CEU MATRIX
THE INSTITUTE FOR ADDICTION & CRIMINAL JUSTICE STUDIES

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

4 Continuing Education Credits

Asynchronous Distance Learning Course

Content Level: Intermediate

Course Author: Diane Sherman, Ph.D.

Last Updated: 2026

Approved by such credentialing bodies as:

• National Association of Alcoholism and Drug Abuse Counselors (NAADAC) #94564

• National Board of Certified Counselors (NBCC) #6310

All approval bodies are listed at ceumatrix.com/accreditations

For questions or to request accessibility accommodations please email us at: support@ceumatrix.com

Welcome to CEU Matrix. We have been committed to supporting the continuing education of behavioral health professionals since 2007. Please reach out with any questions, ideas, or feedback.

Do the best you can until you know better.
Then when you know better, do better.

— Maya Angelou

COPYRIGHT

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's dual-diagnosis 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 diagnostic 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, providing insight that 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 showing "these items exist on one severity dimension"; adding the craving criterion despite consensus that it was "redundant with the other diagnostic criteria" but valued for its conceptual importance and potential as a biomarker validation target; and incorporating gambling disorder as a behavioral addiction within the substance-related disorders chapter (Zachar et al., 2022). For clinicians trained in the DSM-5 framework described in this course, understanding this decision history is practically valuable — it explains why the current diagnostic system works the way it does, and why some aspects (like the craving criterion) 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 SUD, 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 how they communicate the diagnosis 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. The researchers demonstrated that including craving in the DSM-5 diagnosis improved its ability to predict future substance use compared to diagnoses made without the craving criterion. Moderate craving showed stronger predictive power than severe craving (Shmulewitz et al., 2023). For the clinical evaluation competencies described in this course, this finding has direct assessment implications: practitioners should not treat craving as a supplementary or secondary criterion. The Shmulewitz et al. data positions it as one of the most clinically informative items in the DSM-5 SUD checklist — particularly for heroin and opioid use disorders, where the odds ratio exceeded 200. During clinical evaluations, asking about craving with the same rigor and specificity applied to other criteria (tolerance, withdrawal, loss of control) is not a formality. It captures information that predicts the client's immediate trajectory more powerfully than most other diagnostic indicators.

The co-occurring disorders dimension of this course — using DSM-5 to evaluate both substance use and mental health conditions — 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 of individuals presenting with both mental health needs and substance use disorders "increased markedly per year, from 15% in 2009 to 32% in 2017." The overall proportion of admissions with any mental health or substance use need rose from 61% to 75% across the study period.

Methamphetamine use increased nearly fivefold, from 6% to 29% (Butler et al., 2022). For clinicians conducting the DSM-5 evaluations described in this course, these prevalence trends mean that co-occurring disorder assessment is not a specialized add-on for complex cases — it is a baseline competency required for the majority of clients presenting in many treatment settings. The clinical evaluation skills this course teaches must be applied with the expectation that most clients will meet criteria for multiple conditions, and that the interaction between those conditions affects treatment planning, prognosis, and risk assessment in ways that evaluating either condition in isolation would miss.

The treatment implications of co-occurring diagnoses have been quantified in recent research. A 2025 meta-analysis examining 13 primary studies confirmed that individuals with concurrent mental health and substance use disorders face approximately twice the risk of adverse outcomes — relapse, emergency department visits, rehospitalization, and mortality — compared to those with a single disorder, 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 risk of mortality," and recommended treatment combining pharmacological interventions with psychosocial support "within an integrated and multidisciplinary approach" (Neyra et al., 2024). For practitioners conducting the clinical evaluations described in this course, these findings reinforce that the diagnostic process is not merely a classification exercise — it is the foundation for treatment decisions that carry measurable consequences for client outcomes. An evaluation that accurately identifies co-occurring conditions enables integrated treatment planning. An evaluation that misses a co-occurring condition routes the client toward single-disorder treatment that the meta-analytic data shows produces worse outcomes.

The quality of assessment instruments available for clinical evaluation has itself been evaluated. A 2023 systematic review examined 73 brief, freely accessible self-report measures for substance use disorders and found that only 19% achieved excellent psychometric ratings, 37% were rated good, and 44% were rated adequate (Stewart et al., 2023). For the clinical evaluation competencies described in this course, this finding is directly relevant: 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 clinical population. An instrument that performs well in a research setting may not maintain its reliability when administered to a different demographic or in a different clinical context, and the evaluator's competency includes recognizing these limitations.

The Clinical evaluation:

Professional Competencies and

Elements to consider for using DSM-5 for Substance Use and Co-occurring Disorders.

Diane Sherman, PhD, MAC, CCS

Alexandra Huntebrinker, MS

JUNE 2017

TABLE OF CONTENTS

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.

