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Module 4 "Addressing Substance Use Disorders During Involuntary Detainment," is designed to support the knowledge and skills needed for a robust implementation of the Guidelines with the large proportion of individuals whose involuntary detainment is affected by substance use, substance use disorders, and substance induced symptoms.

Key Topics
- the prevalence of substance use disorders among individuals hospitalized for mental disorders
- special issues raised by substance use during involuntary detainment
- screening and assessment tools for co-occurring disorders
- diagnosis of substance use and substance induced disorders
- assessing stage of recovery
- self-help resources for clients with substance use disorders and related conditions
- interactions between mental health specialty services and Drug Medi-Cal Organized Delivery Systems
- third party payor policies regarding co-occurring disorders in mental health specialty programs

Learning Objectives
- improved recognition and diagnosis of substance related conditions during involuntary detainment
- effective implementation of the LPS Consensus Guidelines with substance abusing individuals
- improved continuity of care between pre-admission outpatient services, involuntary detainment units, and post-discharge follow-up services
- improved collaboration between mental health specialty and substance used disorder treatment services

Target Audience
- Staff of outpatient mental health specialty programs serving individuals at risk of involuntary detainment
- Staff of substance use disorder treatment programs serving individuals at risk of involuntary detainment
- Staff of psychiatric emergency and inpatient services
- Administrators and supervisors of the above-listed service programs
An Integrated Approach to Addressing Co-Occurring Disorders

A large proportion of involuntarily detained individuals use intoxicating substances that may not be the primary cause of their psychiatric crisis but do exacerbate symptoms, lead to stressful life circumstances, and interfere with the individual's efforts to engage in services. The information presented in the toolkit modules is relevant to involuntarily detained individuals whether or not they are using intoxicating psychotropic substances. This module is designed to draw attention to special issues that arise when serving those individuals who do use substances.

An integrated approach to addressing substance-related disorders along with primary mental disorders is essential, not only because of the common co-occurrence of these disorders but also because the same symptom patterns (syndromes) can be caused by either substance use or by biopsychosocial factors. Substance use disorders (SUDs) and other mental health problems are associated with:

- marked social impairment such as unemployment, homelessness, and family relationship problems.
- involvement with the criminal justice, child welfare, and social services systems.
- social stigma.
- increased risk of suicide.
- depression, anxiety, cognitive impairments, and problematic behaviors.
- contributing causes such as history of physical or sexual abuse as well as other traumas, poverty, and substance abuse in the family of origin.

SUDs and other mental health problems co-occur. As many as 60% of adults with serious mental illness also have an untreated substance abuse problem. The community standard of practice for addressing co-occurring conditions nationwide has shifted to treating the SUD and other mental health symptoms simultaneously, rather than giving primacy to one or the other. This stance is now well documented throughout the treatment and rehabilitation literature, reflected in Substance Abuse and Mental Health Services Administration (SAMHSA) standards, and encouraged by state agencies.

Evolving from an earlier era of strict fragmentation between mental health and substance abuse treatment, the Medi-Cal program has, in recent decades, permitted and encouraged specialty mental health services to include the assessment and treatment of SUDs as well. The potential for better integrated service delivery is evident by the fact that all behavioral health professions:

- cover these conditions in their coursework leading to degrees.
- are required to take continuing education courses regarding these conditions.
- are expected to address a client's substance use, along with other behavioral health issues, as an aspect of the legal standard of care for their services.
• include the identification, assessment, and treatment of substance-related disorders within their legal scope of practice.

Research Findings

The Agency for Healthcare Research and Quality has conducted an extensive study of hospitalized individuals with mental disorders and SUDs. Although the study addresses all forms of hospitalization, the findings have special implications for psychiatric hospitalizations. The study found that among inpatient stays with a primary mental or SUD diagnosis, stays involving co-occurring conditions were more common than those involving either a mental or SUD diagnosis alone. Among those who were hospitalized primarily for a mental health or SUD condition:

• 15.1% were hospitalized with only a SUD condition,
• 39.3% were hospitalized with only a mental disorder, and
• 45.7% had co-occurring conditions.

In other words, the majority, 54%, of those hospitalized for psychiatric conditions had diagnosable co-occurring SUDs (Heslin et al., 2015).

With such a large proportion of co-occurring conditions among hospitalized individuals, an integrated approach is essential in program design and administration. Furthermore, an integrated approach to services is both desirable and feasible in view of the fact that both SUDs and other behavioral health service programs deal with:

• the same mandatory reporting laws.
• similar confidentiality and privileged communication issues.
• the criminal justice, child welfare, and social services systems.
• similar principles of managed care.
• similar provisions for involuntary holds.
• voluntary holds occurring in the same facility regardless of whether SUDs or other mental disorders precipitated the need for the hold.
LPS CONSENSUS GUIDELINES: SUBSTANCE-RELATED IMPLICATIONS

The module topics are specifically related to one or more of the LPS Consensus Guidelines. Most guidelines are supported by information provided in one or more modules. The relationship between the LPS Consensus Guidelines and the most relevant module contents is presented in the following tables.

1. Stabilization and De-Escalation

<table>
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<tr>
<th>GUIDELINES</th>
<th>SUBSTANCE-RELATED IMPLICATIONS</th>
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<tbody>
<tr>
<td>1.01 Both first responders and behavioral health service staff should identify and document:</td>
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<tr>
<td><strong>1.01 (a)</strong> the specific factors that led the officer or other authorized person to declare a need for involuntary hold (least restrictive environment).</td>
<td>Including documentation of substance-induced symptoms and/or the way that intoxication may have contributed to exacerbating symptoms of a primary mental disorder. Note that substances include legal substances with psychotropic effects, such as alcohol, caffeine, nicotine, and prescribed medications. See “Assessment Tools for Co-Occurring Disorders” in this module, especially tables 1–3.</td>
</tr>
<tr>
<td>1.01 (b) input from family members, when possible (person-centered).</td>
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<tr>
<td>1.01 (c) the individual’s disposition, location, and history, if known (person-centered).</td>
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</tr>
<tr>
<td>1.01 (d) indicators of the person’s various medical, psychiatric, and physical needs, if known (person-centered).</td>
<td>Including substance use and abuse as well as needs arising from harmful effects of such use. See “Assessment Tools for Co-Occurring Disorders” in this module, especially tables 1–3.</td>
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### 2. Engagement

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<th>GUIDELINES</th>
<th>SUBSTANCE-RELATED IMPLICATIONS</th>
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<tbody>
<tr>
<td><strong>2.01</strong> Exercise clear and effective communication skills (relationship-based).</td>
<td>See Module 2, Core Competencies, especially “Verbal De-Escalation,” “Trauma-Informed Care,” and “Motivational Interviewing.”</td>
</tr>
<tr>
<td><strong>2.02</strong> Demonstrate an understanding of and appreciation for (validate and affirm) the individual’s perspective of the situation (person-centered).</td>
<td>Be conscious of culturally based stigmatized perspectives on substance use as well as culturally based support for abstinence, sobriety, and recovery. Pursue information about substance use in a manner that conveys nonjudgmental acceptance, not necessarily approval, of client's substance use.</td>
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<tr>
<td><strong>2.03</strong> Create nonjudgmental, supportive conditions (respectful).</td>
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<tr>
<td><strong>2.04</strong> Create conditions that feel safe (e.g., use potentially intimidating resources such as handcuffs, police cars, and ambulances only when necessary) (respectful).</td>
<td>Consider client concerns about discovery of illegal substances when personal effects are handled by a third party on the client's behalf.</td>
</tr>
<tr>
<td><strong>2.05</strong> Inquire about the individual’s comfort (e.g., dry and warm clothing, food, water) prior to making other assessment inquiries (respectful).</td>
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<tr>
<td><strong>2.06</strong> Address client concerns about personal effects (e.g., cars, bikes, pets, personal belongings, home) (respectful).</td>
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<tr>
<td><strong>2.07</strong> Develop and implement an action plan to secure the individual’s personal effects.</td>
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<tr>
<td><strong>2.08</strong> Include family members and significant others as identified by the client (self-direction).</td>
<td>This may include a client's sponsor or other members of a client's self-help fellowship. Let the client know that these are options and that visits can include but are not limited to family members.</td>
</tr>
<tr>
<td><strong>2.09</strong> Focus the engagement process on discharge (goal-driven services).</td>
<td>Consider a chemically abusing client’s concerns about losing access to their drug of choice during detainment.</td>
</tr>
<tr>
<td><strong>2.10</strong> Practice a recovery orientation.</td>
<td>Including the values of client self-determination and self-responsibility. See Module 1, Philosophies and Practices, especially “Practical Indicators of an In-Patient Service's Recovery Orientation.”</td>
</tr>
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</table>
### 3. Initial Clinical Assessment

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<tbody>
<tr>
<td><strong>Initial Clinical Assessment Process</strong></td>
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<tr>
<td><strong>3.01</strong> Use a “team” or “collaborative process” whereby the mental health clinician references the information from the first responder, including information about prior law enforcement contact (not limited to professional interventions or natural support networks).</td>
<td>Keep in mind that the absence of substance-related legal problems does not rule out the possibility of clinically meaningful substance abuse.</td>
</tr>
<tr>
<td><strong>3.02</strong> Access the individual’s existing behavioral health records to the extent possible (person-centered, respectful).</td>
<td>Keep in mind that the proportion of clients with diagnosed and documented SUDs in mental health specialty programs is far below (1) epidemiologically based prevalence estimates for the general population of persons with mental illnesses and (2) informal outpatient staff observations of substance abuse among their clients. Absence of substance-related diagnoses in a client’s outpatient records does not necessarily indicate an absence of substance abuse.</td>
</tr>
<tr>
<td><strong>3.03</strong> Draw out the individual’s own experience of the situation through “inquiry, not accusation” (person-centered).</td>
<td>For a chemically dependent client, concerns about losing access to their drug of choice during detainment are likely to be a part of that experience. Let the client know that this can be discussed openly without fear of judgement by staff or legal consequences.</td>
</tr>
<tr>
<td><strong>3.04</strong> Conduct a systematic review of interventions that have previously benefited the detained individual.</td>
<td>Including SUD treatment and related self-help program participation.</td>
</tr>
<tr>
<td><strong>3.05</strong> Inform the first responder who initiated the involuntary hold regarding the disposition of the involuntary hold and status of the individual following the initial assessment (community-based).</td>
<td>Such communications do not need to—and should not—include information learned about a client’s substance use.</td>
</tr>
<tr>
<td><strong>Initial Clinical Assessment Content</strong></td>
<td></td>
</tr>
<tr>
<td><strong>3.06</strong> Assess for medical necessity for involuntary hold (least restrictive environment).</td>
<td>Under Medi-Cal the presence of a SUD does not disqualify the psychiatric hospitalization of a client with co-occurring conditions.</td>
</tr>
<tr>
<td><strong>3.07</strong> Include information about history of care (person-centered, respectful).</td>
<td>Including interventions related to a client’s substance use by mental health, SUD treatment</td>
</tr>
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</table>
3.08 Identify alternatives to the hold, such as community and family supports, and reasons for using or not using these alternatives (least restrictive environment, natural support networks).

Consider whether SUD treatment programs and self-help fellowships might be relevant to an individual.

3.09 Identify the individual's needs regarding securing personal property, pets, cars, other family members (e.g., children), safety, and medical and physical needs (respectful focus on meaningful life roles).

Consider client concerns about discovery of illegal substances when personal effects are handled by a third party on the client's behalf.

3.10 Identify the individual's strengths (e.g., problem-solving abilities, capacity to engage others, interests and motivations, awareness of strengths and limitations, symptom management abilities) (strengths-based).

Note strengths exhibited by the individual in relation to contemplation, planning, and action stages of change in the past, even if the individual is now in a different stage.

3.11 Include information about the individual's involvement with support systems (e.g., family, friends, agencies) (strengths-based, community-based, natural support networks, meaningful roles; recovery can occur independent of professional interventions).

Including twelve-step and other self-help programs and supportive relationships developed through such programs in the past. See “Self-Help Resources” in this toolkit.

3.12 Address issues relevant to the individual's ethnicity, social class, religion, gender, sexual orientation, generation, or other cultural considerations and communicate in a linguistically appropriate manner (culturally relevant, respectful).

Consider the role played by intoxicating substances in the client's ethnicity, generation, social class, and various other cultural considerations influencing the client. Consider cultural attitudes regarding both the benefits and disadvantages of substance use as well as the use of intoxicants in culturally based rituals.

3.13 Address any ongoing assessment content (see section 5 below) that is logistically feasible in view of time constraints and client's ability to communicate such information.

In cases where communication with family is acceptable to the client, family members can be a rich source of information about an individual’s substance use and its effects on functioning.

4. Admissions: There were no guidelines for this segment. It was agreed upon by the expert panel and regional stakeholders that the admission process is generally standard across the counties.
5. Ongoing Assessment

This component refers to **daily assessments** to inform diagnosis, medications, discharge plans, and aftercare resources, maintaining a focus on discharge, recovery and wellness planning. Whereas the **initial clinical assessment** may need to focus on the immediate crisis, the **ongoing assessment** offers greater opportunity to gather a fuller range of recovery-oriented information about the client, especially if the quality of the therapeutic relationship between the client and staff has progressed.

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<td><strong>Ongoing Assessment Process</strong></td>
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<tr>
<td><strong>5.01 Use a “team” or collaborative process.</strong></td>
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</tr>
<tr>
<td><strong>5.01 (a) Use an “assessment team” including friends, family members, etc., as requested by the client; whenever possible, include family members who can provide significant information about individual history, daily routines, etc., that could influence the assessment and intervention plan (not limited to professional interventions and, natural support networks).</strong></td>
<td>To what extent is substance abuse expertise represented on the team?</td>
</tr>
<tr>
<td><strong>5.01 (b) The client should be made aware of the option to include family members and significant others in the assessment process and the potential benefits of doing so (empowerment, natural support networks).</strong></td>
<td>The client should be informed that this includes others who are part of a client’s self-help program participation.</td>
</tr>
<tr>
<td><strong>5.01 (c) The client’s decisions about engaging or not engaging others should be respected (self-direction, self-responsibility, person-centered, respectful).</strong></td>
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</tr>
<tr>
<td><strong>5.01 (d) Access behavioral health records, including a review of the client’s own crisis-related perspectives and preferences as expressed in assessments that were documented prior to the time of the involuntary detention (person-centered, respectful).</strong></td>
<td>Keep in mind that the proportion of clients with diagnosed and documented SUDs in mental health specialty programs is far below (1) epidemiologically based prevalence estimates for the general population of persons with mental illnesses and (2) informal outpatient staff observations of substance abuse among their clients. Absence of substance-related diagnoses in a client’s outpatient records does not necessarily indicate an absence of substance abuse.</td>
</tr>
<tr>
<td><strong>5.01 (e) Draw out the individual’s own experience of the situation through “inquiry, not accusation” (person-centered).</strong></td>
<td>For a chemical-abusing client, concerns about losing access to their drug of choice during detention are likely to be a part of that</td>
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Let the client know that this can be discussed openly without fear of judgement by staff or legal consequences.

