5 requires only two criteria of any kind, many former diagnostic orphans now cross the threshold into a mild disorder. A systematic review of 12 studies comparing DSM-IV and DSM-5 alcohol use disorder prevalence found that seven showed an increase, two showed no substantial difference, and three showed a decrease, with the differences ranging widely, and concluded that DSM-5 tends to raise measured prevalence largely because the diagnostic orphans of DSM-IV, who are more numerous than single-criterion abuse cases, now qualify for diagnosis (Bartoli et al., 2015).

For the practitioner, this history clarifies why prevalence figures shifted with the diagnostic change and cautions against reading a rise in diagnosed cases as necessarily a rise in true disorder. It also has a direct clinical meaning. The people who were diagnostic orphans under the old system, and who now receive a mild disorder diagnosis, are a genuinely mixed group: some have an early or emerging

disorder that warrants intervention, while others have a transient or subclinical pattern that may resolve without formal treatment. Distinguishing between them is exactly the kind of clinical judgment that a diagnosis alone cannot supply, and it underscores why the evaluation this course teaches must go beyond criterion-counting to a fuller understanding of the person's history, trajectory, and context.

The diagnostic-orphan phenomenon carries a specific clinical opportunity that the prevalence debate can obscure. The people who now cross into a mild diagnosis, having previously been subthreshold, include many who are at an early and more treatable stage of a developing disorder, and identifying them is precisely the kind of early detection that can alter a trajectory before it hardens. Rather than viewing the lower threshold only as a source of over-diagnosis, the clinician can see it as a wider net that catches emerging problems sooner, provided the clinician then does the harder work of distinguishing an emerging disorder that warrants intervention from a transient pattern that does not. The diagnosis flags the person for attention; the clinical judgment that follows determines what the attention should consist of.

This is also a place where the trajectory of the problem, more than its status at a single moment, carries the decisive information. A young adult who meets two criteria during a period of heavy social drinking may be on a path toward escalation or may be passing through a time-limited phase, and the difference is often visible only over time, in whether the criteria accumulate or recede. A competent evaluation therefore treats a mild, boundary-line diagnosis not as a final verdict but as a reason to follow the person, to reassess, and to intervene early if the pattern worsens. Understanding the diagnostic-orphan history equips the clinician to hold these mild diagnoses with the right mixture of seriousness and provisionality, neither dismissing them nor over-treating them.

How Common Is Substance Use Disorder, and How Many Get Treated?

Competent evaluation is informed by knowing the base rates of the conditions one is assessing, and recent national data give a clear picture. In the largest recent United States epidemiological survey, covering 36,309 adults, the twelve-month prevalence of DSM-5 alcohol use disorder was 13.9 percent and the lifetime prevalence 29.1 percent, meaning that nearly one adult in seven met criteria in the past year and nearly one in three had met them at some point in life (Grant et al., 2015). The same survey found that twelve-month drug use disorder affected 3.9 percent of adults and lifetime drug use disorder 9.9 percent (Grant et al., 2016). These are common conditions, present across every clinical setting, and their frequency means the diagnostic competencies this course teaches are used constantly rather than reserved for specialized addiction practice.

The same data reveal a treatment gap that frames the stakes of accurate diagnosis. Only 19.8 percent of those with lifetime alcohol use disorder were ever treated (Grant et al., 2015), and only 13.5 percent of those with twelve-month drug use disorder and 24.6 percent of those with lifetime drug use disorder received treatment (Grant et al., 2016). The large majority of people with these disorders never reach care, and the clinical evaluation is often the point at which an undiagnosed and untreated condition is finally identified. This gives the diagnostic encounter a significance beyond classification: a substance use disorder detected during an evaluation conducted for some other reason may be the person's first and only opportunity to be recognized and routed toward treatment, and a competent, thorough evaluation is what makes that opportunity real.

The treatment gap also reframes where the clinician's diagnostic effort is most valuable, which is often outside specialty addiction settings. Because most people with substance use disorders never reach addiction treatment, the diagnosis is frequently made, if it is made at all, in a primary care visit, an emergency department, a mental health clinic, or a social service encounter conducted for some other purpose. This means the competencies this course teaches are needed not only by addiction specialists but by every clinician who might encounter an undiagnosed substance use disorder in the course of other work, and that a clinician alert to the possibility, who screens and evaluates rather than assuming the problem would have been caught elsewhere, is often the only line of detection a person has. The base rates make the case: with disorders this common and treatment this rare, the assumption that someone else will catch what one misses is usually wrong.

There is also a systemic reading of the treatment gap that bears on how a clinician frames the diagnosis for the client. Many people with these disorders have never been told plainly that they have one, and have never been offered a path to care, so the diagnostic conversation is frequently a first, not a routine, event in the person's life. Handling it with clarity and without either minimizing or catastrophizing, and pairing the diagnosis with concrete information about what treatment exists and how to reach it, is what converts a diagnosis into the beginning of care rather than merely a label recorded in a chart. The evaluation identifies the condition; the way the clinician communicates it and connects it to treatment determines whether the identification changes anything.

Validating the Individual Criteria

Beyond the reliability of the overall diagnosis lies the question of whether the individual criteria measure what they claim to, and the psychometric research is reassuring while sharpening how specific items should be understood. Analyses using Item Response Theory, a statistical method for examining how well each criterion discriminates across the severity spectrum, have repeatedly found that the DSM-5 criteria form a single coherent dimension. For alcohol, an analysis of more than 22,000 respondents found that the criteria supported a unidimensional model, with the craving criterion loading strongly at 0.818 and endorsed by 4.2 percent of the general population, filling a gap in problem coverage that the older criteria left open (Casey et al., 2012). The craving criterion, in other words, is not statistical padding; it measures a real and distinct aspect of the disorder.

Validation extends to specific substances and to the fairness of the criteria across groups. An emergency-department study of 518 adults reporting opioid use found that the DSM-5 opioid use disorder criteria showed measurement invariance across biological sex, race, and employment status, meaning the criteria functioned equivalently across these groups and could be used to make valid comparisons among them (Himes et al., 2024). This matters for the equity of diagnosis, because a criterion set that behaved differently across demographic groups would produce biased diagnoses, and the evidence that the criteria are largely invariant supports their use across the diverse populations a clinician serves. For the practitioner, the takeaway is confidence tempered by attention: the criteria are psychometrically sound and broadly fair, and the clinician's task is to elicit each one carefully rather than to worry that the criteria themselves are flawed.

The finding that craving functions as a distinct and informative criterion deserves particular practical emphasis, because craving is easy to underweight in a busy evaluation. Unlike tolerance or withdrawal, which have observable physiological markers, craving is an internal experience that a clinician can only

access by asking, and asking about it well requires more than a yes-or-no question. Craving varies in intensity, in the situations that trigger it, and in how the person experiences and responds to it, and a clinician who explores those dimensions rather than checking a box captures information that both establishes the criterion and informs treatment, since the cues that provoke craving are exactly the situations relapse prevention must address. The evidence that craving predicts subsequent use as powerfully as it does is a strong argument for giving it this fuller attention rather than treating it as a minor addition to the checklist.

Attention to how the criteria function across groups also translates into a concrete practice. Although the criteria are broadly invariant across demographic groups, the way a criterion is experienced and reported can still vary with a client's circumstances, so the same underlying feature may be described differently by a client whose life and vocabulary differ from the clinician's. Eliciting each criterion in language the client understands, and probing for the substance of the criterion rather than accepting a particular phrasing, is how a clinician ensures the psychometric fairness demonstrated in the research is realized in the actual encounter. The criteria are sound tools, but like any tools their fair application depends on the skill of the person using them.

Two criteria in particular reward careful elicitation because they are frequently misjudged. Tolerance, the need for markedly increased amounts to achieve the desired effect or a markedly diminished effect with continued use of the same amount, is sometimes recorded on the basis of any increase in use, when the criterion requires a meaningful change reflecting physiological adaptation; and it can be complicated by the fact that some tolerance is a normal pharmacological response even in appropriate medical use, so the clinician must distinguish clinically significant tolerance from expected adaptation. Withdrawal, similarly, requires either the characteristic syndrome for the substance or the use of the substance to relieve or avoid it, and it varies enormously across substances, so a clinician assessing withdrawal for one drug cannot assume the same presentation for another. Knowing the specific withdrawal profiles of the major substance classes, and asking about the relief-or-avoidance pattern rather than only the syndrome, is what turns these criteria from checkboxes into accurate clinical judgments.

The remaining criteria, spanning impaired control, social impairment, and risky use, each capture a distinct facet of the disorder, and eliciting them well means asking about the substance of each rather than accepting a global self-assessment. A client who says their use is not a problem may nonetheless, on specific questioning, report using more than intended, unsuccessful efforts to cut down, continued use despite conflict with family, and giving up activities they once valued, each of which is a criterion the global denial obscured. The skill of the evaluation lies in this patient, criterion-by-criterion inquiry, which surfaces the reality that a single summary question would miss, and it is precisely the discipline that distinguishes a thorough diagnostic evaluation from an impression formed too quickly.

The Hardest Distinction: Substance-Induced Versus Independent Disorders

Among the most demanding judgments in the clinical evaluation of a substance-using client, and one this course addresses directly, is distinguishing a mental disorder that is independent of the substance use from one that is substance-induced, a temporary consequence of intoxication or withdrawal that will

resolve as the substance clears. The distinction has large treatment implications, because an independent depression or psychosis requires its own treatment while a substance-induced one may resolve with abstinence, yet the two can look identical at a single point in time, especially when a client presents intoxicated or in withdrawal.

The instrument built specifically to make this distinction, the Psychiatric Research Interview for Substance and Mental Disorders, demonstrates both that the distinction can be made reliably and how much structure it requires. In a reliability study of 285 substance-abusing patients, the interview achieved kappa values of 0.66 to 0.75 for major depressive disorder in both its primary and substance-induced forms, showing that trained clinicians using a structured approach can reliably separate the two (Hasin et al., 2006). The method depends on careful attention to timing, the relationship between periods of substance use and periods of symptoms, and the persistence of symptoms during abstinence, precisely the elements that unstructured clinical impression tends to gloss.

For the practitioner, the applied lessons are concrete. The distinction between independent and substance-induced disorders cannot usually be made confidently at a single intake, particularly during acute intoxication or withdrawal, and premature diagnosis in that window risks both labeling a transient state as a standing disorder and dismissing a genuine independent condition as merely drug-related. The more defensible approach is to treat the presenting symptoms while holding the diagnosis provisionally, to attend closely to the temporal relationship between substance use and symptoms, and to reassess as the person stabilizes, because it is often the observation of whether symptoms persist during a period of abstinence that resolves the question. This is patient, longitudinal work, and it is exactly the competency this course is designed to build.

The DSM-5 offers concrete guidance that a clinician can apply to this judgment, and knowing it sharpens the evaluation. In general, a mental disorder is more likely to be independent rather than substance-induced when the symptoms preceded the onset of substance use, when they persist for a substantial period, often cited as about a month, beyond acute intoxication or withdrawal, when they are markedly excessive relative to what the amount and type of substance would be expected to produce, or when there is a documented history of similar episodes during periods of abstinence. Each of these is a piece of temporal or contextual evidence that the clinician gathers through careful history-taking, and none is available from a single snapshot of current symptoms. The evaluation for this distinction is therefore largely an exercise in reconstructing the timeline of a client's substance use and psychiatric symptoms and looking for the pattern that reveals which came first and which persists without the other.

The practical difficulty is that clients are often poor historians about exactly the timeline the distinction requires, particularly when heavy use has blurred their memory of when symptoms began. Collateral information from family or prior records, when available, can be decisive here, and where it is not, the clinician may have to make a provisional judgment and revise it as the picture clarifies during a period of abstinence or reduced use. Communicating that provisionality honestly, to the client and in the record, is part of competent practice, because a confidently stated diagnosis that later proves wrong can misdirect treatment and follow the client through the system. The willingness to say that the distinction is not yet clear, and to hold it open while gathering the evidence that will settle it, is itself a mark of diagnostic skill rather than a failure of it.

Structured Versus Unstructured Assessment

Running through the reliability evidence is a consistent theme with direct practical force: structured and semi-structured assessment outperforms unstructured clinical impression, and the more consequential the diagnosis, the more that difference matters. The reliability gains seen with instruments like the PRISM over ordinary clinical evaluation are not marginal; they are the difference between diagnoses that different clinicians agree on and diagnoses that vary with the evaluator.

The advantage of structure extends to how severity itself is captured. A study of the Structured Clinical Interview for DSM-5 in 234 participants found that severity dimensions derived from the interview showed substantial internal consistency, with all reliability coefficients above 0.80, and that these dimensional severity scales showed superior psychometric properties and better predicted future outcomes than the categorical diagnoses alone (Shankman et al., 2018). In other words, measuring how much of a disorder a person has, along a graded scale, carries more clinical information than simply recording whether they cross a diagnostic threshold.

This does not mean every clinical evaluation must use a full research interview, which is often impractical in ordinary settings. It means the clinician should borrow the discipline of structured assessment even when using clinical judgment: asking about every criterion explicitly rather than inferring, attending to severity rather than only to the presence of a diagnosis, and documenting the specific findings that support the conclusion. The competencies this course teaches are, in large part, the habits that close the gap between unstructured impression and structured assessment, and the evidence is clear that closing that gap improves the reliability and the usefulness of the diagnosis.

It is worth being clear about why unstructured clinical impression, despite the experience and skill of the clinician using it, tends to be less reliable, because understanding the mechanism motivates the discipline. Left to unstructured judgment, clinicians vary in which criteria they probe, how they phrase questions, which symptoms they weight, and how they combine information into a conclusion, and these variations accumulate into diagnoses that differ from clinician to clinician even when the underlying client is the same. A structured approach reduces this variation by ensuring every criterion is asked about in a consistent way and combined according to explicit rules, which is why the reliability gains are so consistent across studies. The lesson is not that clinical judgment is worthless, since judgment is essential for interpreting what the client reports, but that judgment operating without structure is more variable than judgment operating within it.

The practical middle path for most settings is a semi-structured approach that captures the reliability benefits of structure without the impracticality of a full research interview. This means using a consistent checklist of the eleven criteria, asking about each one explicitly, anchoring questions to concrete examples and time frames, and recording severity along with the diagnosis, while still exercising clinical judgment in interpreting the client's answers and integrating collateral information. A clinician who works this way gains much of the reliability advantage the structured instruments demonstrate while retaining the flexibility that real clinical encounters require, and building these habits into routine practice is one of the most concrete ways to raise the quality of one's diagnoses. Structure and judgment are not opposites; the best evaluation uses structure to discipline judgment rather than to replace it.

