How to Conduct a Quality Substance Abuse Evaluation

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Handouts

About the Presenter

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- 20 years of experience providing clinical and forensic substance abuse evaluation, substance use treatment, and clinical supervision in residential, outpatient, and correctional settings
- Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, Master Addiction Counselor, Certified Forensic Mental Health Evaluator, Certified Forensic Psychometrist
- BA in Psychology, MA in Rehabilitation and Mental Health Counseling, PhD in Counselor Education and Supervision with cognate in Clinical Psychology
- Executive Director of the National Board of Forensic Evaluators
- Assistant Professor of Instruction at the University of South Florida's Dept. of Mental Health Law & Policy
- Southern Regional Director and Ethics Committee Liaison for the American Mental Health Counselors Association (AMHCA)
- Co-wrote the forensic evaluation standards for the American Mental Health Counselors Association's "Standards for the Practice of Clinical Mental Health Counseling"
- Disclosure: When discussing resources, I mention certification and training provided by the National Board of Forensic Evaluators. I contract with NBFE to provide administrative services for a flat monthly fee.

Objectives

1. Identify the diagnostic criteria for substance use disorders and apply the criteria in a case scenario.
2. Conduct a clinical interview to determine if a client meets diagnostic criteria.
3. Identify tests that detect subtle attributes of SUDs and have built-in validity scales to detect defensiveness, denial, and inconsistencies.
4. Use collateral sources for additional information and identify what to look for when reviewing those sources to help determine diagnoses and treatment needs.
5. Apply the American Society of Addiction Medicine (ASAM) treatment criteria when formulating treatment recommendations.

- “…Relatively few psychologists have adequate training and knowledge in the area of substance abuse evaluation or treatment. There are even fewer psychologists who believe that it is within their area of expertise to evaluate, testify, consult, or provide other substance abuse information to the criminal or civil courts.”

Ackerman (2010), Kindle Locations 4970-4972

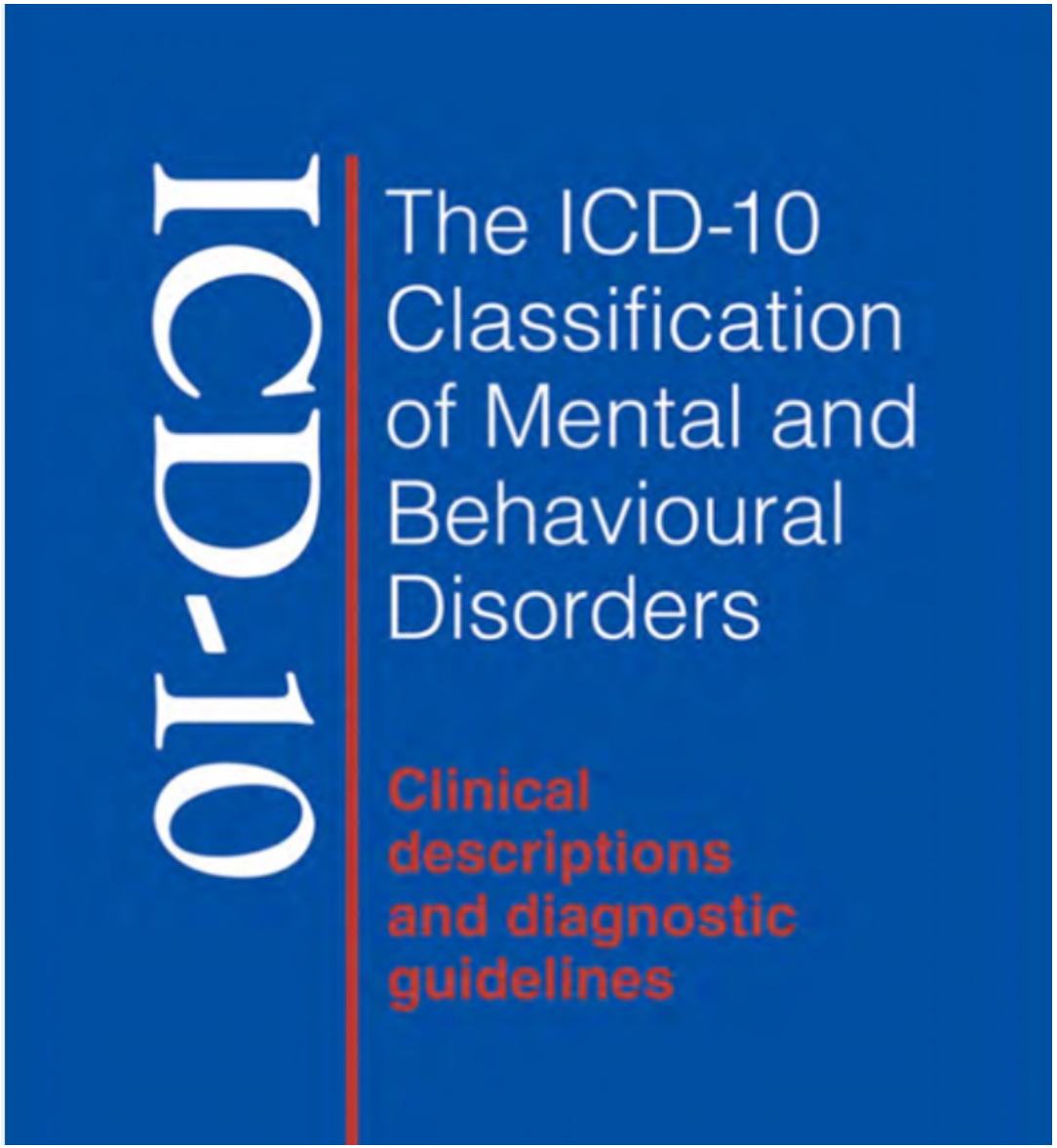
Why is Quality Evaluation So Important to Me?

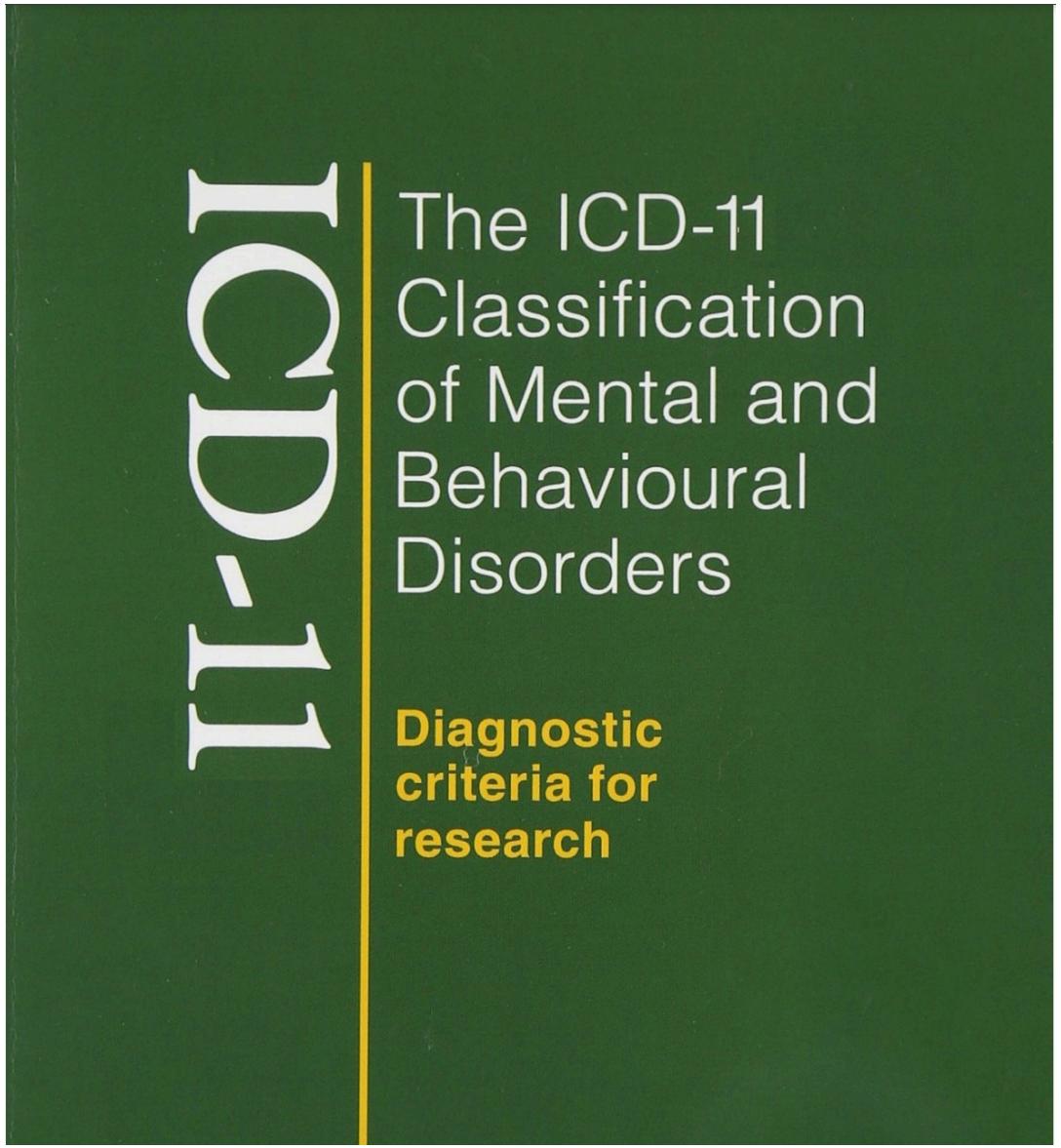
- Clients deserve a thorough and objective evaluation.
- Clients deserve to be treated with dignity and respect.
- Quality evaluations are essential for public safety and welfare
- I want the judicial system to take our profession seriously.

