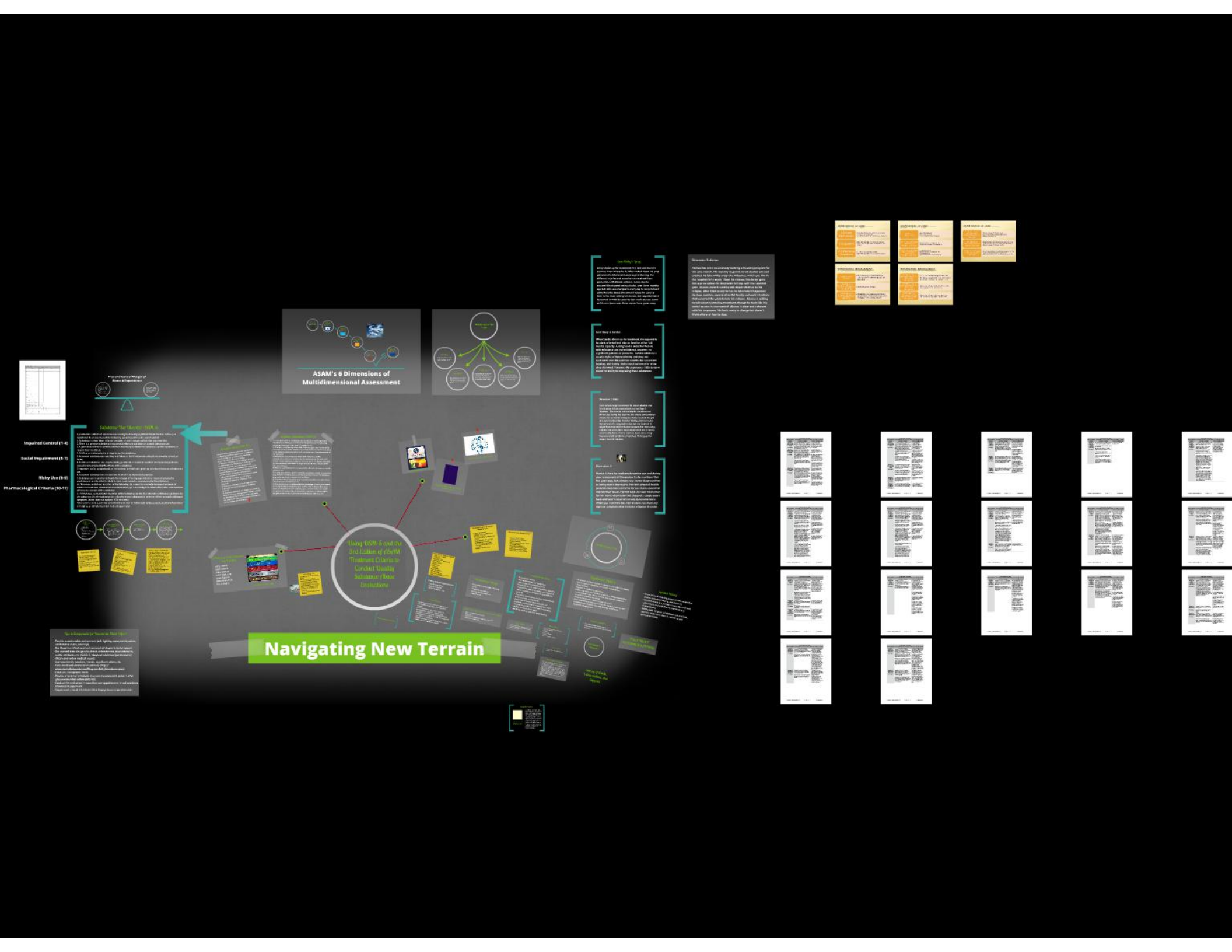
ASAM's 6 Dimensions of Multidimensional Assessment
Impaired Control (1-4)
Social Impairment (5-7)
Risky Use (8-9)
Pharmacological Criteria (10-11)
Using DSM-5 and the 3rd Edition of ASAM Treatment Criteria to Conduct Quality Substance Abuse Evaluations
Navigating New Terrain

Navigating New Terrain

Using DSM-5 and the 3rd Edition of ASAM Treatment Criteria to Conduct Quality Substance Abuse Evaluations

Substance Abuse (DSM-IV)

A maladaptive pattern of substance use leading to clinically significant impairment or distress is manifested by one or more of the following, occurring within a 12-month period:
1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g. repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
2) Recurrent substance use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired)
3) Recurrent substance-related legal problems (e.g. arrests for substance-related disorderly conduct)
4) Continued substance use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g. arguments with spouse about consequences of intoxication, physical fights)

Substance Dependence (DSM-IV)

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by at least three of the following, occurring at any time in the same 12-month period:
1) Tolerance, as defined by either of the following: (a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect; or (b) Markedly diminished effect with continued use of the same amount of the substance
2) Withdrawal, as manifested by either of the following: (a) The characteristic withdrawal syndrome for the substance; (b) The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
3) The substance is often taken in larger amounts or over a longer period than was intended.
4) There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5) A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.
6) Important social, occupational, or recreational activities are given up or reduced because of substance use.
7) 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 substance (e.g., current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

A History of DSM & Substance Use Disorders

1952: DSM-I
1968: DSM-II
1980: DSM-III
1987: DSM-III-R
1994: DSM-IV
2000: DSM-IVTR
2013: DSM-5

Transitional Principles of ASAM Criteria Impacting Evaluation

- From one-dimensional to multidimensional assessment (it's not about a diagnosis)
- Fixed length of service to variable length of service
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What's new in the 3rd Edition for Evaluation?

