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ABSTRACT

The purpose of this paper is to provide an overview of assessment, diagnosis, and treatment planning for individuals with substance abuse problems. The intent is to provide information to professional counselors in school, rehabilitation, school psychology, social work, public mental health, and private treatment settings. Information to be obtained in a comprehensive assessment includes: developmental aspects of adolescence; external influences such as family and peer groups; diagnostic information relating to etiology and prognosis; and recommendations and considerations related to a treatment plan. Several dual diagnoses specifically associated with drug abuse are discussed including depression, conduct, anxiety/panic, substance induced anxiety, and eating disorders. A structured diagnostic interview is presented for use in obtaining information for managed care and other third parties. Also included is a facilitator's manual which is a practical guide for teaching content through guided experiential projects. Four objectives are listed, and four student exercises are provided. (Contains 27 references.) (MKA)

Assessment, Diagnosis, and Treatment

Thomas Mullis

Introduction

The early diagnosis and intervention in the treatment of individuals with substance abuse is critical. It has long been a given that the earlier the treatment for drug abuse the better the results. The purpose of this chapter is to provide an overview of assessment, diagnosis, and treatment planning for individuals with substance abuse problems. While reference is made consistently to processes related to adolescent development, the intent is to provide information to professional counselors in school, rehabilitation, school psychology, social work, public mental health, and private treatment settings. Consequently, the information provided as applicable to one clinical setting may not apply as fully to others. Counselors will need to select the procedures and approaches that are useful and adaptable to their particular setting.

The information to be obtained in a comprehensive assessment includes

(1) developmental aspects of adolescence,
(2) external influences such as family and peer groups,
(3) diagnostic information relating to etiology and prognosis, and
(4) recommendations and considerations related to a treatment plan.

A structured diagnostic interview is presented as a model for clinicians to use because managed care and other third parties often expect structured interview information and clinical documentation (Appendix A). Accountability in practice is required in most settings. The writer does not take the position that a medical diagnosis is in the best interest of the adolescent. However, since managed care generally requires a medical diagnosis, the information is provided on medical diagnoses because the counselor is often left with limited options.

An important aspect in working with adolescent populations is having an understanding of the maturation process. A knowledge of the developmental processes of adolescence helps in discriminating between normal adolescent behavior and abnormal behavior. Therefore, to aid in assessment, diagnosis and planning, a brief consideration of adolescent cognitive, emotional and peer development is presented. The influence of cognitive development is the first area to be investigated.

New counselors may not know the cognitive developmental stages and need to understand that cognitive functioning in adolescence is central to the understanding of adolescent behavior and related drug use. Cognitive processing is directly related to behavior, especially risk-taking behavior. Adolescents' cognitive processes determine their motivation for drug use, as well as how they evaluate its use and consequences.

It is commonly held that most adolescents enter Piaget's formal operational stage, which involves abstract reasoning, at about age 11 or 12. However, it has been found that this is often not the case (Mullis, 1985). Piaget's stage theory allows for significant variability among individuals of approximately the same age. Chronological guidelines for stage development are only approximate. Kohlberg and Gilligan (1971) found that achieving formal operational thought may be related to socio-economic factors.

Some individuals do not ever attain formal operational thought. In fact, it could be argued that, in the case of early adolescents, many are still in the concrete operational stage. Individuals in the concrete operational stage have limited abilities to understand the consequences of their behavior. They tend to be egocentric which brings about feelings of invincibility. Elkind (1967), a Piagetian theorist, postulates that adolescents believe in "personal fables". He maintains that adolescents believe they are special and different; what happens to others will not happen to them. They do not believe that they will suffer the negative consequences of drug use experienced by other people. Moreover, they may not understand the consequences of their behavior which results in impulsive decisions.

During the comprehensive assessment, the counselor needs to be aware of maturation in relation to diagnostic and treatment decisions. Sometimes, counselors tend to judge the adolescent as having a problem with being self-absorbed when this is often normal behavior among adolescents. Drug use should be examined in the context of cognitive maturity.

Cognitive development and emotional functioning are intricately related, but emotional development and maturity have distinctive separate aspects that need to be addressed in assessment and treatment planning. Erikson's theory (1963) helps in the explanation of emotional behavior in adolescence. According to Erikson, everyone

faces predictable developmental crises throughout the lifespan.

Adolescents are in the "identity versus identity confusion stage". The question the adolescent asks is "Who *am I?*" In their search for identity they test limits related to their roles in society. They are vulnerable to social influences and can be very sensitive or insensitive to others feelings. Because they are forming their identity, they are uncertain about issues. This may be reflected in choices made with regard to risk taking behaviors, such as sexual behavior and drug use. The adolescent's identity, or lack of identity, has a dramatic influence on behavior in determining values and behavior. The level of emotional maturation is reflected in the adolescent's ability to understand relationships, and control impulsivity. The counselor needs to understand that a "cocky" exterior often masks a fragile sense of self in the adolescent.

Adolescent development is marked by the emergence of peers who have a dramatic impact on the individual. In attempting to define "who they are", adolescents move from looking to parental influences to validation by peers. Individuation is the process by which the individual develops his or her own sense of identity, and individuation is dramatically influenced by peer group interactions (Mullis, 1997).

Friends are seen as partners in experimentation and their feedback is used to determine what is acceptable and unacceptable behavior. Peer acceptance often determines values and self worth. Consequently, the adolescent is likely to conform to peer norms and expectations. The more cohesive the peer group, the more its influence on behavior. This is manifested in the conformity demonstrated by adolescents who are in gangs. The types of drugs used and frequency of use is often driven by the adolescent peer group control. Early adolescents, adolescents and late adolescents tend to display different drug usage, which is related to the various influences of their different peer groups.

The Comprehensive Assessment Process

There are three important considerations that need to be addressed in conducting an assessment:

(1) the purposes in conducting the assessment,
(2) client and setting issues,
(3) rapport building and informed consent,
(4) and the methods available in assessment (the structured diagnostic interview, drug testing, and psychometric testing) which are used to gather the important information necessary to make diagnosis and referral decisions.

Purposes of Assessment

The three major purposes for a comprehensive assessment are to determine a diagnosis, devise a treatment plan, and to make appropriate referrals. In some instances, the counselor conducting the assessment will be responsible for the treatment and a referral may not be necessary. The assessment should provide a clinical picture of the client's personal level of functioning, history, presenting problems, family, and the social context in which the adolescent lives. It is important to emphasize the assessment process requires the gathering of comprehensive, accurate information, for a valid diagnosis and appropriate treatment.