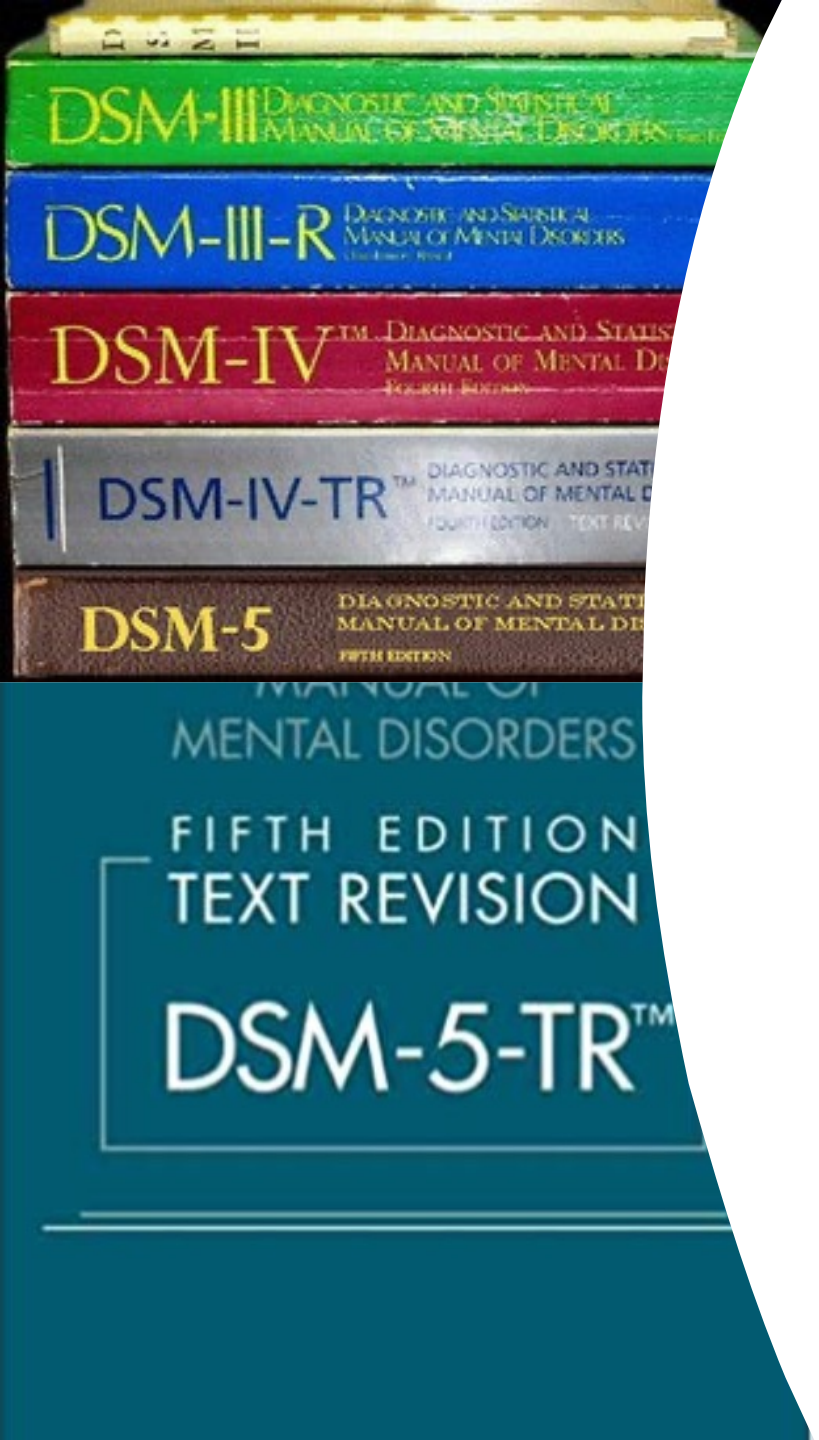
2 Diagnostic Criteria Resources: Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Disorders (ICD)

International Classification of Diseases (ICD)

- 1893: International Statistical Institute created the ICD with the goal of creating a uniform system for classifying and communicating about diseases
- 1898: American Public Health Administration recommended that Canada, Mexico, and the United States uses the system, which would be revised every decade
- 1948: World Health Organization (WHO), an agency under the United Nations, assumed responsibility for the ICD
- 1992: After significant revisions in the 80s and 90s based on collection of epidemiological data, ICD-10 was published (replacing the smaller ICD-9)
- 10/1/2015: US adopted the ICD-10 (Ramiani, 2015)
- 5/25/19: WHO published ICD-11 (WHO, 2022) (not yet adopted by US)


ICD-10
The ICD-10 Classification of Mental and Behavioural Disorders
Clinical descriptions and diagnostic guidelines


ICD-11
The ICD-11 Classification of Mental and Behavioural Disorders
Diagnostic criteria for research



DSM Timeline

- 1952-original DSM; 106 diagnoses
- 1968-DSM-II; 185 diagnoses
- 1980-DSM-III; 265 diagnoses
- 1987-DSM-III-R; 292 diagnoses
- 1994-DSM-IV; 297 diagnoses
- 2000-DSM-IV-TR; 297 diagnoses
- 2013-DSM-5; 298 diagnoses
- 2022-DSM-5-TR; 299 diagnoses
  - (Kawa & Giordano, 2012; Surís et al., 2016)

Differences and Similarities

DSM

- Produced by American Psychiatric Association (APA)
- Intellectual property of APA
- Primarily created for mental health professionals for diagnosis/treatment planning
- Uses ICD codes
- Predominantly US/anglophone perspective
- Approved by APA Board of Trustees and APA Assembly
- Primarily used in US, Canada, Australia, and by chartered clinicians in UK
- Most current edition: DSM-5-TR

ICD

- Produced by World Health Organization (WHO)
- Free/open access
- Primarily created for countries and front-line service providers for universal classification
- Uses ICD Codes
- Global, multidisciplinary, multilingual development
- Approved by World Health Assembly
- Primarily used in European countries
- Most current edition: ICD-11

Substance Categories: DSM and ICD

DSM-5-TR

- Alcohol
- Cannabis
- Opioids
- Sedatives/hypnotics/anxiolytics
- Stimulants (amphetamine-type substances, cocaine, and other/unspecified stimulants)
- Caffeine
- Hallucinogens (phencyclidine vs. other)
- Tobacco
- Inhalants
- Other (or unknown)

ICD-11

- Alcohol
- Cannabis
- Opioids
- Sedatives/hypnotics/anxiolytics
- Cocaine
- Stimulants including amphetamines/methamphetamine/ methcathinone
- Synthetic cathinones
- Caffeine*
- Hallucinogens
- Nicotine
- Volatile inhalants
- MDMA or related drugs
- Dissociative drugs including ketamine and phencyclidine (PCP)
- Other specified psychoactive substances

DSM-5-TR: Substance-Related and Addictive Disorders

Substance-Related and Addictive Disorders

Substance-related disorders encompass 10 separate classes of drugs (i.e., alcohol, caffeine, cannabis, phencyclidine, other hallucinogens, inhalants, opioids, sedatives/hypnotics/anxiolytics, amphetamine-type stimulants, cocaine, other stimulants, tobacco, and other/unknown)

Gambling Disorder included in this chapter because of activation of reward systems similar to those activated by drugs of abuse and that produce some behavioral symptoms that appear comparable to those produced by the substance use disorders

Internet Gaming Disorder, and behavioral addictions (e.g., sex addiction, exercise addition, shopping addiction) may be included in future if sufficient evidence warrants addition

Definitions of Addiction

- Repeated engagement in pattern of behavior that activates reward circuity in the brain despite significant negative consequences in major life areas (me)
- Addiction is defined as a chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences (NIDA, 2022)
- Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences (ASAM, 2019)

Substance-Related and Addictive Disorders

- Substance use disorders
  - A cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems
  - Four diagnostic groupings:
    1. Impaired control (i.e., using more than intended/longer than intended, unsuccessful efforts to cut down/control use, great deal of time spent, cravings)
    2. Social impairment (i.e., use resulting in failure to fulfill major role obligations, continued use despite associated social/interpersonal problems, important activities given up/reduced due to use)
    3. Risky use (i.e., recurrent use in physically hazardous situations, use despite associated physical or psychological problems)
    4. Pharmacological criteria (i.e., tolerance and withdrawal)

Substance-Related and Addictive Disorders (APA, 2022)

- Prevalence of Substance Use Disorders
  - Alcohol Use Disorder: lifetime prevalence for adults of 29.1%
  - Cannabis Use Disorder: past-year prevalence for youth (ages 12- to 17 years): 2.7- to 3.1%; for adults 1.5- to 2.9%
  - Phencyclidine Use Disorder: Unknown but low
  - Other Hallucinogen Use Disorder: Point prevalence of 0.1% for 12 years and older, 0.2% for 12- to-17-year-olds, 0.4% for 18-to-25-year-olds, <0.1% for ages 26 and older
  - Inhalant Use Disorder: 12-month prevalence rate of 0.04% for ages 18 and older
  - Opioid Use Disorder: Point prevalence for prescription opioids use disorder among US adults is 0.6- to 0.9%, heroin use disorder 0.1- to 0.3%
  - Sedative, Hypnotic, or Anxiolytic Use Disorder: 12-month prevalence rate of 0.3% among adolescents 12- to 17 years and 0.04 to 0.5% for adults of various age groups
  - Stimulant Use Disorder: 12-month prevalence of 0.4% for Americans 12 years and older
  - Tobacco Use Disorder: 12-month prevalence of 20% among US adults

Substance Use Disorders: We're *ALL* Working with Them

Lifetime Prevalence:

- 29.1 % for Alcohol Use Disorder, 19.8 % of whom are treated (Grant et al., 2015)
- 9.9 % for other substance use disorders, 24.6 % of whom are treated (Grant et al., 2016)

12-Month Prevalence:

- 13.9% for alcohol use disorders, 7.7 % of whom are treated (Grant et al., 2015)
- 3.9% for other substance use disorders, 13.5 % of whom are treated (Grant et al., 2016)

Substance-Related and Addictive Disorders

- For each category of substances, there is a separate diagnosis for intoxication and for withdrawal, the symptoms of which vary from substance to substance and will not be reviewed at length in this course

The Drug-Crime Connection

The Drugs and Crime Connection

- Drug users report greater involvement in crime
- Drug users are more likely than nonusers to have criminal records
- People with criminal records are much more likely than others without records to report being drug users
- Crime rates increase proportionately with increases in drug use (Ackerman, 2010)

3 Mechanisms of Drug-Crime Relationship

(adapted from Goldstein, 1985)

Psychopharmacological Crime	• Some individuals, because of short- or long-term ingestion of specific substances, may become excitable, irrational, and may exhibit criminal behavior
Economic Compulsive Crime	• Some drug users engage in economically oriented crimes (e.g., robbery to support costly drug use)
Systemic Crime	• Criminal activity is intrinsic to involvement with any illicit substance; systemic crime refers to traditionally aggressive patterns of interaction within the system of drug distribution and use

Mandated Treatment Just as Effective

Kelly, Finney, & Moos (2005)

Forensic vs. Clinical (Therapeuti)c Evaluation

Forensic vs. Clinical (Therapeutic Evaluations)

Forensic evaluation: “the process of forming professional opinions for court or other legal proceedings, based on professional knowledge and expertise, and supported by appropriate data” (ACA, 2014, p. 20)