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- New sections on gambling and tobacco and substance use disorder
- Updated opioid treatment section
- Revised, contemporary terminology

History of the Present Episode

- Precipitating factors
- Current symptoms
- Persistent present risks

Developmental History

- Especially for adolescents and young adults!
- Pregnancy and delivery
- Developmental milestones
- Temperament

Family History

- Family alcohol, tobacco, and other drug use and addictive behavioral history, including past 12 episodes
- Family social history (i.e. profiles of parents/guardians/other caregivers, siblings, home atmosphere, economic status, religious affiliation, cultural influences, leisure activities, reworking and separation, and relocations)
- Religious, spiritual, or faith background and practice
- Family medical and psychiatric history

Personal/Social History

- School/work history
- Peer relationships and friendships
- Leisure and recreational activities
- Sexual activity (i.e. choice of partners, romantic relationships, sexual risk behaviors, relation of sexual activity to substance use and addictive behavior
- Physical or sexual abuse, or other maltreatment, either as victim or perpetrator
- Disruption of healthy social supports and problems in interpersonal relationships, which can also impact the development of resiliencies
- Military service/veteran status
- Religious, spiritual, and faith-based history

Using DSM-5 and the 3rd Edition of ASAM Treatment Criteria to Conduct Quality Substance Abuse Evaluations

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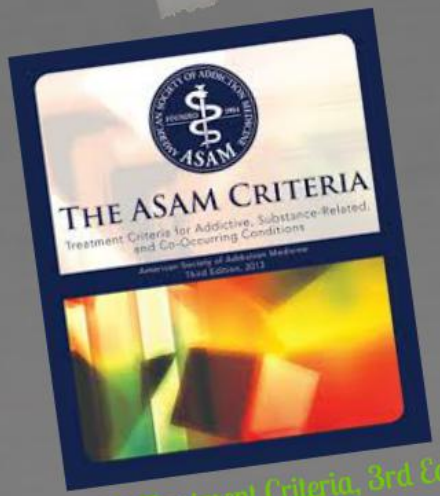

ASAM Treatment Criteria, 3rd Ed.

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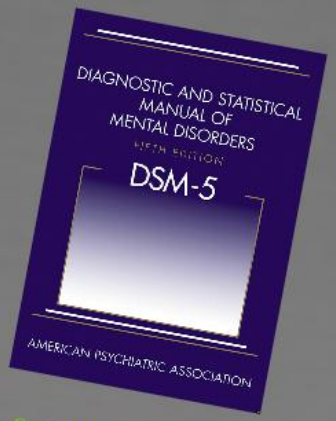

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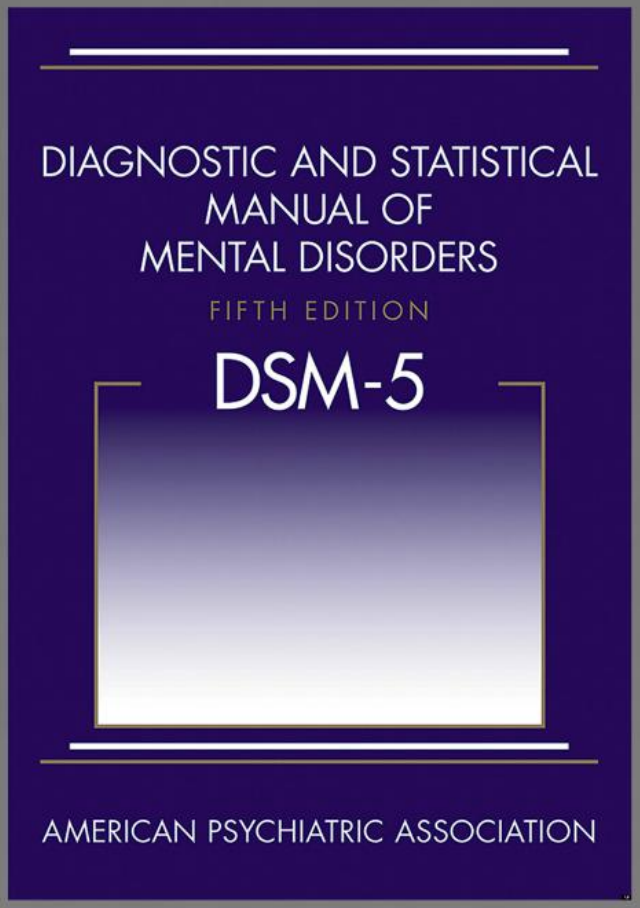