Co-Occurring Disorders: Prevalence, Interaction, and Consequence

Because co-occurring mental health and substance use disorders are so common, the DSM-5 evaluation of a substance-using client is rarely complete without attention to accompanying psychiatric conditions, and the evidence on prevalence and consequence makes this a central rather than peripheral task. The rising co-occurrence documented in correctional admissions, from 15 percent to 32 percent over less than a decade (Butler et al., 2022), reflects a broader clinical reality in which a substantial share of clients carry more than one diagnosis, and the interaction between conditions shapes everything that follows.

The consequences of getting this right or wrong are measurable. The meta-analytic finding that people with concurrent disorders face roughly twice the risk of adverse outcomes such as relapse, hospitalization, and death (Scott & Gorey, 2025) means that missing a co-occurring condition is not a minor omission but a decision that routes a client toward treatment associated with worse outcomes. The expert consensus on serious conditions such as schizophrenia with comorbid substance use, which emphasizes poor physical health, low medication adherence, and high relapse and calls for integrated, multidisciplinary care (Neyra et al., 2024), reflects the same principle: the disorders interact, and treating one while ignoring the other underperforms treating both together.

For the practitioner, this reframes the diagnostic task. Evaluating a substance-using client for co-occurring psychiatric conditions, and evaluating a psychiatric client for co-occurring substance use, is not an optional refinement for complex cases but a routine expectation, because the base rates make co-occurrence the norm rather than the exception in many settings. The DSM-5 competencies this course teaches must therefore be exercised in both directions at once, with the recognition that the accurate identification of a co-occurring condition is often the single most consequential product of the evaluation.

The direction of the diagnostic error matters, and both directions occur. In substance abuse treatment settings, the risk is that a psychiatric condition goes unrecognized because the presenting problem is the substance use and the clinician's attention is trained there, so a co-occurring depression, anxiety disorder, or trauma history is missed and left untreated even as it continues to drive the substance use. In mental health settings, the mirror error occurs: the substance use is overlooked or minimized because the presenting problem is psychiatric, and the client's disorder is treated as if the substance use were incidental rather than central. Each setting has its characteristic blind spot, and awareness of one's own setting's tendency is part of guarding against it. The competent evaluator deliberately looks in the direction their setting is inclined to neglect.

Sequencing is the other recurring pitfall the evidence warns against. A longstanding but mistaken practice holds that the substance use must be resolved first, with the psychiatric condition addressed only once the client is abstinent, but the co-occurring evidence and the integrated-treatment consensus both indicate that treating the conditions together produces better outcomes than treating them in sequence. The reason is that each untreated condition tends to reactivate the other, so a client whose depression is left untreated until they achieve abstinence often cannot achieve the abstinence that is supposedly the precondition for treatment. For the evaluator, this means the diagnostic goal is not to decide which condition to treat first but to identify both accurately so that integrated treatment can address them simultaneously, and an evaluation that surfaces both conditions is what makes that integrated approach possible.

A further diagnostic subtlety in co-occurring evaluation is the overlap of symptoms between substance effects and psychiatric conditions, which can make even a careful clinician uncertain about what is driving a given presentation. Stimulant intoxication can mimic mania or produce paranoia indistinguishable in the moment from a primary psychotic disorder, withdrawal from depressants can produce anxiety and agitation resembling an anxiety disorder, and the depression that follows heavy substance use can be difficult to separate from an independent mood disorder. This overlap is exactly why the temporal and longitudinal reasoning described earlier is indispensable, and why a co-occurring evaluation conducted only at a single acute moment is prone to error. The clinician reads the current presentation as one data point within a history rather than as a self-interpreting fact.

The practical response to this overlap is not diagnostic paralysis but structured, staged assessment. The clinician can treat the acute presentation as it requires, gather the history that begins to separate the conditions, and reassess as the acute substance effects resolve, arriving at a more confident co-occurring diagnosis over time than any single encounter could support. Documenting this process honestly, including the provisional nature of early conclusions, protects the client from a premature label and gives subsequent clinicians the reasoning behind the diagnosis. Co-occurring evaluation, done well, is thus less a single act of classification than an unfolding clinical understanding, and the DSM-5 framework provides the categories within which that understanding takes shape.

Suicide risk assessment deserves explicit integration into the co-occurring evaluation, because the combination of substance use and psychiatric conditions elevates suicide risk substantially, and the evaluation is a natural and necessary point to assess it. Intoxication lowers inhibition and can convert passive ideation into action, withdrawal brings the emotional low in which hopelessness deepens, and the depression and losses that accompany substance use supply the despair that suicidal crisis feeds on, so a client who screens positive for both a substance use disorder and a mood disorder is, by that combination alone, at elevated risk. A clinician conducting a co-occurring evaluation who does not ask directly about suicidal thoughts and prior attempts has left unassessed one of the most consequential risks the client faces, and the evidence is clear that asking directly is protective rather than provocative. The diagnostic evaluation is not complete, for a client with this combination of conditions, until suicide risk has been addressed.

The therapeutic dimension of the evaluation itself is worth naming, because the diagnostic encounter is not merely an information-gathering exercise but the beginning of the treatment relationship, and how it is conducted shapes everything that follows. A client who experiences the evaluation as an interrogation, or as being processed and categorized, discloses less and engages less, whereas a client who experiences it as a genuine effort to understand their situation is more likely to be honest and more likely to return. The clinician who conducts the evaluation with warmth, curiosity, and respect, treating the client as the primary expert on their own experience while bringing diagnostic expertise to bear on what the client reports, gathers better information and builds the alliance on which treatment depends. In this sense the manner of the evaluation is not separate from its accuracy: the trust that produces honest disclosure is built in the encounter, and a diagnosis rests on the quality of the information the encounter elicits. Doing the evaluation well, therefore, means doing it not only rigorously but humanely, because the two are, in practice, inseparable.

It is worth closing on the recognition that diagnosis, for all its apparatus of criteria and instruments, remains an act of understanding a particular human being, and that the framework this course teaches is valuable precisely to the degree that it serves that understanding rather than substituting for it. The

eleven criteria, the severity levels, the structured interviews, and the cultural and ethical considerations are all in service of seeing clearly who this person is, what they are struggling with, and what would help, and a clinician who masters the framework but loses sight of the person has mistaken the map for the territory. The best diagnosticians hold the technical framework and the human encounter together, using the rigor of the criteria to discipline their impressions and the humanity of the encounter to gather the honest information the criteria require, and it is this integration, more than any single technique, that distinguishes expert clinical evaluation. The DSM-5 gives the clinician a shared, validated language for describing what they find, but the finding itself depends on the clinician's willingness to look carefully, listen well, and reason honestly about what they see, which is the enduring core of the professional competence this course exists to build.

Choosing and Judging Assessment Instruments

The clinical evaluation depends on the instruments the clinician chooses, and competent practice includes the ability to judge those instruments rather than trusting them uncritically. The finding that fewer than a fifth of brief substance use measures achieve excellent psychometric ratings (Stewart et al., 2023) is a caution against assuming that a widely used or freely available tool is necessarily a good one. An instrument's published reliability and validity are established in particular populations, and its performance can degrade when it is applied to a different demographic, a different setting, or a different presenting problem than the one it was validated for.

The practical competency here is a form of literacy. A clinician selecting an instrument should know what population it was validated in, what its sensitivity and specificity are for the condition in question, and whether it has been tested for the group being assessed, and should treat a screening result as a prompt to evaluate further rather than as a diagnosis in itself. This is the same discipline that the reliability evidence recommends: the instrument supplies structured information, but the clinician remains responsible for judging whether that information is trustworthy for this client and for integrating it with the rest of the evaluation.

The broader point is that no instrument replaces clinical judgment; it informs it. The DSM-5 criteria, the structured interviews, and the screening tools are all aids to a diagnostic decision that remains the clinician's, and the competency this course builds is precisely the ability to use those aids well, understanding both their power and their limits, rather than either ignoring them or deferring to them uncritically.

A few concepts make this instrument literacy concrete. Sensitivity is the proportion of true cases an instrument correctly identifies, and specificity the proportion of true non-cases it correctly clears, and the two trade off, so an instrument tuned to miss few cases will flag more false positives. Predictive value, the probability that a positive or negative result is correct, depends not only on the instrument but on how common the condition is in the population being assessed, so the same tool yields a more trustworthy positive result in a high-prevalence setting than in a low-prevalence one. A clinician who grasps these relationships can interpret an instrument's output intelligently, treating a positive screen as a prompt to evaluate further rather than as a diagnosis, and recognizing that a tool validated in one population may not perform identically in another. This literacy is what separates using an instrument well from merely administering it.

The distinction between screening and diagnostic instruments deserves emphasis in this context, because conflating them is a common error. A screening instrument is designed to be brief and sensitive, casting a wide net to decide who needs a closer look, whereas a diagnostic instrument or a full clinical evaluation is designed to establish the diagnosis itself. Treating a positive screen as if it were a diagnosis over-identifies and mislabels, while expecting a brief screen to do the work of a full evaluation under-serves the clients whose situations are most complex. The competent clinician uses each kind of instrument for its proper purpose, letting a screen open the door that a fuller evaluation then walks through, and understanding which kind of tool is in hand, and therefore what question it can legitimately answer, is a basic element of the diagnostic competence this course builds.

Biological testing occupies a particular place in this instrument landscape and deserves brief attention, because it is both valuable and frequently misunderstood. Urine, blood, hair, and breath testing can confirm recent use, corroborate or challenge a self-report, and monitor abstinence over time, and in these roles it is a useful complement to the clinical evaluation. But a positive test establishes the presence of a substance, not a disorder, and a negative test establishes recent abstinence, not the absence of a disorder, so biological testing supports diagnosis without making it. The diagnosis remains a clinical judgment about a pattern of use and its consequences, for which the eleven criteria, not a laboratory result, are the standard. A clinician who understands this uses testing to inform the evaluation, corroborating the history and monitoring progress, without mistaking a chemical finding for the diagnostic conclusion that only the full evaluation can reach.

The integration of all these information sources, self-report, structured criteria, collateral information, biological testing, and clinical observation, is itself the core skill of the diagnostic evaluation. No single source is sufficient, each has characteristic strengths and blind spots, and the clinician's task is to weigh them together into a coherent conclusion, giving more weight where they converge and investigating where they diverge. A discrepancy between a client's self-report and a biological test, or between the current presentation and the documented history, is not merely a problem to be resolved but information to be understood, often pointing toward exactly the clinical reality the evaluation most needs to grasp. This integrative judgment, rather than the mechanical application of any one tool, is what the diagnostic competencies of this course ultimately aim to develop.

The documentation of the evaluation deserves its own attention, because a diagnosis is only as useful as the record that communicates it, and a well-reasoned evaluation poorly documented loses much of its value. Good diagnostic documentation records not only the conclusion but the evidence for it: which criteria were met, the severity level, the specific findings that support each criterion, the sources of information relied upon, and, where relevant, the reasoning behind difficult judgments such as the substance-induced versus independent distinction. This detail serves the client across every subsequent encounter, allowing a later clinician to understand how the diagnosis was reached rather than merely inheriting a label, and it serves accountability, making the diagnostic reasoning transparent and reviewable. A record that states a diagnosis without its basis asks everyone downstream to trust a conclusion they cannot examine, whereas a record that shows the reasoning invites the ongoing reassessment that good diagnosis requires.

Documentation also protects the client in a system where a diagnostic label can carry consequences well beyond treatment. Because a diagnosis can affect insurance, employment, custody, and legal standing, the clinician has a responsibility to ensure the record is accurate, appropriately qualified where the diagnosis is uncertain, and free of language that overstates confidence the evidence does not support.

A provisional diagnosis should be labeled as provisional, a mild disorder should not be recorded in terms that imply a severe one, and the uncertainty inherent in boundary-line cases should be honestly reflected rather than smoothed over for the sake of a cleaner chart. This care in documentation is not bureaucratic caution but an extension of the same respect for the client and commitment to accuracy that governs the evaluation itself, and it is part of the professional competence a course on clinical evaluation is meant to build.

The evaluation is also best understood as an ongoing process rather than a single event fixed at intake, and building that expectation into practice changes how the initial diagnosis is held. Because severity can be graded and because many of the hardest judgments, such as the substance-induced versus independent distinction, resolve only over time, the diagnosis established at the first encounter is properly a starting point to be confirmed, refined, or revised as more information accumulates and as the client's condition changes with treatment or with periods of abstinence. Reassessing at intervals, rather than treating the intake diagnosis as fixed, captures the trajectory that carries so much clinical information and catches the errors that any single encounter is prone to. A client whose apparent independent depression lifts with a month of abstinence, or whose mild disorder accumulates criteria over a year, is telling the clinician something that only serial evaluation can hear.

This longitudinal view also aligns the diagnostic process with the reality of substance use disorders as chronic, relapsing conditions in many clients. Just as treatment for such conditions is understood to unfold over time rather than to conclude at a single point, so the evaluation that guides treatment is most useful when it, too, continues, updating the picture as the client moves through stabilization, treatment, relapse, and recovery. The competencies this course teaches are therefore not a set of skills exercised once at the front door and then set aside, but a way of thinking about a client that the clinician returns to throughout the course of care, each reassessment sharpening the understanding on which the next phase of treatment depends. Diagnosis, in this mature sense, is less a verdict than a working understanding that grows more accurate the longer and more carefully the clinician attends to the person.

Culture and the Diagnostic Encounter

Diagnosis does not happen in a cultural vacuum, and the DSM-5 recognized this by introducing the Cultural Formulation Interview, a structured set of questions designed to help clinicians understand how a client's cultural background shapes the experience and expression of distress. The international field trial that led to its inclusion, spanning 318 patients and 75 clinicians across six countries, found the interview feasible, acceptable, and clinically useful, with clinician ratings improving after initial use as familiarity grew (Lewis-Fernández et al., 2017). For the practitioner, the tool is a practical means of surfacing the cultural context that can otherwise distort a diagnosis, because symptoms, idioms of distress, and the very meaning of substance use vary across cultures in ways that a criterion checklist alone does not capture.

The stakes of cultural competence in diagnosis are not abstract, because diagnostic bias is documented and consequential. A study of 610 patients with affective disorders found that African American patients were significantly more likely than non-Latino white patients to receive a diagnosis of schizophrenia, with an odds ratio of 2.7, even though the groups did not differ significantly in the severity of their manic and depressive symptoms (Gara et al., 2012). In other words, comparable presentations were diagnosed differently along racial lines, with mood symptoms apparently

under-weighted and psychotic symptoms over-weighted for African American patients. This is exactly the kind of error that undermines the fairness and accuracy of diagnosis, and it can misroute a client toward the wrong treatment for years.