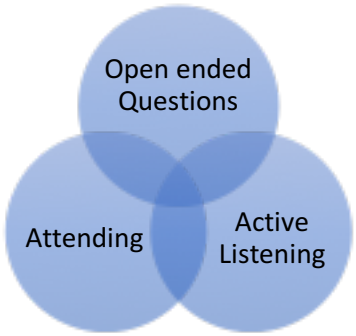
Positive regard and respect: regard is the attitude of respect, while respect is the action. It means that the clinician is nonjudgmental, open-minded, objective, sensitive and trustworthy.

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.

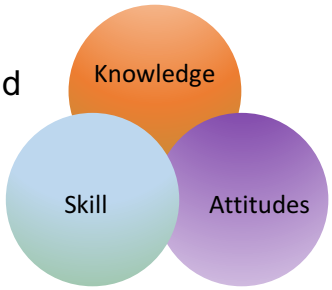
Confrontation – where the clinician points out discrepancies, inconsistencies, or other mixed messages in the client's thoughts, feelings and actions. In order for confrontation to be most effective, the clinician must develop therapeutic rapport before confrontation is used. When used too early in the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

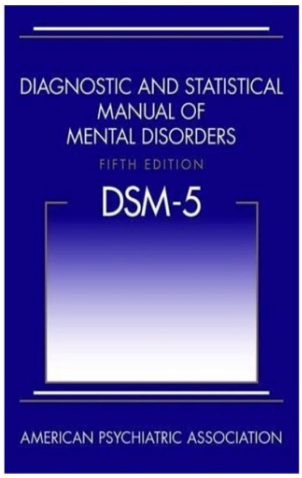
Competency 35: Seek appropriate supervision and consultation.

- 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]:

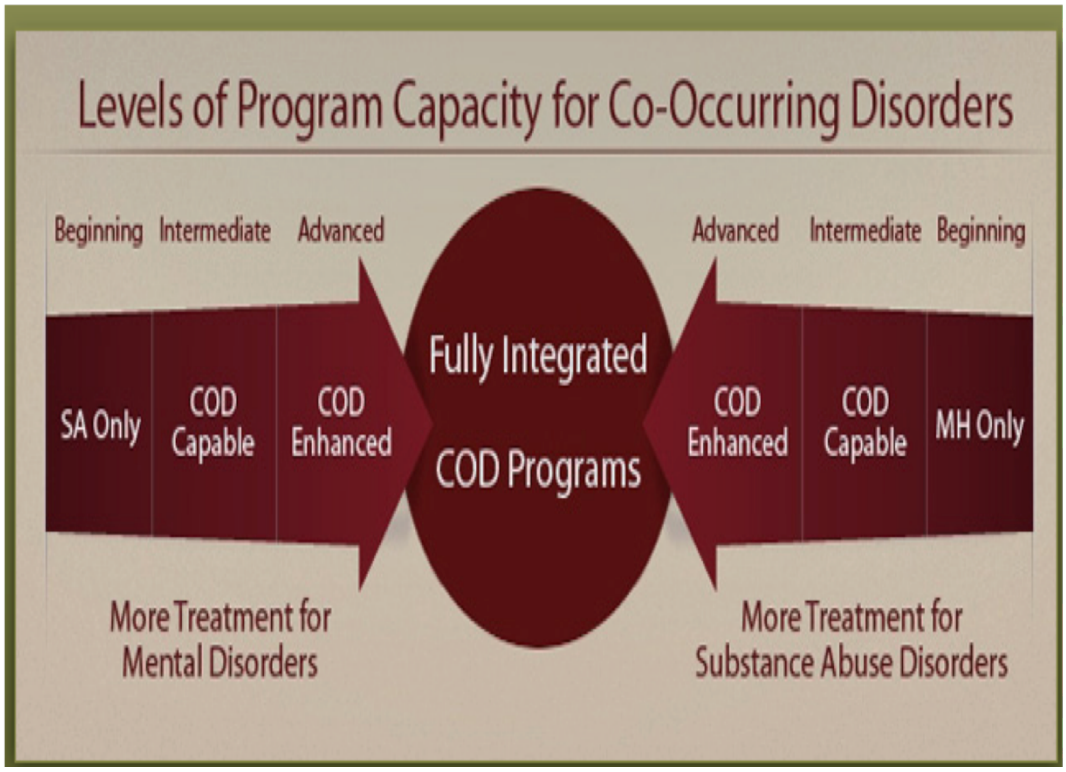
- SUD can cause and/or mimic psychiatric disorders
- SUD can initiate or exaggerate mental disorders
- SUD can hide mental disorders symptoms
- SUD withdrawal can cause or mimic mental disorders
- SUD and mental disorders can independently coexist
- Mental disorders can mimic SUD

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)

