DOWNLOAD PDF PATIENT EVALUATION I : ASSESSMENT, DIAGNOSIS, AND THE PRESCRIPTION OF PSYCHOTHERAPY

Chapter 1 : Drug Screening and Assessment Resources | National Institute on Drug Abuse (NIDA)

A mental health assessment offers a detailed look at all of the factors which contribute to the patient's mental health history. The information entered on the assessment form should be detailed and expansive. The patient's mental health history, medical history and social history contribute to the assessment.

What specific services are needed to address these priorities? Where can these services be provided in the least intensive, but safe, level of care or site of care? How will outcomes be measured? What is the progress of the treatment plan and placement decision? Adapted from Mee-Lee Answers to some of these important questions inevitably will change over time. As the answers change, adjustments in treatment strategies may be appropriate to help the client continue to engage in the treatment process. With regard to COD, clinicians must remember that ethnic cultures may differ significantly in their approach to substance use disorders and mental disorders, and that this may affect how the client presents. In addition, clients may participate in treatment cultures Step recovery, Dual Recovery Self-Help, psychiatric rehabilitation that also may affect how they view treatment. See also chapter 2 for a discussion of culturally competent treatment. Counselors also should be aware that women often have family-related and other concerns that must be addressed to engage them in treatment, such as the need for child care. Trauma sensitivity The high prevalence of trauma in individuals with COD requires that the clinician consider the possibility of a trauma history even before the assessment begins. Trauma may include early childhood physical, sexual, or emotional abuse; experiences of rape or interpersonal violence as an adult; and traumatic experiences associated with political oppression, as might be the case in refugee or other immigrant populations. This pre-interview consideration means that the approach to the client must be sensitive to the possibility that the client has suffered previous traumatic experiences that may interfere with his or her ability to be trusting of the counselor. Identify and Contact Collaterals Family, Friends, Other Providers To Gather Additional Information Clients presenting for substance abuse treatment, particularly those who have current or past mental health symptoms, may be unable or unwilling to report past or present circumstances accurately. For this reason, it is recommended that all assessments include routine procedures for identifying and contacting any family and other collaterals who may have useful information to provide. It is valuable particularly in evaluating the nature and severity of mental health symptoms when the client may be so impaired that he or she is unable to provide that information accurately. Screen for and Detect Co-Occurring Disorders Because of the high prevalence of co-occurring mental disorders in substance abuse treatment settings, and because treatment outcomes for individuals with multiple problems improve if each problem is addressed specifically, the consensus panel recommends that All individuals presenting for substance abuse treatment should be screened routinely for co-occurring mental disorders. All individuals presenting for treatment for a mental disorder should be screened routinely for any substance use disorder. The content of the screening will vary upon the setting. Substance abuse screening in mental health settings should Screen for acute safety risk related to serious intoxication or withdrawal Screen for past and present substance use, substance related problems, and substance-related disorders Mental health screening has four major components in substance abuse treatment settings: Screen for acute safety risk: Safety screening Safety screening requires that early in the interview the clinician specifically ask the client if he or she has any immediate impulse to engage in violent or self-injurious behavior, or if the client is in any immediate danger from others. These questions should be asked directly of the client and of anyone else who is providing information. Once this information is gathered, if it appears that the client is at some immediate risk, the clinician should arrange for a more in-depth risk assessment by a mental-health-trained clinician, and the client should not be left alone or unsupervised. A variety of tools are available for use in safety screening: ASI McLellan et al. See Potential Risk of Harm below. While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to care adequately for oneself, or from altered states of consciousness due to use of