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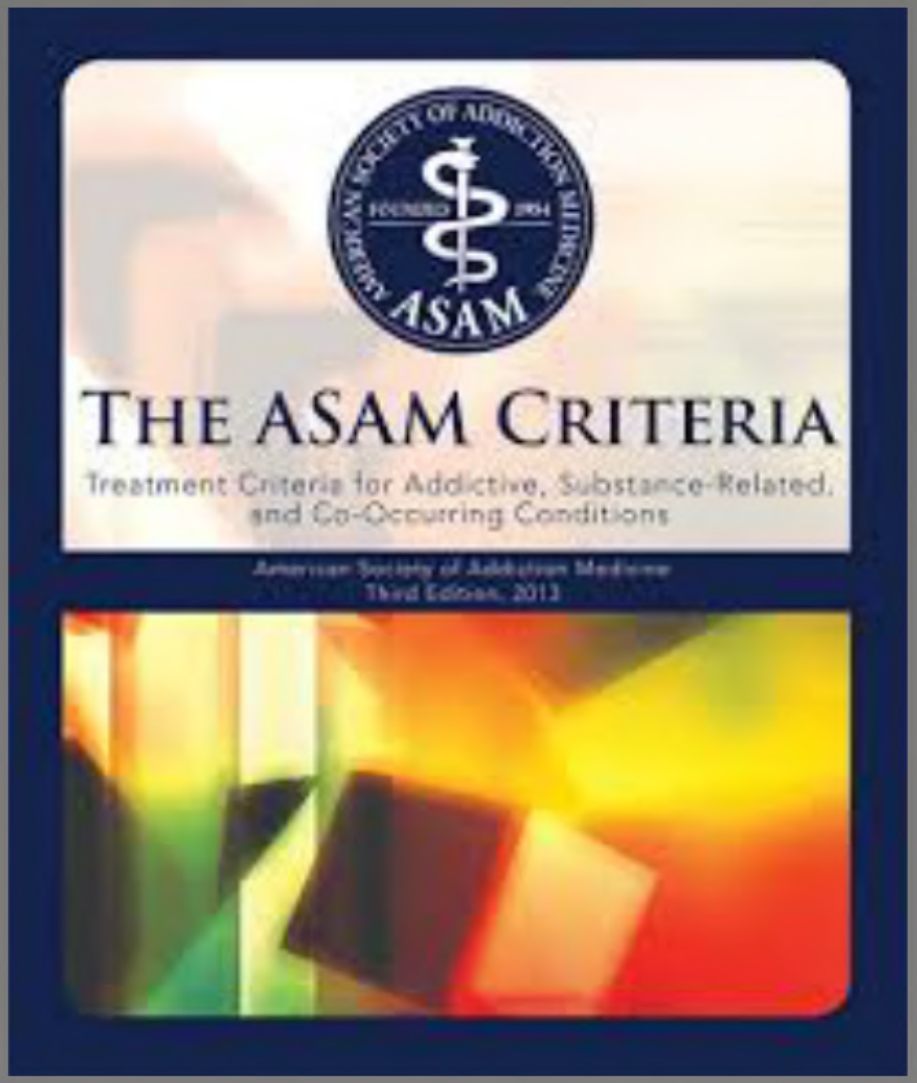

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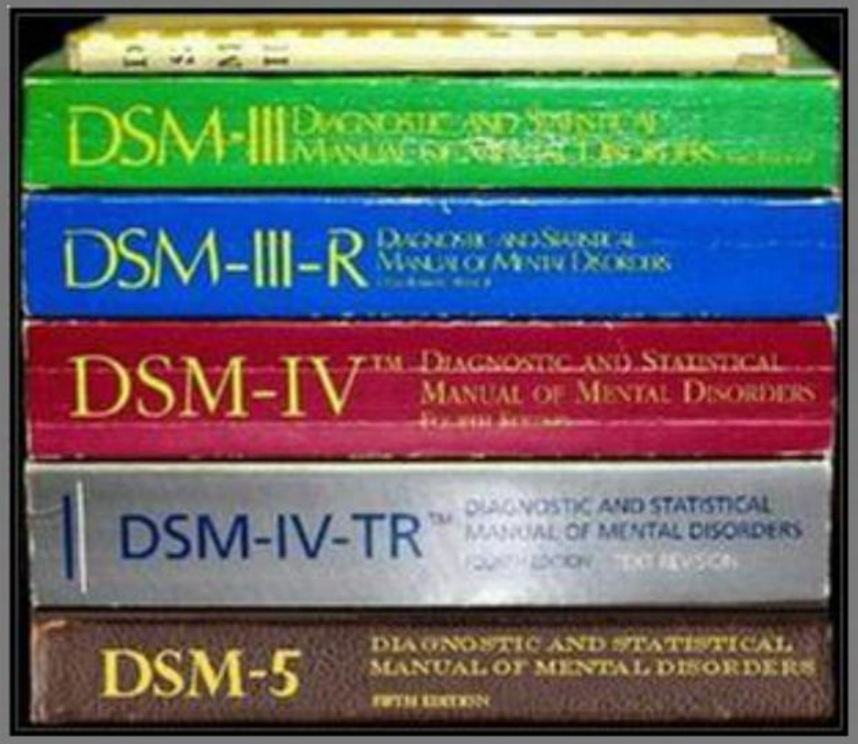

All 7 Editions of the DSM

DSM-5 Paradigm Shift

- Simplification: Group similar disorders together
- Multidimensional assessment: Conceptualize disorders on a spectrum of severity and enhance specifiers
- Counter the concept of mind-body dualism: Recognize overlap between physical and psychological realms
- Delineate between abnormal and disordered
- Enhance cultural and developmental sensitivity

Substance Abuse (DSM-IV)

A maladaptive pattern of substance use leading to clinically significant impairment or distress is manifested by one or more of the following, occurring within a 12-month period:

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3) Recurrent substance-related legal problems (e.g. arrests for substance-related disorderly conduct)

4) Continued substance use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g. arguments with spouse about consequences of intoxication, physical fights)

Substance Dependence (DSM-IV)

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by at least three of the following, occurring at any time in the same 12-month period:

1) Tolerance, as defined by either of the following: (a) A need for markedly increased amounts of the substance to achieve intoxication or desired effe or (b) Markedly diminished effect with continued use of the same amount the substance

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3) The substance is often taken in larger amounts or over a longer period than was intended.