For the practitioner, this evidence is a call to a particular kind of vigilance. Competent diagnosis requires attention to the cultural context of the client's presentation, awareness of the documented tendencies toward bias in psychiatric diagnosis, and a deliberate effort to weight the actual clinical evidence rather than the assumptions that bias introduces. The Cultural Formulation Interview is one concrete tool for this, but the underlying competency is a disciplined self-awareness about how the clinician's own expectations can shape the diagnosis, and a commitment to grounding the diagnosis in the client's actual symptoms understood in their actual context.

The mechanism behind diagnostic bias is worth understanding, because it is rarely a matter of overt prejudice and more often a matter of unexamined pattern-matching. A clinician forms an impression quickly, often within the first minutes of an encounter, and then tends to interpret subsequent information in light of that impression, a tendency that can lead the same symptoms to be read differently depending on the clinician's expectations about a client of a given background. When those expectations track racial or cultural stereotypes, as the evidence on schizophrenia over-diagnosis suggests they can, the result is a diagnosis shaped as much by assumption as by evidence. Recognizing that this operates through ordinary cognitive shortcuts rather than deliberate bias is important, because it means every clinician is susceptible and the remedy is method rather than merely good intentions.

The practical remedy is a disciplined return to the evidence. Slowing the diagnostic process, explicitly considering alternative diagnoses rather than settling on the first impression, weighting the actual reported symptoms rather than the clinician's expectations, and using structured assessment that forces attention to every criterion are all concrete guards against bias. The Cultural Formulation Interview is one such structured aid, prompting the clinician to understand the client's own explanatory model and cultural context before reaching conclusions, but the underlying practice is available to any clinician: to treat one's first impression as a hypothesis to be tested against the evidence rather than a conclusion to be confirmed. Fair diagnosis is not achieved by good will alone but by methods that discipline the clinician's judgment, and adopting those methods is part of the professional competence a course on clinical evaluation must instill.

From Diagnosis to Treatment Plan: The Evaluation as Foundation

Everything in this supplement converges on a single point that this course places at its center: the clinical evaluation is not an end in itself but the foundation on which treatment is built, and the quality of the evaluation determines the quality of everything that follows. A diagnosis that is accurate, appropriately graded for severity, attentive to co-occurring conditions, correct about the independent-versus-substance-induced distinction, and grounded in the client's cultural context leads to a treatment plan that fits the person. A diagnosis that is any of these things wrong leads a client toward treatment that does not fit, with the measurable consequences the outcome research documents.

The evaluation also establishes a baseline against which change can be measured, and this course's attention to the dimensional, severity-graded nature of the DSM-5 diagnosis pays off here. Because severity can be quantified along the criteria a client meets, the evaluation captured at intake can be

compared to reassessments over time, revealing whether the client is improving, stalling, or deteriorating in a way that a single categorical diagnosis cannot. Diagnosis, understood this way, is not a one-time act at the front door but the beginning of an ongoing process of assessment that continues throughout treatment and informs its adjustment.

For the practitioner, the integrating lesson is that the diagnostic competencies this course teaches are valuable precisely because they feed decisions with real consequences. The care taken to distinguish severity levels, to identify co-occurring conditions, to separate substance-induced from independent disorders, and to account for cultural context is not academic precision for its own sake; it is the work that determines whether a client receives treatment that matches their actual condition. The evaluation is where the whole clinical enterprise begins, and doing it well is among the most consequential things a clinician does.

The bridge from diagnosis to treatment runs most directly through severity and through the specific criteria a client meets, which is another reason the evaluation should capture more than the bare diagnosis. Two clients with the same diagnostic label but different severity levels warrant different intensities of care, and two clients with the same severity but different criteria, one whose disorder is marked by physiological dependence and withdrawal, another whose disorder is marked by social and occupational consequences without physical dependence, may warrant different emphases in treatment. The evaluation that records which criteria are met, and how severe the disorder is, hands the treatment planner exactly the information needed to tailor the plan, whereas an evaluation that records only the diagnosis forces the planner to start the assessment over. In this sense the diagnostic detail this course emphasizes is not academic thoroughness but the raw material of individualized treatment.

The co-occurring findings feed the treatment plan just as directly. An evaluation that identifies a co-occurring psychiatric condition signals the need for integrated treatment and for coordination with psychiatric care, while one that identifies the substance use as substance-induced rather than independent signals a different plan again, in which the psychiatric symptoms are monitored for resolution with abstinence rather than treated as a standing disorder. Each diagnostic judgment the evaluation makes therefore has a treatment consequence attached, and this is why the care taken in the evaluation is repaid many times over in the appropriateness of the treatment that follows. The clinician who treats the evaluation as a hurried preliminary to the real work of treatment has the relationship backward, because the evaluation is what makes the treatment fit the person.

The Ethics and Competence of Diagnosis

Diagnosis is an act with power, because a diagnostic label shapes how a client is treated, how they are seen by systems and by themselves, and what care they receive, and this power carries ethical weight that this course rightly treats as foundational. Competence in diagnosis is not optional expertise but an ethical requirement, because a clinician who assigns a diagnosis without understanding the reliability of the criteria, the meaning of severity, the difficulty of the substance-induced distinction, and the risk of cultural bias can do real harm, misclassifying a client, misdirecting treatment, or attaching a label that follows the person and shapes decisions for years.

The evidence reviewed here defines what that competence requires. It requires understanding that psychiatric diagnosis is reliable but not perfect, and holding boundary-line diagnoses with humility. It

requires attending to severity rather than only to the presence of a diagnosis, because the same label covers a wide range. It requires the patience to distinguish substance-induced from independent conditions over time rather than settling the question prematurely. It requires evaluating for co-occurring conditions as a matter of routine. And it requires vigilance about cultural context and about the clinician's own susceptibility to bias. These are not separate rules but facets of a single professional stance, that the diagnosis serves the client and that the clinician remains responsible for its accuracy and its use.

Alongside competence sit the enduring obligations of honesty and respect: explaining the diagnosis to the client in terms they can understand, being candid about its uncertainty where uncertainty exists, and treating the client as a person whose experience is the primary evidence rather than as a case to be categorized. A diagnostic system as detailed as the DSM-5 can tempt a clinician to treat the criteria as the reality and the person as an instance of a category, and resisting that temptation, using the diagnostic framework to understand the person rather than to replace understanding, is the deepest competency this course cultivates. The framework is a powerful tool, and like any powerful tool its value rests entirely on the judgment and the integrity of the clinician who wields it.

The obligation of informed consent takes a particular form in diagnosis that clinicians sometimes overlook. A diagnostic label can affect a client's access to services, insurance, employment, and legal standing, and it can shape how the client understands themselves, so the client has a legitimate interest in understanding what the diagnosis means, how certain it is, and how it will be used and recorded. Explaining the diagnosis in plain terms, being honest about its uncertainty where the picture is not yet clear, and being transparent about who will see it are part of respecting the client as a participant in their own care rather than a passive object of assessment. This is especially important for the milder and boundary-line diagnoses, where the label carries real weight but the underlying condition may be genuinely uncertain, and where an over-confident or carelessly communicated diagnosis can do lasting harm.

There is also a humility proper to diagnosis that the evidence in this supplement supports. The reliability data show that even skilled clinicians using good methods sometimes disagree, the severity and orphan findings show that the boundaries of disorder are genuinely fuzzy, the substance-induced distinction shows that some questions cannot be answered at a single point in time, and the bias findings show that the clinician's own mind can distort the conclusion. None of this counsels paralysis, because clinicians must and do reach usable diagnoses every day, but all of it counsels a stance that holds the diagnosis firmly enough to act on and loosely enough to revise, that treats the label as the best current understanding rather than a fixed truth, and that remains open to the evidence that would change it. That combination of decisiveness and humility, grounded in an accurate understanding of what diagnosis can and cannot do, is the deepest professional competence a clinical evaluation demands, and it is what this course exists to cultivate.

BACKGROUND

Clinical evaluation is the first steps to helping individuals with mental illness, substance use disorder (SUD), and co-occurring disorders (mental illness and SUD) receive the best care. The evaluation process is key to proper diagnosis, treatment planning, and appropriate referrals. Clinicians and clinicians must be trained properly and qualified to be able to provide accurate evaluations. Inaccurate evaluations and lack of appropriate personal qualities, can result in poor or incorrect treatment planning and/or referrals.

Before a person enters a treatment program or counseling, the individual is evaluated per specific criteria that determines if a person has symptoms suggestive of mental illness, SUD or co-occurring disorders (COD). Through building of rapport, this initial process gives the clinician an opportunity to get to know the client better, and begin to establish the therapeutic alliance. In general, the evaluation consists of gathering data such as biopsychosocial history, symptoms, duration and frequency of symptoms, drug/alcohol use history including onset and amounts, and interpersonal relationships. In addition, the data gathered includes health, mental health, substance related treatment histories, mental and functional status, and current social-environmental--economic constraints. Other data collected may include observation of the individuals' appearance, posture, and ability to make eye contact. The evaluation should provide a summary, a possible diagnosis, and treatment recommendations.

Clinical evaluations need to capture the extent and complexity of the many factors that accompany, potentially maintain, and are affected by a mental illness and/or alcohol and other drug use (AOD). The evaluation may also include determining the individual's readiness to change. The process is not one of inclusion but of ruling out. The clinician should always ensure that the individual receives the best and most appropriate treatment and services available, even if it requires referring the individual elsewhere.

It is important for the clinician to build a rapport with the individual both verbally and nonverbally to gain more accurate information. The potential client should always be addressed with patience, empathy, kindness and understanding as they may be experiencing an array of emotions that range from fear, shame, embarrassment, and possibly intoxication.

The client's motivation and commitment to their treatment begins in the clinical evaluation phase. The clinician should be aware of their own biases, values, and beliefs and the effect that it may have on the individual and their treatment process.

INTRODUCTION

Clinical evaluation is defined as a systematic approach in which clinicians or clinicians become to know a client. The purpose of a clinical evaluation is to determine the services and treatment necessary for an individual. This is accomplished by gathering information and data from the client and other sources using screening instruments and other methods that are sensitive to age, developmental level, culture, and gender. The evaluation process consists of two phases: ***screening and assessment***.

Clinicians need to be knowledgeable of SUD and mental illnesses so he/she can ask pertinent questions to discover information or history needed to establish the basis for an intervention. In addition to knowledge, clinicians must process excellent communication skills both verbal and nonverbal. The qualifications must include specific communication skills and key traits that will be described herein.

In addition, the clinician must be familiar with the **DSM-5** (the 5th edition of Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association. Everyone who evaluates mental health clients (including SUD clients), must understand this manual because it is the world standard for evaluation and diagnosis. The clinician must be familiar with terms, descriptions, codes and definitions as presented in the DSM-5. Understanding the DSM-5 is crucial to ensure that the right screening and assessment tools are utilized and that the correct diagnosis is determined during the assessment. In addition, the clinicians conducting evaluations must have an understanding of alcohol/other drugs, mental illness, and how to assess co-occurring disorders.

This is a comprehensive document that includes the qualifications needed for clinicians conducting evaluations, an introduction to the DSM-5, the two phases of evaluations and an introduction to treatment planning as it relates to the outcomes of evaluations.

Section 1 begins with clinician qualifications needed to conduct evaluations. This includes personal qualifications and knowledge. The knowledge base includes an introduction to the DSM-5, SUD classifications and criteria based on the DSM5, mental disorders brief description, and co-occurring disorders.

Section 2 describes the evaluation process which includes screening and assessment. It also contains an introduction to treatment planning as it relates to the results of the evaluation process.

The **appendices** include summaries of DSM-5 SUD and mental disorders symptoms, durations, and differential diagnosis. In addition, last two appendices list some of the tools for screening and assessments with links for those readers that want to gain more insight. The authors do not endorse nor recommend any specific tools. These are included as a guide.

SECTION 1

QUALIFICATIONS FOR CONDUCTING EVALUATIONS

It is critical that the clinician builds a rapport with the client from the beginning which will help obtain a better understanding of the individual's history and other information later in the evaluation process. The clinician should be mindful of the individual's state of mind and be empathetic, kind, and client. The clinicians or clinicians conducting evaluations, must have the following qualifications bases of three main categories*: personal qualities, knowledge, and skill*. Personal qualities apply for both, the screening process and the assessment. However, clinicians conducting assessments must have a deeper knowledge of SUD, mental disorders, co-occurring disorders, and application of knowledge to skill as relevant to the DSM-5 to determine correct diagnoses and give recommendations for treatment.

PERSONAL QUALITIES

According to NADAAC (8), the **personal qualities** of a clinician include **key traits** and excellent **communication skills.** The interconnected **key traits** are: *immediacy, warmth, personal ability, positive regard and respect,* and *genuineness*. **Communication skills** include: *good verbal communication* and *nonverbal responses.* Lastly, the Addiction Counseling Competencies (5) identifies specific competencies, knowledge and skill relevant to the practice domain of clinical evaluation.

KEY TRAITS

Immediacy refers to staying focused on the issue at hand, attending to what is important to the individual being evaluated, and being able to adjust fluently to changing topics.

Warmth is demonstrating humanness, showing empathy, showing understanding, being aware of multi-cultural issues, not being confrontational, and demonstrating acceptance of where the client is at now.

Personal ability means that the clinician has sound psychological health, is competent on his/her role, is comfortable taking about a variety of issues, and has a sense of self-awareness.

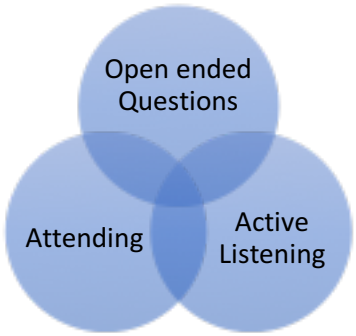
Positive regard and respect: regard is the attitude of respect, while respect is the action. It means that the clinician is nonjudgmental, open-minded, objective, sensitive and trustworthy.

Genuineness in a clinician means that he/she likes helping others, not phony, demonstrates a desire to comprehend, and exhibits congruent external behavior with internal feelings.

COMMUNICATION SKILLS

Verbal communication skills for an effective clinician include knowing when and how to ask *open ended questions*, how to *actively listen verbal responses*, and how to provide *attending responses* to clients.