intoxicating substances. For the purpose of evaluation in this parameter, deficits in ability to care for oneself are considered only in the context of their potential to cause harm. Likewise, only behaviors associated with substance use are used to rate risk of harm, not the substance use itself. In addition to direct evidence of potentially dangerous behavior from interview and observation, other factors may be considered in determining the likelihood of such behavior such as past history of dangerous behaviors, ability to contract for safety, and availability of means. When considering historical information, recent patterns of behavior should take precedence over patterns reported from the remote past. Risk of harm may be rated according to the following criteria: None of these tools is definitive for safety screening. Clinicians and programs should use one of these tools only as a starting point, and then elaborate more detailed questions to get all relevant information. Clinicians should not underestimate risk because the client is using substances actively. For example, although people who are intoxicated might only seem to be making threats of self-harm e. Individuals who have suicidal or aggressive impulses when intoxicated may act on those impulses; remember, alcohol and drug abuse are among the highest predictors of dangerousness to self or othersâ€”even without any co-occurring mental disorder. See chapter 8 and appendix D of this TIP for a more detailed discussion of suicidality. In addition, it is important to remember that the vast majority of people who are abusing or dependent on substances will experience at least transient symptoms of depression, anxiety, and other mental symptoms. Moreover, it may not be possible, even with a skilled clinician, to determine whether an intoxicated suicidal patient is making a serious threat of self harm; however, safety is a critical and paramount concern. A more detailed discussion of each symptom subgroup is provided in appendix D. Safety screening conducted in mental health settings is highlighted in the text box below. If clients obviously are intoxicated, they need to be treated with empathy and firmness, and provision needs to be made for their physical safety. If clients report that they are experiencing withdrawal, or appear to be exhibiting signs of withdrawal, use of formal withdrawal scales can help even inexperienced clinicians to gather information from which medically trained personnel can determine whether medical intervention is required. Mental health clinicians need to be aware that not all drugs have a physiological withdrawal associated with them, and it should not be assumed that withdrawal from any drug of abuse will require medical intervention. Only in the case of alcohol, opioids, sedative-hypnotics, or benzodiazepines is medical intervention likely to be required due to the pharmacological properties of the substance. Screening for past and present mental disorders Screening for past and present mental disorders has three goals: To identify clients who might have a current mental disorder and need both an assessment to determine the nature of the disorder and an evaluation to plan for its treatment. A number of screening, assessment, and treatment planning tools are available to assist the substance abuse treatment team. NIAAA operates a web-based service that provides quick information about alcoholism treatment assessment instruments and immediate online access to most of them, and the service is updated continually with new information and assessment instruments www. NIDA has a publication from a decade ago Rounsaville et al. Of course, NIDA continues to explore issues related to screening and assessment e. The mental health field contains a vast array of screening and assessment devices, as well as subfields devoted primarily to the study and development of evaluative methods. Advanced assessment techniques include assessment instruments for general and specific purposes and advanced guides to differential diagnosis. Most high-power assessment techniques center on a specific type of problem or set of symptoms, such as the BDI-II Beck et al. However, such assessment devices typically are lengthy the MMPI is more than items , often require specific doctoral training to use, and can be difficult to adapt properly for some substance abuse treatment settings. For both clinical and research activities, there are a number of well-known and widely used guides to the differential diagnostic process in the mental health field, such as the Structured Clinical Interview for Diagnosis SCID. These tools generally provide information beyond the requirements of most substance abuse treatment programs. When using any of the wide array of tools that detect symptoms of mental disorders, counselors should bear in mind that symptoms of mental disorder can be mimicked by substances. For example, hallucinogens may produce symptoms that resemble psychosis, and depression

commonly occurs during withdrawal from many substances. Even with well-tested tools, it can be difficult to distinguish between a mental disorder and a substance-related disorder without additional information such as the history and chronology of symptoms. The section below briefly highlights some available instruments available for mental health screening. It is available to the public at no charge from the Project Return Foundation, Inc. On the other hand, the MHSF-III is only a screening device as it asks only one question for each disorder for which it attempts to screen. Considerable validation research has accumulated on the M. For each disorder the M. For example, in terms of suicidality the M. Thought about being better off dead or wishing to be dead 1 point 2. Thought about suicide 6 points 4. Attempted suicide 10 points 5. Developed a suicide plan 10 points M. Scoring rates low current suicide risk as 1 to 5 points, moderate as 6 to 9 points, and high as 10 or more points. Plus an expanded version of the M. The BSI questionnaire contains 18 items and asks clients to rate each question on a five-point scale. In addition to a Global Severity Index score, there are separate scores for anxiety, depression, and somatization subscales. With about items, the ASI is a low-power instrument but with a very broad range, covering the seven areas mentioned above and requiring about 1 hour for the interview. Development of and research into the ASI continues, including training programs, computerization, and critical analyses. It is a public domain document that has been used widely for 2 decades. Screening for past and present substance use disorder This section is intended primarily for counselors working in mental health service settings. It suggests ways to screen clients for substance abuse problems. Screening begins with inquiry about past and present substance use and substance-related problems and disorders. It is important to remember that if the client acknowledges a past substance problem but states that it is now resolved, assessment is still required. Careful exploration of what current strategies the individual is using to prevent relapse is warranted. Such information can help ensure that those strategies continue while the individual is focusing on mental health treatment. Screening for the presence of substance abuse symptoms and problems involves four components: Substance abuse symptom checklists Formal screening tools that work around denial Screening of urine, saliva, or hair samples Symptom checklists: These include checklists of common categories of substances, history of associated problems with use, and a history of meeting criteria for substance dependence for that substance. It is not helpful to develop checklists that are overly detailed, because they begin to lose value as simple screening tools. It is helpful to remember to include abuse of over-the-counter medication e. It also is reasonable to screen for compulsive sexual behavior, Internet addiction, and compulsive spending. It is useful to monitor the severity of substance use disorder if present and to determine the possible presence of dependence. Some programs may use formal substance use disorder diagnostic tools; others use the ASI McLellan et al. The New Hampshire Dartmouth Psychiatric Research Center has developed clinician-rated alcohol- and drug-use scales for monitoring substance abuse severity in individuals with mental disorders: Most common substance abuse screening tools have been used with individuals with COD. The Dartmouth Assessment of Lifestyle Inventory DALI is used routinely as a screening tool in some research settings working with individuals with serious mental disorders Rosenberg et al. It is a item scale, although only 14 items are scored so that scores can range from 0 to These 14 items were selected by the TIP 11 consensus panelists from existing alcohol and drug abuse screening tools.