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Substance Use Disorder (DSM-5)

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

1. Substance is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
4. Craving, or a strong desire or urge to use the substance.
5. Recurrent substance use resulting in a failure to fulfill major role obligations at works, school, or home.
6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
7. Important social, occupational, or recreational activities are given up or reduced because of substance use.
8. Recurrent substance use in situations in which it is physically hazardous.
9. 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 substance.
10. Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of substance to achieve intoxication or desired effect; (b) a markedly diminished effect with continued use of hte same amount of the substance.
11. Withdrawal, as manifested by either of the following: (a) the characteristic withdrawal syndrome for the substance; (b) the substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms. (Note: does not apply to PCP, inhalants)

Note: Criteria 10 & 11 are not considered to be met for individuals taking opioids, sedatives/hypnotics/anxiolytics, or stimulants under medical supervision.

Pros and Cons of Merger of Abuse & Dependence

Pros

- More neutral (less stigmatizing) and less confusing terminology
- Spectrum = less dichotomous
- Eliminates diagnostic orphan problem
- Eliminates double standard for tobacco
- Less rationalizing for clients?

Cons

- De-legitimizes disease concept?
- Government/social programs and legislation will need to catch up!!!
- Client with milder symptom presentation can still rationalize
- Change = Ouch! ;)

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Substance Abuse (DSM-IV)

A maladaptive pattern of substance use leading to clinically significant impairment or distress is manifested by one or more of the following, occurring within a 12-month period:

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Note: Criteria 10 & 11 are not considered to be met for individuals taking opioids, sedatives/hypnotics/anxiolytics, or stimulants under medical supervision.

Specify Current Severity for Each Substance

- 2-3 Symptoms = Mild
- 4-5 Symptoms = Moderate
- 6 or More Symptoms = Severe

Categories:

- Alcohol
- Cannabis
- Hallucinogens (Phencyclidine, Other)
- Inhalants (specify particular inhalant if possible)
- Opioid
- Sedative, Hypnotic, or Anxiolytic
- Stimulant (Amphetamine-type, Cocaine, Other or unspecified)
- Tobacco
- Other (or unknown)

Specify Remission Status (if applicable)

Remission = None of the criteria (except craving) have been met for at least...

- 3 months but less than 12 months (In early remission)
- 12 months or longer (In sustained remission)

Specify if in a Controlled Environment

Used if the individual is in an environment where access to the substance is restricted

Specify if On Maintenance Therapy

Used if the individual is taking a prescribed agonist medication such as methadone or buprenorphine (opioid) or nicotine replacement (tobacco) and none of the criteria have been met for that class of medication (except tolerance to, or withdrawal from, the agonist). Also applies to individuals being maintained on partial agonist, agonist/natagonist, or full antagonist such as oral naltrexone or depot naltrexone

Examples of DSM-5 Diagnoses

- 303.90 (F10.20) Alcohol Use Disorder, Moderate, In sustained remission
- 304.30 (F12.20) Cannabis Use Disorder, Severe, In early remission, In a controlled environment
- 304.00 (F11.20) Opioid Use Disorder, Severe, On maintenance therapy
- 305.90 (F19.10) Other (or Unknown) Substance Use Disorder, Synthetic marijuana, Mild

New Substance-Related Disorders (Graduates)

- Cannabis Withdrawal
- Caffeine Withdrawal

Cannabis Withdrawal

A. Cessation of cannabis use that has been heavy and prolonged (i.e. usually daily or almost daily for at least a few months)

B. 3 or more of the following S/S develop within approximately 1 week after Criterion A:

1. Irritability, anger, or aggression
2. Nervousness or anxiety
3. Sleep difficulty (e.g. insomnia, disturbing dreams)
4. Decreased appetite or weight loss
5. Restlessness
6. Depressed mood
7. At least 1 of the following physical sx, caus... significant discomfort: abdom... sweating, feve...

Summary of Changes from DSM-IV to DSM-5

- Merged Abuse & Dependence into 1 Substance Use Disorder, adding a spectrum of severity ranging from mild to severe
- Added symptom of craving and removed symptom of recurrent substance-related legal problems
- Added Cannabis Withdrawal and Caffeine Withdrawal (but Caffeine Use Disorder isn't yet implemented-in Section III)
- Re-ordered symptoms to fit into 4 groupings
- Specified that criteria grouped under pharmacological criteria (tolerance & withdrawal) are not considered to be met if individual is prescribed Rx (opioids, sedatives, stimulants)
- Changed early remission from 1 month to 3 months of absence of symptoms (except craving)
- Dropped specifiers for full vs. partial remission
- Dropped specifier for with/without physiological dependence
- Replaced "nicotine" verbiage with "tobacco"
- No more Polysubstance Dependence
- New, let's practical http(/www.yh1.com/video/celebrity