Open ended questions are those that start with "who, what, why, how, where, used to elicit more information. Closed ended questions are useful for determining specific information needed such as age, date of birth, education level, place of employment.



Active listening skills requires the clinician to concentrate fully, understand, respond and remember what is being said. It affirms to the client that what they are communicating is important. It involves listening with all of our senses rather than just hearing what is said.

Attending responses are a twofold process. First, it lets the client know that he or she is being heard, and second it helps the clinician ensure understanding of the client's statement. During an evaluation, these responses can be repeating what the client said, paraphrasing, clarifying, and/or summarization.

Listening and attending responses involves multiple processes: Receiving and sending the client's messages, both verbal and non-verbal; Cognitive processing of client's information, both spoken and behavioral; Eye contact; and Maintaining a professional posture and manner.

Nonverbal responses transfer nonverbal signals to the client through the clinician's body language and facial expressions. These include maintaining eye contact, respecting cultural boundaries, and maintaining a professional posture and manner that are relaxed and open style. Being knowledgeable of the many nonverbal responses of self and the client is key to building rapport.

Nonverbal is the majority information, often unintentional, sent between persons. The client look to the clinician for understanding or signs of judgement or approval. Therefore, it is imperative for the clinician to be aware of all message relayed in the interaction. The following are brief examples of body areas that transmit nonverbal responses:

Eyes: maintain direct eye contact to indicate willingness to continue to obtain information.

Head: erect but relaxed head helps indicate receptivity.

General facial expressions: eyebrows should be relaxed to avoid frowning. Nodding while listening shows that the clinician agrees or is actively listening.

Hands and arms: openness may be signaled by relaxed unfolded arms.

Legs and feet: Openness may be signaled by legs and feet that are relaxed and comfortable.

Examples of Listening and Attending Responses

Clarification: to ensure accuracy and understanding. “Are you saying . . .” “Could you clarify that for me?” “Please explain . . . ?

Paraphrasing or Restating: listening for content and affect; a restatement of the clients’ words and emotions that leads to further discussion. “I sense that ...” “Sounds like ...” “As I see it ... “

Reflection: to identify the feelings of the client and to repeat them back to him/her, with an emotional tone or quality to the client’s message; it helps clients differentiate accurately between feelings. “It’s clear you are really angry right now” “Is that pretty close to what you were feeling?” “It seems like you are feeling …”

Summarization: to tie together multiple elements, serving as feedback, carefully tying together patterns or themes. “At the beginning for the session . . . Next in our discussion we explored . . . Finally, we ended with . . . Does that make sense?”

ACTION RESPONSES

To further interact with the client, the clinician must listen and comprehend what is being said, but also elicit information to gain a more complete picture of the presenting problem. Using a variety

of action responses will encourage the client to dig deeper, or disclose more information. These include:

Probing or Questioning – centers on the concerns of the client; for the client to further explore and express information, emotions or experiences. It is helpful for the clinician to open ended questions, asking only one question at a time.

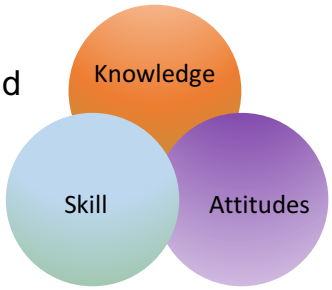
Confrontation – where the clinician points out discrepancies, inconsistencies, or other mixed messages in the client's thoughts, feelings and actions. In order for confrontation to be most effective, the clinician must develop therapeutic rapport before confrontation is used. When used too early in the relationship, confrontation can be detrimental to the client and the therapeutic process.

Interpretation – a type of action response that deals with implicit client messages, where the clinician provides the client with another explanation for his or her thoughts, attitudes, or behaviors. It can identify patterns in the client's behavior or communication, and promote insight.

COMPETENCIES

The *knowledge* includes screening and assessment training, plus understanding the **DSM-5**, **SUD**, **mental disorders**, **co-occurring disorders** and the screening tools for each disorder. This base knowledge will allow the professionals conducting evaluations to screen and assess for a variety of drugs of abuse, alcohol, and co-occurring disorder. Clinicians can obtain their knowledge though training, classes, observation, and research. Necessary skills are needed for the competent substance abuse professional to apply knowledge to practice. Not all substance abuse clinicians are initially experienced or proficient, but with guidance and supervision, one will improve one's **knowledge, skill and attitude**, gradually improving one's competence from novice to mastery.

Competencies



Clinical Evaluation includes two elements: Screening and Assessment. Each competency identifies specific knowledge, skills, and attitudes necessary for the addiction professional. There are 13 Competencies identified for the domain of clinical evaluation (5): nine included under Screening, and 4 included under Assessment.

A summarized listing of each Competency, and respective Knowledge, Skills, and attitudes include:

The competencies for **Screening** include:

Competency 24: Establish rapport, including management of crisis situations.

- Knowledge: understanding the importance of establishing therapeutic rapport; what constitutes a crisis and steps necessary to address or avert crises.
- Skills: communication skills, identifying and reflecting client's feelings, demonstration of empathy, respect and genuineness.
- Attitudes: Recognition of personal biases, values, and beliefs and impact on communication and treatment process; willingness to establish rapport.

Competency 25: Gathering of data systematically

- Knowledge: use of validated screening instruments; interpretation of test results; understanding cultural context of client data collected; client mental status; confidentiality.
- Skills: administration of screening and scoring instruments; communication effectively; writing accurately; concisely and legibly.
- Attitudes: appreciation for value of data gathering process.

Competency 26: Screening for psychoactive toxicity, intoxication and withdrawal symptoms.

- Knowledge: symptoms of intoxication and withdrawal; varied implications and effects of substance use; resources for toxicity screening; risk assessment;

legal requirements concerning suicide and violence potential and respective reporting.
- Skills: eliciting pertinent information, interventions, assessing suicide/violence risk potential, preventing/managing crises.
- Attitudes: willingness to be respectful of client in his or her presenting state; appreciation of importance of empathy; appreciation of importance of legal obligations.

Competency 27: Assisting client in identifying the effect of substance use on one's life.

- Knowledge: the progression and characteristics of SUD, effects of psychoactive substances on thoughts, emotions, and behaviors; denial / defense strategies.
- Skills: establishing therapeutic rapport, interviewing and communication skills, assessing and interpreting skills.
- Attitudes: respect for client's perception of one's experiences.

Competency 28: Determining the client's readiness for treatment and change

- Knowledge: assessing for readiness for and stages of change, treatment options; role of family / significant other in supporting or hindering the change process.
- Skills: assessing readiness for change, internal/external motivators; needs of family/significant others for support, referral and follow-up skills.
- Attitudes: acceptance of non-readiness of change, that motivation is not a prerequisite for treatment, and of client's self-assessment.

Competency 29: Review treatment options as appropriate for client's needs

- Knowledge: treatment options and philosophies; connection of clients' needs to related options and / or treatment resources.
- Skills: eliciting and determining client needs; matching with appropriate recommendations for treatment or community supports.
- Attitudes: appreciation of various treatment approaches; willingness to link clients to various helping resources.

Competency 30: apply accepted criteria for diagnosis of substance use disorders in making recommendations for treatment.

- Knowledge: continuum of care; level of care placement; current diagnostic criteria.
- Skills: use of accepted diagnostic criteria standards; use of appropriate placement criteria; development of diagnostic impression.
- Attitudes: recognition of one's limitations of practice; willingness to base treatment recommendations on client's best interests and preferences.

Competency 31: Construct an initial action plan.

- Knowledge: of appropriate content; format and process to develop initial action plan; assessing client's needs; available resources for admission or referral.
- Skills: development and documentation of action plan; contracting with client for to implement initial action plan.
- Attitudes: willingness to work collaboratively with client and others.

Competency 32: Based on initial action plan, take specific steps to initiate admission to treatment or make appropriate referral.

- Knowledge: admission and referral protocol; referral resources, ethical standards for making referrals; documentation and confidentiality requirements.
- Skills: communication; networking: negotiating, advocating, facilitating client follow through; documenting.
- Attitudes: willingness to renegotiate.

The competencies for **Assessment** include:

Competency 33: Select and use a comprehensive assessment process.

- Knowledge: basic concepts of test reliability and validity; validated assessment instruments and protocols: effect of various elements on appropriateness of assessments: range of areas to be assessed in comprehensive assessment.

- Skills: selection of appropriate assessments: introducing, explaining and conducting comprehensive assessment; addressing client perceptions of issues being assessed.
- Attitudes: respect for limits of assessment instruments, of one's ability to interpret them; willingness to refer for more specialized assessment.

Competency 34: Analyze and interpret the data to determine treatment recommendations.

- Knowledge: appropriate scoring methodology; analysis and interpretation of assessment results; range of treatment options.
- Skills: scoring and interpreting of assessment tools; using results to identify client needs; communication recommendations to client / referral sources.
- Attitudes: respect for the value of assessment in determining the most appropriate treatment plan.

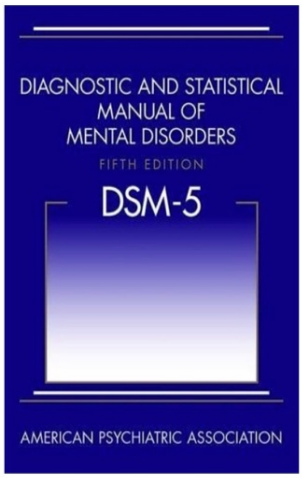
Competency 35: Seek appropriate supervision and consultation.

- Knowledge: clinician's role and responsibilities; scope of practice; limits to one's training/education/scope; role of supervisor; available consultation resources.
- Skills: recognizing need for supervision and consultation; documentation; incorporating information into practice from supervisor's / consultant's findings.
- Attitudes: commitment to professionalism; acceptance of one's limitations and willingness to continue learning and improving clinical skills.

Competency 36: Document assessment findings and treatment recommendations.

- Knowledge: agency policy / procedures; professional terminology; legal implications of actions; application of confidentiality and clients' rights.
- Skills: providing clear, concise, and legible documentation; incorporating information from various sources; preparing and presenting findings to client and other professionals within bounds of confidentiality.
- Attitudes: recognition of the value of accurate documentation.

DSM-5



The DSM-5 does not list co-occurring disorders, however, symptoms, duration, and differential diagnosis for drugs, alcohol, and mental disorders can assist the clinician selecting evaluation tools.

The DSM 5 has moved to nonaxial assessments. Clinicians can, however, use formal or informal assessment to explore and understand the client. The DSM-5 also includes a Cultural Formulation Interview (CFI) that clinicians can use to help them understand the client. The CFI may assist the professional to obtain the most clinically useful information, develop an interpersonal connection with their client and ultimately make accurate diagnoses.

Below is a brief introduction to the DSM-5 which includes SUD and mental disorders. The appendices contain additional information of mental illnesses and summary about how different substances abused may portray symptoms of mental illness.

SUBSTANCE USE DISORDER (DSM-5)

The DSM-5 no longer uses the terms substance abuse and substance dependence. Instead, it collapses them into one single category: Substance Use Disorders (SUD). This offers a recognition that there is no distinguishing line between substance abuse and substance dependence disorders. While the term *addiction* is commonly used in profession, this is a professional term rather than one used as a diagnostic term.

DSM-5 also assembles a certain pattern of behavior into the spectrum of addictive disorders, using broad diagnostic categories associated with each group of substances. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

The DSM-5 uses nine specific classes of substances and three basic substance related categories for each substance.

Specific Classes:

- Alcohol
- Caffeine*
- Cannabis (e.g., marijuana)
- Hallucinogens
- Inhalants
- Opioid (e.g., heroin)
- Sedatives, Hypnotics, or Anxiolytics (e.g., valium, "Quaaludes")
- Stimulants (cocaine, methamphetamine)
- Tobacco

* Substance Use Disorder does not apply to caffeine. Rather Caffeine Intoxication and Caffeine Withdrawal are newly identified in the DSM-5. Also noteworthy is the addition of Gambling Disorder in the DSM-5, identified as a non-substance related disorder. For purposes of this text, please refer to the DSM-5 for the relevant criteria.

The addition to caffeine and gambling as classes included in the SUD section appears associated with increasing emphasis on neurobiological basis of mental disorders and the developing understanding of the impact of the brain as associated with the use of mood altering substances of behaviors. The area of the brain that is affected by gambling is the same area activated by mood altering substances.

Categories:

a) Substance Use Disorder

b) Substance Intoxication

c) Substance Withdrawal

Substance Use Disorder symptoms (a) are the same for most substances. It includes behavioral, physiological, and cognitive symptoms: the use is problematic, the effects are clinically important, it causes distress and/or impairment. The interference in the client's life must be shown by at least *2 symptoms* from a list of eleven:

1. More use than intended
2. Attempts to reduce usage
3. Much time is spent getting or using substance
4. Cravings for substance
5. Not attending consistently to obligations (shrinking of obligations)
6. Social problems
7. Reduction of activities
8. Use despite its physical danger
9. Use despite of physical or psychological disorder
10. Development of tolerance
11. Withdrawal symptoms is substance use is stopped

The degree of severity of the diagnosis is rendered based on affirmation of a number of symptoms. To illustrate how the symptoms, severity, and categories for SUD are applied using the DSM-5, below is an example using alcohol:

Alcohol Use Disorder (AUD)

A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Alcohol is often taken in larger amounts or over a longer period than intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Client experiences craving, or a strong desire, or urges to use alcohol.
5. Recurrent alcohol use, results in a failure to fulfill major role obligations at work, school, or home.
6. Individual continues alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Person has recurrent alcohol use in situations where it is physically dangerous.
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Individual develops tolerance (larger quantities of alcohol are needed to produce the same effect).
11. Individual experiences withdrawal symptoms when alcohol use is stopped or dramatically reduced (see withdrawal symptoms under alcohol withdrawal)

Severity:

Mild: 2-3 symptoms.
Moderate*:* 4-5 symptoms.
Severe: 6 or more symptoms.

Alcohol Intoxication

Shortly after drinking, the client:

- Becomes disinhibited: argues, aggressiveness, rapid mood shifts, impairment of attention, impairment of judgement.
- Has neurological impairment: imbalance, unclear speech, poor coordination, jerking eye movement, and reduced level of consciousness

Differential diagnosis: (when the criteria for a substance /medication induced disorder are included with disorders with which they share phenomenology. DSM-5)

- Alcohol induced anxiety disorder
- Bipolar mania
- Dementia
- Dysthymic disorder
- Inhalant abuse
- Liver failure
- Panic disorder
- Prescription drug abuse
- Primary (idiopathic) insomnia
- Social phobia
- Substance abuse

Alcohol Withdrawal

The symptoms of alcohol withdrawal syndrome develop within several hours to a few days after individual stops drinking. These include: insomnia, autonomic symptoms (including, sweating or racing heart), increased hand tremors (known as “the shakes”), nausea and/or vomiting, psychomotor agitation (feeling physically restless, inability to stop moving), anxiety, seizures (typically the generalized tonic-clonic type, which is characterized by rhythmic, yet jerking movement, especially of the limbs), hallucinations or perceptual disturbances, and convulsions.