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<tr>
<th>5.01 (f)</th>
<th>Use motivational interviewing principles as relevant (person-centered).</th>
<th>Keep in mind that the client’s stage of change may be different in relation to their use of one substance, their use of another substance, and their various other mental health conditions. Expect ambivalence regarding client’s substance use. See “Motivational Interviewing” in Toolkit 2, Core Competencies.</th>
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<tr>
<td>5.01 (g)</td>
<td>Facilitate the client’s own communication with individuals and resources with whom the client chooses to communicate to obtain information about his or her history, status, and post-discharge options (self-responsibility).</td>
<td>This may include communications with a client’s sponsor or other members of a client’s self-help fellowship. Let the client know that these are options and that such communications can include but are not limited to family members.</td>
</tr>
<tr>
<td>5.01 (h)</td>
<td>Facilitate the client’s own communication with those individuals and resources the client chooses to invite as participants in the discharge planning process (self-responsibility).</td>
<td>Are substance-related follow-up resources relevant in view of the client’s stage of change? See “Motivational Interviewing” and “Shared Decision-Making” in Toolkit 2, Core Competencies.</td>
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### Ongoing Assessment Content

<p>| 5.02 | The ongoing assessment should inform discharge planning decisions and occurs simultaneously with the discharge planning process (an ongoing process throughout the involuntary detainment). | The quality of attention to substance use in the assessment is the basis for the quality of discharge planning regarding substance use. |
| 5.03 | To inform discharge planning, the ongoing assessment should include content that informs: | Consider how the individual’s substance use has affected fulfillment of major role obligations. |
| 5.03 (a) | decisions regarding restoration of role functioning and/or introduction to new roles (focus on life roles). | Keep in mind that the client’s stage of change may be different in relation to their use of one substance, their use of another substance, and their various other mental health conditions. Expect ambivalence regarding his or her substance use. See “Assessing Stage of Recovery” in this toolkit. |
| 5.03 (b) | the individual's stage of change so that discharge plan goals and objectives can be linked to the individual’s stage of change (person-centered). (For information about stage of change, see, for example, Prochaska, Norcross, and DiClementi 1992 or Osher and Kofoed 1989.) | Recommend goals and objectives regarding abstinence, sobriety, and/or harm reduction, as relevant to the client’s current stage of change. See Toolkit 2, Core Competencies, especially |</p>
<table>
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<th>the individual or acceptable to the individual (person-centered, self-determination).</th>
<th>“Shared Decision-Making” and “Wellness Recovery Action Planning.”</th>
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<tbody>
<tr>
<td><strong>5.04</strong> Include information about the individual’s history of care that may be available from other sources (person-centered).</td>
<td>Although the Health Insurance Portability and Accountability Act of 1996 (HIPAA)’s support for portability of information does not apply to SUD treatment programs covered by 42CFR (Code of Federal Regulations related to privacy provisions for persons with substance use disorders), attention to a client’s substance use by primary care physicians, mental health programs, and social services is not usually covered by 42CFR.</td>
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<tr>
<td><strong>5.05</strong> Reassess the individual’s needs with regard to securing personal property, pets, cars, other family members (e.g., children), safety, and medical and physical needs (respectful).</td>
<td>Consider client concerns about discovery of illegal substances when personal effects are handled by a third party on the client's behalf.</td>
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<tr>
<td><strong>5.06</strong> Identify strengths (e.g., problem-solving abilities, capacity to engage others, interests and motivations, awareness of strengths and limitations, symptom management abilities) (strengths-based).</td>
<td>Note strengths exhibited by the individual in relation to contemplation, planning, and action stages of change in the past, even if the individual is now in a different stage.</td>
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<tr>
<td><strong>5.07</strong> Include information about the individual's involvement with support systems (e.g., family, friends, agencies) (focus on meaningful life roles, not limited to professional interventions).</td>
<td>Including twelve-step and other self-help programs and supportive relationships developed through such programs in the past.</td>
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<tr>
<td><strong>5.08</strong> Address issues relevant to the client's ethnicity, social class, religion, gender, sexual orientation, generation, or other cultural considerations and communicate in a linguistically appropriate manner (culturally relevant, person-centered, respectful).</td>
<td>Consider the role played by intoxicating substances in the client's ethnicity, generation, social class, and other various cultural considerations influencing the client. Consider cultural attitudes regarding both the benefits and disadvantages of substance use as well as the use of intoxicants in culturally based rituals.</td>
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<tr>
<td><strong>5.09</strong> Evaluate the individual’s role functioning (e.g., employment, raising children, participation in training or education, neighborhood participation) (focus on meaningful life roles).</td>
<td>Consider how the individual's substance use has affected the fulfillment of major role obligations.</td>
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<tr>
<td><strong>5.10</strong> Identify those persons and resources that the individual chooses to communicate with during the detainment (self-direction).</td>
<td>This may include a client’s sponsor or other members of a client’s self-help fellowship. Let the client know that these are options and that visits can include but are not limited to family members.</td>
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<tr>
<td><strong>5.11</strong> Identify those persons and resources the individual chooses to participate with in the discharge planning process (self-direction, not limited to professional interventions).</td>
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### 6. Formulation/Narrative

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<tr>
<th>GUIDELINES</th>
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<tr>
<td><strong>6.01</strong> The formulation should clearly convey:</td>
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<tr>
<td><strong>6.01 (a)</strong> that the documented diagnosis (diagnoses) is (are) supported by evidence (valid).</td>
<td>Reference DSM-5 criteria. Distinguish between substance use, intoxication, withdrawal, substance-induced disorders, and SUDs.</td>
</tr>
<tr>
<td><strong>6.01 (b)</strong> which problems are primarily due to the symptoms of the diagnosed mental disorder.</td>
<td>Also, note which problems are primarily due to, triggered by, or exacerbated by substance use.</td>
</tr>
<tr>
<td><strong>6.01 (c)</strong> which problems are primarily due to factors other than symptoms of the diagnosed mental disorder.</td>
<td>Identify strengths that the individual has used in the past to abstain from substance use and/or reduce harmful effects of substance use.</td>
</tr>
<tr>
<td><strong>6.01 (d)</strong> which strengths are relevant to solving each major problem.</td>
<td></td>
</tr>
<tr>
<td><strong>6.01 (e)</strong> which resources are available for solving each major problem.</td>
<td>Include specialty mental health, specialty SUDs, and integrated behavioral health resources, as relevant and available in the local community. See “Self-Help Resources” in this toolkit.</td>
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### 7. Treatment (Decision-Making and Intervention)

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<tr>
<th>GUIDELINES</th>
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<tr>
<td>7.01 The assessment of treatment includes:</td>
<td>Make and document recommendations related to the individual's substance use and its effects for all individuals with a known history of substance use. Note that substances include legal substances with psychotropic effects, such as alcohol, caffeine, nicotine, and prescribed medications.</td>
</tr>
<tr>
<td>7.01 (a) identifying recommendations made to the individual during the involuntary hold.</td>
<td>Consider what the individual's response indicates regarding his or her stage of change.</td>
</tr>
<tr>
<td>7.01 (b) the individual's response to recommendations (person-centered).</td>
<td>Specify those interventions that were directly relevant to addressing the client's substance use and/or its effects on the client's functioning.</td>
</tr>
<tr>
<td>7.01 (d) identifying therapeutic interventions provided to the individual during the involuntary hold.</td>
<td>Includes contacts with family members and other members of a formal or informal self-help network.</td>
</tr>
<tr>
<td>7.01 (d) the individual's response to therapeutic interventions provided (person-centered).</td>
<td>Include an evaluation of the individual's stage of change. See “Assessing Stage of Recovery” in this toolkit. Also see Toolkit 1, Philosophies and Practices, especially “Ragans’ Stage Model of Recovery” and “Ragans’ Milestones of Recovery Scale.”</td>
</tr>
<tr>
<td>7.01 (e) identifying contacts with significant others during the involuntary hold (not limited to professional interventions).</td>
<td>Include mental health, SUD treatment, integrated behavioral health, primary care, social services, and self-help networks and programs.</td>
</tr>
<tr>
<td>7.01 (f) the individual's response to contacts with significant others (person-centered).</td>
<td>Although HIPAA support for portability of information does not apply to SUD treatment programs covered by 42CFR, attention to a client's substance use by primary care physicians, mental health programs, and social services is not usually covered by 42CFR.</td>
</tr>
<tr>
<td>7.01 (g) an evaluation of the individual's potential and willingness to engage in follow-up outpatient care and supportive services and relationships (self-direction).</td>
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</tr>
<tr>
<td>7.01 (h) staff communication and collaboration with potential outpatient follow-up service providers and those who might provide supportive services and relationships (community-based services).</td>
<td></td>
</tr>
<tr>
<td>7.01 (i) client communication with potential outpatient follow-up service providers and those who might provide supportive services and relationships (self-responsibility).</td>
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</tr>
<tr>
<td>7.01 (j) The service program's access to centralized information within a system of care, fully implementing the “portability” purpose of HIPAA while remaining within the confidentiality and security provisions of HIPAA (community-based services).</td>
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</table>
### 8. Discharge Planning

<table>
<thead>
<tr>
<th>GUIDELINES</th>
<th>SUBSTANCE-RELATED IMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8.01</strong> Discharge decisions should be informed by a validated instrument whenever possible.</td>
<td>Use the indicators contained in the ASAM (American Society of Addiction Medicine) patient placement criteria. This scale is required for use by programs participating in the Drug Medi-Cal Organized Delivery System (DMC-ODS) and also contains useful indicators for use in discharge planning by programs not part of a DMC-ODS system. See “ASAM Patient Placement Criteria” and “Interactions with the Drug Medi-Cal Organized Delivery System” in this toolkit.</td>
</tr>
<tr>
<td><strong>8.02</strong> Discharge decisions should be based on a documented, systematic review of interventions that have previously benefited the detained individual.</td>
<td>Include the individual's history of involvement with and response to both SUD treatment programs and self-help networks.</td>
</tr>
<tr>
<td><strong>8.03</strong> Exercise clear and effective communication skills (relationship-based).</td>
<td>Consider those communication skills addressed by “Motivational Interviewing” and “Crisis Intervention,” described in Toolkit 2, Core Competencies.</td>
</tr>
<tr>
<td><strong>8.04</strong> Demonstrate an understanding of and appreciation for (or validate) the individual’s perspective of the situation (person-centered).</td>
<td>Take a self-inventory of knowledge and attitudes toward substance use. See “A Person-Centered Approach to Interviewing for Substance Use” in this toolkit. Seek consultation as needed.</td>
</tr>
<tr>
<td><strong>8.05</strong> Include family members and significant others, as identified by the client, in discharge planning (self-direction).</td>
<td>This may include a client’s sponsor or other members of a client’s self-help fellowship. Let the client know that these are options and that discharge planning participation can include but is not limited to family members.</td>
</tr>
<tr>
<td><strong>8.06</strong> Focus the discharge process on post-discharge follow-through (goal-driven services).</td>
<td>Attend to client's ambivalence, if any, or other sources of resistance regarding follow-through on accepted SUD-related referrals.</td>
</tr>
<tr>
<td><strong>8.07</strong> The discharge plan should express a recovery orientation; therefore, discharge plans must:</td>
<td>Use a strength-based approach emphasizing client self-determination and self-responsibility. See Toolkit 2, Core Competencies, especially “Wellness Recovery Action Planning (WRAP).” Although the full WRAP planning process might not be relevant to inpatient or emergency</td>
</tr>
<tr>
<td><strong>8.07 (a)</strong> be person centered.</td>
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<tr>
<td><strong>8.07 (b)</strong> reflect client’s own decisions and build self-responsibility whereby the client is expected and empowered to engage in actions on his or her own behalf (self-direction).</td>
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<tr>
<td><strong>8.07 (c)</strong> be respectful.</td>
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</tr>
<tr>
<td><strong>8.07 (d)</strong></td>
<td>be culturally relevant (in view of ethnicity, religion, social class, gender, sexual orientation, and other cultural considerations that are meaningful to the client).</td>
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<tr>
<td>Consider the role played by intoxicating substances in the client's ethnicity, generation, social class, and other various cultural considerations influencing the client. Consider cultural attitudes regarding both the benefits and disadvantages of substance use as well as the use of intoxicants in culturally based rituals.</td>
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<tr>
<td><strong>8.07 (e)</strong></td>
<td>be hopeful and stimulate hope.</td>
</tr>
<tr>
<td>Remind clients of strengths they have successfully used in the past to manage substance use and its effects as well as available resources that have helped others.</td>
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<tr>
<td><strong>8.07 (f)</strong></td>
<td>be strengths based, referring to the client's personal qualities that are relevant to a successful achievement of post-discharge goals and objectives.</td>
</tr>
<tr>
<td><strong>8.07 (g)</strong></td>
<td>empower the client with information and assistance in contacting (linkage) supportive resources.</td>
</tr>
<tr>
<td>Maintain an up-to-date listing of available and accessible SUD-related resources in the local community and online, including contact information. Assist clients in evaluating the relevant pros and cons of each resource vis-à-vis the individual's stage of change and culture. See “Self-Help Resources” in this toolkit.</td>
<td></td>
</tr>
<tr>
<td><strong>8.07 (h)</strong></td>
<td>identify relevant community-based services and natural support networks.</td>
</tr>
<tr>
<td><strong>8.07 (i)</strong></td>
<td>not be limited to professional interventions.</td>
</tr>
<tr>
<td><strong>8.07 (j)</strong></td>
<td>focus on quality of life goals and meaningful life roles (goal-driven services).</td>
</tr>
<tr>
<td>Address how changes in an individual's patterns of substance use can enhance the person's quality of life, especially in terms of the person's own goals and choice of meaningful life roles.</td>
<td></td>
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<tr>
<td><strong>8.07 (k)</strong></td>
<td>express goals and objectives that are sufficiently clear and specific to enable valid and reliable outcome evaluation.</td>
</tr>
<tr>
<td>Goals and objectives should be stated so clearly and specifically that even a very self-critical individual who feels hopeless would have difficulty denying their achievement once it occurs.</td>
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9. Care Coordination

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<tr>
<th>GUIDELINES</th>
<th>SUBSTANCE RELATED IMPLICATIONS</th>
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<tbody>
<tr>
<td>9.01 Prior to discharge, confirm that the planned follow-up resources are in place and ready to engage with the individual (respectful).</td>
<td>Consider all relevant SUD treatment and self-help supports and services when addressing these issues.</td>
</tr>
<tr>
<td>9.02 Prior to discharge, confirm that the individual remains committed to the decisions about use of chosen follow-up resources and remains willing to follow through (self-direction, self-responsibility).</td>
<td></td>
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<tr>
<td>9.03 Prior to discharge, confirm that the individual’s basic needs (e.g., housing, meals, adequate clothing, access to medications) can and will be met if the individual and designated resources follow through on their commitments (respectful, meaningful life roles).</td>
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10. Discharge

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<tr>
<th>GUIDELINES</th>
<th>SUBSTANCE RELATED IMPLICATIONS</th>
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<tbody>
<tr>
<td>10.01 Provide the individual with an opportunity to say goodbye to staff and peers to the extent possible (respectful).</td>
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</tr>
<tr>
<td>10.02 Assess, with the individual, progress that was accomplished during the involuntary hold (strengths-based).</td>
<td>Progress includes acknowledgment of previously denied or minimized effects of substance use on the individual’s behavioral health.</td>
</tr>
<tr>
<td>10.03 Assess, with the individual, how the present experience of stabilizing and resolving the crisis state may be helpful in coping with future crises (strengths-based, self-responsibility).</td>
<td>Consider how substance abusing individuals have been able to deal with the effects of restricted access to their drug of choice during the involuntary detainment. Such adaptation is not always positive or desirable, but in many cases it is.</td>
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## 11. Supports for Wellness and Recovery

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<tr>
<th>GUIDELINES</th>
<th>SUBSTANCE RELATED IMPLICATIONS</th>
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<tbody>
<tr>
<td><strong>11.01</strong> A postcrisis management team should be provided for this phase of support.</td>
<td>The team should include expertise with SUDs and co-occurring disorders.</td>
</tr>
<tr>
<td><strong>11.01 (a)</strong> The postcrisis management team should function as a wraparound type of “warm handoff” to community services and linkage for family supports whenever possible. (In a “warm handoff” the inpatient or emergency service provider arranges for a face-to-face introduction of a client to those who are expected to provide postdischarge services and supports.)</td>
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<tr>
<td><strong>11.01 (b)</strong> The postcrisis management team should follow up with individuals after discharge to ensure that they connect with outpatient services.</td>
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<tr>
<td><strong>11.01 (c)</strong> Engage peer support organizations to participate on the team as aftercare and resource educators, liaisons, and aftercare case managers. This is recommended as a best practice.</td>
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<tr>
<td><strong>11.02</strong> Whether construction of a postcrisis management team as a stand-alone resource is possible or not, increased care coordination among disparate agencies ultimately serving the same individuals should serve this function in a de facto manner.</td>
<td>Specialty mental health and specialty SUD treatment programs should negotiate their respective roles, both on a programmatic level and in each individual client’s treatment plans.</td>
</tr>
<tr>
<td><strong>11.03</strong> Engage the supportive efforts of peer navigators.</td>
<td>Peer navigators should be selected for their substance-related expertise when selected for engagement with substance-abusing individuals. See Module 2, Core Competencies, especially “Emotional CPR.”</td>
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12. Advance Assessment