“Although some therapeutic services can be considered forensic in nature, the fact that therapeutic services are ordered by the court does not necessarily make them forensic” (APA, 2013, Guideline 4.02.03, p.11)

Forensic vs. Clinical Evaluation

Forensic

- Typically a narrow focus on a particular legal question
- Client's perspective is just one data set
- Clients may be compelled to participate
- Client autonomy de-emphasized
- Strong threats to validity
- Evaluative role or examiner
- Less control over pace and setting

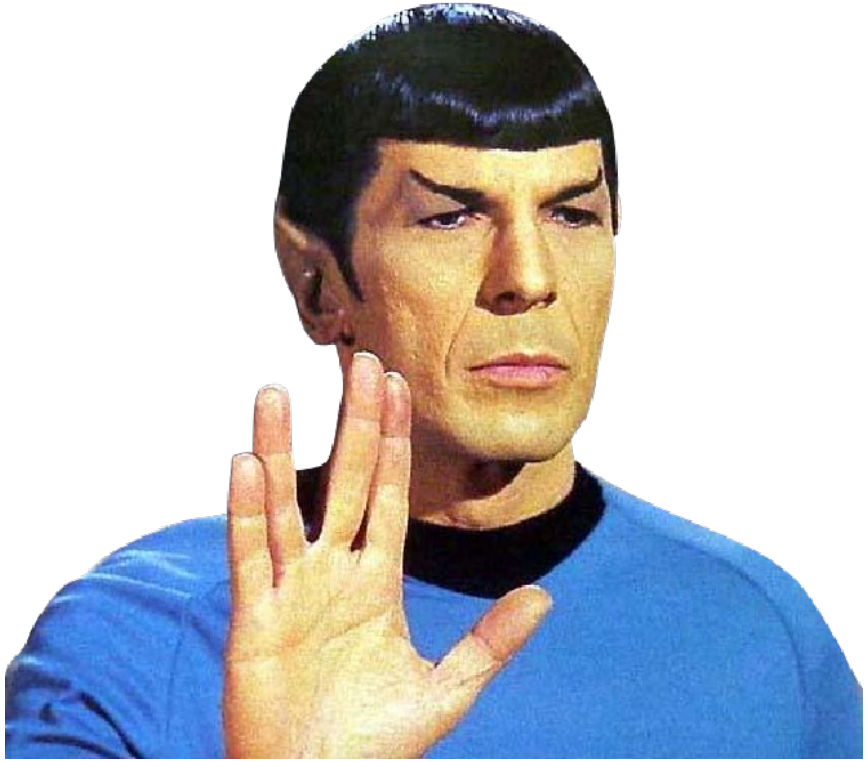
Therapeutic/Clinical

- Broad and holistic focus on the whole person
- Client's perspective is emphasized/most important
- Client is typically voluntary/self-directed
- Client autonomy emphasized
- Client often relatively truthful
- Therapeutic/advocate role
- More control over pace/setting

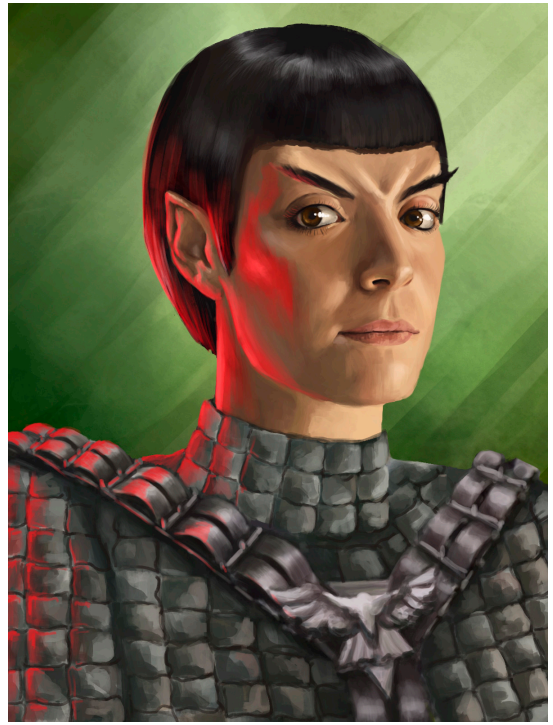
Source: Melton et. al (2018)

In Forensic Evaluation, Reason Prevails

Think Like a Vulcan



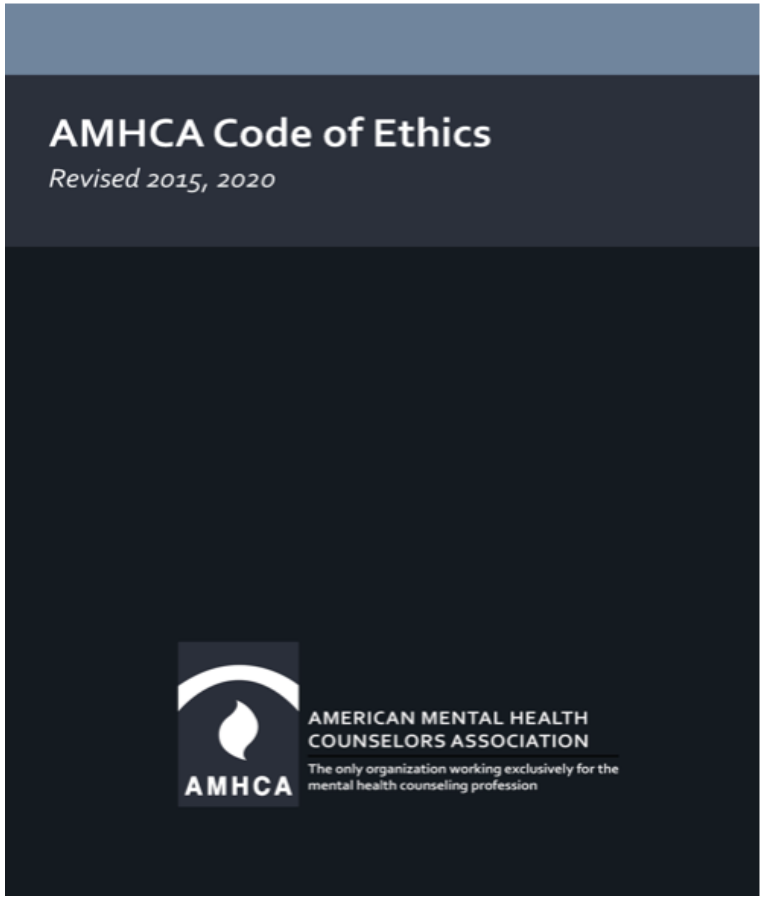
…Not a Klingon or a Romulan



AMHCA Code of Ethics (2020)

- Forensic Activity
  - Must possess appropriate knowledge and competence
  - Objectively offer findings ”without bias or investment in the ultimate outcome”
  - Solicit informed consent
  - Base recommendations on appropriate information and techniques
  - Do not offer recommendations/conclusions on individuals you haven’t evaluated
  - Accurately portray qualifications in court
  - ”Do not typically” evaluate former clients, provide therapy for former forensic examinees
  - Do not advocate for anyone or anything (except the truth)

Mental health counselors base diagnoses and other assessment summaries on multiple sources of data whenever possible.



AMHCA Code of Ethics (2020), Code D2a

Denial is Imbedded in the Disorder

Threats to Validity

- Positive Impression Management
- Negative Impression Management
- Neurocognitive Impairments
- Lack of Insight

Components of a Quality Evaluation

(Ackerman, 2010; APA, 2013)

Clinical Interview

- Structured, semi-structured, or unstructured interviews

Review of Records

- Treatment records (both psychiatric/mental health and biomedical)
- Previous evaluations
- Arrest records/public records
- Court records/hearing transcripts

Collateral Information

- Spouse/partner
- Family members
- Employer
- Sponsor

Objective Test Data

- Normed, substance-related psychological tests
- Drug tests

Informed Consent

Discussion of Circumstances Related to Referral

Diagnostic Interview

Biopsychosocial Assessment

Clinical Interview

Setting the Stage…

- Clean and comfortable environment
- Greet clients warmly and comfortably
- Beverages

4c) "CMHCs inform clients involved in a forensic evaluation about the limits of confidentiality, the role of the CMHC, and the purpose of the assessment.”

(AMHCA, 2020, p. 10)

AMHCA Code of Ethics (2020)

Informed Consent (Example)

I understand that you're here to see me today for a substance abuse evaluation that was ordered by the judge who is overseeing your child custody case. Before we get started, I'd like to explain a few things about our time here together, and about my role in your case. First, I know that you read and signed some paperwork explaining confidentiality, but I also want to review that information with you verbally to make sure it makes sense to you. Whatever you tell me during this evaluation is confidential, which means that I can't tell anyone else what you tell me, but there are some exceptions. First, if you report to me that you are **abusing or neglecting a child, an elderly person, or a person with a disability**, then I may have to report that information in order to protect that person. Second, if you tell me or I have good reason to believe that you are going to **seriously harm yourself or another identifiable person in the near future**, then I will have to take action to protect you or that other person.

Informed Consent (Example)

Third, if you have a **medical emergency**, then I may need to take action to help you. For example, if you had a seizure in my office, I could call 911 without asking you to sign a form first giving me permission to do so. Fourth, if I were to get a **signed court order from a judge**, then I would need to provide the information that the judge has ordered me to provide. Finally, if you sign a **release of information** giving me permission to share information, then I can do so. That is a really important exception, because if you are going to comply with the order from the judge, then you will need to sign a release form allowing me to release my evaluation records to the court. That information will then become a part of your case, and it could play a significant role in the outcome of your case.

Informed Consent (Example)

- Do you understand what I've described about confidentiality?
- Do you have any questions?
- With this information in mind, would you like to go forward with the evaluation?

Informed Consent (Example)

Now, I'm going to tell you a little bit about how this evaluation works. First, I'm going to ask you questions about your substance use history throughout your life, including what you've used, how much, how often you used, when you used, and some of the circumstances surrounding your use. Then, I'll be asking you some questions about things that you may or may not have experienced because of your substance use. If you've participated in any kind of mental health, substance use, or medical treatments that might be relevant to the questions I'm answering for your evaluation, then I'll probably ask you about those experiences.

Informed Consent (Example)

Then, I'll be asking you some follow-up questions about the questionnaires and the tests that you completed. Also, we'll be taking a urine sample from you today that we'll send to a lab to test for substances that you might have recently used. We'll use those results to help support what you tell me today about your recent alcohol or drug use. For example, if you tell me that you recently drank alcohol but that you've never used cocaine, then we might expect to see a positive result for alcohol but a negative result for cocaine. It's very important that you do your best to tell me the truth about your substance use. [Explain the urine drug test procedure in greater detail.].