A person must experience a combination of two of more of these symptoms. Significant distress or impairment in social, occupational, or other important areas of functioning must also be present.

Appendix I contains a table with some drugs of abuse. **Click here for more information**. ***The table is a summary and it not all inclusive. Please use the DSM-5 for detail information of SUD, Intoxication, and Withdrawal***.

Differential Diagnosis:

- Diabetic ketoacidosis
- Essential tremor
- Hypoglycemia
- Sedative hypnotic anxiolytic intoxication
- Sedative hypnotic anxiolytic withdrawal

MENTAL DISORDERS (DSM-5)

It is important for the clinician conducting an evaluation to be familiar with the DSM-5 mental disorders to use the appropriate screening tools. The term *Co-occurring Disorders* refers to when a client that has concurrent SUD and mental illness(es). Therefore, it is critical for a clinician to learn mental disorders in addition to substance use disorders.

Appendix II has a list of the most common mental disorders. **Click here for more information**. ***This is not an all-inclusive list. Please refer to the DSM-5 for detail information about the mental disorders listed, codes, and the mental disorders not mentioned in the table***. *The table is meant to be an introductory summary of mental illnesses.*

CO-OCCURRING DISORDERS

Co-occurring disorder (COD) is the simultaneous presence of two independent but interactive medical disorders. This terminology is used for clients that have SUD and mental disorder(s). It may difficult to treat particularly when one is exacerbated by the other.

Because of the high prevalence of COD in treatment settings, and because treatment outcomes for individuals with multiple problems improve if each problem is addressed specifically, it is recommended that all individuals presenting for treatment for a mental disorder also be routinely screened for substance use disorders.

Common disorders co-occurring with SUD include:

Depressive disorders, including major depression disorder and bipolar disorder. People who suffer from depression often have both physical and psychological symptoms. Excessive guilt, sadness or anger, feelings of worthlessness, lack of interest in things the person once enjoyed and suicidal thoughts are psychological symptoms of depression. Depressed people sometimes feel tired no matter how much sleep they get. They may overeat or under-eat and oversleep or under-sleep. People who suffer from bipolar disorder move back and forth between depression and mania. Mania is a heightened state of elation along with feelings of grandiosity, excessive risk-taking and difficulty concentrating.

Anxiety disorders. Anxiety is characterized by excessive worrying. Anxious people often obsess over real or imagined problems and have difficulty sleeping because of worrying. They may have physical symptoms such as fatigue and muscle tension and often have difficulty concentrating or sitting still.

Neuropsychological disorders. People who have autism spectrum disorders or other disorders with a neurological basis may have thought and behavior patterns that differ from the norm. They process emotional and intellectual information differently and may behave oddly as a result.

Psychotic disorders. Schizophrenia and other psychotic disorders involve experiencing visual or auditory hallucinations and delusions. People suffering from psychotic disorders often have disorganized thought and speech patterns.

Traumatic Disorders. People who have been through extreme stress may be suffering from post-traumatic stress disorder, multiple personality disorder or other disorders that involve dissociation. Sufferers may continually relive a traumatic event such as an assault or may have blocked memory of the event from conscious awareness.

It's also important to realize that substance abuse therapists aren't trying to "prove" that someone has a disorder or diagnose "what's really wrong" with a substance abuse client. Co-occurring disorders contribute to the continuation or problematic development of use of substances, and make it more difficult for the client to stop drinking or using drugs. In addition, clinicians want to build rapport with the client, with the intention of the client feeling comfortable sharing history and emotions so they can effectively provide clinical services. Thus, during the initial meeting, the professional will attempt to understand the problem from the client's point of view rather than ask a series of pointed questions to try to determine the exact nature of the issue. (13)

Psychoactive substances and mental disorders can interact in different ways. In addition, not every client with COD will exhibit the same symptoms. The disorders usually relate as follows [8]:

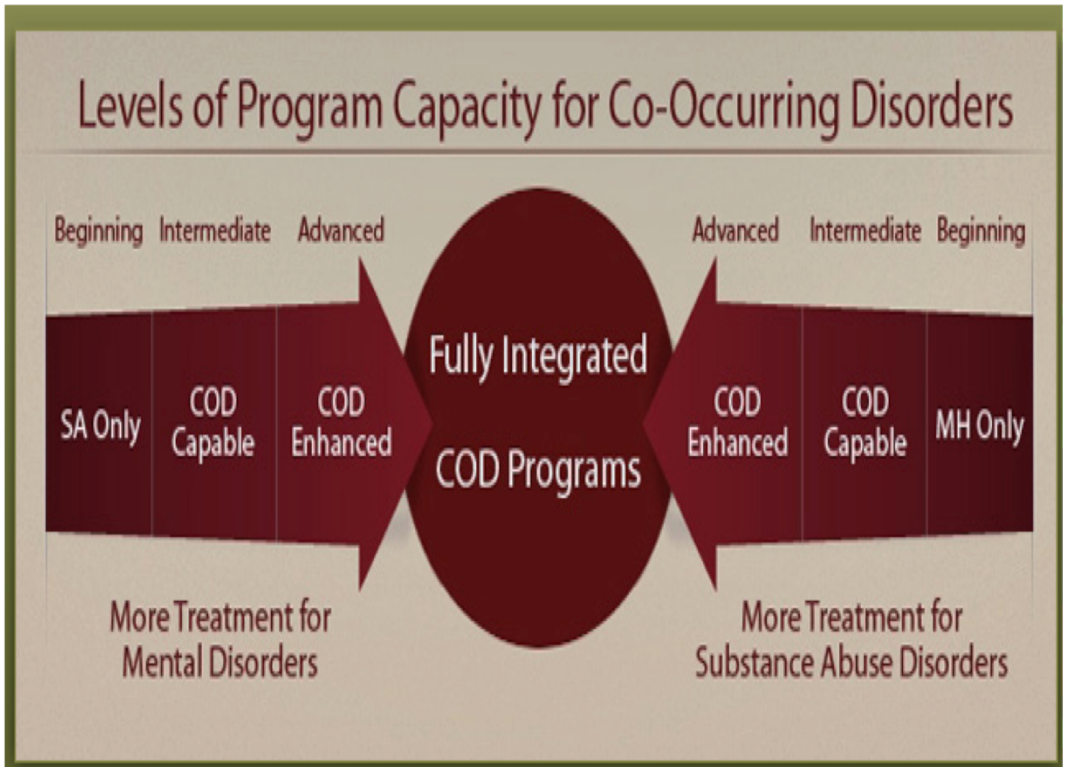
- SUD can cause and/or mimic psychiatric disorders
- SUD can initiate or exaggerate mental disorders
- SUD can hide mental disorders symptoms
- SUD withdrawal can cause or mimic mental disorders
- SUD and mental disorders can independently coexist
- Mental disorders can mimic SUD

The primary diagnosis is the disorder that appeared first in the client's life.

The secondary diagnosis is the disorder that appeared second in the client's life.

Co-occurring disorders can be assessed and treated considering:

1. **Sequential treatment*:*** Client is assessed and participates in one treatment and then the other. In the below diagram this is synonymous with *Beginning* level of program capacity where staff are singly trained in their unique specialization, and have limited knowledge and experience is assessing each MH/SUD.
2. **Parallel treatment*:*** Client simultaneously participates in two separate treatments, i.e. attends substance abuse treatment and mental health treatment at the same time. Again in the below diagram, this is synonymous with *Intermediate* level of programming, or Co-Occurring Capable level, where the substance abuse professional and the mental health profession collaborate on the team.
3. **Integrated treatment**: Client participated in a comprehensive treatment program for co-occurring disorders. Integrated interventions include specific treatment techniques where interventions for both disorders are combined in one session. Finally, Integrated Treatment for Co-occurring Disorders is the best practice, where a single clinician is trained to assess and treat the clients' mental health and substance use disorders.



Levels of Program Capability in Treatment of Co-Occurring Disorders. SAMHSA, TIP 42 (3).

SECTION 2

THE EVALUATION PROCESS

THE EVALUATION

An Evaluation is “a systematic process to screening and assessment of individuals thought to have a substance use disorder, being considered for admission to addiction-related services, or presenting in a crisis situation” (5). When the clinician is evaluating a client, s/he is doing so to establish rapport with the client, screen for appropriateness, determine if admission to treatment is necessary, at what level of care, support initial treatment planning, and to evaluate the client’s progress in treatment.. It is comprised of two elements: Screening and Assessment.

Screening

The screening is a triage process, and should be conducted with all persons accessing services. It is the first element of the evaluation where the potential client is briefly interviewed to determine if s/he has symptoms or behaviors that meet eligibility criteria or conditions that determine appropriateness for treatment at that specific facility. Through preliminary gathering and sorting of information gained in the screening, it is used to determine the most appropriate initial course of action. The screening may be conducted over the phone or in person, and may include gathering of information from the referral source, any available family or significant others as permitted by the client.

During the screening process the clinician gathers client’s *personal information*, explains and has the client sign *confidentiality information*, the client completes a *screening tool*, the clinician *interviews* the client and family members (if available), explains *programs and fees*, and determines if the client needs *further assessment*. More details of the data are listed below:

a) Personal information: the clinician acquires the name, address, age, and gender of the individual; and why they are seeking treatment.

b) Confidentiality: the confidentiality guidelines and limitations are reviewed with the individual. Confidentiality is the legal and professional obligation to the individual and of the profession.

c) Screening Tools: There are many different types of screening instruments/tools that are available. These screening instruments can measure current and past substance use, health, mental health and mental illnesses, mental illness or substance-related treatment histories; mental and functional statuses, and current social and environmental and/or economic constraints. The screening processes always supports a protocol or procedure to determine which clients need further assessment for the condition being screened and to ensure that those clients receive a thorough, comprehensive assessment. Furthermore, a screening protocol must precisely define how to score responses of the screening tools or questions used and what constitutes a positive score for a possible problem (often called a "cutoff" score). In addition, the screening protocol must detail the actions taken after a client scores in the positive range and specifies the standard forms for documenting the results of the screening, the actions taken, the tools used, and the actions each staff member has carried out in the process. The screening does not result in a clinical diagnosis nor provides details of how substances or mental illnesses have affected the client's life, rather it is a process for determining the need for further clinical assessment.

Examples of screening tools are:

SUD

Alcohol Use Disorder: AUDIT, ACE, ADS, AUS, and MAST

Alcohol and Drugs Use Disorders: NIDAMED, CAGE AID, ASSIST, and SASSI

Drugs Use Disorders: DAST-10, ABC

CO-OCCURRING DISORDERS: MMS, K10 and K6 Scales, PRISM, AC-OK

MENTAL DISORDERS

Anxiety: GAD-7

Depression: PHQ-9

Bipolar: MDQ

Trauma: PC–PTSD, PCL-C, LEC

Suicide: C-SSRS, SAFE-T

Appendix IV contains a Screening tools table with links to the tools. **This is not all inclusive and authors do not endorse or prefer any specific tools.**

d) Interview: The process of asking the client questions designed to identify the history (past and present) of AOD use, mental illness or co-occurring disorders, emotional and physical health, social roles, and other areas that may reflect the severity of the individual's SUD / mental illness.

e) Program and fees: The clinician briefly discuss the treatment program of interest, the scope of practice, fees for services, payment plans, appointment scheduling, program philosophy, and the credentials of all primary service providers. This helps the client understand services and treatment that will be provided.

f) Referral for assessment: Based on the information collected during the screening, the clinician makes recommendations and determines if the evaluation needs to continue with and assessment. Should the client not meet the agency's eligibility criteria for admission, the clinician should refer the client to a professional / facility that can best accommodate the identified presenting problem and needs.

Assessment

The primary purpose of the assessment is to get a better picture of the individual's substance abuse, mental illness or co-occurring disorder pattern and history, social and psychological functioning, and treatment needs. The clinician discussed the consequences of his or her substance use or mental illness and he/she is challenged to see that continuing the behavior is a personal choice. The assessment has five major objectives:

1) To identify client's problems related to mental illness or a psychoactive substance use disorder

2) To assess these problems currently experienced by the client. The clinician should rate the symptom severity, diagnose evident mental disorders and screen for related problem areas

3) To provide information for planning and appropriate treatment interventions for the client

4) To involve the appropriate family members or significant others in the client's evaluation and treatment

5) To determine the methods for evaluating the effectiveness of the treatment interventions that will be implemented

There is no standard assessment tool for COD. Assessment of substance use disorders, like mental disorders, may include administration of assessment instruments, as well as an in-depth

clinical interview, a social history, a treatment history, interviews with friends and family after receipt of appropriate client authorization(s), a review of medical and psychiatric records, a physical examination, and laboratory tests.

Regarding COD, one goal of the assessment process is to understand what role alcohol or other drug use plays in the initiation, maintenance, intensification, or diminishment of mental disorders or in the symptoms of mental disorders. Another goal is to understand how, when, or if mental health symptoms influence alcohol or drug use initiation, maintenance, relapse, and/or recovery. For example, sleep disturbances regularly begin to occur after years of heavy drinking, and sleep-related symptoms are also a common part of the symptom picture in depressive disorders. An assessment would aim to clarify the interrelationship between a client's sleep disturbances, alcohol consumption, and depression.

DSM-5 **Differential diagnoses** is a list of possible alternative diagnosis for each substance and for each mental disorder. Refer to Appendix I and II for examples of differential diagnosis in SUD and mental illnesses. They are contained within the brief disorders examples obtained from the DSM-5.

Assessments are grouped under three broad domains: **socio-behavioral domain and support systems, psychological domain, and physical domain.** Once all these data are collected, the clinician prepares a summation.