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<th><strong>GUIDELINES</strong></th>
<th><strong>SUBSTANCE RELATED IMPLICATIONS</strong></th>
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<tr>
<td><strong>Advance Assessment Process</strong></td>
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<tr>
<td><strong>12.01 Use a shared decision-making process.</strong> A systematic approach to decision making is a skill. Most people need to practice systematic approaches to decision making, just as we need to practice any skill. The client who has had repeated opportunities to do so during a course of outpatient services will be best empowered to do so when presented with a shared decision-making approach during an involuntary hold. To support the development of decision-making skills, during advance assessments staff should implement the following guidelines:</td>
<td>Share your recommendations and the reasons for them with the client, but accept the client’s self-determination, self-responsibility, and right to accept or reject those recommendations. See Module 2, Core Competencies, for information about shared decision making as a structured method.</td>
</tr>
<tr>
<td><strong>12.01 (a) If the client brings up a cluster of issues, see if it helps to partialize and prioritize them (empowerment).</strong></td>
<td>If substance use is one of a client's partialized issues, accept the level of priority attributed to it by the individual, even if your evaluation places the issue at a different level. Share your impressions but accept the client's perspective. See Toolkit 2, Core Competencies, especially “Crisis Intervention.”</td>
</tr>
<tr>
<td><strong>12.01 (b) The client’s subjective experience and response to each issue should be identified and clarified (respectful, empowerment).</strong></td>
<td>Attend to issues addressed by motivational interviewing such as ambivalence, change talk, sustain talk, and resistance talk. Keep in mind the individual's experience of both desirable and undesirable, or life-enhancing and problematic, effects of substance use. Be open to accepting the individual’s thoughts and feelings about both.</td>
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<tr>
<td><strong>12.01 (c) Weigh alternative options by “trying them out” hypothetically in discussion. For example, “What do you like best about . . . ? What do you like least about . . . ?” (empowerment)</strong></td>
<td>These principles are especially relevant to weighing alternative options when a client is in the contemplation and planning stages of change. See Toolkit 2, Core Competencies, especially “Shared Decision Making” and “Crisis Intervention.”</td>
</tr>
<tr>
<td><strong>12.01 (d) Ask the client to choose preferences, but don't limit choices to only one primary preference unless the client chooses to do so (self-direction, self-responsibility).</strong></td>
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<tr>
<td><strong>12.01 (e) Help the client identify the steps that were taken in identifying preferences (empowerment).</strong></td>
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(Note: The above five guidelines involve a person-centered, strengths-based approach to supporting client empowerment)

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<tr>
<th>12.02</th>
<th>Those clients who have considered and made decisions about including family and significant others during the outpatient service assessment process will be best able to formulate such decisions during their detainment-based assessments; therefore, clients should be made aware of the option of including family members and significant others in the assessment process and the potential benefits of doing so.</th>
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<tr>
<td>This is especially relevant for clients whose family members and significant others either have experienced codependency, have actively promoted the client's substance use, and/or have problematic relationships with the client resulting from their own substance use. Such family members and significant others should be approached with the same principles of respect, acceptance, and self-determination and techniques of motivational interviewing as are relevant for clients themselves.</td>
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<tr>
<th>12.03</th>
<th>Conduct the advance assessment in a way that strengthens the client's decision-making capacity.</th>
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<tbody>
<tr>
<td>This principle is inherent in shared decision-making and motivational interviewing methods. See Module 2 of this toolkit, Core Competencies, for more information.</td>
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<tr>
<th>12.04</th>
<th>Make the findings of advance assessments accessible during detainment. Whenever information can be gathered during service contacts within a service system that arise prior to an involuntary hold, the information should be:</th>
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<tbody>
<tr>
<td>12.04 (a) documented in a record that is accessible to psychiatric emergency and inpatient services within the same service system (community-based).</td>
<td></td>
</tr>
<tr>
<td>Sharing information among service providers is permitted and even encouraged by both HIPAA and the California Welfare and Institutions Code. Although greater restrictions are placed on information sharing by SUD treatment programs covered by 42CFR, attention to a client's substance use by specialty mental health programs, primary care providers, and social services is not usually covered by 42CFR.</td>
<td></td>
</tr>
<tr>
<td>12.04 (b) accessible to psychiatric emergency and inpatient services within the same service system (community-based).</td>
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</table>
Many abused substances are not captured well by the DSM categories, in part because more sophisticated drug designs are intended to produce a variety of effects which mimic those of several “traditional” categories of substances. The DSM uses existing categories for the most typical and commonly abused substances.

AMPHETAMINES AND OTHER STIMULANTS
Amphetamines (methamphetamine): bennies, blue devils, chalk, CR, crank, crystal, crystal meth, fast, granulated orange, ice, meth, Mexican crack, pink, rock, speckled birds, speed, tina, yellow powder
Methcathinone (a stimulant similar to methamphetamines): bathtub speed, Cadillac express, cat, crank, ephedrine, gagers, go-fast, goob, qat, slick superspeed, star, the C, tweeker, wild cat, wonder star
Cocaine: b, blow, c, candy, coke, do a line, freeze, girl, happy dust, Mama, coca, mojo, monster, nose, pimp, shot, smoking gun, snow, sugar, sweet stuff, white powder
Crack (a form of cocaine): base, beat, blast, casper, chalk, devil drug, gravel, hardball, hell, kryptonite, love, moonrocks, rock, scrabble, stones, tornado
MDMA/Ecstasy (methylenedioxyamphetamine—considered a stimulant that is often laced with amphetamines or other stimulants; can also be considered an hallucinogen): Adam, bean, blue kisses, clarity, club drug, disco biscuits, E, ecstasy, hug drug, love drug, lover’s speed, Mercedes, New Yorkers, peace, roll, white dove, X, XTC
Ritalin: crackers, one and ones, pharking, poor man’s heroin, R-ball, Ritz ants, set, skippy, speedball, Ts and Ritz, T’s and Rs, vitamin R, west coast

CANNABIS (marijuana): 420, Aunt Mary, baby, bobby, boom, chira, chronic, ditch, ganja, grass, greens, hash, herb, Mary Jane, nigra, pot, reefer, rip, root, skunk, stack, torch, weed, zambi

SEDATIVES / CNS DEPRESSANTS (can include barbiturates and benzodiazepines): backwards, blue heavens, downie, drowsy high, green dragons, idiot pills, joy juice, M&M, no worries, peanut, rainbows, red bullets, stoppers, stumbler, tooles, yellow
GHB (gamma-hydroxybutyric acid, a depressant and hallucinogen designer drug): caps, cherry meth, ever clear, easy lay, fantasy, G, G- riffic, gamma hydrate, Georgia home boy, grievous bodily harm, liquid ecstasy, liquid X, soapm sodium oxybate
Rohypnol (a sedative and depressant): circles, “the date rape drug,” forget-me pill, la rocha, lunch money drug, Mexican valium, pungis, R2, Reynolds, roche, roofies, rope, ruffles, wolfies
**HALLUCINOGENS**

**LSD** (lysergic acid diethylamide): A, acid, black star, blotter, boomers, cubes, Elvis, golden dragon, L, microdot, paper acid, pink robots, Superman, twenty-five, yellow sunshine, ying yang

**Ketamine** (an anesthetic, considered a hallucinogen or dissociative anesthetic, a category that also includes PCP, DXM found in cough syrup, and nitrous oxide; major effect is a sense of dissociation): bump, cat killer, cat Valium, Fort Dodge, green, honey oil, jet, K, ket, Kit-Kat, psychedelic heroin, purple, special K, special la coke, super acid, super C, vitamin K.

Mescaline: beans, buttons, cactus, cactus buttons, cactus head, chief, love trip, mesc, mescal, mezcz, moon, peyote, topi

**Psilocybin/psilocin**: boomers, god’s flesh, little smoke, magic mushroom, Mexican mushrooms, mushrooms, musk, sherm, shrooms, silly putty, simple Simon

**INHALANTS**: air blast, bolt, boppers, bullet bolt, climax, discorama, hardware, heart-on, highball, honey oil, huff, laughing gas, medusa, moon gas, Satan's secret, thrust, whiteout

**PCP** (phencyclidine): angel dust, belladonna, black whack, CJ, cliffhanger, crystal joint, Detroit pink, elephant tranquilizer, hog, magic, Peter Pan, sheets, soma, TAC, trank, white horizon, zoom

**OPIOIDS**

Heroin: Aunt Hazel, big H, black pearl, brown sugar, capital H, charley, china white, dope, good horse, H, hard stuff, hero, heroina, little boy, mud, perfect high, smack, stuff, tar

**Fentanyl** (an opioid painkiller): Apache, China girl, Chinatown, dance fever, friend, goodfellas, great bear, he-man, jackpot, king ivory, murder 8, poison, tango, cash, TNT

**Opium**: ah-pen-yen, aunti, big O, black stuff, Chinese tobacco, chocolate, dopium, dover’s deck, dream gun, hard stuff, hocus, joy plant, O, ope, pin yen, toxy, zero

**STEROIDS**: anabolic, anadrol, arnolds, bolosterone, dihdyrlone, equipose, gym candy, juice, methyltestosterone, proviron, pumpers, stackers, therobolin, weight trainers, winstrol V, Roids.
Drug Interactions

The *Physician's Desk Reference (PDR)* is the guide to indications and contraindications for the use of various prescribed medications. All FDA-approved prescription drugs are listed in the PDR, and each one identifies other substances (usually other prescription drugs or foods) that are contraindicated while using the specified prescription drug.

Drug interactions occur in basically two ways.

**Pharmacodynamics** refers to the results of using two or more drugs that produce similar effects. Each one enhances the effect of the other. An example is drinking coffee while intoxicated on amphetamines to enhance an energized speedy high. Pharmacodynamics can cause an overdose, even though each drug used would not have caused an overdose on its own. This can happen, for example, when heroin is used with alcohol, benzodiazepines (e.g., Valium), or other “downers.”

**Pharmacokinetics** refers to two kinds of interactions between drugs. Sometimes one drug causes your body to eliminate another drug faster than usual. This causes an effect similar to drug tolerance in which a person needs to use more and more of a substance to get the desired effect. In other instances one drug will cause your body to hold onto another drug for a longer time. This causes an effect similar to “reverse tolerance” in which a person needs to use less of a drug to get the desired effect.

The National Institutes of Health cite a literature review that scanned multiple sources for documented evidence of drug interactions involving marijuana, methamphetamine, ecstasy, N-methyl-3,4-methylenedioxymethamphetamine, heroin, and others. The authors concluded, “Although the use of illicit drugs is widespread, there are little experimental or clinical data regarding the effects of these agents on common prescription therapies” (Lindsey, Stewart, and Childress 2012; emphasis added).

Despite the lack of evidence about street drug–prescription drug interactions from controlled studies, many such interactions are commonly recognized in clinical practice. These include the following examples. Keep in mind that this information is provided to bring the issue of drug interactions to your attention. Do not advise a client to either increase or reduce their use of prescribed medications based on this information. Clients who receive prescribed medications and also use street drugs or alcohol should consult their prescribing physician for advice.
ALCOHOL–BENZODIAZEPINES

The central nervous system (CNS) effects of many benzodiazepines are potentiated by the effects of acute alcohol intoxication. However, prolonged alcohol use can lead to tolerance for benzodiazepines, thereby decreasing its intended effects. Some have observed that the cognitive side effects of benzodiazepines may be heightened in those who consume large amounts of alcohol over an extended period of time.

ALCOHOL–AMBIEN (prescribed for treatment of insomnia)
Alcohol may potentiate some of the effects of CNS-active agents such as Ambien. Combined use may result in increased CNS depression and impaired judgment, thinking, and psychomotor skills.

ANTIDEPRESSANTS
(Heterocyclic Amines (HCA) are heterocyclics such as Elavil, Anafranil, Sinequan, Tofranil, Pamelor, Vivactil)
Selective Serotonin Reuptake Inhibitor (SSRIs) are any of a class of antidepressants (as fluoxetine or sertraline) that inhibit the inactivation of serotonin by blocking its reuptake by presynaptic nerve cell endings and include Prozac, Paxil, Zoloft.
(Atypicals include Wellbutrin, Serzone, Trazodone/Desyrel, Effexor)
–ALCOHOL: causes CNS depression with HCAs and Trazodone but not with SSRIs
–BARTBITURATES: causes CNS depression, can decrease antidepressant plasma levels
–COCAINE: can cause cardiac arhythmias and increase blood pressure with HCAs

CANNABIS
Cannabis tends to cause drowsiness and, as such, can increase the effects of other drugs that cause drowsiness, such as sedatives, pain relievers, benzodiazepines, seizure medications, and muscle relaxants.

LITHIUM
–ALCOHOL: may increase serum lithium
  –CAFFEINE: increases lithium excretion and increases lithium tremor
  –CANNABIS: causes increased lithium absorption; the implications are unclear

PHENCYCLIDINE (PCP)
PCP’s sedative effects can interact with other CNS depressants, including alcohol and benzodiazepines, to cause coma or accidental overdose. Production of growth hormones in adolescents can also be affected.
Symptoms of Substance Use Disorder: DSM-5 Criteria

Note: SUD is often inaccurately diagnosed based on a person's frequency of use or volume used. The following are the actual DSM criteria for this diagnosis:

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

1. Substance often taken in larger amounts or over a longer period than was intended
2. Persistent desire or unsuccessful efforts to cut down or control substance use
3. Great deal of time 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
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 work, school, or home
6. Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance
7. Important social, occupational, or recreational activities given up or reduced because of substance use
8. Recurrent substance use in situations in which it is physically hazardous
9. Substance use 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)
10. Tolerance, as defined by either of the following:
   a. need for markedly increased amounts of the substance to achieve intoxication or desired effect
   b. markedly diminished effect with continued use of the same amount of the substance
11. Withdrawal, as manifested by either of the following:
   a. the characteristic withdrawal syndrome for the substance (refer to criteria A and B of the criteria sets for withdrawal from the specific substances)
   b. the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
ICD-10 CRITERIA FOR THE ALCOHOL DEPENDENCE SYNDROME

(ICD= International Classification of Disease)

Note that the AUDIT instrument is published by WHO and, as such, is geared to the ICD-10 concept of alcohol dependence. Those criteria are as follows (bolding added):

Three or more of the following manifestations should have occurred together for at least one month or, if persisting for periods of less than one month, should have occurred together repeatedly within a twelve-month period:

- A strong desire or sense of compulsion to consume alcohol
- Impaired capacity to control drinking in terms of its onset, termination, or levels of use, as evidenced by alcohol being often taken in larger amounts or over a longer period than intended or by a persistent desire to or unsuccessful efforts to reduce or control alcohol use
- A physiological withdrawal state when alcohol use is reduced or ceased, as evidenced by the characteristic withdrawal syndrome for alcohol or by use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms
- Evidence of tolerance to the effects of alcohol, such that there is a need for significantly increased amounts of alcohol to achieve intoxication or the desired effect, or a markedly diminished effect with continued use of the same amount of alcohol
- Preoccupation with alcohol, as manifested by important alternative pleasures or interests being given up or reduced because of drinking, or a great deal of time being spent in activities necessary to obtain, take, or recover from the effects of alcohol
- Persistent alcohol use despite clear evidence of harmful consequences, as evidenced by continued use when the individual is actually aware, or may be expected to be aware, of the nature and extent of harm
TABLE 1: Syndromes with Varied Symptoms, Depending on the Substance
- Intoxication
- Withdrawal

TABLE 2: Substance-Induced Syndromes with Standard Symptoms Across Substances
- Delirium
- Neurocognitive disorder
- Psychotic disorder
- Mood disorder
- Anxiety disorder
- Sexual dysfunction
- Sleep disorder
- Hallucinogen persisting perception disorder

TABLE 3: Differential Diagnosis
Distinguishing between substance-induced symptoms and symptoms of a primary mental disorder.