REFERENCES

Butler, A., Nicholls, T., Samji, H., Fabian, S., & Lavergne, M. R. (2022). Prevalence of mental health needs, substance use, and co-occurring disorders among people admitted to prison. Psychiatric Services, 73(7), 737-744. https://doi.org/10.1176/appi.ps.202000927

Neyra, A., Parro-Torres, C., Ros-Cucurull, E., Carrera, I., Echarri, E., & Torrens, M. (2024). Management of schizophrenia and comorbid substance use disorders: Expert review and guidance. Annals of General Psychiatry, 23(1), 40. https://doi.org/10.1186/s12991-024-00529-7

Scott, K. D., & Gorey, K. M. (2025). Concurrent disorders and treatment outcomes: A meta-analysis. Journal of Dual Diagnosis, 21(3), 251-265. https://doi.org/10.1080/15504263.2025.2515015

Shmulewitz, D., Stohl, M., Greenstein, E., et al. (2023). Validity of the DSM-5 craving criterion for alcohol, tobacco, cannabis, cocaine, heroin, and non-prescription use of prescription painkillers. Psychological Medicine, 53(5), 1955-1969. https://doi.org/10.1017/S0033291721003652

Stewart, R. E., Cardamone, N. C., Schachter, A., Becker, C., McKay, J. R., & Becker-Haimes, E. M. (2023). A systematic review of brief, freely accessible, and valid self-report measures for substance use disorders and treatment. Drug and Alcohol Dependence, 243, 109729. https://doi.org/10.1016/j.drugalcdep.2022.109729

The Professional Clinician. 7) Kuhar, Michael. (2011). Substance Abuse Addiction and Treatment. Marshall Cavendish Corporation. 8) NAADAC. (2009) The Basics of Addiction Counseling: Desk Reference and Study Guide. Module II: Addiction Counseling Theories, Practices and Skills, Tenth Edition. 9) United States Department of Transportation. Substance Abuse Professional guidelines-OADPC SAP Guide (Revised 2009) 10) http://emedicine.medscape.com/article/286661-clinical 11) http://lib.adai.washington.edu/dbtw-wpd/exec/dbtwpub.dll 12) http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs 13) http://www.addiction-treatment.com/research/co-occurring-disorder-assessment/ 14) http://www.mdguidelines.com/marijuana-dependence-abuse/differential-diagnosis 15) http://www.mdguidelines.com/easyaccess/alcoholism 16) http://www.uptodate.com/contents/cannabis-use-and-disorder-clinical-manifestations-courseassessment-and-diagnosis 17) http://pcssmat.org/wp-content/uploads/2014/02/5B-DSM-5-Opioid-Use-Disorder-DiagnosticCriteria.pdf 18) https://www.theravive.com/therapedia/opioid-intoxication-dsm--5-292.89-(f11.219)

Zachar, P., First, M. B., & Kendler, K. S. (2022). Revising substance-related disorders in the DSM-5: A history. Journal of Studies on Alcohol and Drugs, 83(1), 99-105. https://doi.org/10.15288/jsad.2022.83.99

ICD–11 Fact Sheet

Key facts

- **The global standard for health data, clinical documentation and statistical aggregation.**
- **Multiple uses, including primary care**
- **Thoroughly and scientifically updated, and designed for use in a digital world.**
- **State-of-the-art technology reduces the costs of training and implementation.**
- **Multilingual design facilitates global use while the proposal platform allows stakeholder participation in keeping ICD–11 up-to-date.**
- **Countries have already commenced preparing for the implementation of ICD–11, with Arabic, Chinese, English[1] ,French and Spanish versions online.**

What is ICD–11?

ICD–11 is the international standard for systematic recording, reporting, analysis, interpretation and comparison of mortality and morbidity data. This 11th revision is the result of an unprecedented collaboration with clinicians, statisticians, classification and IT experts from around the world, making it useable by these groups, as well as by coders.

ICD–11 allows countries to count and identify their most pressing health issues by using an up-to-date and clinically relevant classification system. Health conditions and accidents are assigned ICD–11 codes, resulting in data that can be used by governments to design effective public health policies, and measure their impact, or used for clinical recording.

For the first time, ICD is fully electronic, currently providing access to 17 000 diagnostic categories, with over 100 000 medical diagnostic index terms. The index-based search algorithm interprets more than 1.6 million terms. ICD–11 is easy to install and use online or offline, using free 'container' software.

Improvements in ICD–11

ICD–11 is a vast improvement on previous revisions. It reflects critical advances in science and medicine, aligning classification with the latest knowledge of disease treatment and prevention. There is more meaningful clinical content than ICD–10.

A significant feature of ICD–11 is the improved ease and accuracy of coding requiring less user training than ever before, together with the availability of online and offline functioning. ICD–11 is digital health ready, for use in multiple IT-environments, with a new API. It is presented together with a suite of web services, including multilingual support and in-built user guidance.