Informed Consent (Example)

I'll also be checking public records to see if the records match up what you tell me about your legal history, such as arrests and lawsuits. Also, I may be identifying people to interview about their experiences with you. This may include family members, significant others, treatment professionals or physicians you've worked with, your attorney, or your employer. I would talk with you first before interviewing anyone, explaining what I will be asking them and why, and I would also ask for you to sign a consent form giving me permission to talk to them first.

Informed Consent (Example)

- Do you understand what I've described about how this evaluation works?
- Do you have any questions?
- With this information in mind, would you like to go forward with the evaluation?

Informed Consent (Example)

- Earlier, I mentioned that I will be checking public records to see if the records match up with what you tell me about your history of arrests and involvement in lawsuits and other legal cases. Do you think anything will show up in those records that you've haven't already told us about?
- Earlier, I mentioned that I will be collecting a urine specimen for a drug test. Do you think that anything will show up in that test that you haven't already told me about?
- Now, maybe we could start with you telling me some more about what happened leading up to this evaluation, and why the judge ordered it.

This is an example of what **I do** in **my state** and in **my practice**. Ultimately, it is your responsibility to ensure that your informed consent process is reflective of federal and state law as it pertains to your work in your area of specialization and in your jurisdiction.

Informed Consent Disclaimer

Discussion of Circumstances Related to Referral

- Who, what, where, when, and how?
- Use active listening skills
- Client's opportunity to share his/her "story"
- When you think you have the story, read your notes back to the client, and ask him/her if it sounds right.
- Ensure that you have verified the exact verbiage of what the referral source is looking for (specific questions to be answered in report)

The Diagnostic Interview

Substance Use Disorder Categories (APA, 2013)

- DSM-5 Substance Use Disorder Categories
  - “Uppers”
    - Stimulants (e.g., amphetamines, cocaine)
    - Tobacco
  - “Downers”
    - Alcohol
    - Opioids (e.g., heroin, painkillers)
    - Sedative, hypnotics, or anxiolytics (e.g., barbiturates and benzodiazepines)
  - “All-Arounders”
    - Cannabis
    - Hallucinogens (phencyclidine and other)
    - Inhalants
    - Other (or unknown) (e.g., synthetic marijuana, kratom)

Obtain a Substance Use History

- Explain to the client that you know that he/she will not be able to be a perfect historian, and that you are seeking estimates and approximations
- For each category of substances, ask about…
  - What was used
  - How it was used
  - How much was used
  - What the client liked/disliked about use
  - When it was used

Pay Attention to DSM-5 Verbiage

- Words and phrases like “clinically significant,” “recurrent,” “markedly,” “continued,” “often,” ”persistent,” and “great deal” make it clear that scattered, isolated, and minor manifestations do not meet the diagnostic threshold

With Each Symptom that is Endorsed, Find Out…

- When it was happening
- How often it was happening
- For what substances

Dig Deeper

If the client answers “yes” to any symptom-related questions, then ask follow-up questions, including when (also “when is the most recent time you think that was happening?”), how often, etc. Let them tell their story, use active listening skills, and ask lots of questions.

DSM-5-TR Substance Use Disorder Symptoms: Examples of Questions to Ask During Interview

Substance Use Disorder Diagnostic Criteria

- A pattern of substance use leading to **clinically significant impairment or distress** as **manifested by at least 2** of the following, occurring within a **12-month period**:
  - The substance is often taken in larger amounts or over a longer period than was intended.
    - Was there ever a period of time in your life when you were often using one of these substances more than you planned on?
    - Have you ever thought to yourself something like, “I’m just going to spend 2 hours tops at the bar today, but found yourself staying a lot longer?”
    - Have you ever thought to yourself, “I’m just going to have two this time,” but found yourself drinking more than that?

SUD Criteria (Continued)

- There is a persistent desire or unsuccessful efforts to cut down or control the use of the substance.
  - Have you ever quit? When? Do you know why you wanted to quit? Did you go back to using? What do you think happened?
  - Did you ever try to scale back on your use? What was that like? How did it go? When was that happening? Why do you think you wanted to scale back?
- A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
  - Do you think there was a period of time in your life in which using ____ seemed to be taking up a lot of your time?
  - By “a lot of your time,” I mean a few hours or day or more when you combine getting it, using it, and recovering from it (e.g., nursing a nasty hangover).

SUD Criteria (Continued)

- Craving, or a strong desire or urge to use the substance.
  - Have you ever had an urges, cravings, or strong desires to use _____?
- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home
  - Do you think there was ever a period of time in your life when using one of these substances seemed to be getting in the way of important responsibilities? The could be responsibilities at work, home, or school, for example.
  - (Regardless of above answer) Can I give you some examples?
    - Have you ever skipped school to get high? Have you ever gone home after school, smoked some weed, and then you didn't feel like doing your homework or studying? When all this was happening, what were your grades like?
    - Back when you were drinking a lot, did you notice that you didn't keep your house as clean as usual?
    - Have you ever called in sick because of a hangover?
    - Have you ever gone to work when you had a hangover, but been less productive than usual? Did that ever get you into any trouble?

SUD Criteria (Continued)

- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
  - Do you think that using any of these substances has ever caused any problems with your relationships with family, friends, or significant others?
    - (Regardless of answer), can I give you some examples?
      - Have you ever been drinking, and said something mean or nasty that you probably wouldn't have said had you not been drinking?
      - Have you ever been drinking, and got into a fight that you probably wouldn't have gotten into had you not been drinking?
      - Have you and a significant other ever argued about how much you use, how much money you spend on it, or anything else about your use?
      - Has a significant other or a family member ever said they were concerned or unhappy about your use? (test items may provide additional information)

SUD Criteria (continued)

- Important social, occupational, or recreational activities are given up or reduced because of the use of the substance.
  - Do you think there are any important activities that you stopped doing so much, and you think that maybe your drinking/use had something to do with it?
    - Do you mind if I give you some examples that some other clients have talked to me about?
      - A guy told me that he used to run almost every day, but then he started smoking cigarettes, and he stopped running. He noticed that when he quit smoking, he started running again, but when he went back to smoking, he stopped running again.
      - A guy told me that he quit playing soccer and football in high school because he knew he couldn't pass a drug test.
      - A lady once told me that she went to yoga every Sunday. She said, "Some people go to church on Sundays; I go to yoga." But she started going out on Saturday nights and drinking a lot, and then she stopped getting up on Sunday morning for yoga.

SUD Criteria (Continued)

- Recurrent substance use in situations in which it is physically hazardous
  - Have you ever driven when you could feel high or buzzed? (or “When do you think was the last time you drove when you could feel high or buzzed?”)
  - Do you think you’ve ever driven after you’ve been drinking, and if you happened to get pulled over by a cop and did a breathalyzer, you probably would have blown high enough to get a DUI?
  - Have you ever gone hunting when you were drinking? Boating? Bungee-jumping?
  - You ever done any work around the house when drinking? Roofing? Using a machine?

SUD Criteria (Continued)

- The substance 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 the use of the substance.
  - (If the client has reported medical issues or prescriptions, ask questions about them—get the client talking about them.)
  - What do you think causes ___?
  - Did your doctor ever say that drinking could have an effect on ___?
  - Has a doctor ever suggested that you cut back on ____?
  - Do you know about any physical problems that might be affected by using ____?
  - Sometimes, people notice that when they use ____, they feel anxious, depressed, or paranoid. Has that ever happened to you?

SUD Criteria (Continued)

- Tolerance, as defined by either of the following:
  - a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect; and/or
  - b) A markedly diminished effect with continued use of the same amount of the substance.
- Note that if the client has never used a substance daily or nearly daily for several days or longer, then there is probably no need to ask about this symptom (or the next one)
  - Have you noticed that when you drink now, you get less of a buzz than you used to?
  - Have you noticed it takes more beers to get the same feeling you used to get from less?
  - (note that if the client reports the opposite, this could be a sign of tolerance as well, if its because the client is using less now than he/she used to)

SUD Criteria (continued)

- Withdrawal, as manifested by either of the following:
  - a) The characteristic withdrawal syndrome for the substance; and/or
  - b) The substance is taken to relieve or avoid withdrawal symptoms.
    - (Note, again, that if the client has denied ever using a substance daily or almost daily for at least several days or weeks, then there is likely no reason to ask about this symptom)
    - When you were using ___ frequently, and you stopped (or quit back), did you notice anything weird happening with your body or your mind? Like your system was trying to adjust to the change somehow?
    - Ask questions about the specific withdrawal symptoms in the DSM-5 for the specific categories of substances that the client has used regularly.
    - Consider talking about tobacco/nicotine first, or maybe even caffeine. Clients are often more likely to talk openly about these substances, ”priming the pump” for a more casual exploration of other substances that have a stronger stigma attached to them.

Exception: Tolerance and Withdrawal

- Tolerance and withdrawal cannot be counted as symptoms if the client is using a sedative/hypnotic/anxiolytic, opioid, or stimulant medication as prescribed consistent with physician’s orders

Diagnosis

1. Determine what symptoms have been met for what substances and when
2. Diagnose SUD for substances with 2 or more symptoms present in same 12-month period
3. Specify if in remission (early or sustained)
4. Specify if in a controlled environment
5. Specify current severity

Specify Severity

2-3 symptoms = mild

4-5 symptoms = moderate

6 or more symptoms = severe

Specify if in Remission

- In early remission: After full criteria for a SUD were previously met, none of the criteria have been met for at least 3 months but for less than 12 months (except craving)
- In sustained remission: After full criteria for SUD were previously met, none of the criteria have been met for 12 months or longer (except craving)

In a Controlled Environment

- If disorder is in remission, AND the individual is an environment where access to the substance is restricted, tack on “in a controlled environment”
  - Examples:
    - Jail or prison
    - Halfway house/transitional house
    - Residential treatment program
    - Hospital