******************************************************************************

TABLE 1: INTOXICATION AND WITHDRAWAL SYMPTOMS

Only maladaptive effects are listed in this table. However, keep in mind that effects desirable to the substance user during intoxication might include:
- euphoria,
- relaxation,
- increased energy or alertness,
- sense of spiritual transcendence or dissociation,
- distraction from anxiety arousing circumstances,
- pain relief,
- heightened sensory experience or hallucinations, and/or
- enhanced sociability.
<table>
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<tr>
<th>SUBSTANCE</th>
<th>INTOXICATION</th>
<th>WITHDRAWAL</th>
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| ALCOHOL   | Behavioral or psychological changes:  
|           | • inappropriate sexual behavior  
|           | • inappropriate aggressive behavior  
|           | • mood lability  
|           | • impaired judgment  
|           | • impaired social or occupational function  
|           | Physical changes:  
|           | • slurred speech  
|           | • incoordination  
|           | • unsteady gait  
|           | • nystagmus (eye tremors)  
|           | • impaired attention or memory  
|           | • stupor or coma  |  
|           | Course: Usually peaks during the second day and improves markedly by fourth or fifth day; up to six months at lower levels of intensity  
|           | Symptoms include the following:  
|           | • autonomic hyperactivity  
|           | • increased hand tremor  
|           | • insomnia  
|           | • nausea or vomiting  
|           | • transient visual, tactile, or auditory hallucinations or illusions  
|           | • psychomotor agitation  
|           | • anxiety  
|           | • generalized tonic-clonic seizures  
<p>|           | • perceptual disturbance (“hallucinations” with intact reality testing or illusions) |</p>
<table>
<thead>
<tr>
<th>SUBSTANCE</th>
<th>INTOXICATION</th>
<th>WITHDRAWAL</th>
</tr>
</thead>
</table>
| AMPHETAMINE S AND COCAINE (STIMULANT) | Behavioral or psychological changes:  
- euphoria or affective blunting  
- Changes in sociability  
- hypervigilance  
- interpersonal sensitivity  
- anxiety  
- tension  
- anger  
- stereotyped behaviors  
- impaired judgment  
- perceptual disturbances (hallucinations or illusions with intact reality testing)  
Physical changes:  
- tachycardia (fast heartbeat) or bradycardia (slow heartbeat)  
- pupillary dilation  
- elevated or lowered blood pressure  
- perspiration or chills  
- nausea or vomiting  
- evidence of weight loss  
- psychomotor agitation or retardation  
- muscular weakness, respiratory depression  
- chest pain or arrhythmias  
- confusion, seizures, dyskinesias  
- dystonias or coma |  
- Dysphoric mood and:  
- fatigue;  
- vivid, unpleasant dreams;  
- insomnia or hypersomnia;  
- increased appetite;  
and/or  
- psychomotor retardation or agitation. |
### TABLE 1: INTOXICATION AND WITHDRAWAL SYMPTOMS (3 OF 6)

<table>
<thead>
<tr>
<th>SUBSTANCE</th>
<th>INTOXICATION</th>
<th>WITHDRAWAL</th>
</tr>
</thead>
</table>
| **CAFFEINE** | Behavioral or psychological changes:  
• restlessness  
• nervousness  
• excitement  
• insomnia  
• rambling flow of thought and speech  
• periods of inexhaustibility  
• psychomotor agitation  
Physical changes:  
• flushed face  
• diuresis  
• gastrointestinal disturbance  
• muscle twitching  
• tachycardia or cardiac arrhythmia | Behavioral or psychological changes:  
• difficulty concentrating  
Physical changes:  
• headache  
• marked fatigue or drowsiness  
• dysphoric mood (depressed or irritable)  
• flu-like symptoms (nausea, vomiting, muscle pain or stiffness) |
| **CANNABIS** | Behavioral or psychological changes:  
• impaired motor coordination  
• euphoria  
• anxiety  
• sensation of slowed time  
• impaired judgment  
• social withdrawal  
• perceptual disturbances (hallucinations with intact reality testing)  
Physical changes:  
• conjunctival injection (bloodshot eyes)  
• increased appetite  
• dry mouth  
• tachycardia (rapid heartbeat) | Behavioral or psychological changes:  
• irritability, anger, aggression  
• nervousness or anxiety  
• sleep difficulty (insomnia, disturbing dreams)  
• restlessness  
• depressed mood  
Physical changes:  
• decreased appetite or weight loss  
• abdominal pain  
• shakiness or tremors  
• sweating  
• fever  
• chills  
• headache |
<table>
<thead>
<tr>
<th>SUBSTANCE</th>
<th>INTOXICATION</th>
<th>WITHDRAWAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>HALLUCINOGENS</td>
<td>Behavioral or psychological changes:</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>• marked anxiety</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• marked depression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• ideas of reference</td>
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</tr>
<tr>
<td></td>
<td>• fear of “losing one’s mind”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• paranoid ideation</td>
<td></td>
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<tr>
<td></td>
<td>• impaired judgment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• perceptual changes occurring during full wakefulness and alertness</td>
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</tr>
<tr>
<td></td>
<td>• depersonalization or de-realization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• illusions</td>
<td></td>
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<tr>
<td></td>
<td>• hallucinations</td>
<td></td>
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<tr>
<td></td>
<td>• synesthesia</td>
<td></td>
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<td></td>
<td>Physical changes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• pupillary dilation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• tachycardia (rapid heartbeat)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• sweating</td>
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<tr>
<td></td>
<td>• heart palpitations</td>
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<tr>
<td></td>
<td>• blurring of vision</td>
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<tr>
<td></td>
<td>• tremors</td>
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<tr>
<td></td>
<td>• incoordination</td>
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<tr>
<td>INHALANTS</td>
<td>Behavioral or psychological changes:</td>
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</tr>
<tr>
<td></td>
<td>• belligerence</td>
<td></td>
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<tr>
<td></td>
<td>• assaultiveness</td>
<td></td>
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<tr>
<td></td>
<td>• apathy</td>
<td></td>
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<tr>
<td></td>
<td>• impaired judgment</td>
<td></td>
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<tr>
<td></td>
<td>Physical changes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• dizziness</td>
<td></td>
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<tr>
<td></td>
<td>• nystagmus (eye tremors)</td>
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<td></td>
<td>• incoordination</td>
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<tr>
<td></td>
<td>• slurred speech</td>
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<tr>
<td></td>
<td>• unsteady gait</td>
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<tr>
<td></td>
<td>• lethargy</td>
<td></td>
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<tr>
<td></td>
<td>• depressed reflexes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• psychomotor retardation</td>
<td></td>
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<tr>
<td></td>
<td>• tremor</td>
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<tr>
<td></td>
<td>• generalized muscle weakness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• blurred vision</td>
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<tr>
<td></td>
<td>• diplopia (double vision)</td>
<td></td>
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<tr>
<td></td>
<td>• stupor or coma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• euphoria</td>
<td></td>
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</tbody>
</table>
### TABLE 1: INTOXICATION AND WITHDRAWAL SYMPTOMS (5 OF 6)

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<tr>
<th>SUBSTANCE</th>
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<th>WITHDRAWAL</th>
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<tbody>
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<td>NICOTINE</td>
<td>N/A</td>
<td>Behavioral or psychological changes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- dysphoric or depressed mood</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- insomnia</td>
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<tr>
<td></td>
<td></td>
<td>- irritability, frustration, or anger</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- anxiety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- difficulty concentrating</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- restlessness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- increased appetite or weight gain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physical changes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- decreased heart rate</td>
</tr>
<tr>
<td>OPIATES</td>
<td>Behavioral or psychological changes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- initial euphoria followed by apathy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- dysphoria</td>
<td></td>
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<tr>
<td></td>
<td>- psychomotor agitation or retardation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- impaired judgment</td>
<td></td>
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<tr>
<td></td>
<td>- perceptual disturbances (hallucinations with intact reality testing)</td>
<td></td>
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<tr>
<td></td>
<td>Physical changes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- pupillary constriction or dilation</td>
<td></td>
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<tr>
<td></td>
<td>- drowsiness or coma</td>
<td></td>
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<tr>
<td></td>
<td>- slurred speech</td>
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<tr>
<td></td>
<td>- impairment in attention or memory</td>
<td></td>
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<tr>
<td></td>
<td>Behavioral or psychological changes:</td>
<td></td>
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<tr>
<td></td>
<td>- dysphoric mood</td>
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<td></td>
<td>- insomnia</td>
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<tr>
<td></td>
<td>Physical changes:</td>
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<tr>
<td></td>
<td>- nausea or vomiting</td>
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<td></td>
<td>- muscle aches</td>
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<tr>
<td></td>
<td>- lacrimation (tears) or rhinorrhea (nasal mucous)</td>
<td></td>
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<td></td>
<td>- pupillary dilation</td>
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<td></td>
<td>- piloerection (goose bumps)</td>
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<tr>
<td></td>
<td>- sweating</td>
<td></td>
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<tr>
<td></td>
<td>- diarrhea</td>
<td></td>
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<tr>
<td></td>
<td>- yawning</td>
<td></td>
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<tr>
<td></td>
<td>- fever</td>
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</tr>
<tr>
<td>SUBSTANCE</td>
<td>INTOXICATION</td>
<td>WITHDRAWAL</td>
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<tr>
<td>---------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>PCP (PHENCYCLIDINE)</strong></td>
<td>Behavioral or psychological changes:</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>• belligerence</td>
<td></td>
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<tr>
<td></td>
<td>• assaultiveness</td>
<td></td>
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<td></td>
<td>• impulsiveness</td>
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<tr>
<td></td>
<td>• unpredictability</td>
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<tr>
<td></td>
<td>• psychomotor agitation</td>
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<td></td>
<td>• impaired judgment</td>
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<tr>
<td></td>
<td>• impaired social or occupational function</td>
<td></td>
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<td></td>
<td>Physical changes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• nystagmus (eye tremors)</td>
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<tr>
<td></td>
<td>• hypertension</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• tachycardia (rapid heartbeat)</td>
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<tr>
<td></td>
<td>• numbness</td>
<td></td>
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<tr>
<td></td>
<td>• diminished response to pain</td>
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<tr>
<td></td>
<td>• ataxia (impaired coordination)</td>
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<tr>
<td></td>
<td>• dysarthria (speech difficulty due to weak facial muscles)</td>
<td></td>
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<td></td>
<td>• muscle rigidity</td>
<td></td>
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<tr>
<td></td>
<td>• seizures or coma</td>
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<tr>
<td></td>
<td>• hyperacusis (sounds heard louder)</td>
<td></td>
</tr>
<tr>
<td><strong>SEDATIVES, HYPNOTICS, ANXIOLYTICS</strong></td>
<td>Behavioral or psychological changes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• inappropriate sexual behavior</td>
<td></td>
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<tr>
<td></td>
<td>• inappropriate aggressive behavior</td>
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<tr>
<td></td>
<td>• mood lability</td>
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<td></td>
<td>• impaired judgment</td>
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<td></td>
<td>Physical changes:</td>
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<td></td>
<td>• slurred speech</td>
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<td></td>
<td>• incoordination</td>
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<td></td>
<td>• unsteady gait</td>
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<tr>
<td></td>
<td>• nystagmus (eye tremors)</td>
<td></td>
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<tr>
<td></td>
<td>• impairment in cognition, attention, or memory</td>
<td></td>
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<tr>
<td></td>
<td>• stupor or coma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Behavioral or psychological changes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• insomnia</td>
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<tr>
<td></td>
<td>• transient visual, tactile, or auditory hallucinations or illusions</td>
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<tr>
<td></td>
<td>• psychomotor agitation</td>
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</tr>
<tr>
<td></td>
<td>• anxiety</td>
<td></td>
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<tr>
<td></td>
<td>Physical changes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• autonomic hyperactivity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• increased hand tremor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• nausea or vomiting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• grand mal seizures</td>
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</tr>
</tbody>
</table>
## TABLE 2: Substance-Induced Syndromes with Standard Symptoms Across Substances

### CORE CRITERIA FOR SUBSTANCE-INDUCED SYNDROMES

Diagnose when:
(a) the substance in question can produce the symptoms by its chemical effects,
(b) symptoms are substantially more than those usually associated with intoxication or withdrawal and severity warrants independent clinical attention,
(c) timing of symptom onset is closely related to substance intoxication or onset of abstinence (usually persisting for no more than a month following abstinence),
(d) symptoms are not better accounted for by another non-substance-related condition,
(e) symptoms do not occur exclusively during delirium (except for substance-induced delirium), and
(f) symptoms cause clinically significant distress and/or impairment in functioning.

### Table 2 Substance-Induced Syndromes with Standard Symptoms Across Substances

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>INTOXICATION</th>
<th>WITHDRAWAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DELIRIUM</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Disturbance in attention (reduced ability to direct, focus, sustain, shift attention) and awareness (reduced orientation to the environment)</td>
<td>alcohol&lt;br&gt;cannabis&lt;br&gt;cocaine&lt;br&gt;hallucinogens&lt;br&gt;inhalants&lt;br&gt;opioids&lt;br&gt;phencyclidine&lt;br&gt;sedatives&lt;br&gt;stimulants</td>
<td>alcohol&lt;br&gt;opioids&lt;br&gt;sedatives&lt;br&gt;hypnotics&lt;br&gt;anxiolytics</td>
</tr>
<tr>
<td>B. Developed over short period (hours to days) and tending to fluctuate over course of the day</td>
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<tr>
<td>C. Change in cognition (e.g., memory deficit, disorientation, language, visuospatial ability, or perception)</td>
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</tr>
<tr>
<td>D. Symptoms not better explained by another neurocognitive disorder or severely reduced level of arousal (e.g., coma)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| NEUROCOGNITIVE DISORDER (NCD) | | |
| A. Criteria are met for an NCD: | alcohol<br>inhalants<br>sedatives<br>hypnotics<br>anxiolytics | N/A |
| • significant cognitive decline (complex attention, executive function, learning and memory, language, perceptual, motor, or social cognition) | | |
| B. Core criteria for substance-induced disorders are met. | | |
Table 2 Substance-Induced Syndromes with Standard Symptoms Across Substances
(2 of 4)

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>INTOXICATION</th>
<th>WITHDRAWAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PSYCHOTIC DISORDER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Hallucinations and/or delusions.</td>
<td>alcohol amphetamines</td>
<td>alcohol sedatives</td>
</tr>
<tr>
<td>B. Core criteria for substance-induced disorders are met.</td>
<td>cannabis meperidine</td>
<td>hypnotics anxiolytics</td>
</tr>
<tr>
<td></td>
<td>cocaine phencyclidine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>hallucinogens inhalants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>opioids meperidine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>phencyclidine sedatives</td>
<td></td>
</tr>
<tr>
<td></td>
<td>hypnotics anxiolytics</td>
<td></td>
</tr>
<tr>
<td><strong>MOOD DISORDER (DEPRESSION, BIPOLAR)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Prominent, persistent mood disturbance predominates and is characterized by:</td>
<td>alcohol amphetamines</td>
<td>alcohol amphetamines</td>
</tr>
<tr>
<td>1. Depressed mood or anhedonia, or</td>
<td>cocaine hallucinogens</td>
<td>cocaine</td>
</tr>
<tr>
<td>2. Elevated, expansive, or irritable mood.</td>
<td>inhalants opioids</td>
<td>sedatives</td>
</tr>
<tr>
<td>B. Core criteria for substance-induced disorders are met.</td>
<td>meperidine phencyclidine</td>
<td>hypnotics anxiolytics</td>
</tr>
<tr>
<td></td>
<td>sedatives</td>
<td></td>
</tr>
<tr>
<td></td>
<td>hypnotics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>anxiolytics</td>
<td></td>
</tr>
<tr>
<td><strong>ANXIETY DISORDER</strong></td>
<td>alcohol amphetamines caffeine</td>
<td>alcohol sedatives</td>
</tr>
<tr>
<td></td>
<td>cannabis cocaine</td>
<td>hypnotics anxiolytics</td>
</tr>
<tr>
<td></td>
<td>hallucinogens</td>
<td></td>
</tr>
<tr>
<td></td>
<td>inhalants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>phencyclidine</td>
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Table 2 Substance-Induced Syndromes with Standard Symptoms Across Substances
(3 of 4)

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>INTOXICATION</th>
<th>WITHDRAWAL</th>
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<tbody>
<tr>
<td><strong>MOOD DISORDER (DEPRESSION, BIPOLAR)</strong></td>
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<td>cocaine</td>
</tr>
<tr>
<td>2. Elevated, expansive, or irritable mood.</td>
<td>inhalants opioids</td>
<td>sedatives</td>
</tr>
<tr>
<td>B. Core criteria for substance-induced disorders are met.</td>
<td>meperidine phencyclidine</td>
<td>hypnotics anxiolytics</td>
</tr>
<tr>
<td></td>
<td>sedatives</td>
<td></td>
</tr>
<tr>
<td></td>
<td>hypnotics</td>
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<tr>
<td></td>
<td>anxiolytics</td>
<td></td>
</tr>
<tr>
<td><strong>ANXIETY DISORDER</strong></td>
<td>alcohol amphetamines caffeine</td>
<td>alcohol sedatives</td>
</tr>
<tr>
<td></td>
<td>cannabis cocaine</td>
<td>hypnotics anxiolytics</td>
</tr>
<tr>
<td></td>
<td>hallucinogens</td>
<td></td>
</tr>
<tr>
<td></td>
<td>inhalants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>phencyclidine</td>
<td></td>
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</table>