Socio-Behavioral Domain and Support Systems

The socio-behavioral domain explores the individual's social world, behavioral history, AOD use, social support and social roles. The following, describe in more detail most of the information that a clinician should record.

a) Client's alcohol / other drug use history**:** age at first use; last use; frequency, amounts, and patterns of use; route of administration; types of drugs used and most recent use; progression of use; tolerance change; times of loss of control; resulting consequences; previous attempts at self-help; prior formal treatments, environment of care, length of stay, and outcome; sobriety history; relapse history; client's perception of the problem; client's current level of motivation for treatment; DSM-V classification.

b) Client's mental illness history: age when first symptoms appeared; frequency of symptoms, progression of symptoms or disorder; consequences; prior treatment, environment of care, length of stay, and outcome; client's perception of the problem; client's current level of motivation for treatment; DSM-V classification.

c) Precipitating circumstances**:** internal/familial stress; trauma/grief; stress/stressors; legal issues; financial issues; career status; school issues and status.

d) Education: highest level of education completed / from where/ year completed; previous academic performance; general academic abilities; attitude concerning school; disciplinary actions in school; learning disabilities, if any; literacy; emotional supports within school; impact of AOD or MH symptoms on school performance.

e) Employment: work history, attendance and absenteeism; special abilities or competencies; employment needs, if applicable; impact of AOD or MH symptoms on work performance.

f) Legal Issues: history or arrests, charges and convictions; charges that were dropped or did not result in a legal disposition; pending charges: probation and/or parole history, and any violation of probation; amount of time incarcerated (jail or prison); previous arrests, charges, convictions; criminal involvement due to addiction; potential impact on treatment and/or continuing care.

g) Social life**:** general peer group associations; history and stability of friendships, relationships, and associations; Level of "connectedness" or belonging; general level of trust for others; behavioral background; attitude toward authority figures; personal involvement in drug culture; impact of addiction in social realm.

In the Support Systems, the professional should discuss with the client the extent of their support system as it pertains to their treatment. The professional should also discuss with the individual what their role is in the family and how it will affect them if they are a caretaker. This may be important if they are a primary caregiver. Another area of importance is spirituality or religious beliefs. Also, assessor needs to consider if the individual has certain cultural beliefs.

- Family**:** current living situation; family of origin configuration; socioeconomic situation; role of extended family; history of communication patterns; boundary issues; impact of addiction on family relationships.
- Cultural Background**:** connection to cultural roots; current involvement in culture; attitudes towards culture; cultural attitudes towards addiction; description of community.
- Religious or Spiritual background**:** current attitude toward spirituality; extent of involvement; previous interaction; religious or spiritual attitude towards addiction.

Psychological Domain

The psychological domain consists of gathering data about developmental, cognitive, and psychiatric issues. It determines if the individual needs to be referred to more specialized care due to co-occurring (COD) disorders, cognitive issues, or trauma. Therefore, the clinician needs to be familiar with the diagnostic criteria for common mental disorders and with the names of common psychiatric medications. In addition, the clinician should be familiar with providers in the area who can assist the client with the appropriate treatment.

According to SAMSHA, up to 50% of SUD clients have a co-occurring disorder. COD diagnosis is established by referral to a psychiatrist, clinical psychologist, or other qualified healthcare professional. Assessment of the client with COD is an ongoing process that should be repeated over time to capture the changing nature of the client's status. (Substance Abuse Treatment for Persons with Co-Occurring Disorders, SAMHSA).

The assessment process for someone with a COD (co-occurring disorder), may vary a little from the assessment process of an individual with a substance use disorder alone. A clinician may need to pay attention to the way instructions are given to the individual, the setting the assessment takes place, and the amount of privacy. The professional should always remember that this part of the evaluation is to get to know the individual with complex and individual needs. Further, it is important to always make every effort to contact all involved parties, including family members, persons who have treated the client previously, other mental health and substance abuse treatment providers, friends, significant others, probation officers as quickly as possible in the assessment process.

The clinician also records personality traits, overall developmental level of the client, and the individual's learning ability and speed. It is important to ask the individual how they learn best and what their strengths and weaknesses are so that the clinician can make a good fit with treatment.

The following, describes in more detail most of the information that a clinician should record for this domain:

a) General development**:** overall stage of development; physical maturation; cognitive development, language skills; best way to learn, impact of addiction on development.

b) Abuse Issues**:** physical, sexual, emotional.

c) Family History**:** family history of addiction, mental illness, and/or crises.

d) Co-existing mental health issues**:** pre-addiction mental illnesses; current psychotropic medications; diagnosis from previous psychiatric care; mental illness resulting from addiction.

e) Psychosexual history**:** current level of sexual activity; extent of sexual activity; sexual orientation; history of sexually transmitted diseases; impact of addiction on sexual life.

Physical Domain

In the physical domain, the professional gathers information in regards to the clients' medical history.

- Infectious disease and contagious diseases
- HIV/AIDS
- Medical history
- Head trauma
- Current medications

Each recovery establishment will have their own collection of required data.

Appendix V has examples of assessment tools with links. **The list is not all inclusive and authors do not recommend or endorse any specific assessment tool.** Each establishment utilizes their preferred assessment tools.

Continuous or Re-Assessment

Clients engaged in services are often reassessed or continually assessed. Continual assessment means as the clinician is developing a deeper therapeutic rapport with the client, we continually look for more information to evolve, or information to confirm or disconfirm our impressions. With improved therapeutic rapport and trust building, the client may gradually reveal more information about the problem or about one's history that may aid the clinician in directing individualized services appropriate for the client. Also as more information is revealed, the treatment plan may be modified.

Agencies usually have policies on when to re-assess. Reassessments may be completed for a specific purpose. For example, for renewing insurance authorization, the clinician may have to reassess the client every 6 months. Or when a client is moving from one level of care to a different level, a brief reassessment may be completed. Re-assessment may be completed annually, to ensure information is accurate from the time of entry to the program to the present. They may not be a thorough or comprehensive, but to determine treatment progress and continuity in services

Clinical Summation

Clinical summation of the assessment process is a critical analysis of all the data gathered that incorporates all the relevant and important information available on the individual. It is the core of the individual and should be clear to anyone who reads during the client treatment. The summation may also include other collateral data collected from the referral source or other significant persons. It may also include data collected from other sources such as a primary health provider or discharge documentation from a prior treatment provider

The summation needs to be as clear, concise, and individualized as possible. The individuals' issues or concern should be listed in order of priority and what can be reasonably treated at the current facility and what needs to be addressed later. Thus, it is from the clinical summation that the treatment plan will be constructed.

The professional should take care to use scoring assessment tools and to seek appropriate supervision and consultation, if consultation is needed. The recommendations should be communicated to the individual and appropriate service providers. Documentation of assessment findings should be legible and clear using appropriate terminology and abbreviations.

Treatment Planning

Treatment planning (not a part of the evaluation) is a collaborative process that involves the clinician and the client developing a written document that will formulate the focus of the treatment process. In general, the treatment plan identifies important treatment goals; describes measurable, time sensitive action steps toward achieving those goals; goals expected outcomes; and reflects a verbal agreement between the clinician and the client.

An individualized treatment plan is an outline for treatment based on the client's needs and results from the assessment. The plan provides the client and family information about the treatment:

- Has pertinent data collected during the assessment, explains the findings, and examine the implications.
- Determines the client readiness
- Identifies the appropriate treatment interventions for each prioritized need or issue outlined.
- formulates mutually agreed needs, desirable treatment outcomes, and ways to measure progress.
- Prioritizes problems and identifies appropriate treatment interventions for each issue
- Shows the coordination of treatment activities with the individual's diagnosis and existing placement criteria which will be re-assessed at specific interims or as needed throughout the treatment process.

There are four key components to a quality individualized treatment plan and may vary based on the facility.

a) Problem statement: identifies the issues of the client and contains the problems with examples using specific language that details each issue.

b) Goal statement: is the opposite of the problem statement and should represent the treatment outcome and how the client will behave if the treatment is successfully completed.

c) Measurable objectives: are the steps that the client will take to reach a goal. Each objective includes timeframes, identified support staff, and outcome.

d) Strategies: may consist of counseling theories, techniques, and assignments that the clinician will use to assist the individual in attaining an objective.

Generally, SUD consists of four equally important key factors: biological, psychological, social and spiritual. Frequently, when an individual is being treated, attention is given to one or more of these areas, but not all of them. Therefore, the clinician must take into consideration the all factors to ensure that the treatment will be successful: sexual orientation, gender differences, family dynamics, homelessness, special services for children/prenatal care, learning, physical, developmental disabilities, employment issues, cultural, racial, religious norms, developmental

needs, co-occurring disorders, and legal issues. “Think of this concept in terms of a chair. Each leg represents one component of a client’s individualized treatment plan. All of the legs are required to support the individual and if one leg is missing, the chair will be unstable and unable to fully achieve its goal” (NAADAC Basics of addiction counseling: Desk reference and Study Guide).

Successful addiction treatment consists of matching the client to the appropriate type of counseling and selecting the appropriate modalities. Three types of counseling are available: individual, group, and family or systems counseling. The need for these are be explored through the treatment process.

Types of Clinical Evaluations

There are three types of Clinical Evaluations:

- Interviewing – the process of actually sitting with the client, using interviewing skills, to gain information needed via the screening and assessment process. Interviewing may also include receiving information from other persons such as family, significant others, court officials. Interviews may be structured, semi-structured, or unstructured. Structured interviews are conducted by using a specific list or questions, domains to be followed in a specific sequence, and protocol. The clinician cannot deviate from the list, sequence, or protocol. Unstructured interviews are a process of asking specific question and gathering information in certain domains, but the clinician has the liberty to explore different areas outside of a specific sequence with the responsibility of assuring all information needed is gathered. An unstructured interview is where no specific questions are asked, but the clinician is tailoring the evaluation to the client’s presenting problem, history and needs, while gathering background information relevant for the clinical intervention
- Screening or Assessment Instruments – may be given to client; may be self-report and some may be required to be administered by a trained clinician.
- Observation – actual observing of the client for behavioral indicators or interactions; usually part of the interviewing process, but may also be observing of the client in the treatment environment with others.

APPENDIX I

SUBSTANCE USE DISORDER– DSM-5

	Use disorder	Substance Intoxication	Substance Withdrawal	Information
Substance	**CANNABIS**			
Symptoms	The characteristics of this disorder are like those of all other specific substance use disorder.	• Psychological symptoms of altered cognition: anxiety, exhilaration, poor judgement, isolation, sense of slowed time. • Neurological symptoms: motor incoordination, red eyes, dry mouth, rapid heart rate, hunger.	After cessation of use that has been heavy and prolonged: ➢ 3 or more of the following symptoms: irritability, anger or aggression, anxiety, sleep difficulty (i.e., insomnia, disturbing dreams), decreased appetite or weight loss, restlessness, depressed mood. ➢ At least one physical symptom: abdominal pain, shakiness, sweating, fever, chills, or headache.	Immediate effects include distorted perception, difficulty thinking and problem solving, and loss of motor coordination. Long-term use of the drug can contribute to respiratory infection, impaired memory, and exposure carcinogens.
Duration	12 months	Shortly after using	within 1 week after cessation	
Differential Diagnosis	– Alcoholism – Anxiety disorder – Bipolar affective disorder – Cocaine toxicity – Depression – Hallucinogen PCP use – Inhalant-related psychiatric disturbances – Opioid use – Panic disorder – Schizophrenia	– Hallucinogens and PCP use – Alcohol, sedatives, hypnotics, or anxiolytics – Panic disorder – Generalized anxiety disorder – Major depressive disorder – Bipolar I or II disorder – Schizophrenia, paranoid type	– Physical disorders – Anxiety disorder – Depression – Schizophrenia – Panic disorder	
Substance	**HALLUCINOGENS PCP**			
Symptoms	Characteristics of this disorder are like those of all other specific substance use disorder.	Serious, sometimes lethal symptoms: •Behavioral disinhibition: Unpredictable impulsive, aggressive, and poor Judgement •Neurological impairment and muscle dyscontrol: Jerking eye movements, trouble walking or speaking, stiff muscles, numbness, coma, seizures, high blood pressure, and abnormal acute hearing	A significant withdrawal pattern has not been documented in humans. Therefore, there are no criteria for phencyclidine withdrawal, or hallucinogen withdrawal.	Hallucinogen-related disorders have two sub-types: 1) phencyclidine and 2) other hallucinogens. These drugs can produce visual and auditory hallucinations, feelings of detachment from one's environment and oneself, and distortions in time and perception.
Duration	12 months	Shortly after using		
Differential Diagnosis	– Sedative-hypnotic and/or alcohol withdrawal – Psychotic disorders – Physical disorders	– Sedative-hypnotic and/or alcohol withdrawal – Psychotic disorders – Physical disorders		

Substance	OPIOIDS			
Symptoms	characteristics of this disorder are like those of all other specific substance use disorder.	Shortly after using an opioid, the client experiences: • Psychological changes: mood changes such as elation and later apathy, poor judgement, and poor memory. • Neurological functioning changes: constricted pupils, dilated pupils in overdose, lethargy, unclear speech, or wondering attention	When client suddenly stops, or reduces intake after several weeks of heavy opioid use it may cause: ➢ Rebound excitation: dysphoria, nausea, diarrhea, pain, tearing, runny nose, yawning, and sleeplessness. ➢ Autonomic symptoms: dilated pupils, hairs standing up, or sweating.	Illegal opioid drugs, such as heroin and legally available pain relievers such as oxycodone and hydrocodone are often misused. People misusing opioids try to intensify their high by snorting or injecting which increase their risk for overdose. Users switch from prescription opiates to heroin due to availability & lower price.
Duration	12 months	Shortly after use	Within several days	
Differential Diagnosis	Opioid induced mental disorders dysthymia/depression Alcohol intoxication Sedative, hypnotic, or anxiolytic intoxication Anxiety disorders	Alcohol Intoxication and other sedative-hypnotics	– The flu – Other physical illnesses – Alcohol withdrawal – Sedatives or hypnotics withdrawal – Anxiety disorder – Panic	
Substance	SEDATIVES, HYPNOTICS OR ANXIOLYTICS			
Symptoms	characteristics of this disorder are like those of all other specific substance use disorder.	Shortly after using, the client exhibits: • Psychological symptoms: argumentative, aggressiveness, rapid mood shifts, and/or impaired judgement. • Neurological impairment: imbalance, unclear speech, poor coordination, Jerking eye movements, and/or reduced level of consciousness.	When client suddenly stops or markedly reduces intake, within hours it can cause: Increased nervous system and motor activity: trembling, sweating, nausea, rapid heartbeat, high blood pressure, agitation, headache, sleeplessness, hallucinations, and/or convulsions.	A sedative reduces excitement and induces quietness without drowsiness. A hypnotic helps sleep and stay there. An anxiolytic reduces anxiety. The major classes are benzodiazepines, alprazolam, & barbiturates. SUD Clients use barbiturates and benzodiazepines because they cause euphoria, reduce anxiety & guilt, boost self-confidence & energy.