Diagnosis: The counselor needs to obtain valid, reliable information, which may be vital in drug abuse cases. If the adolescent has had therapy in the past, then a previous assessment can be useful in making modifications in treatment. If not, formal diagnosis, as listed in the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 1994) or an informal diagnosis, which may be more appropriate for public school settings may be done. The writer encourages the counselor to use an informal diagnosis when possible to avoid possible later stigmatization of the adolescent. Managed care and clinical settings tend to require formal diagnoses for reimbursement.

Treatment Plan: A comprehensive assessment is essential in designing a treatment plan. Obviously, the more information provided concerning the etiology, functioning level, and prognosis of the problem, the better the treatment plan. Devising a sound treatment plan is fundamental in helping clients deal with an addiction.

Appropriate Referral: A third reason for conducting an assessment is to provide information in order to make an appropriate referral. Conducting a comprehensive assessment and developing a thorough treatment plan facilitates the referral process. The counselor may decide that he or she solely may provide treatment or provide it in conjunction with some other drug treatment specialists.

In addressing these purposes, counselors need to be aware of some important therapeutic aspects and their approach when conducting an assessment with adolescents. Miller, Zweben, Diclemente, & Rychtarik (1999)

emphasize that, during the assessment phase, motivational techniques should be used which will be beneficial in treatment and recovery. They maintain that the assessment should be presented in a motivational fashion, and the counselor should express empathy, avoid argumentation, be flexible with resistance, and help the client with self-efficacy. According to Miller et al., Motivational Enhancement Therapy emphasizes that the counselor should motivate clients to work on their problems. After the assessment, the client should feel positive about the assessment phase and be amenable to enter treatment. It is important to re-emphasize that the assessment process involves the gathering of comprehensive, accurate information, which is required for a valid diagnosis and appropriate treatment. Therefore, the counselor needs to obtain valid, reliable information, which may be vital in drug abuse cases.

There are a number of considerations that should be addressed in the assessment process. Important considerations include the client and setting, rapport building, structured interviewing, types of drugs and use, history of past treatments, psychiatric diagnoses, and co-morbity issues such as family dynamics, school adjustment, and conformity.

Client and Setting Characteristics

In planning an assessment, counselors need to be aware of the circumstances under which the adolescent is being seen. Since adolescent clients may be voluntary or involuntary, counselors should possess counseling skills to work with both types of clients. Many of the adolescent clients involved in the use of drugs are either court referred or school referred. The setting may require drug screening by the counselor or it may restrict confidentiality.

An important concern with involuntary adolescents is facilitating honesty. Strategies that may help in dealing with involuntary clients are

(1) giving them the opportunity to vent their negative feelings and concerns about being assessed, and conveying to them an empathic understanding of their frustrations;
(2) explaining the counselor's role and limitations of the role, legally and ethically; and
(3) attempting to bond with them. Having a truthful account of the drug use is critical in making treatment decisions.

Rapport Building Interview/Informed Consent

While adolescents do not have the same legal rights as adults, the rapport building interview should at the outset provide the adolescent with information related to informed consent. Confidentiality is important, even if the client is a minor and an involuntary referral. The client always has the choice of being non-compliant even in the face of adverse consequences, such as being placed in detention. The adolescent should be provided with an overview of the questions that will be asked, how they will be used, who will have access to the information, how the information provided may impact on him or her personally, what legal options they have, and what kind of legal access they have to their own records.

Adolescents are often resistant to self-disclose to professional counselors, and adolescent clients who are court referred or school referred can be exceedingly resistant. They have serious concerns regarding privacy, violating peer confidentiality, disappointing parents, and incurring legal and other negative consequences of admitting drug use. These concerns are valid because in many instances the counselor cannot guarantee confidentiality. When possible the counselors should not pursue identifying information about peers unless it is essential. It is vital that any concerns that the client has about the process be addressed before the structured diagnostic interview begins. The counselor may need to ask specific questions to determine what anxieties or fears the client has during the interview. Counselors need to be supportive of the client's feelings and thoughts, which can be communicated by being empathic, non-judgmental, and nonconfrontive.

The rapport building interview may be conducted at a separate time or simply precede the structured interview. While the major purpose of this interview is to establish rapport, this is an excellent opportunity to gain a wealth of information. Non-verbal communications such as: eye contact, facial expressions, head movements, tense or relaxed mood, and variations in voice pitch present significant clinical information. Initiating a rapport-building interview prior to a diagnostic structured interview is essential to ensure the validity of the latter.

While it may not be legally necessary, it is helpful to have the adolescent agree to sign a waiver of

confidentiality so that the counselor may gain additional information. The adolescent should be informed what a waiver entails, how long it will be in effect, what questions will be asked, who will be contacted, and he or she should be provided with a copy of the signed waiver

The use of an unstructured interview is important in rapport building; however, a structured diagnostic interview is necessary in order to obtain specific details about drug use.

The Structured Diagnostic Interview

A structured clinical interview can be considered an empirically driven instrument if it includes concrete questions and scoring procedures. The structured diagnostic interview needs focus to maximize relevant information gathering. The interview should be direct, concrete, and completed in a logical and timely manner. It should include questions regarding:

(1) the types, combinations, frequency, and duration of substances used;
(2) past history of treatment;
(3) psychiatric/comorbidity issues;
(4) suicide concerns;
(5) family dynamics and family drug use (genetic factors);
(6) school/work performance; and
(7) peer conformity issues.

Counselors should obtain sufficient information to protect the welfare of the client or others. Since adolescent suicide has increased over the years and alcohol is associated with suicide (Rich, Young & Fowler, 1990), counselors need to ascertain in a structured format, suicidal thoughts and drinking behaviors. There are many intake forms used by mental health agencies and other settings to obtain information. However, adolescent compliance is better if the information is taken face-to-face. If written intake forms or psychometric instruments are used, it is recommended that they be used after the diagnostic interview begins.

Type/Combinations/ Frequency/ Amounts/Duration

Accurate information on the kind of drug being used is important for physical and mental health reasons. Inhalants, cannabis, and alcohol are some of illicit drugs more frequently used by adolescents (APA, 1994). Counselors need to develop a substance abuse profile and a history of the progression of the drug use. While this information may be provided in a drug screening or a psychometric profile, there is no substitute for the diagnostic interview. Patterns in drug use at different ages have been found to occur in adolescents. One pattern, proposed by Kandel (1975), is a gateway theory of drug use among adolescents. She contends that adolescent involvement occurs in four stages which progress from beer and cigarettes or liquor, as gateway drugs, to marijuana, and other drugs. Research indicates that 28% of 10th graders and 33% of 12th graders smoke (National Institute on Drug and Alcohol Abuse, 1996).