Chapter 2 : 4 Assessment - Substance Abuse Treatment for Persons With Co-Occurring Disorders - NCBI

A mental health assessment is when a professional -- like your family doctor, a psychologist, or a psychiatrist -- checks to see if you might have a mental problem and what type of treatment may help.

International Classification of Diseases, 9th Rev. Volumes 1 and 2. Salt Lake City, UT: Common Comorbid Medical Conditions Individuals addicted to opioids may have the same chronic diseases seen in the general population and should be evaluated as appropriate for diseases that require treatment e. In addition, a number of medical conditions are commonly associated with opioid and other drug addictions. During the course of a medical history and physical examination, the possible existence of these conditions should be evaluated. Refer to figure for a detailed list of selected medical disorders related to drug and alcohol use. Atherosclerosis, stroke, myocardial infarction, peripheral vascular disease, cor pulmonale, erectile dysfunction, worse control of hypertension, angina, dysrhythmia. Aerodigestive lip, oral cavity, tongue, pharynx, larynx, esophagus, stomach, colon , breast, hepatocellular and bile duct cancers. Oral cavity, larynx, lung, cervical, esophagus, pancreas, kidney, stomach, bladder. Hepatocellular carcinoma related to hepatitis C. Hypoglycemia and hyperglycemia, diabetes, ketoacidosis, hypertriglyceridemia, hyperuricemia and gout, testicular atrophy, gynecomastia, hypocalcemia and hypomagnesemia because of reversible hypoparathyroidism, hypercortisolemia, osteopenia, infertility, sexual dysfunction. Osteopenia, alteration in gonadotropins, decreased sperm motility, menstrual irregularities. Graves disease, azoospermia, erectile dysfunction, osteopenia, osteoporosis, fractures, estrogen alterations, insulin resistance. Steatosis fatty liver , acute and chronic hepatitis infectious [that is, B or C] or toxic [that is, acetaminophen] , alcoholic hepatitis, cirrhosis, portal hypertension and varices, spontaneous bacterial peritonitis. Infectious hepatitis B and C acute and chronic and delta. Hepatitis C, pneumonia, tuberculosis including meningitis , HIV, sexually transmitted diseases, spontaneous bacterial peritonitis, brain abscess, meningitis. Bronchitis, pneumonia, upper respiratory tract infections. Endocarditis, cellulitis, pneumonia, septic thrombophlebitis, septic arthritis unusual joints, that is, sternoclavicular , osteomyelitis including vertebral , epidural and brain abscess, mycotic aneurysm, abscesses and soft tissue infections, mediastinitis, malaria, tetanus. Stroke, seizure, status epilepticus, headache, delirium, depression, hypersomnia, cognitive deficits. Seizure overdose and hypoxia , compression neuropathy. Stroke, small vessel ischemia and cognitive deficits. Vitamin and mineral deficiencies B1, B6, riboflavin, niacin, vitamin D, magnesium, calcium, folate, phosphate, zinc. Ischemic bowel and colitis. Peptic ulcers, gastroesophageal reflux, malignancy pancreas, stomach. Prenatal and Perinatal Alcohol: Fetal alcohol effects and syndrome. Placental abruption, teratogenesis, neonatal irritability. Neonatal abstinence syndrome, including seizures. Teratogenesis, low birth weight, spontaneous abortion, abruptio placentae, placenta previa, perinatal mortality, sudden infant death syndrome, neurodevelopmental impairment. Withdrawal, perioperative complications delirium, infection, bleeding, pneumonia, delayed wound healing, dysrhythmia , hepatic decompensation, hepatorenal syndrome, death. Pulmonary infection, difficulty weaning, respiratory failure, reactive airways exacerbations. Aspiration, sleep apnea, respiratory depression, apnea, chemical or infectious pneumonitis. Nasal septum perforation, gingival ulceration, perennial rhinitis, sinusitis, hemoptysis, upper airway obstruction, fibrosis, hypersensitivity pneumonitis, epiglottitis, pulmonary hemorrhage, pulmonary hypertension, pulmonary edema, emphysema, interstitial fibrosis, hypersensitivity pneumonia. Pulmonary edema, bronchospasm, bronchitis, granulomatosis, airway burns. Lung cancer, chronic obstructive pulmonary disease, reactive airways, pneumonia, bronchitis, pulmonary hypertension, interstitial lung disease, pneumothorax. Pulmonary hypertension, talc granulomatosis, septic pulmonary embolism, pneumothorax, emphysema, needle embolization. Hepatorenal syndrome, rhabdomyolysis and acute renal failure, volume depletion and prerenal failure, acidosis, hypokalemia, hypophosphatemia. Rhabdomyolysis and acute renal failure, vasculitis, necrotizing angiitis, accelerated hypertension, nephrosclerosis, ischemia. Rhabdomyolysis, acute renal failure, factitious hematuria. Focal glomerular sclerosis HIV, heroin , glomerulonephritis from