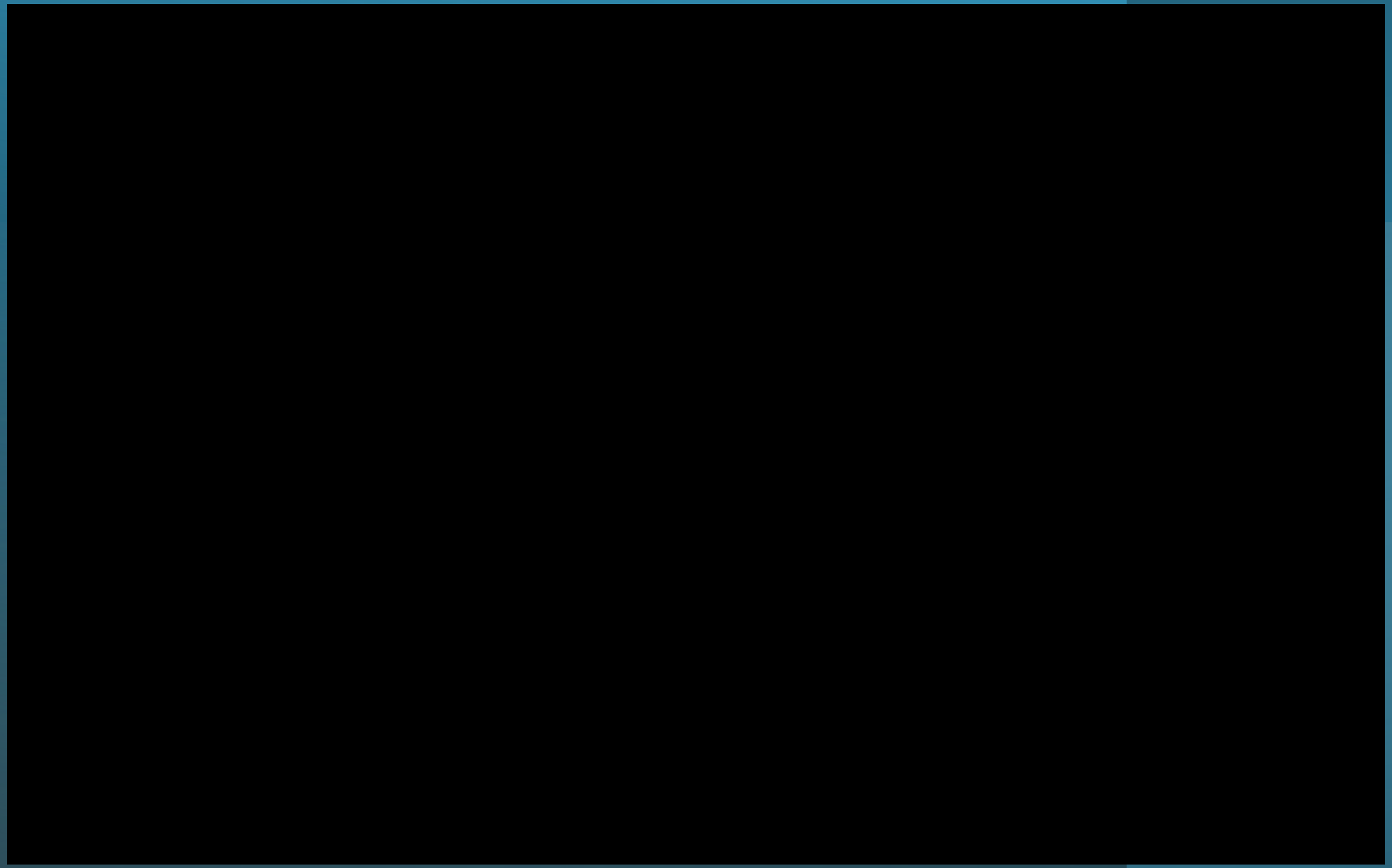
On Maintenance Therapy

- If the client has met criteria for an opioid use disorder, but is taking a prescribed agonist medication such as methadone or buprenorphine and none of the criteria for opioid use disorder have been met for that class of medication (except tolerance to, or withdrawal from, the agonist)

Resource

DSM-5 Substance Use Disorder Assessment Tool

Let’s Practice!



ICD-11: Substance-Related Disorders (WHO, 2018)

Disorders due to substance use or addictive behaviours (Block L1-6C4)

- Disorders due to substance use and addictive behaviours are mental and behavioural disorders that develop as a result of the use of predominantly psychoactive substances, including medications, or specific repetitive rewarding and reinforcing behaviours.

Disorders due to substance use (Block L2-6C4)

- Disorders due to substance use include single episodes of harmful substance use, substance use disorders (harmful substance use and substance dependence), and substance-induced disorders such as substance intoxication, substance withdrawal and substance-induced mental disorders, sexual dysfunctions and sleep-wake disorders.

ICD-11: Substance Use Disorders

"Harmful use pattern" vs. "dependence"

ICD-11: Substance Use Disorders

- Harmful Pattern of Use
  - A pattern of substance use that has caused damage to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others
  - Evident over a period of at least 12 months if use is episodic or at least once a month if continuous
  - Harm to health of individual occurs due to 1 or more of the following:
    - (1) behaviour related to intoxication;
    - (2) direct or secondary toxic effects on body organs and systems; or
    - (3) a harmful route of administration.
  - Harm to others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to intoxication on the part of the person to whom the diagnosis applies

ICD-11 Substance Dependence

- A disorder of regulation of substance use arising from repeated or continuous use of alcohol.
- Characteristic feature is a strong internal drive to use substance, manifested by:
  - impaired ability to control use,
  - increasing priority given to use over other activities and persistence of use despite harm or negative consequences.
- These experiences are often accompanied by a subjective sensation of urge or craving to use substance.
- Physiological features of dependence may also be present, including tolerance, withdrawal, repeated use of substance or pharmacologically similar substances to prevent or alleviate withdrawal symptoms.
- Features of dependence are usually evident over a period of at least 12 months, but the diagnosis may be made if substance use is continuous (daily or almost daily) for at least 1 month.

Biopsychosocial Assessment

- Review the client's biopsychosocial history and ask follow-up questions designed to help you conceptualize the case holistically from an *ASAM Treatment Criteria* perspective

Tip: Use a Biopsychosocial Questionnaire

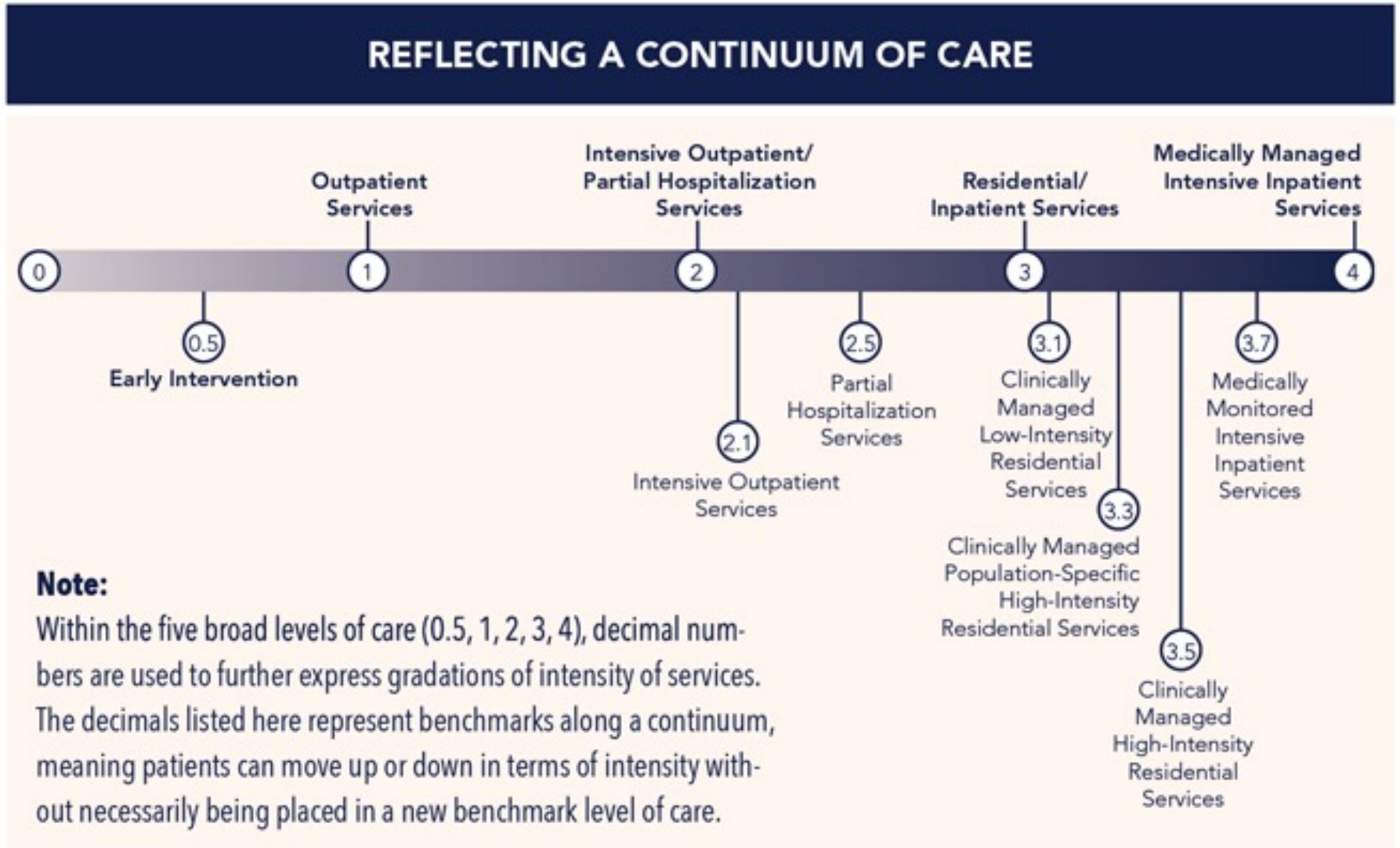
- Find one online
  - (e.g., http://www.anorton.com/SubstanceAbuseEvaluationForms.en.html)
- Create your own
- Use a structured tool
  - Addiction Serverity Index (ASI)
  - ASAM Criteria Assessment Interview Guide
  - Quickview Social History
  - TCU Criminal Justice Comprehensive Intake (free) and other TCU intake / assessment tools

ASAM Treatment Criteria

(ASAM, n.d.)

Dimension 1	Acute Intoxication and/or Withdrawal Potential • Past and current experiences of substance use and withdrawal
Dimension 2	Biomedical Conditions and Complications • Health history and current physical condition
Dimension 3	Emotional, Behavioral, or Cognitive Conditions and Complications • Thoughts, emotions, and mental health issues
Dimension 4	Readiness to Change • Readiness and interest in changing
Dimension 5	Relapse, Continued Use, or Continued Problem Potential • Unique relationship with relapse or continued use or problems
Dimension 6	Recovery/Living Environment • Recovery/living situation and surrounding people, places, and things


MAINTENANCE
RELAPSE
ACTION
CONTEMPLATION
PREPARATION
PRECONTEMPLATION


REFLECTING A CONTINUUM OF CARE
Outpatient Services
Intensive Outpatient/ Partial Hospitalization Services
Residential/ Inpatient Services
Medically Managed Intensive Inpatient Services
0
1
2
3
4
0.5
Early Intervention
2.1
Intensive Outpatient Services
2.5
Partial Hospitalization Services
3.1
Clinically Managed Low-Intensity Residential Services
3.3
Clinically Managed Population-Specific High-Intensity Residential Services
3.5
Clinically Managed High-Intensity Residential Services
3.7
Medically Monitored Intensive Inpatient Services
Note:
Within the five broad levels of care (0.5, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.