An analysis of frequency, amount used, and duration issues of substances among this group is complicated because of the different maturational levels of early adolescence, adolescence, and late adolescence. Exposure to various types of drugs, and the number of years that they have to develop drug dependency is quite different among these different age groups. How does the counselor evaluate drug abuse in a 13 year old versus a 17 year old, when both are using the same amounts of drugs? What is abusive drinking for a 13-year-old versus a 17-year-old? Counselors need to be aware of the different norm behaviors for these different groups.

A common mistake of counselors in conducting interviews with adolescents regarding frequency and amounts of drugs used is that the questions are not precise or specific. For example, in response to the interviewer asking how much do you drink, the adolescent responds that he or she drinks "some beer on the weekends". It is important to know the number of cans, bottles, cups, (the size of the container), and over what period of time the drinking occurs. It is not unusual for individuals who are drug dependent to underestimate their consumption. A "couple of drinks" of bourbon might be two 12 ounce glasses without ice. If the counselor is getting contradictory responses to the questions, follow-up questions are required and clinical judgment is needed in accessing the situation. Client background, weight, and age are important variables to consider during the assessment.

Counselors should be aware that "multiple dependence," the simultaneous use of multiple drugs and alcohol, is a major problem and is common (Frances & Miller, 1991).

Past History of Treatment

The past history of treatment is important. If possible, the records from previous providers should be obtained. It is helpful to obtain a waiver of confidentiality from the adolescent, parents, or guardians. Often, the client's memory of previous treatment is faulty. A telephone call to previous therapists is recommended, if confidentiality has been waived.

Psychiatric Diagnoses

The primary problem in diagnosing drug abuse in adolescence is that there is no valid system for diagnosis. Consequently, the diagnoses are at best marginal. The *DSM- IV* (APA, 1994) classifies drug disorders into substance use disorders (substance dependence and substance abuse) and substance-induced disorders (substance intoxication, substance withdrawal, substance-induced delirium, substance induced anxiety, depression, psychosis, mood disorders). The counselor, in using this diagnostic system, should be careful in assigning medical diagnoses to adolescent behavior. The *DSM-IV* (APA, 1994), the most widely-used diagnostic system, defines the term "substance dependency" as:

(1) tolerance (increases in the drug for the desired effects),
(2) withdrawal (distress or impairment when the drug is not available),
(3) increased amounts of use over longer periods of time,
(4) lack of control of use,
(5) high amount of time spent obtaining drugs,
(6) negative influence on social and work activities, and
(7) use continues despite knowledge of health problems.

The client must exhibit three or more of the indicators in a 12-month period to be diagnosed as substance dependent. The diagnostic criteria may be inappropriate for adolescents because adolescents may have developed neither tolerance, nor withdrawal symptoms. They might not meet any three of the criteria, but still have a significant drug problem. The diagnosis becomes particularly problematic for an early adolescent who may be having as much of a problem but may not be involved in the level of drug use that an older adolescent is experiencing. The *DSM-IV* has no developmental norms for the different stages of adolescence (APA, 1994).

The problems of appropriate diagnosis are not resolved by the *DSM-IV*'s second drug category "drug abuse" which is generally defined as a maladaptive pattern of substance use, which brings about adverse consequences. The definition further states that one or more of the following must occur in a 12 month period:

(1) failing to fulfill major role obligations at work, school, and or home (absences from school, suspensions, or expulsions from school);
(2) operating a machine or vehicle in a hazardous manner;
(3) recurring legal problems; and
(4) developing social and interpersonal problems (APA, 1994).

Many adolescents do not drive, do not have legal problems, and in the short run, have minimal conflict with peers because their peers are often using drugs with them. Adolescents who abuse drugs do not develop good interpersonal skills at a critical time of their development.

Inhalant-Related Disorders

According to the *DSM-IV*, children and adolescents are the main users of inhalants, which are low in cost and available. Inhalants use of such substances as gasoline, glue, spray paints, hair spray, and paint thinners usually begins in childhood and ends during adolescence. The *DSM-IV* lists dizziness, in coordination, slurred speech, lethargy, tremor and many other symptoms as relating to this use. Males account for 70%-80% of inhalant emergency room visits (APA, 1994). Research indicates that among 8th 10th and 12th graders, the percentage of adolescents using inhalants is approximately 20%, with use being higher in the 8th and 10th grades (National Institute on Drug and Alcohol Abuse, 1996).

Cannabis-Induced Disorders

Cannabis abuse interferes with performance at work or school and it is hazardous in situations such as driving a car or operating a machine. It is the most commonly used illicit substance and it is not surprising that adolescent usage is high. Marijuana usage for 8th graders was 23%, 10th graders was 40%, 12th graders was 45%, and 5% of seniors reported using marijuana daily (National Institute on Drug and Alcohol Abuse, 1996). It has been found that 81% of juvenile offenders met the *DSM-IV* criteria for substance abuse (Latimer, Winters, & Stinchfield, 1997).

Alcohol-Related Disorders

The first episode of alcohol intoxication is likely to occur in mid-teens. Withdrawal problems are likely to occur in adulthood. It has been found that use of alcohol is 55% in the 8th grade, 72% in the 10th grade, and 79% in the 12th grade. Approximately 4% of the seniors use alcohol daily. Alcohol consumption has increased and has become a major drug problem for adolescents (National Institute on Drug and Alcohol Abuse, 1996).

Comorbidity/Dual Diagnosis

The assessment of drug use of clients presents a major problem because of comorbidity (an additional clinical disorder or disorders occurring at the same time) or dual diagnoses. Latimer, Winters, and Stenchfield (1997) cite research indicating that 80% of adolescents in correctional institutions met the criteria for substance abuse, while 82% of adolescents who were inpatients for drug abuse met the *DSM-IV* for an Axis I disorder. When comorbidity is present, assessment is more difficult because the counselor may have problems determining a differential diagnosis for the presenting two or more diagnoses. Frances and Miller (1991) found that adolescent drug use brings about behaviors which appear similar to various forms of psychopathology since psychiatric symptoms may develop while using drugs. There are a number of dual diagnoses that are specifically associated with drug abuse or drug dependency. These include depression, conduct, anxiety/ panic, substance-induced-anxiety, and eating disorders.

Depression

There is no more important situation in which a dual diagnosis must be determined correctly than in the case of depression and drug abuse. It may be a major depression, dysthymia or adjustment disorder with depressed mood (APA, 1994). Depression is often masked in early adolescence. Some of the symptoms to look for are fatigue, poor concentration, and hypochondriasis (Cobb, 1998).