hepatitis or endocarditis, chronic renal failure, amyloidosis, nephrotic syndrome hepatitis C. Apnea, periodic limb movements of sleep, insomnia, disrupted sleep, daytime fatigue. Insomnia, increased sleep latency. Motor vehicle crash, fatal and nonfatal injury, physical and sexual abuse. Death during "Russian Roulette. Motor vehicle crash, other violent injury. Sexual and physical abuse. Rhabdomyolysis, compartment syndromes, gout, saturnine gout, fracture, osteopenia, osteonecrosis. Overview of medical and surgical complications. Principles of Addiction Medicine, 3rd ed. Infectious diseases are more common among individuals who are addicted to opioids, individuals who are addicted to other drugs, and individuals who inject drugs. For example, in some areas, more than 50 percent of injection drug users may be HIV positive. There are wide variations in the epidemiology of HIV infection, however, and in other areas the prevalence of HIV infection among injection drug users may be less than 10 percent. Because of the potential impact of HIV on the lives of affected patients and the availability of effective treatments, it is important to screen for HIV infection among patients who present for buprenorphine treatment. Tuberculosis is also a major problem among substance abusers. See tables 28, 29, and Among individuals who are opioid addicted, other common medical conditions are related to the use of other drugs and to the life disruptions that often accompany addiction. These conditions include nutritional deficiencies and anemia caused by poor eating habits; chronic obstructive pulmonary disease secondary to cigarette smoking; impaired hepatic function or moderately elevated liver enzymes from various forms of chronic hepatitis particularly hepatitis B and C and alcohol consumption; and cirrhosis, neuropathies, or cardiomyopathy secondary to alcohol dependence. Summary After completing a comprehensive assessment of a candidate for treatment, the physician should be prepared to Establish the diagnosis or diagnoses Determine appropriate treatment options for the patient Make initial treatment recommendations Formulate an initial treatment plan Plan for engagement in psychosocial treatment Ensure that there are no absolute contraindications to the recommended treatments Assess other medical problems or conditions that need to be addressed during early treatment Assess other psychiatric or psychosocial problems that need to be addressed during early treatment The next section describes methods for determining the appropriateness of buprenorphine treatment for patients who have an opioid addiction. Determining Appropriateness for Buprenorphine Treatment Several issues should be considered in evaluating whether a patient is an appropriate candidate for buprenorphine treatment of opioid addiction in the office or other setting. In such a case, a short course of buprenorphine may be considered for detoxification. Second, a candidate for buprenorphine treatment should, at a minimum Be interested in treatment for opioid addiction Have no absolute contraindication i. Evaluation Questions To thoroughly evaluate a patient for appropriateness for opioid addiction treatment with buprenorphine, the physician should ask the following questions: Does the patient have a diagnosis of opioid dependence? Candidates for buprenorphine treatment should have a diagnosis of opioid dependence. Buprenorphine treatment is not indicated for other disorders. Are there current signs of intoxication or withdrawal? Is there a risk for severe withdrawal? The physician should assess the patient for current signs of intoxication or withdrawal from opioids or other drugs as well as for the risk of severe withdrawal. The risk of severe opioid withdrawal is not a contraindication to buprenorphine treatment. Is the patient interested in buprenorphine treatment? If a patient with opioid addiction has not heard of or presented specifically for buprenorphine treatment, buprenorphine treatment should be discussed as a treatment option. Does the patient understand the risks and benefits of buprenorphine treatment? Refer to chapter 2 and appendix H. It should be assumed that many patients are unaware that buprenorphine is an opioid, thus they should be so informed. The risks and benefits of buprenorphine treatment should be presented to potential patients, and their understanding of these factors evaluated. Physicians must review the safety, efficacy, side effects, potential treatment duration, and other factors with each patient. Can the patient be expected to adhere to the treatment plan? Is the patient willing and able to follow safety procedures? Does the patient agree to treatment after review of the options? Buprenorphine treatment is not coercive; the patient must agree to treatment before it is initiated. Can the needed resources for the patient be provided either onsite or offsite? If the resources that are available onsite or offsite are