Specify Current Severity for Each Substance

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- 4-5 Symptoms = Moderate
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- Tobacco
- Other (or unknown)

DSM-5 Substance Use Disorder Assessment			
A. 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:			
Met	**Symptom**	**Substance(s)**	**Examples**
☐	1) The substance is often taken in larger amounts or over a longer period than was intended.		
☐	2) There is a persistent desire or unsuccessful efforts to cut down or control the use of the substance.		
☐	3) A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.		
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☐	5) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.		
☐	6) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.		
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☐	11) Withdrawal, as manifested by either of the following: (A) The characteristic withdrawal syndrome for the substance; (B) The substance is taken to relieve or avoid withdrawal symptoms.		
☐	**Mild Substance Use Disorder (2-3 Symptoms)**	Substance(s):	
☐	**Moderate Substance Use Disorder (4-5 Symptoms)**	Substance(s):	
☐	**Severe Substance Use Disorder (6 or More Symptoms)**	Substance(s):	
☐	In Early Remission (no symptoms for 3 to under 12 months)		Substance(s):
☐	In Sustained Remission (no symptoms for more than 12 months)		Substance(s):
☐	In a Controlled Environment (if in an environment in which access to substances is limited)		
☐	On Maintenance Therapy (if taking a prescribed agonist medication and none of the criteria have been met for the agonist medication except symptoms 10 and 11)	Medication:	

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Remission = None of the criteria (except craving) have been met for at least...

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Foundational Principals of ASAM Criteria Impacting Evaluation

- From one-dimensional to multidimensional assessment (it's not just about a diagnosis)
- Fixed length of service to variable length of service
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Intake and Assessment
• What does the patient want? Why now?
• Does the patient have immediate needs due to imminent risk in any of the six assessment dimensions?
• Conduct multidimensional assessment
• What are the DSM diagnoses?
ASAM Decisional Flow
Service Planning and Placement
• Multidimensional Severity/Level of Function Profile
• Identify which assessment dimensions are currently most important to determine treatment priorities
• Choose a specific focus and target for each priority dimension
• What specific services are needed for each dimension?
Level of Care Placement
• What "dose" or intensity of those services is needed for each dimension?
• Where can these services be provided, in the least intensive but safe level of care or site of care?
• What is the progress of the treatment plan and placement decision; outcomes measurement?

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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

WITHDRAWAL MANAGEMENT

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

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

WITHDRAWAL MANAGEMENT

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

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 Biopsychosocial Assessment

15 ASAM Biopsychosocial Assessment Elements

- History of the present episode
- Family history
- Developmental history
- Alcohol, tobacco, other drug use, addictive behavior history
- Personal/social history
- Legal history
- Psychiatric history
- Medical history
- Spiritual history
- Review of systems
- Mental status examination
- Physical examination
- Formulation and diagnoses
- Survey of assets, vulnerabilities, and supports
- Treatment recommendations

- Survey of assets, vulnerabilities, and supports
- Treatment recommendations

History of the Present Episode

- Precipitating factors
- Current symptoms
- Pertinent present risks

Family History

- Family alcohol, tobacco, and other drug use and addictive behavioral history, including past tx. episodes
- Family social history (i.e. profiles of parents/ guardians/other caregivers, siblings, home atmosphere, economic status, religious affiliation, cultural influences, leisure activities, monitoring and supervision, and relocation)
- Religious, spiritual, or faith background and practice
- Family medical and psychiatric history

Developmental History

- Especially for adolescents and young adults!
- Pregnancy and delivery
- Developmental milestones
- Temperament

Alcohol, Tobacco, Other Drug Use, Addictive Behavior History

- Onset and pattern of progression
- Past sequelae
- Past treatment episodes, including past successes and barriers to treatment

Personal/Social History

- School/work history
- Peer relationships and friendships
- Leisure and recreational activities
- Sexual activity (i.e. choice of partners, romantic relationships, sexual risk behaviors, relation of sexual activity to substance use and addictive behavior
- Physical or sexual abuse, or other maltreatment, either as victim or perpetrator
- Disruption of healthy social supports and problems in interpersonal relationships, which can also impact the development of resiliencies
- Military service/veteran status
- Religious, spiritual, and faith-based history

Legal History

- Past behaviors and their relation to substance use and addictive behavior, arrests, adjudications, and details of current status

Psychiatric History

- Symptoms and their relation to substance use/addictive behavior
- Current and past diagnoses, treatments, and providers
- Belief systems
- Cognitive and affective distortions
- Patterns of attribution of life problems (e.g. taking responsibility vs. projecting it onto others, accurate links between substance use and life problems vs. denial)
- Patterns of internal vs. external locus of control
- Other psychological processes which can impair perceptions and compromise the ability to deal with feelings, resulting in significant self-deception

Medical History

- Pertinent medical problems and treatment
- Emergency Dept. visits
- Surgeries
- Head injuries
- Present medications
- Allergies
- Most recent medical evaluation

Spiritual History

- One's sense of meaning, pujrpose, and values that guides attitudes, thinking, and behavior
- Any distortions in a person's connection with self, wtih others, and with the transcendent (e.g. higher Power)
- History with religious affilitations and practices, and how thsoe may relate to current or past spiritual practices