LPS Clinical Assessment Guidelines: Addressing Substance Use Disorder/Involuntary Detention  35
### Table 2 Substance-Induced Syndromes with Standard Symptoms Across Substances (4 of 4)

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>INTOXICATION</th>
<th>WITHDRAWAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SEXUAL DYSFUNCTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Clinically significant sexual dysfunction resulting in marked distress or interpersonal difficulty predominates in the clinical picture.</td>
<td>alcohol amphetamines cocaine opioids sedatives hypnotics anxiolytics</td>
<td>hypnotics anxiolytics</td>
</tr>
<tr>
<td>B. Evidence that the symptoms developed during or within a month of intoxication or withdrawal or is caused by medications.</td>
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</tr>
<tr>
<td>C. Not better accounted for by another sexual dysfunction. Specify if with: impaired desire, impaired arousal, impaired orgasm, sexual pain.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Core criteria for substance-induced disorders are met.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SLEEP DISORDER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Prominent sleep disturbance severe enough to warrant independent clinical attention.</td>
<td>alcohol amphetamines caffeine cocaine opioids hypnotics anxiolytics</td>
<td>sedatives hypnotics anxiolytics</td>
</tr>
<tr>
<td>F. Evidence that the symptoms developed during or within a month of intoxication or withdrawal or is caused by medications.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Core criteria for substance-induced disorders are met.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PHANTOM PERCEPTION DISORDER

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>INTOXICATION</th>
<th>WITHDRAWAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HALLUCINOGEN PERSISTING PERCEPTION DISORDER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Re-experiencing one or more perceptual symptoms that were experienced during hallucinogen intoxication (e.g., geometric hallucinations, false perceptions of movement in the peripheral visual fields, flashes of color, intensified colors, trails of images of moving objects, positive afterimages, halos around objects, macropsia, and micropsia).</td>
<td>hallucinogens</td>
<td>N/A</td>
</tr>
<tr>
<td>B. Core criteria for substance-induced disorders are met.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TABLE 3: DIFFERENTIAL DIAGNOSIS**

The following are indicators that are useful in the differential diagnosis of substance-induced syndromes and primary mental disorders. Usually, the diagnosis should be based on a combination of indicators rather than the presence of any single indicator.

TABLE 3: DIFFERENTIAL DIAGNOSIS** (1 of 3)

<table>
<thead>
<tr>
<th>SUBSTANCE-INDUCED PSYCHOSIS**</th>
<th>PRIMARY PSYCHOTIC DISORDERS**</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Psychotic symptoms were not present prior to substance use</td>
<td>• Psychotic symptoms may have been present before substance use</td>
</tr>
<tr>
<td>• The psychotic symptoms are typical for the substance used (see Table 1)</td>
<td>• Prior to onset of psychotic symptoms substances were used for substantial period of time without these symptoms</td>
</tr>
<tr>
<td>• Psychotic symptoms don’t persist when not intoxicated or in withdrawal except following amphetamine or hallucinogen use</td>
<td>• The psychotic symptoms are atypical for the substance used (see Table 1)</td>
</tr>
<tr>
<td>• No prodromal or residual symptoms</td>
<td>• Psychotic symptoms persist when not intoxicated or in withdrawal</td>
</tr>
<tr>
<td>• Delusions or hallucinations without disorganized thought and speech</td>
<td>• Often associated with prodromal/residual symptoms before/after the active phase</td>
</tr>
<tr>
<td>• May involve tactile, gustatory, olfactory, or kinesthetic hallucinations as well as auditory or visual hallucinations</td>
<td>• Disorganized thought and speech in addition to delusions or hallucinations</td>
</tr>
<tr>
<td>• Hallucinations may involve synesthesias (e.g., seeing a sound), geometric forms, trailing images, flashes of color, afterimages, halo effects, or seeing things larger or smaller than they are</td>
<td>• Primarily auditory and visual hallucinations</td>
</tr>
<tr>
<td>• Delusions more likely non-bizarre</td>
<td>• Not usually tactile, gustatory, olfactory, or kinesthetic hallucinations</td>
</tr>
<tr>
<td>• May realize that hallucinations are result of substance use (known as “perceptual disturbance”; not a true hallucination)</td>
<td>• Hallucinations may involve two voices conversing or a voice maintaining a running commentary on the person’s thoughts, feelings, and/or behaviors</td>
</tr>
<tr>
<td>• Content of hallucinations or delusions occurring after intoxication/withdrawal are flashbacks of the same symptoms that occurred during intoxication and or withdrawal</td>
<td>• Bizarre or nonbizarre delusions</td>
</tr>
<tr>
<td></td>
<td>• May eventually learn to realize hallucinations are result of mental illness</td>
</tr>
<tr>
<td></td>
<td>• Content of hallucinations or delusions occurring after intoxication/withdrawal are different than hallucinations or delusions that have previously occurred during intoxication/withdrawal</td>
</tr>
</tbody>
</table>
### TABLE 3: DIFFERENTIAL DIAGNOSIS** (2 of 3)

<table>
<thead>
<tr>
<th>SUBSTANCE-INDUCED SYMPTOMS**</th>
<th>PRIMARY MENTAL DISORDER SYMPTOMS**</th>
</tr>
</thead>
</table>
| • Presence of substance-induced symptoms specific to the substance being used (see Table 1)  
  • Presence of symptoms that are atypical for a specific primary mental disorder  
  • Symptoms in full remission after four or more weeks of abstinence | • Absence of substance-induced physical symptoms (see Table 1)  
  • Presence of symptoms that are atypical for the substance being used (see Table 1)  
  • Symptoms still present after four or more weeks of abstinence |
<table>
<thead>
<tr>
<th><strong>SUBSTANCE-INDUCED SYMPTOMS</strong></th>
<th><strong>TRAUMATIC BRAIN INJURY</strong></th>
</tr>
</thead>
</table>
| • Presence of symptoms specific to the substance being used (see Table 1)  
  • Absence of symptoms specific to the affected part of the brain (physician consultation indicated) | • Presence of symptoms atypical for the substance being used (see Table 1)  
  • Presence of symptoms typical for the affected part of the brain (physician consultation indicated)  
  • Physical symptoms with postinjury onset such as headaches, difficulty speaking, sensory impairments, dizziness, or trouble with balance |
<table>
<thead>
<tr>
<th><strong>SUBSTANCE-INDUCED SYMPTOMS</strong></th>
<th><strong>CRISIS REACTION</strong></th>
</tr>
</thead>
</table>
| • Presence of symptoms specific to the substance being used (see Table 1)  
  • Substance-specific symptoms were present before the stressful event | • Presence of symptoms atypical for the substance being used (see Table 1)  
  • Symptoms appear within three months of a stressful event  
  • Symptoms were not present before the stressful event, but substances were used before the stressful event  
  • Feelings of shame, self-blame, guilt for causing or failing to manage the stressful event  
  • Postcrisis symptoms go into remission within six months of the stressful event, even though substances are still used |
TABLE 3: DIFFERENTIAL DIAGNOSIS** (3 of 3)

<table>
<thead>
<tr>
<th>SUBSTANCE-INDUCED MANIC SYMPTOMS**</th>
<th>MANIC EPISODE**</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Manic symptoms are typical for the substance used (see Table 1)</td>
<td>• Manic symptoms present before substance use began</td>
</tr>
<tr>
<td>• Manic symptoms were not present prior to substance use</td>
<td>• Manic symptoms are atypical for the substance being used (see Table 1)</td>
</tr>
<tr>
<td>• Manic symptoms only occur during intoxication or withdrawal</td>
<td>• Manic symptoms present when not intoxicated or withdrawing from a substance that can cause manic symptoms</td>
</tr>
<tr>
<td>• Manic symptoms have not been episodic</td>
<td>• Manic symptoms have been episodic, even when substance use has been continuous</td>
</tr>
<tr>
<td>• Manic episodes do not alternate with depressive episodes</td>
<td>• Manic episodes alternate with depressive episodes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUBSTANCE-INDUCED ONLY **</th>
<th>PRIMARY MENTAL DISORDER ONLY **</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Presence of substance-induced symptoms specific to the substance being used (see Table 1)</td>
<td>• Absence of substance-induced physical symptoms (see Table 1)</td>
</tr>
<tr>
<td>• Presence of symptoms that are atypical for a specific primary mental disorder</td>
<td>• Absence of symptoms that are atypical for a primary mental disorder</td>
</tr>
<tr>
<td>• All symptoms in full remission after four or more weeks of abstinence</td>
<td>• Symptoms still present after four or more weeks of abstinence</td>
</tr>
<tr>
<td>• Absence of symptoms atypical for the substance being used (see Table 1)</td>
<td>• No symptoms have gone into remission within four or more weeks following abstinence</td>
</tr>
</tbody>
</table>

**"In an emergency department setting, it may be possible to identify only the most prominent symptom expressions associated with a chapter—for example, delusions, hallucinations, mania, depression, anxiety, substance intoxication, or neurocognitive symptoms—so that an ‘unspecified’ disorder in that category is identified until a fuller differential diagnosis is possible” (DSM-5 [Publication Year], 19–20). In the DSM-IV this principle was expressed in relation to not otherwise specified (NOS) diagnoses: “If the clinician is unable to determine whether the presenting symptoms are substance induced, due to a general medical condition, or primary, the appropriate not otherwise specified category should be diagnosed (e.g., psychotic symptoms with indeterminate etiology would be diagnosed as psychotic disorder NOS)” (DSM IV TR [Publication Year], 209).

When the need to use this rule applies be sure to document the reason for the use of the “unspecified” (formerly “NOS”) diagnosis, explaining why it was not possible to determine the cause of the symptoms using criteria such as those provided in this module.
This section provides an array of effective interview methodologies to assess for substance use.

Before Raising the Issue of screening and assessment, it is highly suggested that the provider completed the following steps.

I. **RESOLVE BIASES:** Develop self-awareness of any issues that might affect your ability to be neutral (nonjudgmental) about your client's substance use. What do you like and dislike about the substances you use? How do you feel about substance use by others?

II. **OVERCOME NAÏVETÉ:** Become familiar with substance use and abuse as well as common patterns of denial and minimization.

III. **ENGAGE:** Engage the client in a therapeutic alliance or working relationship in which you demonstrate empathic understanding, warmth, and acceptance of the client, and the client comes to see you as a trustworthy, competent, and authoritative service provider.

IV. **CONFIDENTIALITY:** Be sure your client understands applicable confidentiality and privileged communication protections.

V. **PRIMACY OF CLIENT’S INTERESTS:** If the client is mandated or coerced by others to meet with you, be clear that your commitment is to the client and not to the referring party.

Raising the Issue:

VI. **CLARIFICATIONS:** Be clear about what you mean by “substances.” Give a variety of examples that are not limited to illegal “street drugs.”

VII. **SELF-DETERMINATION:** Be clear that you understand and accept the client’s right and ability to either use substances or abstain from substance use.

VIII. **RELATE THE ISSUE TO CLIENT’S PURPOSE AND GOALS:** Be clear about the ways that you and the client need this information to effectively collaborate in achieving his or her goals and purposes in seeking help.

IX. **ADDRESS ALL EFFECTS, GOOD AND BAD:** Demonstrate an interest in all effects of the substances used by the client—both positive and negative—on the client’s own purposes and goals.

X. **ELABORATE:** Ask a variety of questions and follow-up questions. The more information you gather, the easier it will be to confront an unreliable reporter with discrepancies as they arise in the client's “story.” Ask about substance use by family members and friends. Ask how the client reacts to others who offer substances and encourage the client to use them.

XI. **VICARIOUS DEMONSTRATIONS OF COMPETENCE:** Demonstrate your acceptance, respect for self-determination, openness to both positive and negative effects of substance use, etc. by commenting on the substance use of the clients’ significant others.
XII. SHOW SURPRISE: Express surprise when the client presents information that is surprising. For example, “I’ve never used any substances,” or “I don’t know anyone who uses substances.” The ability to do this effectively is influenced by item II above.
Upon admission to a psychiatric emergency or inpatient service, the primary assessment issue is to determine whether an involuntarily detained individual is currently intoxicated and, if so, to identify the intoxicating substance and the client’s blood levels for that substance. Not all individuals with high blood levels of an intoxicating substance have an ongoing SUD, but for those who do, it is this psychosocial condition, not the admission blood levels, that is most relevant to both treatment planning and discharge planning.

The ability to address these issues with involuntarily detained individuals is greatly facilitated in the case of individuals with an outpatient history if the SUD has been assessed and diagnosed prior to the involuntary hold. In such cases:

- the outpatient clinical record will provide emergency and inpatient staff with information about substances used and the individual's pattern of substance use.
- the client will have had experience discussing the substance use with behavioral health staff, thereby decreasing the felt need for guardedness.
- the client's strengths with regard to harm reduction and recovery from the SUD will have been identified more thoroughly than the extent of revelation possible during most brief involuntary holds.

Screening, Brief Intervention, Referral To Treatment (SBIRT)

SBIRT (Screening, Brief Intervention, and Referral to Treatment) is SAMHSA’s model for a “comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders.” It is a public health model designed primarily for use by primary care providers, hospital emergency rooms, trauma centers, and other community settings that commonly encounter substance-abusing individuals.

In this model, the term “screening” refers to a quick assessment of the severity of substance use and identifying an appropriate level of treatment based on these screening findings. A major goal of SBIRT is to achieve universal screening of all healthcare patients, regardless of whether the patient presents substance use or abuse as a problem.

The “brief intervention” component focuses on increasing insight, awareness, and motivation toward behavioral change, much in the manner done by motivational interviewing with individuals at the precontemplation and contemplation levels of recovery.

The “referral to treatment” component provides access to specialty care for those in need of more extensive treatment. From the perspective of this public health model, it appears that all behavioral healthcare services, not only alcohol and drug specialty providers, are viewed as potentially appropriate sources of treatment services.
SAMHSA describes the purpose of its SBIRT program as follows:

SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

Screening in an SBIRT Program
A major goal of SBIRT is to achieve universal screening of all healthcare patients, regardless of whether the patient presents substance use or abuse as a problem.

Some commonly used screens for the implementation of SBIRT for alcohol and drug use include the following:

- AUDIT (Alcohol Use Disorders Identification Test)
- DAST (Drug Abuse Screening Test)
- ASSIST (Alcohol, Smoking, Substance Involvement, Screening Test)
- CAGE (Cut Down, Annoyed, Guilty, Eye-Opener)

Although prescreening is not a core, required aspect of SBIRT, it is frequently used. The following are examples of validated prescreens:

- AUDIT-C (a three-item short form of AUDIT)
- NIAAA(( National Institute on Alcohol Abuse and Alcoholism) prescreening question (“On any single occasion during the past three months, have you had more than five drinks containing alcohol?”)

Brief Intervention

Brief intervention is used in an SBIRT program to educate patients about the effects of substance abuse and the consequences of avoiding treatment and to increase motivation to reduce risky behavior. Brief intervention as defined by the SAMHSA SBIRT program involves one to five sessions lasting five minutes to an hour. Brief intervention is provided to those whose screening score indicates a moderate risk. Among
SBIRT grantees funded by SAMHSA, about 15% of patients receive scores that indicate a brief intervention should be implemented.

Referral to Brief Treatment

Brief treatment as part of SBIRT involves five to twelve sessions, each lasting up to an hour. Referral to treatment is provided to those whose screening score indicates a moderate to high risk. The SBIRT program also recommends referral for those who meet the diagnostic criteria for substance dependence or other DSM mental disorders. Among state SBIRT grantees funded by SAMHSA, about 3% of patients receive a score that dictates a brief treatment. Referral to intensive, long-term specialty treatment is provided to those whose screening score indicates a severe risk or dependency.

Referral to treatment involves coordination across various types of services. The referring party needs to have linkages to treatment resources. SAMHSA requires SBIRT grantees to have a comprehensive system of referral and follow-up.