insufficient for a particular patient, he or she should be referred to an appropriate treatment setting or provider. Is the patient psychiatrically stable? Is the patient actively suicidal or homicidal? Has he or she recently attempted suicide or homicide? Do current emotional, behavioral, or cognitive conditions complicate treatment? A full psychiatric assessment is indicated for all patients who have significant psychiatric comorbidity. Psychiatric comorbidity requires appropriate management or referral as part of treatment. Is the patient pregnant? If a patient is pregnant or is likely to become pregnant during the course of treatment, buprenorphine may not be the best choice. Currently, methadone maintenance, when it is available, is the treatment of choice for patients who are pregnant and are opioid addicted. Is the patient currently dependent on or abusing alcohol? Patients with alcohol abuse or dependence, whether continuous or periodic in pattern, may be at risk of overdose from the combination of alcohol with buprenorphine. Does the patient have a history of multiple previous treatments or relapses, or is the patient at high risk for relapse to opioid use? Is the patient using other drugs? Multiple previous attempts at detoxification which were followed by relapse to opioid use, however, are not a contradiction to maintenance with buprenorphine. Rather, such a history is a strong indication for maintenance treatment with pharmacotherapy. Has the patient had prior adverse reactions to buprenorphine?

Chapter 3 : How to Write a Mental Health Assessment: 13 Steps (with Pictures)

Psychiatric evaluation is critical to the assessment of a patient for psychotherapy, just as it is for the patient who is to be seen for medication management (Ursano and Silberman). The prescription of psychotherapy can be the outcome of the psychiatric evaluation.

A common fluency in language or competent translator is essential for information gathering and questioning. Identifying information These are general and emotionally neutral questions that usually include name, age, occupation, and marital status. Chief complaint presenting problem This consists of questions such as "Why are you seeking psychological help today? History of present illness The patient describes the onset of signs and symptoms that comprise the current mental problem. Questions include information about temperament, walking, talking, toilet training, nutrition and feeding, family relationships, behavioral problems, hospitalization, and separation from early childhood caregivers. Pertinent information will be gathered concerning learning, relationship with peers and family, behavioral problems, and general personality development. Information typically includes school history, behavioral problems, and sexual development. Family history Family history is crucially important since many mental disorders can be inherited genetically. The psychological assessment also called the biopsychosocial or psychiatric assessment gathers information to diagnose any mental disorder that the person may have. A complete psychological assessment should include: Once complete, the assessment will help establish a diagnosis. Questions usually focus on age of first use, age of last use, period of heaviest use, usage within the past 30 days, frequency, quantity, and route of usage. Appearanceâ€”hygiene, general appearance, grooming, and attire. Behaviorâ€”abnormal movements, hyperactivity and eye contact with the interviewer. A fast-talking person, for example, may be anxious. Speech can also reveal intoxication or impairment as well as problems in the mouth i. Is that all right with you? The clinician can ask the patient to describe his or her current mood "How do you feel? Thought process and content Thought process or form indicates whether or not the interviewee is properly oriented to time and place. Disturbed thought content can also indicate delusions , hallucinations , phobias, and obsessions. Preparation An evaluation session appointment is made with a qualified mental health practitioner. A private, quiet, nonthreatening, environment is recommended to ensure comfort and confidentiality. Aftercare Aftercare depends on the results of the evaluation. Risks There are no known risks involved. A person seeking a mental health evaluation does so for a reason and may learn of an existing or potential mental problem. Normal results The patient does not require psychological therapy or psychotropic drug medications beneficial to treat certain mental disorders treatment. Abnormal results The person suffers from a mental disorder that may require psychotherapy or a combination of psychotherapy and medications. Laith Farid Gulli, M. Robert Ramirez Other articles you might like:

Chapter 4 : Assessment and diagnosis - therapy, drug, person, medication, brain, personality, health, mood

five-part decisions-making system that includes assessment, nursing diagnosis, planning, implementation and evaluation objective data information gathered through physical assessment, laboratory tests, and other diagnostic sources.