Mee-Lee (2013)

ASAM Levels of Care

0.5 Early Intervention

- For individuals who are at-risk or those for whom there is not yet a diagnosis
- e.g. EAPs, motivational interviewing, DUI classes, etc.

1 Outpatient

- Client with diagnosis of SUD/addictive disorder
- Can be used for clients who are ambivalent about change

2.1 Intensive Outpatient

- 9-19 hrs. of programming per week
- Client with diagnosis of SUD or addictive disorder

ASAM Levels of Care

2.5 Partial Hospitalization

- a.k.a. “day treatment”
- Min. 20 hrs. per week
- SUD or addictive disorder diagnosis

3.1 Clinically Managed Low-Intensity Residential Services

- Moderate-severe SUD/addictive D/O
- At least 5 hrs. weekly of “low intensity” tx.

3.3 Clinically Managed Population-Specific High-Intensity Residential Services

- Cognitive limitations
- Moderate-severe SUD/addictive D/O
- No/minimal MH dx
- Open to recovery but needs residential

ASAM Levels of Care

3.5 Clinically Managed High-Intensity Residential Services

- Moderate-severe SUD/addictive dx
- Co-occurring disorders/severe limitations
- Marked difficulty w/ tx.

3.7 Medically Monitored Intensive Inpatient Services

- Biomedical/mental problems are so severe that they require inpatient but don’t require full hospitalization
- Moderate-severe SUD/addictive D/O

4 Medically Managed Intensive Inpatient Services

- Acute biomedical/mental problems so severe that they require primary medical and nursing care
- Meets dx criteria for SUD or substance-induced D/O

ASAM Levels of Care

Opioid Treatment Services

- Pharmacological treatments for individuals with severe opioid use disorders

1-WM Ambulatory Withdrawal Management without Extended On-Site Monitoring

- Mild S/S of withdrawal

2-WM Ambulatory Withdrawal Management with Extended On-Site Monitoring

- Moderate risk of severe withdrawal syndrome but free of severe physical and psychiatric complications

ASAM Levels of Care

3.2-WM Clinically Managed Residential Withdrawal Management

- Criteria varies depending on substance
- Withdrawal symptoms but no risk of severe withdrawal and requires residential care

3.7-WM Clinically Managed Residential Withdrawal Management

- Severe withdrawal syndrome but can be managed with this level of care

4-WM Medically Managed Intensive Inpatient Withdrawal Management

- Severe withdrawal; requires more than hourly monitoring and withdrawal RX

Resource

ASAM Criteria Matrix for Matching Severity/Functioning with Type/Intensity of Service

ASAM Matching Matrix

- For all six biopsychosocial domains, clinicians offer a rating value of 0 to 4
  - 0: Indicates full functioning, no severity, and no risk in this dimension. No need for specific services in this dimension.
  - 1: Mildly difficult issue, or present minor signs and symptoms. Any existing chronic issues or problems would be able to be resolved in a short period of time.
  - 2: Moderate difficulty in functioning. However, even with moderate impairment, or somewhat persistent chronic issues, relevant skills, or support systems may be present.
  - 3: Serious issue or difficulty coping within a given dimension. A patient presenting at this level of risk may be considered in or near “imminent danger.”
  - 4: Indicates issue of utmost severity. The patient would present with critical impairments in coping and functioning, with signs and symptoms, indicating an “imminent danger” concern.

Case Study 1: Leroy

Leroy shows up for treatment very late and doesn't seem to know where he is. When asked about his past patterns of withdrawal, Leroy begins showing the different injuries and scars he has received from going into withdrawal seizures. Leroy says he successfully stopped using alcohol over three months ago but still uses marijuana every day to keep himself calm. He talks about the several voices he used to hear in his head telling him to use, but says that since he moved in with his parents last week and cut down on his marijuana use, these voices have gone away.

Dimension 1 Case Example

- 0: Indicates full functioning, no severity, and no risk in this dimension. No need for specific services in this dimension.
- 1: Mildly difficult issue, or present minor signs and symptoms. Any existing chronic issues or problems would be able to be resolved in a short period of time.
- 2: Moderate difficulty in functioning. However, even with moderate impairment, or somewhat persistent chronic issues, relevant skills, or support systems may be present.
- 3: Serious issue or difficulty coping within a given dimension. A patient presenting at this level of risk may be considered in or near “imminent danger.”
- 4: Indicates issue of utmost severity. The patient would present with critical impairments in coping and functioning, with signs and symptoms, indicating an “imminent danger” concern.

Dimension 2 Case Example

- 0: Indicates full functioning, no severity, and no risk in this dimension. No need for specific services in this dimension.
- 1: Mildly difficult issue, or present minor signs and symptoms. Any existing chronic issues or problems would be able to be resolved in a short period of time.
- 2: Moderate difficulty in functioning. However, even with moderate impairment, or somewhat persistent chronic issues, relevant skills, or support systems may be present.
- 3: Serious issue or difficulty coping within a given dimension. A patient presenting at this level of risk may be considered in or near “imminent danger.”
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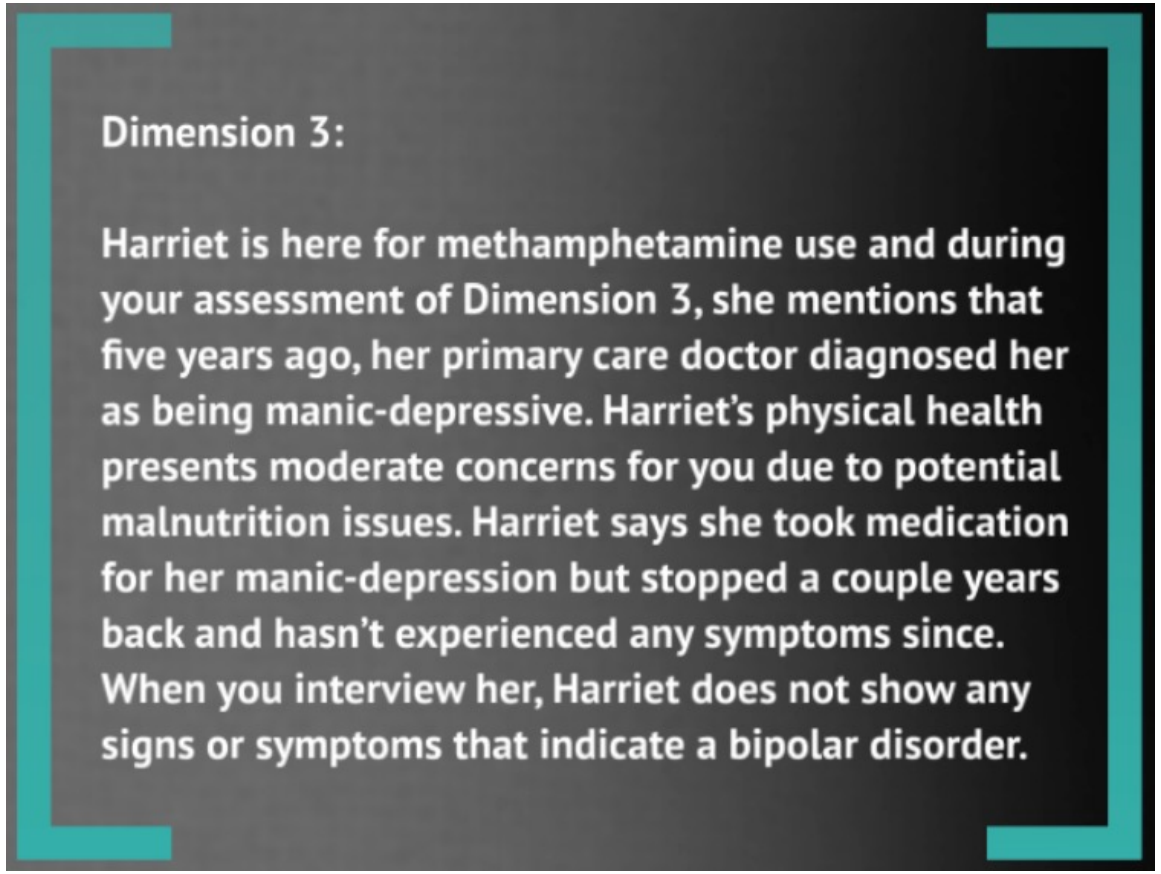

Dimension 3 Case Example

- 0: Indicates full functioning, no severity, and no risk in this dimension. No need for specific services in this dimension.
- 1: Mildly difficult issue, or present minor signs and symptoms. Any existing chronic issues or problems would be able to be resolved in a short period of time.
- 2: Moderate difficulty in functioning. However, even with moderate impairment, or somewhat persistent chronic issues, relevant skills, or support systems may be present.
- 3: Serious issue or difficulty coping within a given dimension. A patient presenting at this level of risk may be considered in or near "imminent danger."
- 4: Indicates issue of utmost severity. The patient would present with critical impairments in coping and functioning, with signs and symptoms, indicating an "imminent danger" concern.

Dimension 5: Alonzo

Alonzo has been successfully working a recovery program for the past month. He recently relapsed on his alcohol use and crashed his bike while under the influence, which put him in the hospital for a week. Upon his release, his doctor gave him a prescription for OxyContin to help with the reported pain. Alonzo doesn't want to talk about what led to his relapse, other than to say he has no idea how it happened. He does mention several stressful family and work situations that occurred the week before his relapse. Alonzo is willing to talk about reentering treatment, though he feels like his initial success is now wasted. Alonzo is clear and coherent with his responses. He feels ready to change but doesn't know where or how to stop.