The importance of identifying depression if present cannot be overstated. If the adolescent is depressed, but the drug use covers up the depression so that the counselor does not identify it, a dangerous situation is present. Suicide is the third leading cause of death among 15-to-19 years olds and the rate has tripled over the last three decades (National Center of Health Statistics, 1991). Many adolescents who attempt suicide either get drunk first or use other drugs prior to the attempt. Individuals who use drugs have two to eight times higher rates of suicide than those who do not use drugs (Cobb, 1998). Counselors should always conduct a suicidal assessment if there is a concern about depression. Suicidal assessments should examine risk factors, prior attempts, family histories of suicide attempts or completions, life stressors, losses, suicide plans, availability of lethal method, and death of family members or friends.

Conduct Disorders

According to the *DSM- IV*, conduct disorders are related to the use of illegal substances and illegal drug use may increase the likelihood that this disorder will persist. Individuals with conduct disorder tend to show little empathy or concern for the feelings of others. They have no real guilt and they tend to have low frustration tolerance. They are reckless and involve themselves in risk-taking behaviors like drug use (APA, 1994). Some other indicators of a conduct disorder are violations of basic rights of others, aggression to people and animals, destruction of property, deceitfulness or theft, and violation of parental rules. The diagnosis is often difficult to

reach because many normal adolescents appear self-centered, selfish, and impulsive. The *DSM-IV* indicates that a conduct disorder and repeated antisocial behavior often co-occur with alcohol abuse or with other substance-related disorders (APA, 1994). Grilo, Daniel, Levy, Edell, & McGlashan (1995) found that conduct disorder is predominately diagnosed more often with substance abuse disorder and disruptive behavior is also associated with drug abuse. Milin, Halikas, Meller & Morse (1991) found that approximately 91% of adolescents abusing substance had psychiatric disorders and there was a high rate of conduct disorders in the psychiatric group.

Panic and Anxiety Disorders

Anxiety is characterized by persistent and excessive worry, which includes symptoms of sweating, nausea, dizziness trembling, fear of dying, and palpitations (APA, 1994). Substance-induced anxiety disorder individuals who have panic or anxiety disorders tend to self-medicate most notably with cannabis, alcohol, and cocaine (APA, 1994).

Eating Disorders

While there is limited research on the relationship between eating disorders and drug use, Holderness, Brooks-Gunn, and Warren (1994) did find a relationship between eating disorders and substance abuse. They reported that the concurrence was higher for bulimic anorectics than restrictive anorectics.

Family Dynamics and Drug Behavior

Assessing the family dynamics and drug related behavior in a family is a critical element of the diagnostic interview. Genograms are recommended for family assessments. Gladding (1998) describes a genogram as a visual representation of a family, which is depicted by geometric figures, lines and words. The counselor who would like to conduct a genogram may wish to use a standard marriage and family systems text as a reference on how to do a genogram. The counselor will find that a genogram will provide a wealth of information relating to drug use among family members, suicidal attempts, deaths, illnesses, socio-economic factors, verbal and physical abuse, sexual abuse, family roles, triangulation (the case where two family members develop a coalition against another member), family values, communication patterns, criminal behavior, and family secrets.

While parents who do not use drugs tend to model non-drug behavior in their children, parents who use drugs are more likely to have children who use them (Chassin, Curran, Husson & Colder, 1996). Washton (1995) emphasizes that drug use by parents, grandparents, uncles, aunts, or siblings is related to the client's drug use. If there is a history of chemical dependence in the family of one or both parents, there is a tendency for increased use by children. Washton further maintains that just the history of drug use in the family can provoke the client's continued use. These families often serve as enablers, and financially support the patient's use, help in obtaining the drugs, sabotage the client's recovery, and tolerate the client's dysfunctional behavior.

Counselors should also look for patterns of genetic aspects of addiction, particularly alcoholism. The *DSM- IV* states that alcohol dependence has a familial pattern, and some of the transmission can be genetic (APA, 1994). Alcohol dependence is three to four times higher if the adolescent has family members who have the disease. There is a higher risk with a greater number of affected relatives, and it is higher in monozygotic than dizygotic twins (APA, 1994).

An interview should be completed with the adolescent's family after the structured interview with the adolescent. The counselor should make certain the adolescent knows about the planned interview and what questions will be asked. The counselor may choose to include or not include the adolescent in the family interview.

School Work Performance

The impact of drug abuse can have a dramatic impact on grades, class attendance, completion of work, and involvement in school related activities. Abrupt patterns of dramatic change, grades suddenly falling, truancy, dropping out of athletics or school related activities can be indicative of drug use. Counselors will find it helpful if teachers do a behavioral checklist or give an evaluation of the adolescent's performance.

When adolescents have worked or are working, an assessment by their employer can be helpful. Counselors

may ask the adolescent to sign a waiver of confidentiality to contact teachers or supervisors at work. The problems of confidentiality and protecting the privacy of the student may override the opportunities to obtain their input.

According to the *DSM-IV*, school and work problems are often linked to a conduct disorder, wherein teenagers do poorly in school, get into fights, have temper outbursts, have lower than average intelligence, have low academic achievement, get school suspension, get expulsion, or have problems at work (APA, 1994).

Peer Conformity

The major differentiation between children and adolescents is the emergence of the importance of peer groups. Adolescents spend more time with individuals belonging to their age group and persons who share their interests than at any other time in their life. They tend to break away from parents and seek peer group recognition and approval. Conformity is an important aspect of adolescent behavior. It not only impacts on the use of drugs, but influences other behaviors such as sexual activity, music choices, dress preference, and language.

Early and middle adolescents tend to exhibit more conformity behavior than older adolescents (Gavin, Furman & Miller 1989). Urberg (1992) indicates that peer influence impacts on the adolescent in regard to the use of drugs. Conformity research by Kandel (1978) suggests that adolescents seek out friends who engage in the activities they enjoy, and he finds that friendship plays a role in the use of marijuana. Assessment of the adolescent's conformity to peer pressure is essential in determining causation of substance abuse. Cobb (1998) states that gangs have risen in number dramatically in the past generation and believes that gangs have changed their function from protecting certain territories to engaging in criminal enterprises. Violence has increased, and 93% of gangs are involved in drug activities. The gangs no longer are involved just in the streets, but control the schools (Cobb, 1998).

Adolescent Substance Abuse Diagnostic Model Interview.