Effectiveness of the SBIRT Approach

There is substantial research on the effectiveness of SBIRT in reducing risky alcohol consumption. However, the evidence for the effectiveness of SBIRT in reducing risky drug use, although promising, is still accumulating. The results for the SAMHSA model of SBIRT for drug misuse are inconsistent depending on the characteristics of the provider, the specific setting, and the patient population that is targeted for SBIRT implementation. While there is robust evidence for screening and referral for depression in primary care, to date, little empirical evidence for the use of comprehensive SBIRT-like models for mental health problems commonly reported by healthcare patients. There is also no research that has demonstrated the implementation or effectiveness of SBIRT-like models in addressing trauma or anxiety disorders in clinical health settings.
Substance-Related Screening and Assessment Frameworks

Two-Item Conjoint Screen (TICS) for Alcohol and Other Drug Problems (Brown et al 2001)

1. In the last year, have you ever drunk or used drugs more than you meant to?
2. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

**Scoring and Validation:** At least one positive response detected current substance use disorders with nearly 80% sensitivity and specificity in persons age 18–59.

CAGE-AID (Cut Down-Annoyed-Guilty- Eye Opener) – CAGE Adapted to Include Drugs- Questionnaire (Brown et al 1995)

C: Have you ever felt you ought to **cut down** on your drinking or drug use?
A: Have people **annoyed** you by criticizing your drinking or drug use?
G: Have you ever felt bad or **guilty** about your drinking or drug use?
E: Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (**eye opener**)?

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

CRAFFT (Car, Relax, Alone, Forget, Family, Friends, Trouble) (for Adolescents)

The CRAFFT is a validated screening tool designed specifically for use with adolescents ages 11–17. It consists of six questions to be answered “yes” or “no.”

1. Have you ever ridden in a **Car** driven by someone (including yourself) who was high or had been using alcohol or drugs?
2. Do you ever use alcohol or drugs to **Relax**, feel better about yourself or fit in?
3. Do you ever use alcohol or drugs while you are **Alone**?
4. Do you ever **Forget** things you did while using alcohol or drugs?
5. Do your **Family** or **Friends** ever tell you that you should cut down on your drinking or drug use?
6. Have you ever gotten into **Trouble** while you were using alcohol or drugs?

**Scoring:** Two or more “yes” answers indicate the need for further assessment consisting of a brief “motivational conversation” to determine if specialized treatment is needed.
Simple Screening Instrument for Substance Abuse (SSI-SA)

Note: Questions 1, 2, 3, and 16 constitute a short version of the screening instrument that can be administered in situations that are not conducive to administering the entire test. Such situations may occur because of time limitations or other conditions.

Introductory statement:
“I’m going to ask you a few questions about your use of alcohol and other drugs during the past six months. Your answers will be kept private. Based on your answers to these questions, we may advise you to get a more complete assessment. This would be voluntary—it would be your choice whether to have an additional assessment or not.”

During the past six months:
1. Have you used alcohol or other drugs (such as wine, beer, hard liquor, pot, coke, heroin or other opioids, uppers, downers, hallucinogens, or inhalants)? Yes / No
2. Have you felt that you use too much alcohol or other drugs? Yes / No
3. Have you tried to cut down or quit drinking or using drugs? Yes / No
4. Have you gone to anyone for help because of your drinking or drug use (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program)? Yes / No
5. Have you experienced any of the following? Yes / No
   • blackouts or other periods of memory loss
   • injury to your head after drinking or using drugs
   • convulsions or delirium tremens (DTs)
   • hepatitis or other liver problems
   • feeling sick, shaky, or depressed when you stopped drinking or using drugs
   • feeling “coke bugs,” or a crawling feeling under the skin, after you stopped using drugs
   • injury after drinking or using drugs
   • using needles to shoot drugs

6. Has drinking or other drug use caused problems between you and your family or friends? Yes / No
7. Has your drinking or other drug use caused problems at school or at work? Yes / No
8. Have you been arrested or had other legal problems (such as bouncing bad checks, driving while intoxicated, theft, or drug possession)? Yes / No
9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? Yes / No
10. Are you needing to drink or use drugs more and more to get the effect you want? Yes / No
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? Yes / No
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone you wouldn't normally have unprotected sex with? Yes / No
13. Do you feel bad or guilty about your drinking or drug use? Yes / No

Now I have some questions that are not limited to the past six months:
14. Have you ever had a drinking or other drug problem? Yes / No
15. Have any of your family members ever had a drinking or drug problem? Yes / No
16. Do you feel that you have a drinking or drug problem now? Yes / No

Closing statement:
“Thanks for answering these questions. Do you have any questions for me? Is there something I can do to help you?”

Observation Checklist
The following signs and symptoms may indicate a substance abuse problem in the individual being screened.

- needle track marks
- skin abscesses, cigarette burns, or nicotine stains
- tremors (shaking and twitching of hands and eyelids)
- unclear speech: slurred, incoherent, or too rapid
- unsteady gait: staggering, off balance
- dilated (enlarged) or constricted (pinpoint) pupils
- scratching
- swollen hands or feet
- smell of alcohol or marijuana on breath
- drug paraphernalia such as pipes, paper, needles, or roach clip
- “nodding out” (dozing or falling asleep)
- agitation
- inability to focus
- burns on the inside of the lips (from freebasing cocaine)

**Scoring for the SSI-SA:** Score 1 point for every question answered “yes” except that items 1 and 15 are not scored.

0–1: None to low risk
2–3: Minimal risk
4+: Moderate to high risk; possible need for further assessment

National Institute on Alcohol Abuse and Alcoholism (NIAAA) Screening Tool (NIAAA 2005)

Prescreen:
Do you sometimes drink alcoholic beverages?

- If response is no, the screening is complete.
- If response is yes, ask single question.

Screening:
1. How many times in the past year have you had:
   - For men: five or more drinks in a day?
   - For women: four or more drinks in a day?

If response is zero times, the screening is complete.
If response is one or more times, ask two questions about weekly use.

2. On average, how many days a week do you have an alcoholic beverage?
3. On a typical drinking day, how many drinks do you have?

If the responses for weekly use fall within the NIAAA standards, the screening is complete.
If the responses for weekly use fall outside the NIAAA standards, assess for an alcohol use disorder.

At-risk drinking is defined as the following:
- For healthy men up to age 65:
  - more than four standard drinks a day AND
  - more than fourteen standard drinks a week
- For healthy women and healthy men over age 65:
  - more than three standard drinks a day AND
  - more than seven standard drinks a week


TWEAK and T-ACE: Designed to Screen for Pregnancy At-Risk Drinking

TWEAK (Tolerance-Worried-Eye Opener-Amnesia-Kut down)

In the past year:
1. Tolerance: how many drinks can you hold? (Score if more than five drinks without falling asleep or passing out.)
2. Have close friends or relatives worried or complained about your drinking?
3. **Eye-opener**: Do you sometimes take a drink in the morning when you first get up?
4. **Amnesia**: Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?
5. Do you sometimes feel you need to **cut down** on your drinking?

**Scoring**: Questions 1 and 2 are scored two points each. Questions 3, 4, and 5 are scored one point each. A score of two or more indicates at-risk or problem drinking.

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**T-ACE**

1. **Tolerance**: How many drinks does it take to make you feel high?
2. Have people **annoyed** you by criticizing your drinking?
3. Have you ever felt you ought to **cut down** on your drinking?
4. **Eye-opener**: Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

**Scoring**: Question 1 is scored two points if the response is three or more drinks. Questions 2, 3, and 4 are one point each if the response is positive. A score of two or more indicates at-risk drinking.


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**Alcohol Use Disorders Identification Test (AUDIT)**

The AUDIT and AUDIT-C are validated screening tools published by the World Health Organization (WHO) Department of Mental Health and Substance Dependence. There is no fee for the noncommercial clinical use of this instrument. Full instructions are available at: http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf. At this website two versions are described. One is a self-administered questionnaire, and the other is an interview version, which is presented here:

Instructions: Read questions as written. Record answers carefully. Begin the AUDIT by saying, “Now I am going to ask you some questions about your use of alcoholic beverages during this past year.” Explain what is meant by “alcoholic beverages” by using local examples of beer, wine, vodka, etc. Code answers in terms of “standard drinks.” Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?
   (0) Never [Skip to questions 9–10]
   (1) Monthly or less
   (2) Two to four times a month
   (3) Two to three times a week
   (4) Four or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) One or two
   (1) Three or four
   (2) Five or six
   (3) Seven, eight, or nine
   (4) Ten or more

3. How often do you have six or more drinks on one occasion?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   (0) Never
   (1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
(0) No
(2) Yes but not in the last year
(4) Yes and during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?
(0) No
(2) Yes but not in the last year
(4) Yes and during the last year

Skip to questions 9 and 10 if total score for questions 2 and 3 = 0.
Record total of specific items here. If total is greater than recommended cut-off, consult User’s Manual.

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AUDIT-C

This is a three-item screening test for alcohol abuse or dependence. It is a modification of the ten-item AUDIT instrument that uses only the first three items.

In the AUDIT-C a score of four or more in men is considered positive or optimal for identifying hazardous drinking or active alcohol use disorders. A score of three or more is considered positive for women. If the points are all from question one (i.e., no points scored from questions two and three), it is suggested that the service provider review the individual’s alcohol intake over the past few months to confirm accuracy.

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Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)

The ASSIST is another validated screening tool published by WHO. Like many other screening tools, it is designed for use in primary care settings but may also be useful in behavioral healthcare services. An extensive manual is provided for the ASSIST. It can be found at http://whqlibdoc.who.int/publications/2010/9789241599382_eng.pdf

The following is a summary of its key points.

When administering the ASSIST, read the following introductory remarks to the individual being screened.

The following questions ask about your experience of using alcohol, tobacco products and other drugs across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled or injected (show response card). Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

The client is then presented with a set of eight questions, each associated with the following list of substances.

- Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
- Alcoholic beverages (beer, wine, spirits, etc.)
- Cannabis (marijuana, pot, grass, hash, etc.)
- Cocaine (coke, crack, etc.)
- Amphetamine-type stimulants (speed, meth, ecstasy, etc.)
- Inhalants (nitrous, glue, petrol, paint thinner, etc.)
- Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)
- Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)
- Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)
- Other—specify: ________________________
**Question 1:** In your life, which of the following substances **have you ever used** (nonmedical use only)? (The individual answers yes or no for each substance listed above. If all answers are no, follow up with “Not even when you were in school?” If the answer to any substance is “yes,” then ask the following questions about that substance.)

The next five questions ask about the frequency of various occurrences. The answer options are “never,” “once or twice,” “monthly,” “weekly,” and “daily or almost daily.”

**Question 2:** In the past three months, **how often have you used** the substances you mentioned? (Ask about each substance one at a time.)

**Question 3:** In the past three months, **how often have you had a strong desire or urge to use**? (Ask about each substance one at a time.)

**Question 4:** During the past three months, how often has your use of (ask about each substance one at a time) **led to health, social, legal, or financial problems**?

**Question 5:** During the past three months, how often have you **failed to do what was normally expected of you** because of your use of (ask about each substance one at a time)?

**Question 6:** Has a friend or relative or **anyone else ever expressed concern about your use** of (ask about each substance one at a time)?

**Question 7:** Have you ever **tried to cut down on using** (ask about each substance one at a time)? (The answer options are “no, never,” “yes, in the past three months,” and “yes but not in the past three months.”)

**Question 8:** Have you ever used **any drug by injection** (nonmedical use only)? (The answer options are “no, never,” “yes, in the past three months,” and “yes but not in the past three months.”)

For scoring procedures, see: [http://whqlibdoc.who.int/publications/2010/9789241599382_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241599382_eng.pdf)

Those who have used any of the substances listed are provided with a card describing the negative short-term and long-term effects of the substance and information about the potential consequences of not taking action.

**Michigan Alcohol Screening Test (MAST)**

The Michigan Alcohol Screening Test (MAST) is a validated screening test that has been in use since 1971 and has been found to be effective in identifying drinkers who are alcohol dependent. This screening tool is based on the client’s own appraisal of social, vocational, and family problems that are commonly associated with problem drinking. The test was developed to screen for alcohol problems in the general population. As compared to the CAGE, the MAST is longer, takes more time to administer, and focuses on
the client’s lifetime patterns of alcohol use. It may be more suited to use during a comprehensive clinical assessment rather than during a brief intake interview. Shorter versions of the MAST are available. The following is the full twenty-two-item version.

**Instructions:** The MAST Test is a simple, self-scoring test that helps assess if you have a drinking problem. Answer yes or no to the following questions:

1.  Do you feel you are a normal drinker? ("Normal" is defined as drinking as much or less than most other people.)
   ___ Yes ___ No

2.  Have you ever awakened the morning after drinking the night before and found that you could not remember a part of the evening?
   ___ Yes ___ No

3.  Does any near relative or close friend ever worry or complain about your drinking?
   ___ Yes ___ No

4.  Can you stop drinking without difficulty after one or two drinks?
   ___ Yes ___ No

5.  Do you ever feel guilty about your drinking?
   ___ Yes ___ No

6.  Have you ever attended a meeting of Alcoholics Anonymous (AA)?
   ___ Yes ___ No

7.  Have you ever gotten into physical fights when drinking?
   ___ Yes ___ No

8.  Has drinking ever created problems between you and a near relative or close friend?
   ___ Yes ___ No

9.  Has any family member or close friend gone to anyone for help about your drinking?
   ___ Yes ___ No

10. Have you ever lost friends because of your drinking?
    ___ Yes ___ No

11. Have you ever gotten into trouble at work because of drinking?
    ___ Yes ___ No

12. Have you ever lost a job because of drinking?
    ___ Yes ___ No

13. Have you ever neglected your obligations, family, or work for two or more days in a row because you were drinking?
    ___ Yes ___ No

14. Do you drink before noon often?
    ___ Yes ___ No

15. Have you ever been told you have liver trouble, such as cirrhosis?
    ___ Yes ___ No

16. After heavy drinking, have you ever had delirium tremens (DTs), severe shaking, or visual or auditory (hearing) hallucinations?
    ___ Yes ___ No
17. Have you ever gone to anyone for help about your drinking?
   ___ Yes ___ No
18. Have you ever been hospitalized because of drinking?
   ___ Yes ___ No
19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward?
   ___ Yes ___ No
20. Have you ever gone to any doctor, social worker, clergyman, or mental health clinic for help with any emotional problem in which drinking was part of the problem?
   ___ Yes ___ No
21. Have you been arrested more than once for driving under the influence of alcohol?
   ___ Yes ___ No
22. Have you ever been arrested, or detained by an official for a few hours, because of other behavior while drinking?
   ___ Yes ___ No

**Scoring the MAST Test:** Score one point if you answered “no” to questions 1 or 4. Score one point if you answered “yes” to the following questions: 2, 3, 5–22. A total score of six or more indicates hazardous drinking or alcohol dependence and further evaluation by a healthcare professional is recommended.


**Short Michigan Alcohol Screening Test—Geriatric Version (S-MAST-G)**

1. When talking to others, do you ever underestimate how much you drink?         Y N
2. After a few drinks, have you sometimes not eaten or avoid a meal because you didn’t feel hungry?         Y N
3. Does having a few drinks help decrease your shakiness or tremors?         Y N
4. Do you usually take a drink to relax or calm your nerves?    Y N
6. Do you drink to take your mind off your problems?     Y N
7. Have you ever increased your drinking after experiencing a loss in your life?  Y N
8. Has a doctor or nurse ever said they were worried or concerned about your drinking? Y N
9. Have you ever made rules to manage your drinking?     Y N
10. When you feel lonely, does having a drink help?         Y N

**Scoring:** Referral for a complete assessment of alcohol use should be made for individuals answering “yes” to two or more questions.

**American Society of Addiction Medicine (ASAM) Patient Placement Criteria**

The following are the six dimensions of ASAM and how they are defined by ASAM (Lee 2001). While county behavioral health departments are not required to use the ASAM Placement Criteria in their mental
health specialty programs, the following standards serve to draw attention to a variety of clinical assessment issues relevant to discharge planning from involuntary detentions.

Dimension 1. Acute Intoxication and Withdrawal
What risk is associated with the patient's current level of acute intoxication?
1. Is there significant risk of severe withdrawal symptoms or seizures, based on the patient's previous withdrawal history, amount, frequency, chronicity, and recency of discontinuation or significant reduction of alcohol or other drug use?
2. Are there current signs of withdrawal?
3. Does the patient have supports to assist in ambulatory detoxification, if medically safe?

Dimension 2. Biomedical Conditions and Complications
1. Are there current physical illnesses, other than withdrawal, that need to be addressed or that may complicate treatment?
2. Are there chronic conditions that affect treatment?