Substance	STIMULANTS			
Symptoms	characteristics of this disorder are like those of all other specific substance use disorder.	• Psychological changes of mood/affect, impaired judgement, and impaired psychosocial function, hostility, paranoia, or psychotic symptoms. • Physical neurological: excitation, raised blood pressure, increased heart rate and motor activity, dilated pupils, sweeting, nausea, chest pain, irregular heartbeat, seizures, coma, or perplexity	When client suddenly stops or markedly reduces intake it can cause: ➢ Symptoms of dysphoria ➢ Nervous system stimulation or exhaustion: intense dreams, hunger, reduced motor activity, and reduced or increased sleep.	They include a wide range of drugs that have historically been used to treat conditions, such as obesity, attention deficit hyperactivity disorder and, occasionally, depression. The most commonly abused stimulants are amphetamines, methamphetamine, and cocaine. They are usually taken orally, snorted, or intravenously.

APPENDIX II

MENTAL DISORDERS – DSM-5 (not all disorders are included)

	MOOD DISORDERS				
	Major Depressive Disorder	**Dysthymia**	**Bipolar I**	**Bipolar II**	**Cyclothymic Disorder**
Symptoms	1. *One or more major depressive episode: at least 2 weeks can't enjoy life/ feels sad* 2. *Eating & sleeping problems* 3. *Guilt or shame* 4. *Low energy* 5. *Low concentration* 6. *Suicidal thoughts*	1. *Symptoms not severe enough to be called major depression. Also, called persistent depressive disorder (includes chronic major depression)* 2. *Fatigue* 3. *Poor concentration* 4. *Poor self-image* 5. *Feeling hopeless*	1. *One or more manic episode: client feels elated or irritable may be grandiose, talkative, hyperactive leading to bad judgement* 2. *Zero or more hypomanic and major depressive episodes*	1. *At least one of each: major depressive episode and hypomanic episode* 2. *Not manic episode* 3. *Hypomanic episode: like manic episode but less severe and briefer*	*Repeated mood swings but not severe enough to be called major depressive episodes or manic episode*
Duration	Months - years	2+ yrs. Not absent for more than 2 mo.	At least 1 week for manic episode		2+ years
Differential Diagnosis	– Substance use – Physical disorders – Other mood disorder – Ordinary grief – Schizoaffective Disorder	– Substance use – Physical disorders – Major depression – Ordinary grief – Adjustment to stressor – Bipolar disorder	– Substance use – Physical disorders – Other bipolar disorder – Psychotic disorder	– Substance use – Physical disorders – Other bipolar disorder – Major depressive disorder	– Substance use – Physical disorders – Other bipolar disorder

	SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS				
	Schizophrenia	**Schizophreniform Disorder**	**Schizoaffective Disorder**	**Brief Psychotic Disorder**	**Delusional Disorder**
Symptoms	Two of the following: 1. *Delusions* 2. *Hallucinations* 3. *Disorganized or incoherent speech* 4. *Abnormal psychomotor behavior* 5. *Negative symptoms* One must be delusions, hallucinations, or disorganized speech (criterion A)	*Rapid onset and offset.* Two of the following: 1. *Delusions* 2. *Hallucinations* 3. *Disorganized or incoherent speech* 4. *Abnormal psychomotor behavior* 5. *Negative symptoms* One must be delusions, hallucinations, or disorganized speech (criterion A)	A period of illness where: 1. Manic or major depression episode last at least half time of illness 2. Schizophrenia criterion A symptoms last at least 2 weeks by themselves	At least one psychotic symptom	Delusions but no other psychotic symptoms
Duration	6+ months, criterion A symptoms for 1+ mo.	30 days to 6 months. fully recovers within 6 mo.	At least one month	Less than 1 month	At least one month
Differential Diagnosis	– Mood disorders – Cognitive disorders – Physical & substance induced – a medical condition – Delusional disorder – Personality disorders – Specific phobias – Religious ideas	– Mood disorders – Cognitive disorders – Physical and substance induced psychotic disorder – Schizophrenia	– Psychotic mood disorder – Substance Use – Physical disorders	– Mood disorders – Cognitive disorders – Physical & substance induced psychosis – Schizophrenia	– Mood disorders – Cognitive disorders – Physical and substance induced psychotic disorder – Schizophrenia – OCD

	ANXIETY DISORDERS					
	Panic Disorder	**Agoraphobia**	**Specific Phobia**	**Social Anxiety Disorder**	**Generalized Anxiety Disorder**	**Separation Anxiety Disorder**
Symptoms	1. Panic attack: 4 symptoms – Sudden fear & terror with fight or flight symptoms – Chest pain – Chills or too hot – Shortness of breath rapid or irregular heartbeat, perspiration – Nausea, dizziness & tremors 2. Several panic attacks and worries about having another. 3. Avoids places, people and things for fear of re-experiencing attacks.	1. Inordinate anxiety when home alone or have to leave the home being in crowds 2. Afraid that they won't be able to scape 3. Enduring it brings suffering	1. Fear of specific objects or situations 2. Situation may lead to vomiting, choking or developing illness	1. Inordinate anxiety when thinking about public speaking, eating, writing 2. Fear of embarrassment or social rejection 3. Avoids these situations or endures with much anxiety	1. Excessive uncontrollable worrying about: health, family, money, school, work 2. Worrying causes physical & mental issues: pain, fatigue restlessness, poor concentration, sleeping problems	1. Anxiety when separated from a parent or loved one 2. Fear that something may happen (die) 3. Separation thought may cause: vomiting, or other physical complaints 4. Reluctant to attend school, work, go out, or sleep.
Duration	At least one month	6+ months	6+ months	6+ months	6+ months	
Differential Diagnosis	– Substance use – Physical disorders – Other anxiety disorders – Mood disorders – Psychotic disorders – OCD – PTSD – Actual danger	– Substance use – Physical disorders – Other anxiety disorders – Mood disorders – Psychotic disorders – OCD – PTSD – Social and separation anxiety – Situational phobias – Panic disorder	– Substance use – Physical disorders – Agoraphobia – Mood disorders – Psychotic disorders – Social and separation anxiety – Anorexia nervosa – OCD – PTSD	– Substance use – Physical disorders – Avoidant personality disorder – Mood disorders – Psychotic disorders – separation anxiety – Anorexia nervosa – OCD – PTSD	– Substance use – Physical disorders – Mood disorders – Other anxiety disorders – OCD – PTSD – Realistic worry	– Substance use – Physical disorders – Avoidant personality disorder – Mood disorders – Psychotic disorders – Social anxiety – Anorexia nervosa – OCD – PTSD

	PERSONALITY DISORDERS				
	CLUSTER A		CLUSTER B (there is also cluster C)		
	Paranoid	**Schizoid**	**Antisocial**	**Borderline**	**Narcissistic**
Symptoms	1. Distrust others 2. Suspicious 3. Reluctant to share information	1. Isolation 2. Narrow emotional range 3. Don't enjoy close relationships nor sex 4. Cold or detached 5. Indifferent to criticism or praise	1. History of destroying property near age 15 2. Serious rules violations 3. Aggression 4. Tend to fight, assault 5. Lie or con 6. Show no remorse 7. Impulsivity 8. Irresponsibility	1. Constantly in crisis 2. Feel empty and bored 3. Insecurity 4. Strong attachment 5. Impulsiveness 6. Self-mutilation 7. Sexual indiscretions 8. Over spending 9. Binges 10. Reckless driving 11. Rage 12. Rapid mood swing	Grandiosity 1. Crave admiration 2. Perfectionist 3. Uniqueness 4. Arrogant 5. Nonempathetic 6. Exploit others 7. Selfishness
Duration	Begins in teens or early 20's	Begins in teens or early 20's	Begins prior to age 18	Begins in teens or early 20's	Begins in teens or early 20's
Differential Diagnosis	– SUD – Physical disorders – Schizotypal – Schizoid	– SUD – Physical disorders – Mood disorders – Psychotic disorders – Autism – Schizotypal – Paranoid	– SUD – Physical disorders – Bipolar disorders – Schizophrenia – Other PD's – Ordinary criminality	– SUD – Physical disorders – Mood disorders – Psychotic disorders – Other PD's	– SUD – Physical disorders – Bipolar disorders – Other PD's

	OBSESSIVE-COMPULSIVE AND RELATED DISSORDERS		TRAUMA AND STRESS RELATED DISORDERS		
	OCD	**Body Dysmorphic Disorder**	**PTSD**	**Acute Stress Disorder**	**Adjustment Disorder**
Symptoms	1. Fear of contamination 2. Doubts that lead to excessive checking 3. Obsessions w/o compulsion 4. Slows down and interferes with daily life	1. Frequent request for medical procedure or plastic surgery 2. May avoid social situations 3. Hides perceived deformity with hair or clothing	1. Experienced something awful 2. Relive the event 3. Nightmares 4. Negative moods 5. Lost interest 6. Numbness 7. Hypervigilance 8. Insomnia	1. Experienced something awful 2. Relive the event 3. Nightmares 4. Amnesia 5. Lost interest 6. Numbness 7. Hypervigilance 8. Insomnia	1. Stressor cause depression, anxiety or behavioral symptoms 2. Stressor ends symptoms continue
Duration	Distress or disability occupy and hour or more a day.	–Chronic –May begin during teen years –May peak after menopause	Over 1 month	As soon as exposed to event. 3 days to 1 month	Starts within 3 mo. of stressor. Ends within 6 mo. after stressor ends
Differential Diagnosis	– Substance use & physical disorders – Superstitions and rituals without distress – Depressive & psychotic disorders – Anxiety & impulse-control disorders – Tourette's disorder – Obsessive compulsive personality disorder	– Substance use & physical disorders – Mood & psychotic disorders – Eating disorder such as anorexia nervosa – OCD – Illness anxiety disorder – Dissatisfaction with personal appearance	– SUD & physical disorders – Mood & anxiety disorders – Traumatic brain injury – Normal reactions to stressful events.	– Sud – Physical Disorders – Brain injury – Panic disorder – Mood disorders – Dissociative disorders – PTSD	– SUD & physical disorders – Mood & anxiety disorders – Trauma related dis. – Somatic disorder – Psychotic disorder – Normal stress

APPENDIX III

SCREENING TOOLS FOR SUD

Acronym	Instrument Name	Instrument Description	Instrument Hyperlink
AUDIT	Alcohol Use Disorders Identification Test	Screens for hazardous or harmful **alcohol** consumption. Developed by the World Health Organization (WHO), the test correctly classifies 95% of people into either alcoholics or non-alcoholics.	http://www.integration.samhsa.gov/AUDIT_screener_for_alcohol.pdf
NIDAMED	National Institute on Drug Abuse…	gives medical professionals tools and resources to screen their clients for **tobacco**, **alcohol**, **illicit drug**, and **nonmedical prescription drug use**. Developed by the National Institute on Drug Abuse.	https://www.drugabuse.gov/nidamed-medical-health-professionals
CAGE AID		Used to screen for **drugs and alcohol**. The CAGE Assessment is a quick questionnaire to help determine if an alcohol assessment is needed. If a person answers yes to two or more questions, a complete assessment is advised.	http://www.integration.samhsa.gov/images/res/CAGEAID.pdf
AUDIT-C		Simple 3-question screen for hazardous or harmful **alcohol** drinking that can stand alone or be incorporated into general health history questionnaires.	http://www.integration.samhsa.gov/images/res/tool_auditc.pdf
DAST-	Drug Abuse Screen Test	designed to provide a brief instrument for clinical screening for **drugs** abuse and treatment evaluation and can be used with adults and older youth.	http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs
ABC	Addiction Behaviors Checklist	designed to track behaviors characteristic of addiction related to **prescription opioid** medications in chronic pain populations. designed to be administered in an interview format and scored based on the participant's responses to questions, the interviewer's observations of displayed behaviors during the session, and pertinent information gathered from medical chart review.	http://store.samhsa.gov/shin/content//SMA12-4671/SMA12-4671.pdf#page=70
ACE	Alcohol Craving Experience Questionnaire	Developed to measure **sensory aspects of cravings** (imagining taste, smell, or sensations of drinking and intrusive cognitions associated with craving) when craving was maximal during the previous week (ACE-S: Strength, 13 items), and to assess frequency of desire-related thoughts in the past week (ACE-F: Frequency, 14 items).	
ADS	Alcohol Dependence Scale	Quantitative measure of the severity of **alcohol** dependence consistent with the concept of the alcohol dependence syndrome. The 25 items cover alcohol withdrawal symptoms, impaired control over drinking, awareness of a compulsion to drink, increased tolerance to alcohol, and salience of drink-seeking behavior.	A complete copy of this instrument can be found in NIAAA's "Assessing Alcohol Problems: A Guide for Clinicians and Researchers / 2nd edition," p. 285-286.
ASSIST	Alcohol, Smoking, and Substance Involvement Screening Test	The ASSIST is an 8-item questionnaire It's purpose is to detect **psychoactive substance** use and related problems among primary care clients. The ASSIST provides information about: the substances people have ever used in their lifetime; the substances they have used in the past three months; problems related to substance use; risk of current or future harm; level of dependence; and injecting drug use. Substances addressed include: tobacco, alcohol, cannabis, cocaine, amphetamine type stimulants, sedatives, hallucinogens, inhalants, opioids, and other drugs.	http://www.who.int/substance_abuse/activities/en/ASSIST%20V.3-%20Guidelines%20for%20use%20in%20primary%20care_TEST.pdf

MAST	Michigan Alcoholism Screening Test	The MAST is one of the most widely used measures for assessing **alcohol** abuse. The measure is a 25-item questionnaire designed to provide a rapid and effective screening for lifetime alcohol-related problems and alcoholism. It is also useful in assessing the extent of lifetime alcohol-related consequences. Although not intended to be a complete measure of alcohol-related problems, the MAST provides a gross, general measure of lifetime problem severity that can be used for choosing treatment.	http://adai.washington.edu/instruments
SASSI	Substance Abuse Subtle Screening Inventory	The SASSI is a brief self-report, easily administered psychological screening measure that is available in separate versions for adults and adolescents.	http://pubs.niaaa.nih.gov/publications/sassi.pdf