Dimension 5 Case Example

- 0: Indicates full functioning, no severity, and no risk in this dimension. No need for specific services in this dimension.
- 1: Mildly difficult issue, or present minor signs and symptoms. Any existing chronic issues or problems would be able to be resolved in a short period of time.
- 2: Moderate difficulty in functioning. However, even with moderate impairment, or somewhat persistent chronic issues, relevant skills, or support systems may be present.
- 3: Serious issue or difficulty coping within a given dimension. A patient presenting at this level of risk may be considered in or near “imminent danger.”
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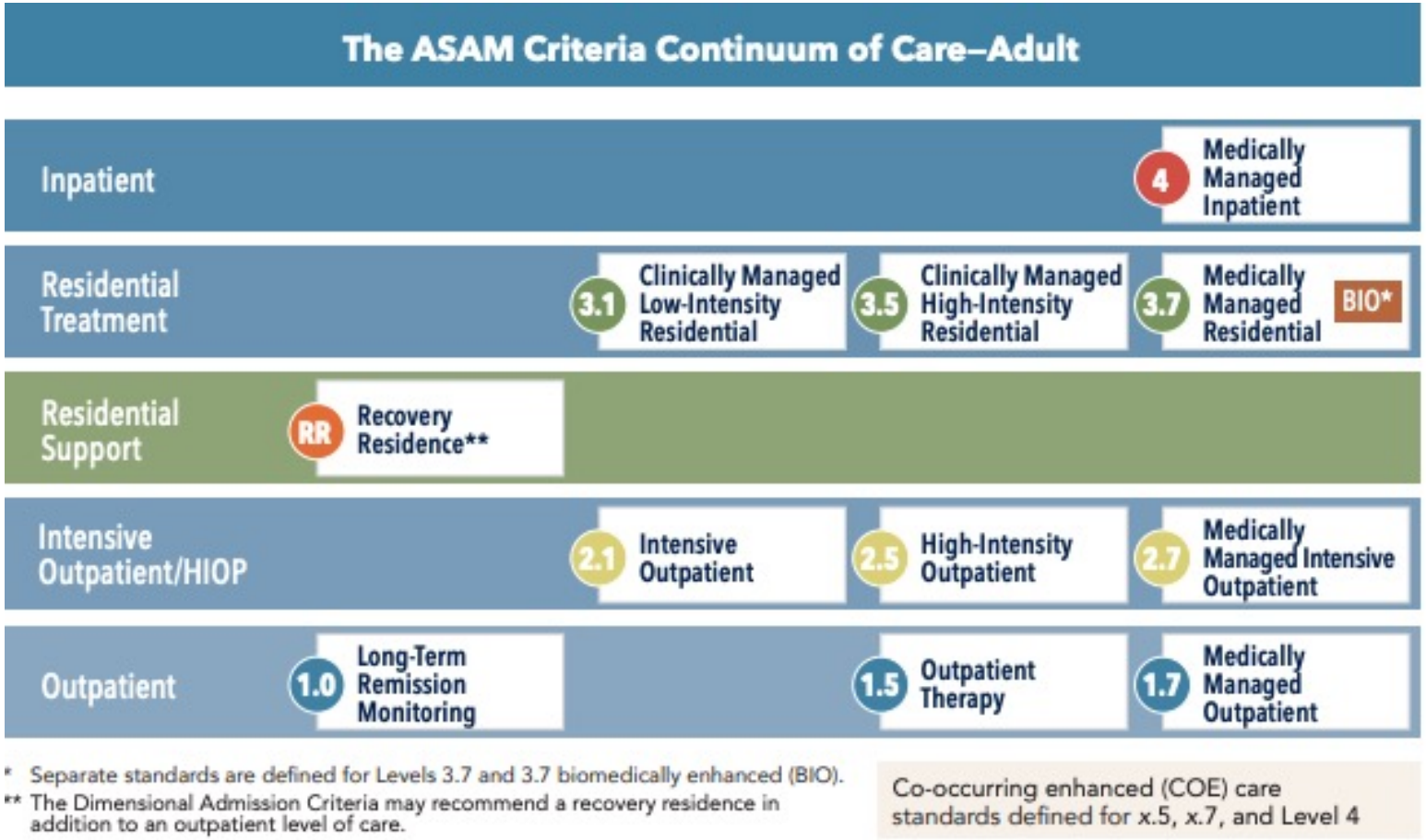
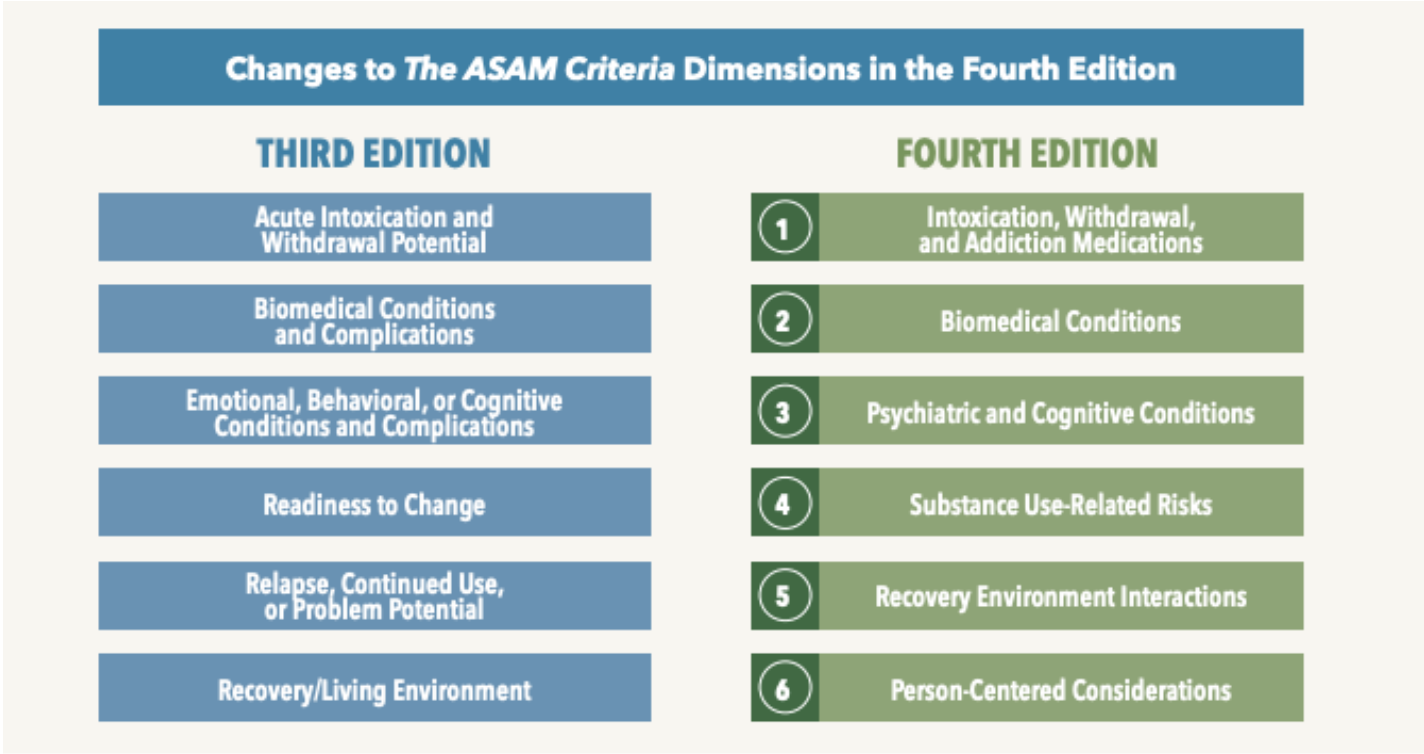


It's Going to Change in November 2023!

https://www.asam.org/asam-criteria/4th-edition-development

It’s Going to Change!



It’s Going to Change!

Dimension 1: Intoxication, Withdrawal, and Addiction Medications

- Intoxication and Associated Risks
- Withdrawal and Associated Risks
- Addiction Medication Needs

Dimension 2: Biomedical Conditions

- Physical Health Concerns
- Pregnancy-Related Concerns
- Sleep Problems

Dimension 3: Psychiatric and Cognitive Conditions

- Active Psychiatric Symptoms
- Persistent Disability
- Cognitive Functioning
- Trauma-Related Needs
- Psychiatric and Cognitive History

Dimension 4: Substance Use-Related Risks

- Likelihood of Engaging in Risky Substance Use[1]
- Likelihood of Engaging in Risky SUD-Related Behaviors[2]

Dimension 5: Recovery Environment Interactions

- Ability to Function Effectively in Current Environment
- Safety in Current Environment
- Support in Current Environment
- Cultural Perceptions of Substance Use and Addiction

Dimension 6: Person-Centered Considerations

- Barriers to Care
- Patient Preferences
- Need for Motivational Enhancement

Records Reviews

Review of Records

- Legal/Judicial Records
  - What is the exact nature of the client's current charges or current case?
  - What specific questions does the referral source want answered in the report? (do not stray from intended focus)
  - Who does the report go to, and what are its possible implications?
  - Any history of substance-related legal problems?
  - Did the client under-report legal history during clinical interview?

Review of Records

- How to Find Public Records
  - Obtain records from attorney/court
  - Go straight to public records website for involved county(ies)
  - Consider a public records search engine
    - e.g., Truthfinder
    - But do not use as a final resource- it is just a screening tool

Review of Records

- Treatment records
  - Are there additional symptoms not reported in the evaluation?
  - What was the client's history of progress?
  - What was the nature of discharge from treatment (e.g., successful vs. unsuccessful)?
  - What was recommended by treatment staff, and did the client follow-up?
  - What the client's participation like?
  - Are there co-occurring disorders that could factor in?
  - What are the client's relapse triggers?

Review of Records

- Medical records
  - Any evidence of substance-related medical problems?
  - Any co-occurring biomedical conditions?
  - Any evidence that healthcare professionals have advised the client to quit or cut back?
  - Any medications that can interact with other substances used by the client?
  - Medical compliance history?
  - Under-reporting to medical professionals?

Collateral Sources

Family members, partners, friends, co-workers, relatives, employers, sponsors, etc. may have fruitful information to corroborate the client's self-report of substance use patterns, treatment histories, coping strategies, etc.

AMHCA Code of Ethics (2020), Code D1

D. Assessment and Diagnosis

1. Selection and Administration

   CMHCs utilize educational, psychological, diagnostic, and career assessment instruments (herein referenced as "tests"), interviews, and other assessment techniques and diagnostic tools in the counseling process for the purpose of determining the client's particular needs.

   a. CMHCs choose assessment methods that are reliable, valid, and appropriate based on their client's age, gender, race, ability status, etc. If tests must be used in the absence of information regarding the aforementioned factors, the limitations of generalizability should be duly noted.

   b. In selecting assessment tools, CMHCs justify the logic of their choices in relation to the client's needs and the clinical context in which the assessment occurs.

   c. CMHCs avoid using outdated or obsolete tests and remain current regarding test publications and revisions.

   d. CMHCs use assessments only in the context of professional, academic, or training relationships.

   e. CMHCs provide the client with appropriate information regarding the reason for the assessment and to whom the report will be distributed.

   f. CMHCs provide an appropriate assessment environment.