A diagnostic interview, which has been designed specifically for adolescents, is provided (Appendix A) and addresses the major areas that need to be investigated. Some of the questions are very direct and may be anxiety provoking to the adolescent. The counselor needs to determine based on his/her relationship with the client how the questions are to be asked, how they can be rephrased or whether they should be asked. The purpose in using a structured interview is to provide a means of obtaining sufficient information to make a diagnosis and treatment plan. The questions do not have to follow the sequence that is presented. It may be necessary to complete the interview in two or three sittings. It is recommended that questions concerning depression and suicide should be covered in the first structured interview period. The structured interview includes questions regarding drug usage, previous treatment, psychiatric/diagnostic issues, family influences, school and work information, and peer group influences. Notes should be taken when conducting the interview in order to provide documentation. Some counselors may chose to use mental status examinations to supplement this interview format. The use of a mental status exam is a clinical decision and depends on the severity of the problems. The structured interview that is provided in Appendix A has mental status questions, but the counselor may wish to add additional questions. Mental status exams usually assess appearance, behavior, mood and affect, speech and language, thought processes and content, cognitive functioning, and insight. A full mental status exam should be pursued if the adolescent appears to have severe problems in orientation, thought processes, and mood. Counselors need to determine if the behaviors are due to a drug induced problem or other psychiatric disorders.

Drug Testing

Drug testing is ideally done with the client's permission. However, if the drug screening is involuntary, it is preferable that the counselor not be placed in the role of punishing the client if the results are positive. According to Washton (1995), urine testing is recommended way to confirm whether or not a person is using drugs. He suggests that the testing can occur through a lab that picks up the sample at the counselor's office, or by the counselor requesting that the adolescent go to the screening office. Washton observes that the most common drugs found in urine tests are alcohol, cocaine, amphetamines, benzodiazepines, barbiturates, opioids, cannabinoids and heroin, and LSD.

When counselors request urine testing or blood testing, they need to understand the probabilities of false

positives or false negatives. Additionally, it is important to know how long a particular drug stays in the body after use. Interpreting drug tests requires a knowledge about pharmacology. The writer recommends using a consultant for these interpretations.

Psychometric Evaluations

Psychometric tests or inventories have distinct advantages over the structured interviews because they provide norming data. Frances & Miller (1991) suggest that the two best tests for adolescents are the Personal Experience Inventory (PEI) and the Chemical Dependency Assessment Survey. Washton (1995) stresses that structured questionnaires like the Michigan Alcoholism Screening Test (MAST) are not appropriate for adolescents because they were designed for adults. He recommends the PEI because it provides norms for comparisons of client scores with scores of "normal" individuals and also scores with adolescents in drug treatment centers. Latimer, Winters, & Stinchfield (1997) found that the Problem-Oriented Screening Instrument for Teenagers (POSIT) did well in identifying psychoactive substance use disorders in adolescents. Commonly used screening instruments include the *Psychosocial and Substance Use History, Initial Behavioral Assessment and Functional Analysis, Comprehensive Drinker Profile, Michigan Alcoholism Screening Test,* and *Questionnaire on Drinking and Drug Abuse.* Counselors must be aware that managed care or third party payers prefer structured interviews over psychometric testing (Ben-Porath, 1997).

Diagnosis

To arrive at a diagnosis, all the information which has been gathered, including age of the adolescent, frequency of drug use, amount of use, duration, and physical and psychological symptoms, must be organized and analyzed. Washton (1995) makes the following recommendations in determining a diagnosis:

(1) the client's substance use should be placed on a continuum that ranges from normal-to-abuse-to-dependency;
(2) the client's behavior should be assessed in relation to the criteria as found in the *DSM-IV*; and
(3) the counselor needs to be careful in making diagnoses related to illegal drug use because there are societal pressures when dealing with illegal drugs.

The counselor should not be placed into a situation where moral or political considerations are used in making a diagnosis. An informal diagnosis or using a diagnostic procedure other than *DSM-IV* is quite acceptable; however, it generally does not ensure third party payments. Counselors, in their diagnostic statement, need to include considerations regarding etiology, symptoms, and the prognosis of the disorder. At this time, it is necessary to decide if a dual diagnosis is appropriate. This information is essential in devising a treatment plan.

Treatment Planning

Once the diagnosis has been reached, it is important to formulate the treatment plan in conjunction with the client and significant others. The major considerations are:

(1) how severe is the drug disorder;
(2) is it a dual diagnosis situation;
(3) what is the optimal therapy to treat the individual and his or her disorder or disorders (residential vs.outpatient, confrontive vs. supportive, group versus individual);
(4) where should the adolescent reside (in his or her home or at a different location;
(5) what are the referral sources;
(6) what should be the duration of the treatment;
(7) what is the plan for aftercare or relapse;
(8) what role will the family play in treatment (family therapy, couples therapy, etc.);
(9) what are the financial resources that are available;
(10) what will be the arrangements regarding educational needs (should he or she continue to attend the same school, change school or have school provided in a treatment center);
(11) what role will the counselor play in the treatment; and
(12) what role will managed care play in the final decisions.

Most of these considerations interact with each other and need to be assessed in concert with each other. For example, type of drug use and severity impacts on residential or outpatient treatment, cost, possible referral resources, need for specialized treatment, school placement, duration of treatment, relapse issues, type of treatment, family treatment, and the role of the interviewing counselor. The limitation of space prevents examining in detail each of these aspects in treatment planning.

It is essential that the counselor be knowledgeable about the available services in his or her area, as well as outside of the area. Simply having a listing of the agencies and the providers is insufficient. Counselors need to have a good working knowledge of mental health providers who specialize in drug treatment, the population they typically serve (Is it an adolescent program?), the theoretical approach (Is it confrontive or supportive?), the effectiveness of treatment, their credentials, the cost, and the referral procedures to begin treatment. Counselors need to be aware that there are malpractice issues regarding making improper referrals. In the case of residential treatment, it should be with other adolescents not with different age groups.

In some ways, the role that managed care plays in influencing a treatment plan is a most important consideration. Whether the counselor agrees or not, managed care often drives the treatment plan in terms of type and availability of residential treatment, duration of treatment, number or outpatient visits, and type of service provider. The provider often has to be a part of a panel of providers approved by the managed care company.

Summary

In order to conduct a valid, comprehensive assessment, counselors need to be able to:

(1) use developmental norms for the different stages of adolescence (early adolescence, adolescence, and late adolescence) in making any decision regarding normal use or abuse of drugs;
(2) conduct an informal rapport building interview, which includes providing informed consent information to the client;
(3) conduct a structured diagnostic interview, which includes questions related to drug use, family history, peer relations, psychiatric issues, physical and psychological symptoms, and other relevant information;
(4) devise, if necessary, a drug screening procedure;
(5) select, if necessary, an appropriate psychometric instrument for the assessment;
(6) arrive at a definitive diagnosis (which may require a dual diagnosis);
(7) devise a treatment plan which uses the diagnostic information; and
(8) make an appropriate referral.