Dimension 3. Cognitive, Behavioral, and Emotional Conditions
1. Are there current psychiatric illnesses or psychological, behavioral, emotional, or cognitive problems that need to be addressed because they create risk or complicate treatment?
2. Are there chronic conditions that affect treatment?
3. Do any emotional, behavioral, or cognitive problems appear to be an expected part of addictive disorder or do they appear to be autonomous?
4. Even if connected to the addiction, are they severe enough to warrant specific mental health treatment?
5. Is the patient able to manage the activities of daily living?
6. Can he or she cope with any emotional, behavioral, or cognitive problems?

Dimension 4. Readiness and Motivation
1. What is the individual's emotional and cognitive awareness of the need to change?
2. What is his or her level of commitment to and readiness for change?
3. What is or has been his or her degree of cooperation with treatment?
4. What is his or her awareness of the relationship of alcohol or other drug use to negative consequences?

Dimension 5. Relapse, Continued Use, and Continued Problem
1. Is the patient in immediate danger of continued severe mental health distress and/or alcohol or drug use?
2. Does the patient have any recognition of skills, understanding of skills, or skills with which to cope with his or her addictive or mental disorder to prevent relapse, continued use, or continued problems such as suicidal behavior?
3. How severe are the problems and further distress that may continue or reappear if the patient is not successfully engaged in treatment now?
4. How aware is the patient of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or others?
Dimension 6. Recovery Environment

1. Do any family members, significant others, living situations, school situations, or work situations pose a threat to the patient’s safety or engagement in treatment?

2. Does the patient have supportive friendships, financial resources, or educational and vocational resources that can increase the likelihood of successful treatment?

3. Are there legal, vocational, social service agency, or criminal justice mandates that may enhance the patient’s motivation for engagement in treatment?

4. Are there transportation, childcare, housing, or employment issues that need to be clarified and addressed?
Assessing Stage of Recovery

The Prochaska, Norcross, and DiClementi Model (for short, the Prochaska Model) (Prochaska, Norcross, and DiClemente 1992)

1. Precontemplation: characterized by denial and avoidance with no thought of changing now or later
2. Contemplation: the individual is considering making changes and wondering why one engages in a harmful habit and what its payoff might be
3. Preparation: the individual is planning to act
4. Action: now the individual is actively modifying behavior and environment
5. Maintenance: the individual works on maintaining new behaviors developed during the action stage
6. Termination: this refers to a termination of the problem, rather than a termination of services; in some presentations of the Prochaska model, this stage is not mentioned

Stages 1 and 2. Precontemplation and Contemplation

At these stages the individual is unable to accept or acknowledge the consequences of his or her substance abuse. The person's behavior is characterized by denial, guilt, shame, and defensiveness.

Stage 3. Preparation

Once the individual begins to plan to act, it is helpful to engage him or her in an assessment. The findings of the assessment will help clarify the individual's thinking about goals and objectives as well as the best approach or program to follow. The assessment can help the client see the connection between substance use and both psychiatric symptoms and psychosocial problems.

Initially the client may only be willing to respond to general assessment questions. At this stage, more information may be forthcoming from family members or other professionals who have known the client over the years. If the client is willing to participate, toxicity screening can be a useful tool to identify patterns of abuse and help confront the client's denial system.

When an adequate level of trust has developed, and the client is engaged in dialog regarding substance use, the practitioner can introduce a more specific and in-depth assessment process.

Through direct observation, direct questioning, and, if the client is willing, collateral reports and toxicity screens, the practitioner can obtain information about:

- drugs used;
- drug or drugs of choice;
- frequency and duration of substance use;
• maladaptive patterns of substance use and the resulting effects on relationships, employment, dangerous behavior, health;
• signs of physiological dependence, that is, tolerance and/or withdrawal symptoms;
• evidence of a compulsive use pattern;
• client's awareness of primary mental disorder;
• client's awareness of the effects of substance use on the primary mental disorder;
• client's perceived motivation for substance use;
• client's perceived positive aspects of substance use;
• social environmental factors that support or inhibit substance use
• cultural factors that influence client's use patterns and help seeking behavior.

Stage 4. Action

At this point the client will likely need help in choosing and entering a recovery program. If the client has been seeing you as a solo practitioner in an office-based practice, it is important to remember that substance abuse treatment, especially treatment of substance dependence, is usually a multidisciplinary, multimodality process.

Stage 5. Maintenance

There should now be an increased focus on helping the individual identify signs and symptoms of relapse risk. The acceptance and encouragement of a self-help group can be very supportive. The client should be exposed to others more advanced in their recovery who can model relapse prevention and coping skills. During this phase the client develops an increasing sense of responsibility for his or her illness and recovery program as well as an increasing sense of manageability in his or her life.

Stage 6. Termination

For some individuals, and depending on the goal of one’s change effort, the problem may be “conquered,” but for others a lifetime of careful maintenance may be necessary. The temptation to resume previous habits may continue for years after the individual considers the change process to have been a success.
Integrated treatment produces better outcomes for individuals with co-occurring mental and substance use disorders. Without integrated treatment, one or both disorders may not be addressed properly. Mental health and substance abuse authorities across the country are taking steps to integrate systems and services and promote integrated treatment.” —SAMHSA

SAMHSA standards for a “Dual Diagnosis Capable” Mental Health Program

While county behavioral health departments are not required to be certified as a SAMHSA Dual Diagnosis Capable Mental Health Program, the following standards serve to draw attention to administrative innovations that would promote the integration of behavioral health services.

1. Primary focus is mental health: co-occurring disorders are treated.
2. Has no barrier to providing addiction treatment or treating co-occurring disorders within the context of mental health treatment.
3. Formalized and documented coordination or collaboration with an addiction agency.
4. Can bill for either service type; however, a mental health disorder must be primary.
5. Focus is on mental health disorders but accepts substance use disorders by routine and if mild and relatively stable as reflected in program documentation.
6. Routine set of standard interview questions for substance use to avoid using, apply a generic framework.
7. The program has a mechanism for providing diagnostic services in a timely manner. Substance use diagnoses are documented in 50 to 69 percent of the records.
8. Routine documentation of both mental health and substance use disorder history in record in narrative section.
9. Admits persons in program who have low to moderate acuity but are primarily stable.
10. Admits persons in program with low to moderate severity and persistence of substance use disability.
11. (Stage-wise assessment is . . .) Clinician assessed and routinely documented, focused on mental health motivation.
12. (Treatment) Plans routinely address both disorders although mental health disorders are addressed as primary, substance use disorders as secondary with generic interventions.
13. Routine clinical focus in narrative (e.g., treatment plan review or progress note) on substance use disorder change; description tends to be generic.
14. Documented guidelines: referral or collaborations (to local addiction agency, detox unit, or emergency department).
Third Party Payor Policies Toward Co-Occurring Disorders in Mental Health Specialty Programs

There is no legitimate risk of audit disallowance since substance-related disorders are being diagnosed and addressed by the staff of a specialty mental health program, if a Medi-Cal “included diagnosis” is the major focus of treatment. In fact, for well over two decades, state agencies with oversight responsibility for county mental health services have consistently encouraged mental health specialty programs to address the substance-related issues of their clients. The following are a few examples of policy directives from these state authorities. (Bolding added throughout these examples.)

Joint DMH/ADP Information Notice No. 96-09
Subj: Dual Diagnosis Demonstration Projects

Although the primary purpose of this Information Notice was to announce the Dual Diagnosis Demonstration Projects sponsored by both the Department of Mental Health and the Department of Alcohol and Drug Programs, a clear policy position was presented:

Profiles of consumers with dual disorders demonstrate that they require coordinated and integrated services. Presently, this population is being treated in a variety of public settings including mental health services, alcohol and drug programs, as well as the health care and criminal justice systems. Lack of integrated services contributes to the ineffective, costly treatment of these individuals. They have higher rates of homelessness and legal and medical problems. They have more frequent and longer hospitalizations and higher acute care utilization rates. For example, among patients with schizophrenia, episodes of violence and suicide are twice as likely to occur among those who abuse street drugs as among those who do not. The Departments of DMH and ADP are actively exploring methods to eliminate any barriers to treatment at the federal, state, and local level.

A “Policy on Clients with Dual Diagnosis: September 1996” was attached. It references the 1995–96 Governor’s Budget Language, which set forth the following message to the Departments of Mental Health (DMH) and Alcohol and Drug Programs (ADP) regarding the service/treatment of persons with a dual diagnosis: “The Departments of Mental Health and Alcohol and Drug Programs will be actively exploring methods to eliminate any barriers between the two systems at both the state and local levels.”

In response to that message, DMH and ADP formed the Dual Diagnosis Task Force in May 1995. The following were among the principles that were set forth to guide the plans and actions of DMH and ADP in the development of systems of care for clients with dual diagnosis:

The DMH and ADP will, to the extent resources are available, promote the development of systems of care at the local level that incorporate the following factors (among others):
Client-Centered Approach—All services and programs will be client centered and family focused, and they will recognize the rights of persons to receive services in the most appropriate and least restrictive environment.

System Responsibility—Systems of care will require that providers assume responsibility for the consumer at the initial point of entry into either the mental health or substance abuse system and assure, to the extent possible, that the person receives necessary and coordinated services for both problems.

Welfare and Institutions Code, Section 5600.2

To the extent resources are available, public mental health services in this state should be provided to priority target populations in systems of care that are client-centered, culturally competent, and fully accountable, and that include the following factor:

(e) Multiple Disabilities. Mental health services should address the special needs of children and youth, adults, and older adults with dual and multiple disabilities.

Welfare and Institutions Code, Section 5600.3

To the extent resources are available, the primary use of funds deposited in the mental health account of the local health and welfare trust fund should be to serve the target populations identified in the following categories, which shall not be construed as establishing an order of priority:

(b) (1) Adults and older adults who have a serious mental disorder.
(2) For the purposes of this part “serious mental disorder” means a mental disorder which is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period. Serious mental disorders include, but are not limited to, schizophrenia, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.

(3) Members of this target population shall meet all the following criteria:

(A) The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2).

Welfare and Institutions Code, Section 5600.9. (C)

To the extent permitted by law, counties should maximize all available funds for the provision of services to the target populations. Counties are expressly encouraged to develop interagency programs and to blend services and funds for individuals with multiple problems, such as those with mental illness...
and substance abuse, and children, who are served by multiple agencies. State departments are directed to assist counties in the development of mechanisms to blend funds and to seek any necessary waivers which may be appropriate.

**California Code of Regulations, Title 9, Division 1**

Regulations governing the Medi-Cal mental health plans are found in the California Code of Regulations, Title 9, Division 1 (Department of Mental Health). Medical necessity criteria for “specialty mental health services” (i.e., non-hospital services) are presented in Article 2: Provision of Services, Section. 1830.205.

Substance-related disorders are not listed as an “included diagnosis.” This means that a Medi-Cal mental health plan is not obligated to provide treatment for a substance-related disorder in the absence of an “included diagnosis.” The regulations clearly state that they are not intended to exclude persons with substance-related disorders:

Sec. 1830.205 (c) When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in subsection (b)(1) even if a diagnosis that is not included in subsection (b) (1) is also present.

**State DMH Medical Necessity Criteria for the Medi-Cal Mental Health Carve Out**

Excluded DSM Diagnoses: “A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present. An included diagnosis must be the principal diagnosis.”
The California Healthcare Services Agency has established a variety of terms and conditions for establishing a county’s Drug Medi-Cal Organized Delivery System (DMC-ODS) and integrating services between mental health specialty and SUD treatment programs. Examples of those terms and conditions with potential implications for the service integration that can affect involuntary detentions are presented here.

130. Early Intervention Services (ASAM Level 0.5) Screening, brief intervention, and referral to SBIRT are provided by non-DMC providers to beneficiaries at risk of developing a SUD.

Referrals by managed care providers or plans to treatment in the DMC-ODS will be governed by the memorandum of understanding (MOU) held between the participating counties and managed care plans. The components of the MOUs governing the interaction between the counties and managed care plans related to SUD will be included as part of the counties’ implementation plan and waiver contracts.

The components of early intervention are:

- **Screening:** Primary care physicians screen adults ages 18 years or older for alcohol misuse.
- **Counseling:** Persons engaged in risky or hazardous drinking receive brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services, as medically necessary.
- **Referral:** Managed care plans and fee-for-service primary care providers will make referrals from SBIRT to the county for treatment through the DMC-ODS.

132. Case Management: Counties will coordinate case management services. Case management services can be provided at DMC provider sites, county locations, regional centers, or as outlined by the county in the implementation plan; however, the county will be responsible for determining which entity monitors the case management activities. Services may be provided by a licensed practitioner of the healing arts or certified counselor.

- **Counties will be responsible for coordinating case management services for the SUD client.** Counties will also coordinate a system of case management services with physical and/or mental health to ensure appropriate level of care.
- **Case management services are defined as services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.** These services focus on coordination of SUD care, integration around primary care especially for
beneficiaries with a chronic SUD, and interaction with the criminal justice system, if needed.

i. Case management services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.

ii. Case management services include:

1. Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services;
2. Transition to a higher or lower level of care for SUD;
3. Development and periodic revision of a client plan that includes service activities;
4. Communication, coordination, referral, and related activities;
5. Monitoring service delivery to ensure beneficiary access to service and the service delivery system;
6. Monitoring the beneficiary’s progress;
7. Patient advocacy, linkages to physical and mental healthcare, transportation, and retention in primary care services;

Case management shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2 and California law.

133. Care Coordination: Counties’ implementation plans and state/county contracts (managed care contracts per federal definition) will describe their care coordination plan for achieving seamless transitions of care. Counties are responsible for developing a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e., withdrawal management, residential, outpatient) without disruptions to services. In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, the county will describe in the implementation plan and state/county intergovernmental agreement (managed care contracts per federal definition) how beneficiaries will access recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.

a. The county implementation plan and state/county intergovernmental agreement (managed care contract per federal definition) will indicate whether their care transitions approach will be achieved exclusively through case management services or through other methods. The county implementation plan and state/county intergovernmental agreement (managed care contract per federal
definition) will indicate which beneficiaries receiving SUD services will receive care coordination.

b. The participating county shall enter a MOU with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS. This requirement can be met through an amendment to the Specialty Mental Health Managed Care Plan MOU. The components of the MOUs governing the interaction between the counties and managed care plans related to SUD will be included as part of the counties' implementation plan. If upon submission of an implementation plan, the managed care plan(s) has not signed the MOU(s), the county may explain to the state the efforts undertaken to have the MOU(s) signed and the expected timeline for receipt of the signed MOU(s). Any MOU shall be consistent with the confidentiality provisions of 42 CFR Part 2.

c. The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:
   I. Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services;
   II. Beneficiary engagement and participation in an integrated care program as needed;
   III. Shared development of care plans by the beneficiary, caregivers, and all providers;
   IV. Collaborative treatment planning with managed care;
   V. Delineation of care management responsibilities;
   VI. A process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved;
   VII. Availability of clinical consultation, including consultation on medications;
   VIII. Care coordination and effective communication among providers including procedures for exchanges of medical information;
   IX. Navigation support for patients and caregivers; and
   X. Facilitation and tracking of referrals between systems including bidirectional referral protocols.

156. DMC-ODS County Oversight, Monitoring, and Reporting. The intergovernmental agreement with the state and counties that opt into the waiver must require counties to have a Quality Improvement Plan that includes the county’s plan to monitor the service delivery, capacity as evidenced by a description of the current number, types, and geographic distribution of SUD services. For counties that have an integrated mental health and SUDs department, this Quality Improvement Plan may be combined with the Mental Health Plan (MHP) Quality Improvement Plan.
a. The county shall have a quality improvement (QI) committee to review the quality of SUD services provided to the beneficiary. For counties with an integrated mental health and SUD department, the county may use the same committee with SUD participation as required in the MHP contract.
b. The QI committee shall recommend policy decisions, review and evaluate the results of QI activities, institute needed QI actions, ensure follow-up of QI process, and document QI committee minutes regarding decisions and actions taken. The monitoring of accessibility of services outlined in the Quality Improvement Plan will at a minimum include coordination of physical and mental health services with waiver services at the provider level.
ATTACHMENT Z: TEMPLATE FOR COUNTY DMC-ODS IMPLEMENTATION PLANS

Part II—Plan Description
Pursuant to the above stated terms and conditions, counties applying to establish a DMC-ODS system must address the following questions, among others:

5. **Coordination with Mental Health.** How will the county coordinate mental health services for beneficiaries with co-occurring disorders? Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored? Please briefly describe the county structure for delivering SUD and mental health services. When these structures are separate, how is care coordinated?