SCREENING TOOLS FOR MENTAL DISORDERS

Acronym	Instrument Name	Instrument Description	Instrument Hyperlink
BSI	Brief Symptom Inventory	**Multidimensional** symptom inventory designed to reflect psychological symptom patterns of psychiatric and medical clients. It can be useful in initial evaluation of clients at intake as an objective method of screening for psychological problems.	http://www.pearsonassessments.com
CES-D	Center for Epidemiological Studies - Depression Scale	self-report **depression** scale. Items refer to the frequency of symptoms during last week. It can also be administered as a structured interview. The CES-D is a brief questionnaire that assesses the frequency and duration of the symptoms associated with depression.	http://adai.washington.edu/instruments/pdf/Center_for_Epidemiological_Studies_Depression_Scale_434.pdf
CAPS	Clinician-Administered PTSD Scale	assessing **posttraumatic stress disorder** in individuals over age 15. This user-friendly structured interview is ideal for screening, differential diagnosis, confirmation of a PTSD diagnosis, or identifying Acute Stress Disorder	National Center for PTSD page about the CAPS
SAMISS	Substance Abuse and Mental Illness Symptoms Screener	Used for detecting symptoms of **co-occurring disorders**. It was developed primarily from existing and tested scales. The SAMISS includes 13 items assessing mental illness symptoms and substance abuse	
THQ	Trauma History Questionnaire	Self-report measure that examines experiences with potentially **traumatic events** such as crime, general disaster, and sexual and physical assault using a yes/no format. For each event endorsed, respondents are asked to provide the frequency of the event as well as their age at the time of the event.	http://ctc.georgetown.edu/toolkit/.
Lifetime MDE	Screening Scale for Lifetime Major Depressive Episodes	Developed to measure lifetime **major depressive episodes** (MDE). The scale is novel in that it requires either of the core symptoms of MDE (depressed mood or anhedonia) and a duration of at least two weeks. Clients are screened as "positive" if they endorse a history of symptom(s) lasting two weeks or longer.	ADAI Library Search: Brief Screening Scale for Lifetime Major Depressive Episodes
MDQ	Mood Disorder Questionnaire	Screening tool **for bipolar disorder** in a psychiatric outpatient population.	http://www.integration.samhsa.gov/images/res/MDQ.pdf

K10, K6	Kessler Psychological Distress Scale	Widely used, simple self-report measure of **psychological distress** which can be used to identify those in need of further assessment for **anxiety and depression**. This measure was designed for use in the general population to detect high-prevalence mental health disorders	
PDSQ	Psychiatric Diagnostic Screening Questionnaire	Self-administered screening tool. The final version contains 13 subscales (**major depressive disorder** [MDD], bulimia, post-traumatic stress disorder [**PTSD**], **panic disorder**, **agoraphobia**, **social phobia**, **generalized anxiety disorder** [GAD], obsessive-compulsive disorder [**OCD**], **alcohol abuse/dependence**, **drug abuse/dependence**, somatization, hypochondriasis, and **psychosis**). Additionally, there is a six-item psychosis screen.	http://portal.wpspublish.com/portal/page?_pageid=53,70444&_dad=portal&_schema=PORTAL
NPQ	Neuropsych Questionnaire	The NPQ scores client in terms of 20 symptom clusters: **inattention**, **hyperactivity-impulsivity**, learning problems, memory, **anxiety**, **panic**, **agoraphobia**, **obsessions and compulsions**, **social anxiety**, **depression**, mood instability, **mania**, aggression, **psychosis**, somatization, fatigue, sleep, **suicide**, pain, and **substance abuse**.	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2234274/

APPENDIX IV

ASSESSMENT TOOLS FOR SUD

Acronym	Instrument Name	Instrument Description	Instrument Hyperlink
ADCS	Alcohol & drug confrontation scale	Assesses confrontation received from 9 different sources: spouse/significant other, family, friends, work, sober housing residents, health care professionals, mental health professionals, substance abuse professionals, and criminal justice.	
ADCQ	Alcohol & Drug Consequences Questionnaire	Assesses the pros and cons (or costs and benefits) of quitting **substance use** as useful indexes of client motivation and for predicting long-term change.	http://www.ncbi.nlm.nih.gov/books/NBK64967/
ASI	Addiction Severity index	Identifies problem areas for targeted intervention. Assesses problem severity. 200 items in 7 subscales. Addresses medical, employment and support, drug use, alcohol use, legal, family/social, and psychiatric.	http://www.tresearch.org/index.php/tools/download-asi-instruments-manuals/
CDAP	Chemical Dependency Assessment Profile	Self-report questionnaire for **alcohol and other drugs** use. Assesses use history, patterns, beliefs and expectancies, symptoms, self-concept, and interpersonal relations. Measures frequency/quantity of use, stressors, antisocial behavior, interpersonal skill, dysfunction, attitude toward treatment, and degree of life impact.	http://pubs.niaaa.nih.gov/publications/cdap.pdf
AUS	Clinician Alcohol Use Scale	Rates the **alcohol** use of **persons with severe mental illness**, especially psychotic disorders. It consists of a single item that asks the clinician to "rate your client's use of alcohol over the past 6 months according to the following scale." The clinician draws on the client's self-reported behavior, clinical observations, interview, and collateral requests.	
AOD ladder	Combined Alcohol and other drug contemplation ladder	Measures readiness to quit a behavior (alcohol, e.g.), based on the stages of change model. Responses choices range from 1 to 7: (1) I do not have a problem with drinking/drugs, and I do not intend to cut down; and (7) I have decided to quit drinking **alcohol/using drugs** and plan never to drink/use again. Combined ladder score for alcohol and other drugs, can derive a single readiness score	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845310/
CSS	Commitment to Sobriety Scale	Brief 5-item measure, completed via interview to assess level of client commitment to **alcohol and drug** use cessation and continued abstinence.	http://bit.ly/CSScale_inst
IAP	Individual Assessment Profile	Designed to serve as a screening and assessment tool for individuals seeking drug treatment of all types. It covers many areas, including a detailed assessment of current and historical drug use patterns. Provides data for the multiple purposes of initially screening clients, planning client assessments and treatment.	http://adai.uw.edu/instruments/pdf/Individual_Assessment_Profile_509.pdf

ASSESSMENT TOOLS FOR MENTAL DISORDERS

Acronym	Instrument Name	Instrument Description	Instrument Hyperlink
BAI	Beck Anxiety Inventory	recommended for use in assessing **anxiety** in clinical and research settings. The scale consists of 21 items, each describing a common symptom of anxiety.	http://www.myonlinetherapy.com/Therapists/Documents/Beck%20Anxiety%20Inventory.doc
BDI	Beck Depression Inventory	The Beck **Depression** Inventory was developed to measure the behavioral manifestations of depression in adolescents and adults. It was designed to standardize the assessment of depression severity in order to monitor change over time or to simply describe the illness.	http://www.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8018-370
BASIS-	Behavior and Symptom Identification Scale	Measures changes in self-reported symptoms and functional problem difficulty from the client's perspective. It is a brief yet comprehensive instrument that cuts across diagnoses by identifying a **wide range of symptoms** and problems that occur across the diagnostic spectrum. The BASIS-32 allows evaluation of change over the course of treatment, and can be used in evaluating outcomes.	http://www.basissurvey.org/pdf/Basis32SurveyRevB320108Eng.pdf
CGI-BP	Clinical Global Impressions Scale for Bipolar Disorder	Specifically developed for use in assessing global illness severity and change in clients with **bipolar** disorder.	
CAAPE	Comprehensive Addictions and Psychological Evaluation	comprehensive diagnostic assessment interview providing documentation **for substance-specific** abuse or dependence diagnoses. Covered conditions include: substance-specific dependence and abuse, **depression**, **mania**, **panic/anxiety**, **PTSD**, **obsessive-compulsive** disorder**, psychosis**, and a wide range of **personality disorders** (antisocial, paranoid, schizoid, borderline, e.g.).	http://www.changecompanies.net
PRIME-MD	Primary Care Evaluation of Mental Disorders	The Primary Care Evaluation of Mental Disorders is an instrument designed to assist the primary care physician in efficiently and accurately diagnosing the **mental disorders** that are most commonly seen in adults in primary care settings.	ADAI Library Search: Personal Experience Screening Questionnaire (PRIME-MD)
ReSUS	Reasons for Substance Use in Schizophrenia	The ReSUS is a valid and reliable measure for assessing reasons for **substance use in people with schizophrenia** and other psychotic disorders. It comprises three subscales: the first contains items related to coping with distressing emotions and symptoms (including feelings of shame, boredom, and depression), the second consists of items related to social acceptance and enhancement (to fit in, feel good, and get high), and the third contains items that are related to the improvement of internal emotional and physical states (to feel sexy, creative, and confident).	ADAI Library Search: Reasons for Substance Use in Schizophrenia (ReSUS)

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EXAM:

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in any the following manner:

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions using the answer sheet found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

http://www.ceumatrix.com/studentcenter

Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'View the lesson quiz' and you will be presented with the electronic exam.

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation, You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and/or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

NOTE: THE EXAM QUESTIONS AND /OR ANSWERS MAY BE IN A DIFERENT ORDER IN THE ONLINE EXAM

1.
During an assessment, the psychological domain includes:

A. General development, substance abuse issues, family history, abuse issues, and psychosexual history
B. General development, substance abuse issues, family history, co-existing mental health issues, and psychosexual history
C. Co-existing mental health issues, psychosexual history, general development, family history, and abuse issues
D. Psychosexual history, abuse issues, family history, PTSD, substance abuse issues, and general development

2.
John B. has SUD. According to him, his symptoms include: He continues to use cocaine in spite of horrible consequences, missing work 20 times this year due to his use, and trying to down but he can't. According to the DSM-5 the severity of his SUD would be considered:

A. High
B. Low
C. Mild
D. Severe

3.
A part of the assessment objectives is:

A. Rate the symptoms severity, diagnose SUD and/or mental illnesses, and screen diagnosis related problems
B. Provide information for planning, refer client to another program, develop treatment plan
C. Rate the symptoms severity, develop a treatment plan, and screen for HIV
D. Recommend a psychiatrist, diagnose SUD, and rate symptoms severity

4.
Co-occurring disorders treatments are:

A. Parallel treatment, differential treatment, and secondary treatment
B. Sequential treatment, integrated treatment, and differential treatment
C. Sequential treatment, integrated treatment, and parallel treatment
D. Parallel treatment, sequential treatment, and psychosocial treatment

5.
A clinical summation should include the following:

A. Analysis of gathered data, other assessments, the client's concerns, and recommendations
B. Goal statement, measurable objectives, advice, and priorities
C. Problem statement, strategies, goal statement, and measurable objectives
D. Client's responses, other assessments, strategies, and problem statement

6.
Personal key traits of a counselor conducting evaluations include:

A. Intelligence, knowledge about addiction, personal ability, and intimacy
B. Positive regard, respect, warmth, personal ability, and genuineness
C. Good communication skills, knowledge about DSM-5, respect, and warmth
D. Knowledge of SUD, positive regard, respect, and good verbal and non-verbal responses

7.
The DSM-5 has 3 main categories for Substance use: Intoxication, withdrawal, and addiction

A. True
B. False

8.
The main purpose of screening is:

A. To inspiring motivation to change, to gather personal information and to provide referrals
B. To prepare clients to enter treatment, to retain clients in treatment, and to improve treatment outcomes
C. To determine is he/she is appropriate for treatment plus gather and sort information to determine the initial course of action
D. To gather and sort information for initial course of action and to prepare clients for treatment

9.
SUD can cause and/or mimic a mental disorder and a mental disorder can mimic SUD

A. True
B. False

10.
Which of the following is not a symptom of SUD according to the DSM-5?

A. A reduction or neglect of social, recreational and occupational activities because of drug use
B. Drug is taken over a longer period than intended and in larger amounts
C. Alcohol is used in several situations where it is physically dangerous
D. A desire to reduce or stop drug use can be accomplished if consequences are significant

11.
According to the DSM-5, substance use disorder applies to caffeine.

A. True
B. False

12.
According to the DSM-5, the following substance is not considered addictive.

A. Marijuana
B. Anxiolytics that are prescribed by a doctor
C. Hydrocodone
D. Prozac

13.
A counselor with good verbal communication skills will:

A. Maintain direct eye contact
B. Ask open ended questions
C. Be mindful of his/her facial expressions
D. Display respect for the client

14.
When a counselor collects a client's use/mental illness history, education, precipitating circumstances, and support system, he/she is conducting:

A. Psychological screening
B. Psychological assessment
C. Diagnostics assessment
D. Socio-behavioral and support systems assessment

15.
During the screening process, the counselor completes the following:

A. Personal information, surveys, personal contacts, confidentiality, referral for a psychiatrist, assessment evaluation, referrals to other programs
B. Referral for assessment, explanation of the program, explanation of fees, interview, explanation of confidentiality, surveys, and personal information
C. Personal information, explanation of the program, explanation of fees, interview, explanation of confidentiality, surveys, and assessment results
D. Explanation of screening tools, personal information, assessment results, surveys, interview, confidentiality agreement, and surveys

16.
Communication non-verbal responses do not include

A. Close-ended questions
B. Eye contact
C. Relaxed posture
D. Facial expressions

17.
The desirable qualifications for counselors conducting SUD evaluations include two main categories:

A. Knowledge of SUD, and mental illnesses
B. Flexibility
C. Personal qualities and Knowledge
D. None of the above

During an evaluation, SUD counselors are trying to prove that a person has the disorder.

A. True
B. False

19.
During an assessment, a counselor gathers information about HIV, infectious diseases, medications the client is taking, and significant injuries or head trauma. The counselor is working on the domain that is usually called:

A. Clinical summation domain
B. Medical diagnosis domain
C. Physical domain
D. Psychological domain

20.
A client with co-occurring disorder is easier to treat if the counselor has an in-depth knowledge of mental illnesses and SUD.

A. True
B. False

21.
The Screening process enables a clinical diagnosis to be made.

A. True
B. False

22.
An example of clarification is:

A. Please explain …
B. As I understand it . . .
C. Is that pretty close to what you were feeling?
D. I sense that . . .

23.
One of the key traits of the clinician is Immediacy, which refers to:

A. Staying focused on the issue at hand
B. Attending to what is important to the individual being assessed
C. Being able to adjust fluently to changing topics
D. All of the above

24.
The purpose of the clinical evaluation is

A. To provide communication between the clinician and the client
B. To determine the services and treatment necessary for an individual
C. To support a dynamic process to inform treatment planning
D. Interpret verbal and nonverbal communication to assign a clinical diagnosis

25.
Clinical evaluations need to capture:

A. The extent of many factors related to mental health and substance use disorders
B. The simplicity of circumstances and relationships
C. Words of the client regarding his or her history and concerns
D. Information that is ruled in versus ruled out