Review of Systems

- Present and past medical and psychological symptoms

Mental Status Examination

- General appearance, behavior, attitude (age, grooming, posture, facial expressions, psychomotor activity, manner and attitude)
- Speech (rate, form, quantity: e.g. slow to accelerated, hesitant, whispering, screaming, mumbling, pressured)
- Emotional state: Mood (subjective report); affect (your assessment of emotional expression, including qualitative description; range of emotion such as blunted, constricted, or absent; lability; and appropriateness to content and situation)
- Thought processes, including thought form (how a person is thinking; e.g. normal thought form = logical and goal directed vs. circumstantial, tangential, blocking, neologisms, clang associations, flights of ideas, loose associations), thought content (what the patient is thinking; look for feelings of unreality and depersonalization, passivity feelings, persecutory trends, obsessions and compulsions, somatic trends, expansive trends, illusions, hallucinations)
- Sensorium and mental capacity (orientation, memory, attention and concentration, intellect)
- Insight and judgment

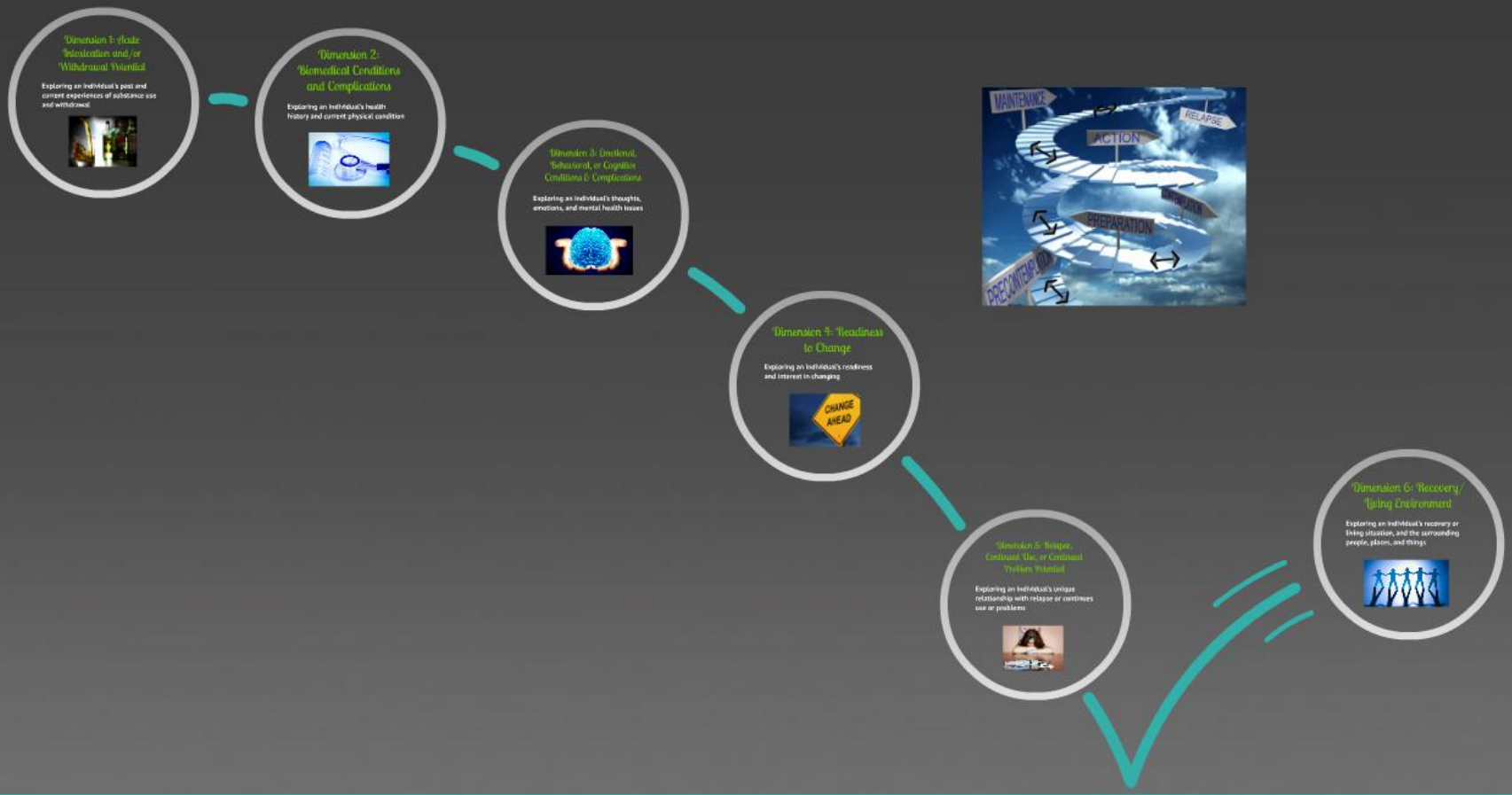
Physical Examination

- Especially physical manifestations of intoxication or withdrawal, signs of chronic illnesses

Formulation & Diagnoses

Survey of Assets, Vulnerabilities, and Supports

TREATMENT RECOMMENDATIONS



ASAM's 6 Dimensions of Multidimensional Assessment

Dimension 1: Acute Intoxication and/or Withdrawal Potential

Exploring an individual's past and current experiences of substance use and withdrawal