---

[1] Icd.who.int/en

A proposal platform allows all interested parties to suggest changes or additions to ICD–11 and to viewed and discussed transparently. The ICD–11 translation tool ensures internationally consistent translations and the addition of locally used terms.

New core chapters include 'Diseases of the immune system', 'Sleep-wake disorders', and 'Conditions related to sexual health'. New supplementary chapters and sections permit the assessment of functioning, and the optional recording of traditional medicine diagnoses.

All concepts for recording and reporting in primary care are included.

Overall coding improvements in ICD–11 allow more precise and more detailed data recording and collection. However, newly available clinical precision is possible. Examples include:

- Codes for antimicrobial resistance, in line with GLASS[2]
- Codes for full documentation of patient safety, in line with the WHO patient safety framework
- Necessary detail for cancer registration is fully embedded in ICD–11
- Specific coding for clinical stages of HIV
- More clinically relevant coding for complications of diabetes.
- Codes for common skin cancers basalioma, and melanoma subtypes. Classification of heart valve diseases and pulmonary hypertension, now matching current diagnostic and treatment capacity.
- Coding for traffic accidents and causes of injuries is now consistent with current international practice for data documentation and analysis.

The creation of extension codes allows flexible addition of detail relevant for clinical documentation, and device or substance safety. Extension codes provide for the recording of medicaments with WHO INN[3] and WHO Medical Device nomenclature, as well as documenting the severity of conditions, anatomy or histopathology.

Why WHO is interested in countries moving to ICD-11

Meaningful data for prevention, resourcing or evaluation are best produced with a standardised classification that is based on the latest medical and scientific knowledge.

ICD–10 is scientifically and technologically outdated; it is missing content for several de-facto uses of ICD, like primary care or clinical decisions.

ICD–11 is a flexible system which eliminates the need for local variants and allows to document all kind of clinical detail. In such a way, and in combination with the simplified coding, it can be integrated seamlessly in the routine of clinical documentation.

ICD–11 lowers the costs for using ICD because correct use requires less training and less time for coding, and as such allows the implementation of standard reporting in places where it has not been possible to use ICD before. It is free for use in all countries, as a package with user guides and tools, providing inexpensive coding of patient encounters in the clinical setting.

[2] The Global Antimicrobial Resistance Surveillance System (GLASS) https://www.who.int/initiatives/glass

[3] WHO International Nonproprietary Names (INN) facilitate the identification of pharmaceutical substances or active pharmaceutical ingredients. Each INN is a unique name that is globally recognised and is public property. A nonproprietary name is also known as a generic name. https://www.who.int/teams/health-product-and-policy-standards/inn/

There are other applications for ICD–11

ICD–11 is flexible in the level of detail captured, it can be adapted to the primary care setting, for surveillance of rare conditions, to generate adverse event reporting inpatient quality and safety management, and to the use of casemix for reimbursement and resource allocation is possible.

Alternative applications include using ICD–11 as a multilingual dictionary, or as a terminology server for studies, surveys and other areas of recording of health information.

WHO response

In response to Member State needs for moving to ICD–11, WHO is providing technical assistance to help countries develop their national implementation plans and to strengthen their health and surveillance systems. WHO has already undertaken training workshops in several WHO Regions. Early adopters start implementation, providing valuable information to other countries for that process. Technical support by WHO includes instructions on the use of the translation platform and integration of the ICD–11 coding tooling in a local information system.

The ICD–11 implementation package includes all information, tools, training materials, mapping tables and more in support to use of ICD.

The ICD–11 Proposal platform and translation tool is open to all interested parties and facilitates the ongoing update process, and the translation tool allows translations by the clinical community who uses ICD.

General aspects of implementation

The time and amount necessary for the implementation of ICD-11 largely will depend on two factors:

1. Whether a previous version has been in use

2. Level of penetration of ICD use in the national information infrastructure

As as an estimate, a Member State newly introducing ICD-11 in a simple information system may need 1-2 years. Member States with a highly sophisticated information system where earlier versions of ICD are already in use calculate 4-5 years time necessary for the implementation of a new version of ICD.

In the cause of death coding, ICD-11 facilitates the transition from ICD-10, and the ICD Startup Mortality List (SMoL).

WHO Family of Classifications

ICD is part of the WHO Family of International Health Related Classifications (WHOFIC).

ICD, the International Classification for Health Interventions (ICHI) and the International Classification for Functioning, Disability and Health (ICF) are the core classifications that are complemented by Classifications for Nursing, Primary Care or Medicaments (ATC/DDD).

Primary care has been incorporated in ICD-11, and the Medicaments, as well as cancer histopathology (ICD-O), have been embedded in ICD-11

Related Links

International Classification of Diseases 11th revision homepage https://icd.who.int

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