Tests

- Substance Abuse Subtle Screening Inventory (SASSI-4) or Substance Abuse Subtle Screening Inventory for Adolescents (SASSI-A2)
  - Detects subtle attributes of individuals with addictions
  - Detects defensiveness and inconsistencies
  - Determines high or low probability of a SUD
- Maryland Addiction Questionnaire (MAQ)
  - Also detects inconsistencies and defensiveness
  - Face valid alcohol and drug-related scales
  - Provides rich information on treatment fit (e.g., resentment about treatment, motivation, social anxiety, emotional distress, perception of degree of control, cravings/relapse potential, cognitive impairments, etc.)
  - Assumes SUDs; do not use as a standalone test

Tests

- Screening/Assessment Tests Without Validity Scales
  - Behaviors and Attitudes Drinking and Driving Scale (BADDS)
  - Michigan Alcohol Screening Test (MAST)
  - Drug Abuse Screening Test-10 (DAST-10)
  - Alcohol Use Disorders Identification Test (AUDIT)

Screening Tools for Co-Occurring Disorders

DSM-5 Cross Cutting Symptom Measures

SAMHSA Screening Tools

Tests

- Urinalysis Drug Testing
  - Chain of custody
  - Lab tests vs. screening tests
  - Know about urine detection periods (e.g., ethyl alcohol vs. EtG/EtS)
  - Know about confirmatory testing procedures

Testing Considerations

- Evaluator should be trained and competent to conduct tests utilized
- Tests should be administered consistent with testing protocols
- Tests should be carefully selected and justified

Evaluation Report Tips

- Follow NBFE's recommended format
- Do not stray from intended focus of referral source
- Diagnoses, clinical formulation, conclusion, and recommendations should be seamless (i.e., no surprises; all flow logically from one to another)
- Neat and well-written with appropriate spelling, grammar, and formatting
- Avoid "psychobabble;" consider the audience

Evaluation Report Tips: Rules of Thumb

- A “responsible drinking” approach will sometimes (and sometimes not) be appropriate for mild alcohol use disorders, whereas abstinence/recovery is the ideal approach for moderate-to-severe alcohol use disorders (Harvard Health Letter, 2009)
- Treatment episodes should not be less than 90 days in duration (NIDA, 2018)
- The greater the number of exposures to treatment, the higher the probability of success this time around
- If you have leverage, use it. If you don’t have leverage, meet the client where he or she is at
- Generally speaking, prescription of potentially addictive medications should be avoided (APA, 2010)

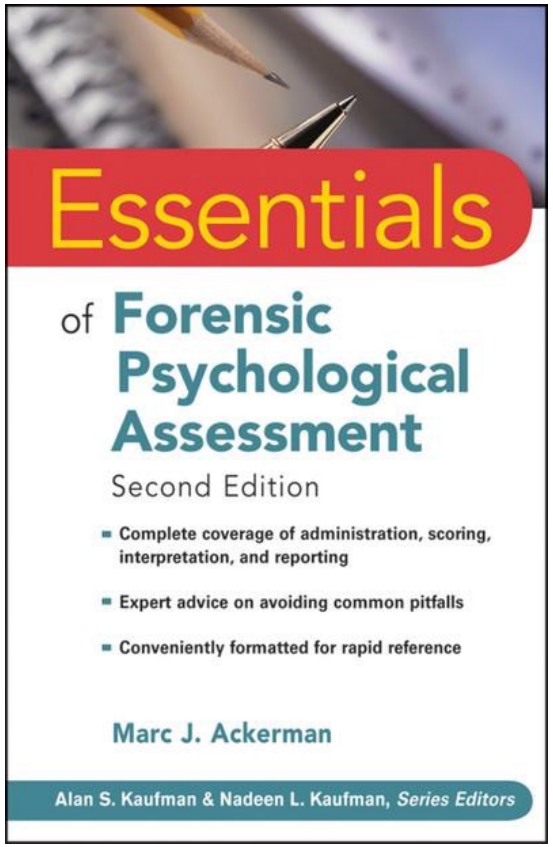
Evaluation Report Tips: Recommendation Section

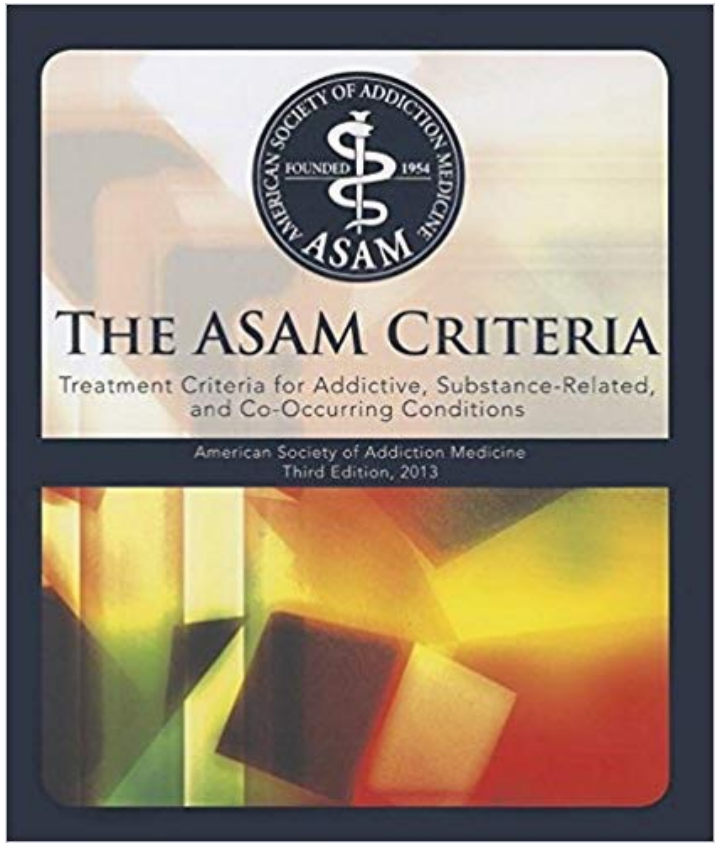
- Recommendations:
  - Include level of treatment
  - Include length and duration of treatment
  - Indicate focus of treatment
  - Indicate need for abstinence/sobriety and drug testing
  - Indicate if dual disorder-enhanced treatment is warranted
  - Indicate if concerns about prescribed medication
  - Specify that after recommendations should be adhered to
  - Include treatment resources
  - Specify that all treating professionals should review a copy of the report

Example of Recommendations

1. Mr. Romero should successfully complete a minimum of 16 weeks of ASAM Level I outpatient substance abuse treatment focused on relapse prevention in a dual-disorder enhanced program that can simultaneously address his co-occurring anxiety and depressive disorders.
2. Mr. Romero should maintain abstinence form alcohol and illicit substances throughout his treatment as evidenced by participating in random monthly urinalysis drug tests.
3. Mr. Romero should comply with any aftercare recommendations offered by his treatment team.
4. To ensure continuity of care, Mr. Romero's treatment provider should review this report as part of the admission and treatment planning process.

Resources: Reading





Training Resources

- NBFE's Certified Forensic Mental Health Evaluator (CFMHE) Training and Certification and Forensic Testing Workshop-How to Write Reports, Testify, Conduct Evaluations, Administer Tests
  - www.nbfe.net/events
  - www.nbfe.net/cfmhe
- ASAM Training
  - https://www.asam.org/resources/publications/magazine/read/article/2014/02/17/asam-launches-asam-criteria-endorsed-etraining-series
- SASSI Training
  - https://sassi.com/sassi-training-online/

Join us for the NBFE/ISSUP Forensic Mental Health Evaluation Certification Workshop!

- 1st and 8th of November, 2023
- 9am-1pm EST / 2pm-6pm UK
- Register at https://nbfe.net/event-5385662

References

Ackerman, M.J. (2010). *Essentials of forensic psychological assessment* (2nd ed.) Wiley.

American Counseling Association. (2014). *2014 ACA code of ethics*. https://www.counseling.org/resources/aca-code-of-ethics.pdf

American Mental Health Counselors Association. (2020). *2020 AMHCA code of ethics*. https://www.amhca.org/events/publications/ethics.

American Psychiatric Association. (2010). *Practice guideline for the treatment of patients with substance use disorders*. APA. https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th edition, text-revised). APA.

American Psychological Association. (2013). Specialty guidelines for forensic psychology. https://www.apa.org/practice/guidelines/forensic-psychology

American Society of Addiction Medicine (2019, September 15). *What is the definition of addiction*? ASAM. https://www.asam.org/quality-care/definition-of-addiction

American Society of Addiction Medicine [ASAM] (n.d.) *What is the ASAM Criteria*? ASAM. https://www.asam.org/resources/the-asam-criteria/about

Goldstein, P. J. (1985). The drugs/violence nexus: A tripartite conceptual framework. *Journal of Drug Issues, 15*(4), 493-506.

References

Grant, B.F., Goldstein, R.B., Saha, T.D., Chou, S.P., Jung, J., Zhang, H., Pickering, R.P., Ruan, W.J., Smith, S.M., Huang, B., & Hasin, D.S. (2015). Epidemiology of DSM-5 Alcohol Use Disorder: Results from National Epidemiologic Survey on Alcohol and Related Conditions III. *JAMA Psychiatry, 72*(8), 757-766. doi: 10.1001/jamapsychiatry.2015.0584

Grant, B. F., Saha, T. D., Ruan, W. J., Goldstein, R. B., Chou, S. P., Jung, J., Zhang, H., Smith, S. M., Pickering, R. P., Huang, B., & Hasin, D. S. (2016). Epidemiology of DSM-5 Drug Use Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions-III. *JAMA psychiatry*, *73*(1), 39-47. doi: 10.1001/jamapsychiatry.2015.2132

Harvard Health Letter (2009). Alcohol abstinence vs. moderation. Retrieved from https://www.health.harvard.edu/mind-and-mood/alcohol-abstinence-vs-moderation

Mee-Lee, D. (Ed.). *The ASAM criteria: Treatment criteria for addictive, substance-related, and co-occurring disorders* (3rd ed).

Melton, G.B., Petrila, J., Poythress, N.G., Slobogin, C., Otto, R.K., Mossman, D., & Condie, L.O. (2018). *Psychological evaluations for the courts: A handbook for mental health professionals and lawyers* (4th ed.). Guilford Press.

National Institute on Drug Abuse (2018). *Principles of drug addiction treatment: A research-based guide* (3rd ed.). NIDA. https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-long-does-drug-addiction-treatment

National Institute on Drug Abuse (2022, July 13). *Drug misuse and addiction*. NIDA, NIH. https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction

World Health Organization (2018). *The ICD-11 classification of mental and behavioural disorders: Diagnostic criteria for research.* WHO.