Dimension 2: Biomedical Conditions and Complications

Exploring an individual's health history and current physical condition

Dimension 3: Emotional, Behavioral, or Cognitive Conditions & Complications

Exploring an individual's thoughts, emotions, and mental health issues

Dimension 4: Readiness to Change

Exploring an individual's readiness and interest in changing

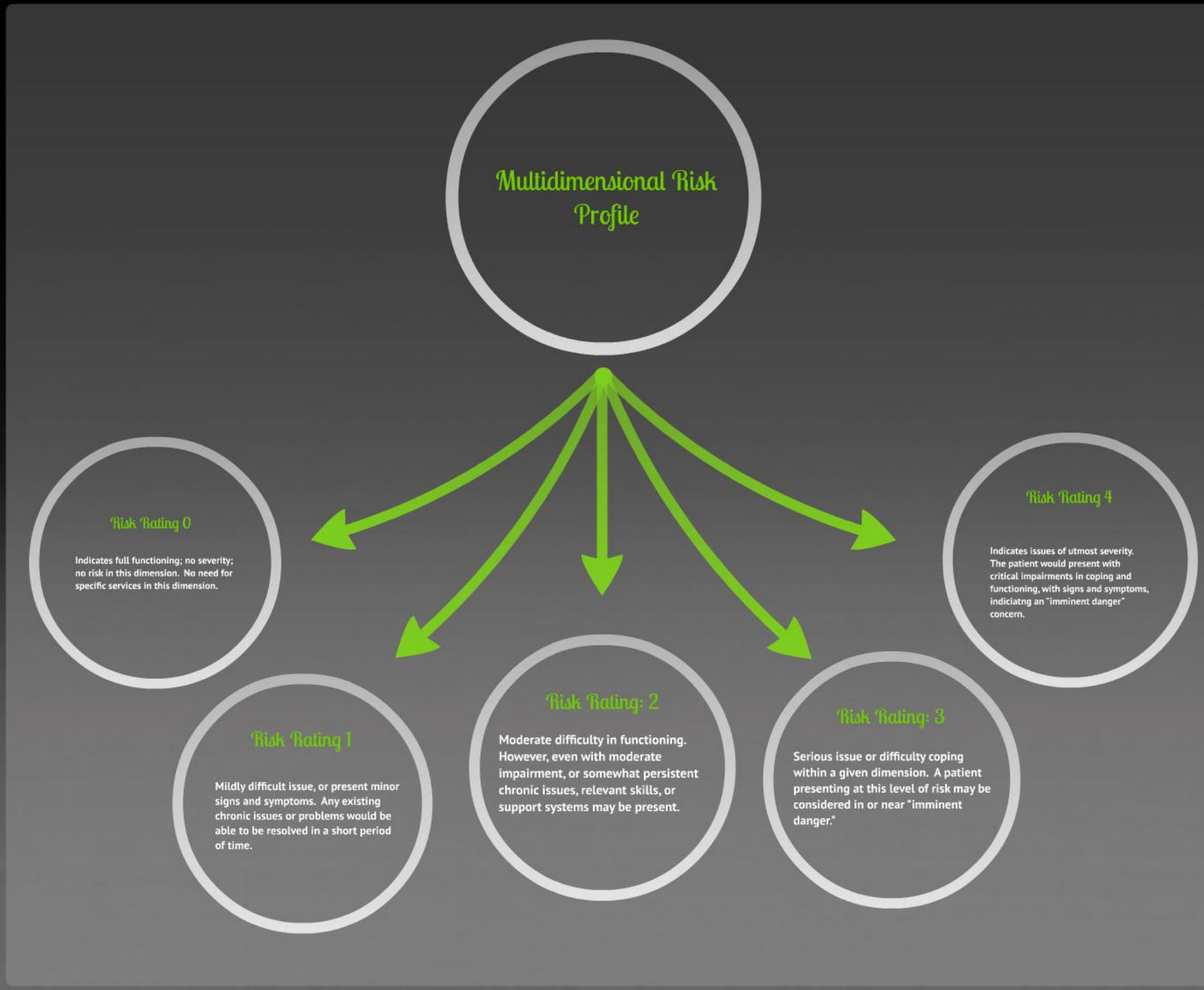

MAINTENANCE
RELAPSE
ACTION
CONTEMPLATION
PREPARATION
PRECONTEMPLATION

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

Exploring an individual's unique relationship with relapse or continues use or problems

Dimension 6: Recovery/ Living Environment

Exploring an individual's recovery or living situation, and the surrounding people, places, and things


Multidimensional Risk Profile
Risk Rating 0
Indicates full functioning; no severity; no risk in this dimension. No need for specific services in this dimension.
Risk Rating 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.
Risk Rating: 2
Moderate difficulty in functioning. However, even with moderate impairment, or somewhat persistent chronic issues, relevant skills, or support systems may be present.
Risk Rating: 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."
Risk Rating 4
Indicates issues of utmost severity. The patient would present with critical impairments in coping and functioning, with signs and symptoms, indiciatng an "imminent danger" concern.

Multidimensional Risk Profile

Risk Rating 0

Indicates full functioning; no severity; no risk in this dimension. No need for specific services in this dimension.

Risk Rating 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.

Risk Rating: 2

Moderate difficulty in functioning. However, even with moderate impairment, or somewhat persistent chronic issues, relevant skills, or support systems may be present.