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APPENDIX A

ADOLESCENT SUBSTANCE ABUSE DIAGNOSTIC INTERVIEW

A: DRUG, TOBACCO OR ALCOHOL USE

Directions to using the table. (1) Enter the name of the drug used. (2) Enter the number of days that usage occurred in the past week, the number of months the drug was used in the last year, and the number of years the client has been using the drug, (3) Enter the amount of the drug used, and over what period of time, record for the past week the highest usage event (the highest consumption over the shortest period of time). For example, if the client drank 24 beers in 10 hours, which was the highest instance of abuse, circle 10 hours when active continuous drug use occurred, and then write in 24 beers for number, and 12 ounce bottles for volume. For months and years usage, record the high usage behavior reported in the clinical observation column. (4) enter the age at first use. (5) Below the following table indicate the last drugs used how long ago did it occur, and the names of drugs.

Table for Drug Usage

First choice/most used DRUG _____ Maximum usage in relation to hours 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 (continuing active use)	Number of days of drug use in past week	Number of months of drug use in Past year	Number of years of Use _____	Age at first use ___	Highest usage in the last week, amount used ounces, pills, etc Number Type, form container volume amount _____ _____	Clinical observations

Last Drug Used

Approximate last time any drug was used: ___3-10 hours ago, name of drug (s)_____
_____, ___11-24 hours, drug _____
over 24 hours, drugs_____, when_____

Second choice/most used DRUG _____ Maximum usage in relation to hours	Number of days of drug use in past week	Number of months of drug use in Past year	Number of years of Use _____	Age at first use ___	Highest usage in the last week, amount used ounces, pills, etc Number Type, form container volume	Clinical observations

Last Drug Used

Approximate last time any drug was used: ___3-10 hours ago, name of drug (s)_____
_____, ___11-24 hours, drug _____
over 24 hours, drugs_____, when_____

Third choice/most used DRUG _____ Maximum usage in relation to hours 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	Number of days of drug use in past week	Number of months of drug use in Past year	Number of years of Use _____	Age at first use ___	Highest usage in the last week, amount used ounces, pills, etc Number Type, form container volume amount _____ _____	Clinical observations

Last Drug Used

Approximate last time any drug was used: ___3-10 hours ago, name of drug (s)_____
_____, ___11-24 hours, drug _____
over 24 hours, drugs_____, when_____

Fourth choice/most used DRUG _____ Maximum usage in relation to hours 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	Number of days of drug use in past week	Number of months of drug use in Past year	Number of years of Use _____	Age at first use ___	Highest usage in the last week, amount used ounces, pills, etc Number Type, form container volume amount _____ _____	Clinical observations

Last Drug Used

Approximate last time any drug was used: ___3-10 hours ago, name of drug (s)_____
_____, ___11-24 hours, drug _____
over 24 hours, drugs_____, when_____

Fifth choice/most used DRUG _____ Maximum usage in relation to hours 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	Number of days of drug use in past week	Number of months of drug use in Past year	Number of years of Use _____	Age at first use ___	Highest usage in the last week, amount used ounces, pills, etc Number Type, form container volume amount _____ _____	Clinical observations

Last Drug Used

Approximate last time any drug was used: ___3-10 hours ago, name of drug (s)_____
_____, ___11-24 hours, drug _____
over 24 hours, drugs_____, when_____

Sixth choice/most used DRUG _____ Maximum usage in relation to hours 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	Number of days of drug use in past week	Number of months of drug use in Past year	Number of years of Use _____	Age at first use ___	Highest usage in the last week, amount used ounces, pills, etc Number Type, form container volume amount _____ _____	Clinical observations

Last Drug Used

Approximate last time any drug was used: ___3-10 hours ago, name of drug (s)_____
_____, ___11-24 hours, drug _____
over 24 hours, drugs_____, when_____

1. Are there any other drugs that you have used that you did not mention? Yes No

2. What was the first drug you ever had?
When?
Who did you do it with?

3. What effects have you felt from your drug use?
Physically (list reactions)

Psychologically (list reactions)

4. Do you believe that you can stop using these drugs (be specific)? **Yes No**
Have you ever stopped taking a drug? If no, go to questions 4.
Yes No
Which ones and how long?

5. Have you ever overdosed? If no, go to question 6. **Yes No**
When and how many times? 1 2 3 4 5 6 What were the drugs used?

6. **Where do you get your drugs?** (this may be a question you may not ask)
7. **Who uses drugs with you?** (the clinician needs to decide if identify information is appropriate)

8. **Do you smoke cigarettes?** If no go to questions 9. **Yes No**

   How many per day? 1-5 5-10 15-20 25-30 35+

   How many years have you been smoking? Less than 1, 1 2 3 4 5 6 7 8 9 10+

   How old were you when you started smoking? 8 9 10 11 12 13 14 15 16 17

9. **Have you ever had a blackout from drinking?** If no, go to question 10. **Yes No**

   How many times ? 1 2 3 4 5 6 7 8 9 10+
   Tell me about it.

   How old were you when you started drinking?
   7 8 9 10 11 12 13 14 15 16+

10. **If you have sniffed or used inhalants, would you tell me about it?** **Yes No**

    What have you sniffed? When did you do it?

11. **Did you ever use diet pills? Yes No**

COUNSELOR DRUG SUMMARY

_____**multiple drug use same time** _____**single drug use**

_____ **high drug usage** _____**moderate** _____**some**_____**none**

_____ **serious health problem** ____**moderate health** ___**mild health problem**___**no problem**

_____ **self report appears honest** _____**self report appears guarded** ____**self report unreliable**

_____ **problems very serious** _____**problems somewhat serious**_____**problems not too serious**

_____ **use disrupts school, social relations, etc**_____**does some disruption**___**no disruption**

Comments:

B. PREVIOUS TREATMENT (Inpatient and Outpatient)

1. Have you ever been treated or seen anyone for a drug problem in the past or for any other personal problem? Yes No
(If yes, determine the history of the care, dates, duration, problem treated, and names of providers (obtain a release of information if appropriate)

C. PSYCHOLOGICAL DISORDERS

The counselor asks about the symptoms that the client is experiencing, if any, in order to determine a diagnosis and to determine if there is a coexisting drug use problem.

1. Circle any of these that the client reports having: headaches, vomiting, sadness, unable to sleep, uncontrollable anger, anxiety, fear, panic attacks, no energy, crying, hearing voices, feeling alone, sleeping too much, loss of memory, unable to concentrate, dizziness, speech problems, tremor, blurred vision, sweating, fear of dying, black-outs, shaking, hallucinations, anxiety due past events (sexual abuse, rape, physical abuse), what kinds of problem related to past events?_____)
Other problems_____ Total number circled or listed_____

2. Do you ever have any these feelings mentioned without drugs? If no, go to question 3 **Yes No**

Which ones?

How long have you had these feelings or symptoms without the use of drugs?