7. **Coordination Assistance.** The following coordination elements are listed in the STCs, Standard terms and conditions. Based on discussions with your health plan and providers, do you anticipate substantial challenges and/or need for technical assistance with any of the following? If so, please indicate which and briefly explain the nature of the challenges you are facing.
   - Comprehensive substance use, physical, and mental health screening
   - Beneficiary engagement and participation in an integrated care program as needed
   - Shared development of care plans by the beneficiary, caregivers, and all providers
   - Collaborative treatment planning with managed care
   - Care coordination and effective communication among providers
   - Navigation support for patients and caregivers
   - Facilitation and tracking of referrals between systems

12. **Quality Assurance.** Describe the County’s quality management and QI programs. This includes a description of the QI committee (or integration of DMC-ODS responsibilities into the existing Mental Health Plan Quality Improvement (MHP QI committee). The monitoring of accessibility of services outlined in the Quality Improvement Plan will at a minimum include the following:
   - Timeliness of first initial contact to face-to-face appointment
   - Frequency of follow-up appointments in accordance with individualized treatment plans
   - Timeliness of services of the first dose of Narcotics Treatment Program (NTP) services
   - Access to after-hours care
   - Responsiveness of the beneficiary access line
   - Strategies to reduce avoidable hospitalizations
   - Coordination of physical and mental health services with waiver services at the provider level
   - Assessment of the beneficiaries’ experiences, including complaints, grievances, and appeals
   - Telephone access line and services in the prevalent non-English languages
SAMHSA STANDARDS FOR A “DUAL DIAGNOSIS CAPABLE” MENTAL HEALTH PROGRAM

“Integrated treatment produces better outcomes for individuals with co-occurring mental and substance use disorders. Without integrated treatment, one or both disorders may not be addressed properly. Mental health and substance abuse authorities across the country are taking steps to integrate systems and services and promote integrated treatment” (SAMHSA).

While County behavioral health departments are not required to be certified as SAMHSA Dual Diagnosis Capable Mental Health Programs, the following standards serve to draw attention to administrative innovations that would promote the integration of behavioral health services. Note that SAMHSA has set separate, more stringent standards that apply to “Dual Diagnosis Enhanced” programs.

I. PROGRAM STRUCTURE

A. Primary focus is mental health: co-occurring disorders are treated.
B. Has no barrier to providing addiction treatment or treating co-occurring disorders within the context of mental health treatment.
C. Formalized and documented coordination or collaboration with addiction agency.
D. Can bill for either service type; however, a mental health disorder must be primary.

II. PROGRAM MILIEU

A. Focus is on mental health disorders but accepts SUDs by routine and if mild and relatively stable as reflected in program documentation.

III. CLINICAL PROCESS: ASSESSMENT

A. Routine set of standard interview questions for substance use using generic framework (e.g., ASAM-PPC Dim. I&VB, LOCUS Dim. III) or biopsychosocial data collection.
B. Assessment for SUDs is present, formal, standardized, and documented in 50%–69% of the records.
C. The program has a mechanism for providing diagnostic services in a timely manner. Substance use diagnoses are documented in 50%–69% of the records.
D. Routine documentation of both mental health and SUD history in record in narrative section.
E. Admits to program persons with low to moderate acuity, but who are primarily stable.
F. Admits to program persons with low to moderate severity and persistence of substance use disability.
G. Clinician assessed and routinely documented, focused on mental health motivation.
IV. CLINICAL PROCESS: TREATMENT

A. Plans routinely address both disorders, although mental health disorders addressed as primary, whereas SUDs are secondary with generic interventions.
B. Routine clinical focus in narrative (treatment plan review or progress note) on SUD change; description tends to be generic.
C. Documented guidelines: referral or collaborations (to local addiction agency, detox unit, or emergency department).
D. Stage of change or motivation routinely incorporated into individualized plan, but not specific stage-wise treatment.
E. Some types of medication for SUDs are routinely available. Present, coordinated policies regarding medication for SUDs. Some access to prescriber for medications and policies to guide prescribing are provided. Monitoring of the medication is largely provided by the prescriber.
F. In program format as generalized intervention with penetration into routine services. Routine clinician adaptation of an evidence-based mental health treatment.
G. Education about SUDs, treatment, and interaction with mental health disorders has generic content, routinely delivered in individual and/or group formats.
H. SUDs routinely but informally incorporated into family education or support sessions. Available as needed.
J. Availability of peer recovery supports off-site and facilitated with contact persons or informal matching with peer supports in the community, some co-occurring focus.

V. CONTINUITY OF CARE

A. Co-occurring disorder systematically addressed as secondary in planning process for off-site referral.
B. No formal protocol to manage SUD needs once program is completed, but when indicated most individual clinicians provide extended care until appropriate linkage takes place. Routine documentation.
C. Routine focus is on recovery from mental health disorders; addiction viewed as potential relapse issue only.
D. Hospital discharge planning is generic, but no specific or intentional facilitation based on SUDs. More routine facilitation to mental health peer support groups (e.g., NAMI, Procovery) upon discharge.

VI. STAFFING

A. Psychiatrist or other physician or prescriber of medication for SUD: consultant or contractor on site.
B. 25%–33% of clinical staff are licensed or certified substance abuse professionals or have substantial experience, sufficient to establish competence in addiction treatment.
C. Access to addiction clinical supervision or consultation is provided as needed or variably on site by consultant, contractor, or staff member.
D. Peer/alumni supports available with co-occurring disorders but as part of the community. Routine referrals made through clinician relationships or more formal connections such as peer support service groups (e.g., AA Hospital and Institutional committees or NAMI).
VII. TRAINING

A. Basic training in attitudes, prevalence, common signs and symptoms, detection, and triage for co-occurring disorders: certain staff are trained, encouraged by management, and with systematic training plan (25%–50% would have been trained).

B. Advanced specialized training in integrated psychosocial or pharmacological treatment of persons with co-occurring disorders: certain staff trained, encouraged by management, and with systematic training plan (25%–50% trained).
NO-OR LOW-COST ENHANCEMENTS TO INCREASE CO-OCCURRING CAPABILITY PROGRAM STRUCTURE

The following suggestions are provided in SAMHSA’s Dual Diagnosis Capability in Mental Health Treatment Toolkit, available at: http://www.easacommunity.org/PDF/ddcmht_toolkit.pdf

Note that each suggestion is linked to a specific criterion for a Dual Diagnosis Capable Program, as presented in the preceding section.

I. Program Structure
   - Revise mission statement to include focus on co-occurring disorders.
   - Develop formal memorandum of understanding with an addiction program.

II. Program Milieu
   - Revise materials and procedures to welcome individuals with co-occurring disorders.
   - Display/distribute free educational materials about substance use/co-occurring disorders.

III. Assessment
   - Implement free standardized mental health and substance use screening measures.
   - Implement a standard set of substance use biopsychosocial assessment questions.
   - Implement a standard section of the assessment to capture substance use history.
   - Assess patients’ stage of change for both their substance use and mental health problems.

IV. Treatment
   - Include addiction related interventions in treatment plans.
   - Observe and document changes in mental health and substance use symptoms over time.
   - Implement guidelines and advance directives for substance abuse emergencies.
   - Adjust objectives and interventions to match persons’ stages of change.
   - Incorporate free addiction or COD (Co Occurring Disorders) curricula into program services.
   - Implement family education or support group with co-occurring curricula.
   - Assertively link patients to peer support groups welcoming to co-occurring issues.
   - Incorporate program alumni and other peer supports with COD into program.

V. Continuity of Care
   - Implement discharge procedures that plan for mental health and substance use services.
   - Focus on ongoing recovery from both disorders.
   - Assertively link patients to peer support groups welcoming to COD upon discharge.
VI. Staffing
- Implement routine case reviews that support co-occurring disorder treatment.
- Include peers with co-occurring disorders on-site as paid or volunteer staff.

VII. Training
- Implement training plan that routinely includes basic training on co-occurring disorders.
Community behavioral health services are not only in and of the community, but they are also designed to help clients become more fully engaged in supportive aspects of the community. Referrals to “adjunctive resources” (persons and organizations who can provide the client with something needed that can't be provided by the behavioral health service system) are an important part of recovery-oriented practice. Such organizations have been especially relevant for persons with SUDs.

Many of the LPS Consensus Guidelines call for use of community-based self-help resources. Self-help groups provide emotional and practical support as well as valuable information. They tend to use participatory processes that offer opportunities to pool resources and share knowledge, common experiences, problems, and solutions. Many self-help groups have no professional involvement at all. Occasionally professionals are engaged to develop the supporting organization, assist with fundraising, or organize political advocacy.

These groups are especially valuable in helping people with long-standing mental and physical problems. They are generally:
- led by members.
- voluntary.
- open to new members.
- meet in person, over the internet, or both.

Self-help programs are clearly relevant to involuntary detentions at the point of discharge planning when offering follow-up referrals to the detained individual. Such programs also hold the potential of providing valuable support during hospitalization.

Some self-help organizations, most notably Alcoholics Anonymous and Narcotics Anonymous, promote and support the development of “institutional meetings.” These are meetings of the fellowship that are regularly held on-site at institutional settings such as psychiatric inpatient units. Generally these fellowships:
- work closely with facility administration.
- arrange for distribution of their literature at the facility.
- seek to understand, respect, and adhere to treatment setting regulations, policies, and procedures.
- make information about their function and purpose available.
- assist in the formation of new meetings at both inpatient and outpatient treatment settings.

An institutional meeting can be useful in introducing some involuntarily detained individuals to the self-help program. Those involuntarily detained clients with previous ties to such organizations can benefit by maintaining what may have come to serve as an important source of support during the detainment by attending an institutional meeting.
Of course, even those self-help programs that offer institutional meetings primarily operate in the community. Examples of such nationwide self-help organizations are listed here; most have California-based chapters or affiliates. These organizations have not been evaluated for this toolkit in any way but are listed here to indicate the wide array of community-based organizations available for treatment planning and discharge planning.

Note the variety and specificity of the various self-help programs, including both twelve-step programs modeled on the recovery principles and traditions of the original Alcoholics Anonymous and others. These programs generally provide self-help meetings, conferences, literature, and assistance in forming new group meetings. Many have associated social and recreational gatherings.

TWELVE-STEP PROGRAMS

Chemical Dependency
- Alcoholics Anonymous
- Narcotics Anonymous
- Al-Anon (for friends and family of alcoholics) and Alateen (for youth)
- Chemically Dependent Anonymous
- Co-Anon Family Groups (for friends and family of substance abusers)
- Dual Recovery Anonymous ("dual diagnosis" of mental illness and SUDs)
- Dual Diagnosis Anonymous (other co-occurring disorders)
- Families Anonymous (for friends and family members of substance abusers and those with behavioral problems)
- Nar-Anon (for friends and family of those who abuse other drugs)
- Marijuana Anonymous
- Methadone Anonymous
- Methadone Anonymous Support
- Narcotics Anonymous

Substance-Specific Recovery Programs
- Cocaine Anonymous
- Crystal Meth Anonymous
- Heroin Anonymous
- Marijuana Anonymous World Services
- Methadone Anonymous
- Pill Addicts Anonymous
- Prescription Anonymous
Profession-Based Affiliations Addressing Chemical Dependency

- Anesthetists in Recovery
- International Doctors in Alcoholics Anonymous
- Inter-congregational Alcoholism Program (for women in Roman Catholic religious orders)
- International Lawyers in Alcoholics Anonymous
- International Ministers and Pastors in Recovery
- International Nurses Anonymous
- Psychologists Helping Psychologists
- Social Workers Helping Social Workers
- Veterinarians in Recovery

NON-TWELVE-STEP SUBSTANCE-RELATED PROGRAMS

- SMART (Self-Management and Recovery Training) Recovery (for all types of addictive behaviors, including alcoholism, drug abuse, substance abuse, drug addiction, alcohol abuse, cocaine addiction, addiction to other substances, gambling addiction, and addictions to other activities)
- Rational Recovery ("we take a rather old-fashioned view of the addiction as willful misconduct, voluntary and for physical pleasure")
- Moderation Management ("problem drinkers can make informed choices about moderation or abstinence goals based upon educational information and the experiences shared at self-help groups")
- YES, Recovery (emphasizing a secular approach)
- LifeRing Secular Recovery (an abstinence-oriented and secular approach)
- Secular Organizations for Sobriety (SOS, also known as “Save Our Selves”)

OTHER ORGANIZATIONS THAT ADDRESS CONDITIONS COMMONLY EXPERIENCE BY PERSONS WITH SUDS

- Sexual Addictions
- Sex Addicts Anonymous
- Sex and Love Addicts Anonymous (Augustine Fellowship)
- COSA (Codependents of Sex Addicts)
- Co-Sex and Love Addicts Anonymous
- S-Anon (for friends and family of sex addicts)
- Sexaholics Anonymous
- Sexual Compulsives Anonymous
- Sexual Recovery Anonymous (SRA)
- SRA-Anon (for friends and family of sex addicts)
Other Twelve-Step Programs
- Abortion Survivors Anonymous
- Batterers Anonymous
- Co-Dependents Anonymous
- Compulsive Eaters Anonymous
- Debtors Anonymous
- Dep-Anon (for family members of depressed individuals)
- Eating Addictions Anonymous (“the SANE Fellowship”)
- Eating Disorders Anonymous
- Emotions Anonymous (addressing a broad range of emotional difficulties)
- Food Addicts Anonymous (focus on abstinence from sugar, flour, and wheat)
- Food Addicts in Recovery Anonymous
- Gamblers Anonymous
- GreySheeters Anonymous (for weight management)
- HIV Anonymous
- Incest Survivors Anonymous
- Molesters Anonymous
- Overeaters Anonymous
- Parents Anonymous, Inc. (for parents with children who have experienced child abuse)
- Recovering Couples Anonymous (for any dysfunctional relationship)
- Schizophrenics Anonymous
- Spenders Anonymous
- Survivors of Incest Anonymous
- Suicide Anonymous (for individuals with suicidal ideation and/or history of suicide attempts)
- Trauma Anonymous (PTSD and survivors of all forms of trauma)
- Workaholics Anonymous

Other Non-Twelve-Step Self-Help Programs
- Weight Watchers
- Toastmasters International (helpful for those with social anxiety and performance anxiety)
- Dental Phobia Support
- Sibling Support Project (focused on siblings of persons with developmental disabilities, also welcomes siblings of those with physical and mental disabilities)
- National Alliance on Mental Illness (focused on policy development with support groups for family members of the mentally ill)
- California Network of Mental Health Clients (social support and advocacy for persons with serious, persistent mental illness, also operates in other states)
Several additional major information and referral directories are commonly used by community behavioral health programs across the country. Note that even though such directories may be published by local organizations to cover major urban areas, they are useful in California as well because one is able to ignore the local listings and focus on those that are national in scope. Such organizations can be found throughout the country.

**ONLINE RESOURCES**

**National Empowerment Center**  
http://www.power2u.org/consumerrun-statewide.html  
Provides contact information about mental health consumer and survivor state organizations, which in turn can advise people of local self-help groups and other consumer-run services.

**NIMH/SAMHSA Resource Directory**  
Thousands of national support groups and public service agencies for addictions, bereavement, health, mental health, disabilities, abuse, parenting, and many other issues.

**EXAMPLES OF RELIGIOUS COMMUNITY–ORIENTED SERVICES**

**Catholic Social Services**  
http://www.cssdoorway.org/programs.html  
A comprehensive range of services including adoption, caregiver assistance, counseling, jail chaplaincy, anger management classes, parenting, pregnancy counseling, refugee resettlement, and many others.

**Christian Services Directory—Crosswalk Directory**  
http://directory.crosswalk.com  
An extensive online directory that is primarily oriented to business listings, but also includes many social services in its “Family Resources” section.

**Islamic Social Services Association—USA**  
http://www.issausa.org  
ISSA is developing a network of professional, paraprofessional, and volunteer social service providers and strives to enhance their capacity through education, training, technical assistance, research, mentorship, and collaboration.

**Jewish Community Federations (or Jewish Federations)**  
https://www.jewishfederations.org/
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