Risk Rating: 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."

Risk Rating 4

Indicates issues of utmost severity. The patient would present with critical impairments in coping and functioning, with signs and symptoms, indiciatng an "imminent danger" concern.

ASAM Criteria, Third Edition Matrix for Matching Adult Severity and Level of Function with Type and Intensity of Service		
Dimension	**Risk Rating & Description**	**Services & Modalities Needed**
Dimension 1: Acute Intoxication and/or Withdrawal Potential **Risk Rating: 0**	The patient is fully functioning and demonstrates good ability to tolerate and cope with withdrawal discomfort. No signs or symptoms of intoxication or withdrawal are present, or signs or symptoms are resolving. For patients in Opioid Treatment Programs (OTP), the dose is well stabilized, with no opioid intoxication or withdrawal.	No immediate intoxication monitoring or management services are needed. The patient in OTP requires opioid agonist medications, such as methadone or buprenorphine.
Dimension 1: Acute Intoxication and/or Withdrawal Potential **Risk Rating: 1**	The patient demonstrates adequate ability to tolerate and cope with withdrawal discomfort. Mild to moderate intoxication or signs and symptoms interfere with daily functioning, but do not pose an imminent danger to self or others. There is minimal risk of severe withdrawal (eg, as a continuation of withdrawal management at other levels of service, or in the presence of heavy alcohol or sedative-hypnotic use with minimal seizure risk). For patients in Opioid Treatment Programs (OTP), the dose is inadequately stabilized and the patient has mild symptoms of withdrawal, or occasional compensatory use of opioids or other drugs.	Low-intensity intoxication monitoring or management, or withdrawal management services are needed. For patients who require intensive mental health services (a Dimension 3 risk rating of 2 or higher), low-intensity withdrawal management can be provided in a mental health setting with ongoing case management to coordinate care. The patient in OTP requires dose adjustment, counseling services to assess and address readiness to change and relapse issues, and random urine testing.
Dimension 1: Acute Intoxication and/or Withdrawal Potential **Risk Rating: 2**	The patient has some difficulty tolerating and coping with withdrawal discomfort. Intoxication may be severe, but responds to support and treatment sufficiently that the patient does not pose an imminent danger to self or others. Moderate signs and symptoms, with moderate risk of severe withdrawal (eg, as a continuation of withdrawal management at other levels of service, or in the presence of heavy alcohol or sedative-hypnotic use with minimal seizure risk, or many signs and symptoms of opioid or stimulant withdrawal). For patients in Opioid Treatment Programs (OTP), the dose is inadequately stabilized and the patient has moderate symptoms of withdrawal, or frequent compensatory use of opioids or other drugs.	Moderate-intensity intoxication monitoring or management, or withdrawal management services are needed. For patients who require partial hospital or more intensive mental health services (a Dimension 3 risk rating of 2 or higher), moderate-intensity withdrawal management can be provided in a mental health setting with ongoing case management to coordinate care. The patient in OTP requires dose adjustment, counseling services to assess and address readiness to change and relapse issues, and random urine testing.

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.

Case Study 2: Sandra

When Sandra shows up for treatment, she appears to be alert, oriented and able to function at her full mental capacity. Asking Sandra about her history with substance use and withdrawal uncovers no significant patterns or problems. Sandra admits to a couple nights of heavy drinking and drug use each week over the past four months due to a recent breakup, and feeling shaky and disoriented for a few days afterward. However, she expresses a little concern about her ability to stop using these substances.

Dimension 2: Katie

Katie is here to get treatment for severe alcohol use. She is about 60 lbs. overweight and has Type 2 Diabetes. She tries to eat healthy for breakfast and dinner, but during the daytime she snacks constantly on sweets her co-worker brings in. Katie received the gift of a gym membership from her family, which includes the services of a personal trainer, but she is afraid it might have expired. Her doctor supports her exercising, and also has prescribed medication which she is taking consistently. Katie tries to exercise about once every two weeks but complains of soreness if she goes for longer than 15 minutes.

Dimension 3:

Harriet is here for methamphetamine use and during your assessment of Dimension 3, she mentions that five years ago, her primary care doctor diagnosed her as being manic-depressive. Harriet's physical health presents moderate concerns for you due to potential malnutrition issues. Harriet says she took medication for her manic-depression but stopped a couple years back and hasn't experienced any symptoms since. When you interview her, Harriet does not show any signs or symptoms that indicate a bipolar disorder.

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.

Tips to Compensate for Inaccurate Client Report

- Provide a comfortable environment (soft lighting, warm/earthy colors, comfortable chairs, beverage)
- Use Rogerian/reflective/client-centered strategies to build rapport
- Use normed tests designed to detect defensiveness, inconsistencies, subtle attributes, etc. (SASSI-3, Maryland Addiction Questionnaire)
- Obtain and review medical records
- Interview family members, friends, significant others, etc.
- Calculate blood alcohol level estimate (http://www.alcoholhelpcenter.net/Program/BAC_Standalone.aspx)
- Conduct a background check
- Provide a "surprise" urinalysis drug test (recommend 8-panel + ethyl glucoronide/ethyl sulfate (EtG/EtS)
- Conduct the evaluation in more than one appointment; re-ask questions answered in paperwork
- Supplement clinical interview with a biopsychosocial questionnaire

About the Presenter

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