3. Do you ever feel depressed? Yes No If no, go to question 4
_____very_____somewhat____a little____not at all
When and how long?

Can you usually get over it?

How do you get over it?

Do you have trouble getting up in the morning? Yes No

Tell me about your sleeping.

Do you cry a lot? **Yes No** *If yes, what do you cry about?*

Has anyone that is a good friend died recently? **Yes No**
If yes, tell me about it.

4. Have you ever thought of hurting yourself or others? Yes No
If yes, tell me about it. (Look for a plan)

Have had those thoughts today? **Yes No** *If yes, tell me about them?*

How would you do it if you were going to hurt yourself or someone else?

5. Has anyone in your family hurt themselves or someone else?
Yes No

6. Have you ever been in trouble with authorities or your parents? Yes No
If no, go to question 7.
What were some of complaints?

7. Have you ever been arrested when using drugs? Yes No
If no, go to question 8.
What were you charged with?

8. Have you ever destroyed anyone's property? Yes No
If no, go to 9.

9. Have you ever hurt an animal or a person for fun? Yes No
If no, go to 10. Tell me about it.

10. Have you ever hurt a friend with a weapon? Yes No
If yes, tell me about it.

11. Have you ever stayed out all night when your parents did not give you permission?
If yes, how often? Tell me about it.

12. Do you feel upset a lot? Yes No *If yes, tell me about it.*

13. Have you ever been fearful of going to school or going anywhere? Yes No *If yes, tell me about it.*

14. Have you ever felt overcome with fear, sweating, and breathing problems? Yes No
If yes, tell me about it.

15. Do you have mood swings or do you get angry or sad quickly?
Yes No
If yes, tell me about it.

16. Do you sometimes seem to stay up all night without any problem? Yes No
If yes, tell me about it.

COMMENTS

Counselor's Psychological Summary

(If necessary)(If necessary)
Tentative Diagnosis (1)_____ (2) _____

_____ severely depressed _____somewhat depressed _____not very depressed

_____ suicidal ____somewhat suicidal ____does not seem suicidal _____cannot access

_____ a lot of anxiety _____some anxiety _____very little anxiety_____

_____ very insensitive to others _____somewhat insensitive _____sensitive

_____ manic _____somewhat manic_____not manic

_____ very angry_____somewhat angry_____not angry

_____ dangerous to self or others_____does not seem dangerous to self or others

_____ psychotic features_____some psychotic features_____no psychotic features

_____ Single diagnosis _____dual diagnosis

(If necessary)

Axis I _____. _____ _____ . _____

Axis II _____ . _____ _____ . _____

GAF SCORE:____

Comments:

Code: (3,4,5) depression
(6,7,8,9,19,11) conduct **(12,13,14,15) Mood, Anxiety**

D. FAMILY DYNAMICS

Complete a genogram on the back of the form. Summarize the finding of the genogram. Include any family psychiatric disorders, dual diagnoses, depression, suicide attempts or completions, overdoses, pay attention to communication patterns in the family, and dysfunctional aspects, note deaths, divorces, blended families, drug use in family.

Counselor School Adjustment Summary

_____ has major school problems __has some problems___has no real problems

_____ has major work problems __ has some problems ____does not apply

_____very involved in school_____some involvement_____little involvement

_____good peer/teacher relations_____poor peer/teacher relations

_____good overall school adjustment _____ moderate_____ poor

Comments:

1. Has anyone in your family ever taken drugs? (if not answered in genogram) **Yes No** *If no, go to question 2*

What drugs?
Are they presently doing drugs? (*Check for each if drug use is occurring)*
Father Stepfather
Mother Stepmother Siblings

Who are other members of the family system/boyfriend/girlfriend/ that use drugs? Look for genetic aspects (particularly alcoholics).

2. What kinds of problems, if any, have you had with your parent.

Counselor's Family Summary

_____ family intact _____divorced_____blended_____single parent

_____ family income_____high _____moderate_____low

_____ deaths/parent(s)_____sibling_____other_____none

_____ sexual abuse____parent ____sibling____other____none reported

_____ physical or verbal abuse____parent____sibling____other ____none reported

_____ severe Illness or disability_____none reported

_____ family history drug use ___very involved ____somewhat involved ___none

_____criminal history _____none reported

_____communication_____good_____average_____poor

_____warmth, coehesion_____good_____average_____poor

_____drug use family high _____moderate_____none

Comments:

E. SCHOOL/WORK ADJUSTMENT

What is the school performance like? Does he or she have a record of poor grades, and other problems at school? The counselor should be looking at any abrupt change in behavior in work or school. Interviewsschool could be helpful.

1. How are you doing in school? What subjects do you like? *(be specific)*

2. What are your grades like? *(you may not wish to ask if you have the records)*
3. What grade are you in?

4. Do you like school? Yes No *Why?*

5. What kinds of things do you do at school other than your studies? *Are you involved in any clubs, sports or band?*

6. **Do you go to school activities? Yes No** *Which ones?*

7. **Have you had to miss classes lately? Yes No** *If yes, how many times this year?*

8. **Have you had any problems at school? Yes No** *If yes, what?*

9. **Have you ever taken a weapon to school? Yes No** *If yes, tell me about it.*

10. **Have you ever been suspended or expelled from school? Yes No**
If Yes, tell me about it.

11. **Do you have/had a part time job? Yes No** *How are things going with it?*

Counselor School Adjustment Summary

_____ has major school problems __has some problems___has no real problems

_____ has major work problems __ has some problems ____does not apply

_____very involved in school_____some involvement_____little involvement

_____good peer/teacher relations_____poor peer/teacher relations

_____good overall school adjustment _____ moderate_____ poor

Comments:

F. PEER RELATIONS

1. **Who are some of your good friends?** *(identifying information is not necessary)*

2. **What do you like to do with your friends?** Do you ever do pranks with friends?

3. **Do you and your friends do drugs?** *If no, go to question 4.* If yes, what drugs?
   How long have you been in this group?
   Did your friends that you knew before these friends do drugs? Yes No
   How do you get drugs? *(you may not wish to ask)*

4. **Are their gangs where you live? Yes No** *If no, go to question 5.*
   Do you belong to a gang? **Yes No** *(questions could be asked if this is true)*
   How long have you been in this gang?
   Who were your friends before? Does the gang you belong to do drugs? Yes No If yes, what drugs? How often?

5. **Have you ever had any problems, fights etc. with individuals your age? Yes No**

6. **Do you have a boyfriend or a girlfriend? Yes No.** How long have you been seeing this person?