Several researchers pointed out that patients with comorbidity have poorer outcomes than those with single diagnoses, such as increasing psychiatric symptoms, homelessness, higher risk for relapse, institutionalization, worse compliance, difficulties in managing their lives Drake and Wallach, , lower satisfaction with familial relationships Dixon et al. Upon recognizing the existence of patients with co-occurring psychiatric and substance use disorders, the treatment of these individuals became a great challenge for professionals. An additional challenge has been the poor fit between dually diagnosed patients and the traditional treatment system. In the traditional treatment system, the earliest model of treatment is the serial model, in which the clients are treated only for one type of disorder at a time. Once one type of disorder is under control, the patients are referred to another agency for treatment of the co-occurring disorder. Another traditional approach is separate, parallel treatment, where two agencies work with the clinicians at the same time, each treating one type of disorder in a parallel fashion. Many clinicians working within this model have difficulty coordinating treatment and understanding comorbidity. In addition, the clients often become lost between the two systems. In an effort to solve these problems, addiction treatment and psychiatric programs have developed a variety of mechanisms and moved toward integrated treatment services. Integrated treatment programs serve people with severe mental illness and substance abuse and treat both types of disorders simultaneously at one site. The effectiveness of integrated treatment programs has been discussed in several studies Ahrens, ; Bachrnann eta! The authors have reported some reduction of substance abuse, psychopathology, and time spent hospitalized; improvement in treatment, functional status, quality of life, housing stability, and awareness of the disorders; progress in recovery, medication compliance and linking with self-help groups; and greater satisfaction and remission. In recent years, there has been an improvement in knowledge about treatment of dually diagnosed patients, but barriers still exist for effective services delivery. Grella and Hser assessed mental health service delivery in drug treatment programs in Los Angeles County and found that the majority of addiction programs had restrictions on admission of dually diagnosed clients and nearly half did not serve patients with comorbidity. In traditional addiction programs, the confrontational approach, restriction of use of medications, and use of former clients as counselors Rohrer and Schonfeld, do not fully meet the needs of dually diagnosed patients. In addition to a lack of appropriate integrated treatment programs there are other problematic issues with respect to the treatment of dually diagnosed patients. For example, professionals often miss the second diagnosis. In fact, some of the patients who present with psychiatric illness in mental health settings are not diagnosed as having substance use disorder by psychiatrists Breakey et al. Lehman and colleagues reported that dually diagnosed persons with independent mental disorders were more likely to be referred for mental health treatment and less likely to receive substance abuse treatment and follow-up. In order to improve outcomes of dually diagnosed patients, adequate assessment and treatment have to be provided. The appropriate assessment gives information about, 1 severity of psychiatric and substance use disorders, 2 conditions, associated with occurrence and maintenance of these disorders, 3 psychosocial needs and problems, including cultural issues, 4 treatment motivation, and, 5 areas for treatment intervention. The treatment goals are based on the severity of the symptoms and the leading needs. Recent guidelines for treatment of dually diagnosed patients suggested improvement in three areas: Assessment of dually diagnosed patients is based on a detailed history of psychiatric and substance abuse symptoms. Important information on psychiatric status includes: Important information on substance abuse includes: It is useful to place the results of the evaluation in one of the following categories:

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Chapter 5 : Psychological Tests | HealthyPlace

Laboratory testing is an important part of the assessment and evaluation of patients who have an addiction. Laboratory tests cannot make a diagnosis of addiction, but a variety of laboratory evaluations are useful in the comprehensive assessment of patients who have an addiction.

Chapter 6 : Assessment and Treatment of Patients with Co-Occurring Psychiatric and Substance Abuse Di

Chart of Evidence-Based Screening & Assessment Tools for Adults and Adolescents Screening and Assessment Tools Chart - Provides validated tools to guide screening, evaluation, and referral to treatment of patients with a substance use disorder.