Counselor Peer Group Control Summary

_____Peer group very controlling ___somewhat controlled_____little control

____is a gang member ___appears to be a gang member___does not appear

___peers support drug use __peers tend to support drugs ___no peer support

Comments:

Assessment, Diagnosis, and Treatment Planning

Thomas Mullis

Rationale

In order to complete a comprehensive assessment, it is necessary to establish rapport with the client, pursue a structured diagnostic interview, determine a diagnosis (understand dual diagnoses), and develop a treatment plan.

Overview

The chapter content addresses the material identified in the above rationale. During the rapport building interview, the adolescent should be provided with information related to informed consent. Confidentiality is important, even if the client is a minor and an involuntary referral. The client always has the choice of being non-compliant even in the face of adverse consequences, like being placed in detention. The adolescent should be provided with an overview of the questions that will be asked such as: how they will be used; who will have access to the information, and how the information provided may impact on him or her personally, legally, or both, what legal options they have; and what kind of legal access they have to their records. Adolescents are often resistant to self-disclose to professional counselors and many adolescent clients involved in drug use are either court referred or school referred. They have serious concerns regarding their privacy, violating peer confidentiality, disappointing parents, incurring legal and other negative consequences of admitting drug use. These concerns are valid because in most instances, the counselor cannot guarantee confidentiality. The recommendation is that, when possible, the counselor should not pursue obtaining identifying information about peers, unless the information provided is important for legal or personal reasons. Counselors need to be very aware of their feelings and thoughts concerning the situation they find themselves. Counselors should be empathic, non-judgmental, non-confrontive, and use open-end questions to establish rapport in the adolescent and counselor relationship. A sense of trust needs to be developed. The rapport building interview may be conducted at a separate time or simply precede the structured interview. While the major purpose of this interview is to develop rapport with the adolescent, the counselor is provided with significant opportunities to assess a wealth of information. Non-verbal communications such as: eye contact, facial expressions, mood, head movements, tense or relaxed mood, and variations in voice pitch are important to observe in assessment. Initiating a rapport-building interview prior to a diagnostic structured interview is essential to ensuring the validity of the latter. During this interview, while it may not be legally necessary, it could help if the adolescent would agree to sign a waiver of confidentiality so that the counselor may interview significant others. The use of an unstructured interview is important in assessment; however, a structured diagnostic interview is necessary in order to obtain specific detail about drug use.

The purpose in conducting a structured interview is to provide a format that provides the counselor with the essential information needed to conduct a comprehensive assessment. The interview should be direct, concrete and done in a logical and timely manner. It is comprehensive as outlined in chapter 5 and provides a means to identify use and abuse of drugs, alcohol or tobacco, and related social context as well as psychiatric symptoms needed to reach a diagnosis.

Once the diagnosis has been reached, it necessary to formulate the treatment plan in conjunction with the client and significant others. The major considerations that need to be addressed are

(1) How severe is the drug disorder;
(2) Is this a dual diagnosis situation;
(3) What is the optimal therapy to treat the disorder or disorders (residential vs. outpatient, confrontive vs. supportive, group versus individual. Where should the adolescent reside (in his or her home or reside at a different location);
(4) What are the referral sources;
(5) What should be the duration of the treatment;
(6) What is the plan for aftercare or relapse;
(7) What role will the family play in treatment (family therapy, couples therapy, etc);

(8) What are the financial resources that are available;
(9) What will be the arrangements regarding educational needs (should he or she continue to attend the same school, change school or have school provided in a treatment center); and finally
(10) What role will the counselor who does the assessment play in the treatment?

Most of these concerns interact with each other and need to be assessed in concert with other considerations in devising the treatment plan. For example, type of drug use and severity impacts on residential or outpatient treatment, cost, possible referral resources, need for specialized treatment, school placement, duration of treatment, relapse issues, type of treatment, family treatment, and the role of the interviewing counselor.

Objectives

1. To provide an understanding of how to establish rapport with an adolescent drug client.
2. To provide an understanding in how to conduct a structured diagnostic interview, which asks specific personal questions to adolescents.
3. To provide the student an understanding of how to do a diagnosis and how to do dual diagnoses.
4. To provide the student with an understanding of important considerations in how to develop a treatment plan.

Activities

Exercise I: Informal Assessment Interviewing

1. One of the class members is to play the role of a 14-year-old adolescent male who is involved in excessive use of alcohol. He is an involuntary referral who has never been assessed. He is drinking on a regular basis about a six-pack a day. Three member groups will be formed from the class. They will act as counselor, observer, or client. The purpose of the interviewing is to develop rapport, explain the limits of confidentiality, and other issues relating to informed consent. This is a rapport building interview and obtaining specific drug information is not the goal. The primary goal is to develop trust. After the interviewing, the client (student), observer (student), and counselor (student) will discuss the experience in terms of what seems to be effective in working with adolescents. After the small group processing, the entire class will discuss the experience.
2. The client is a 17-year-old female who is an involuntary referral. Students are to complete an assessment, but as in the first, you need to have a rapport building interview. She is reportedly using crack. One member of the class acts as counselor and another member acts as the client. Different members of the class are given the opportunity to interview the client, and the class evaluates the experience.

Exercise II: Interviewing in a Structured Diagnostic Format (Sensitive Areas)

1. Have a number of different counselors (students) take some of the questions from the diagnostic interview as presented in Chapter 5 and role play a situation in which sensitive questions about the history of drug use are asked of a client (student). Questions asked would be what drugs are being using, how often, etc. The instructor will give the client (student) information about his or her drug use. After the interview, the instructor will reveal the drug use, and the class will then evaluate how effective they were in interviewing and determining the drug use.
2. Do the same exercise, however, change it to ask the client (student) about peer use of drugs. Use the diagnostic interview as a format to select questions.
3. This exercise may be modified by age, gender, type of drug use. The client could be interviewed about family.

Exercise III: Diagnoses

1. The instructor provides a group of three students with a dual diagnosis (only for the person playing the client) with background information. The students will not be told that it is a dual diagnosis situation. The counselor (student) will briefly interview the client (student) looking for dual diagnosis issues and the other student will observe. The students should use the questions in the diagnostic intervention proved in chapter 5. The observer may interview the client when the first student

finished. The students in each group will make a diagnosis. They will also do a Global Assessment Functioning. When the counselor (student) has finished the interview, members of the class will write down what they did in the small groups.

2. The instructor leads a discussion regarding dual diagnosis and depression and how it relates to suicide.

Exercise IV: Treatment Planning

I. The students are provided with an assessment of a drug client by the instructor. The case is written to reflect the kinds of clients the students in the class will probably encounter, and what treatment options are available in the setting they work. The case needs to be specific in diagnosis and the student needs to be provided with information that is in the structured interview as presented in the text.

2. The students are then divided into groups of three to discuss treatment planning. One of the individuals is designated as spokesperson and reports to the class on a treatment plan.

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