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Excluding a Psychoactive Substance Use Disorder in Forensic Psychiatric Evaluations

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ABSTRACT: The forensic psychiatrist is sometimes asked to exclude that a person has a psychoactive substance use disorder, for example, in a security worker who has access to weapons, in a health care professional who may be alcohol/drug impaired, or in a parent, in a deprived child or custody hearing matter. After examining the data that are leading to the evaluation, these evaluations require corroborated background information to look for developmental and genetic antecedents that might be consistent with substance abuse and dependence; inquiry into the history of substance use; and an examination of areas, in which problems from substance use can occur, namely in family and other social relationships, at work, in legal settings, in physical health, and in personal and psychiatric reactions, for example, in suicidal behavior. Then a physical exam and laboratory evaluation are conducted to look for medical evidence of substance use and complications therefrom, and a mental status exam is performed and psychological testing is obtained as required, for example, a Minnesota Multiphasic Personality Inventory (MMPI) or neuropsychological testing. When such an evaluation is essentially negative, the examiner can say, within the limits of the evaluation, that a psychoactive substance use disorder does not exist.

KEYWORDS: psychiatry, psychoactive substance use disorder, psychiatric evaluations

"I'm not an alcoholic!" is frequently heard by physicians, and there are times when it is an accurate statement. This presentation will review how to conduct a forensically oriented psychiatric evaluation to determine if a person is an "alcoholic" or a "drug addict," or in *Diagnostic and Statistical Manual of Mental Disorders* (DSM III-R) [*1*] terms, to determine if the person has a "psychoactive substance use disorder," particularly of a dependence or abuse nature.

There are many contexts for such evaluations, and they include criminal contexts in which a person is trying to avoid substance abuse treatment as part of the disposition, for example, in a driving while intoxicated (DWI) or a fraudulently obtained controlled substance charge; in a malpractice case in which the plaintiff is claiming that the substance use disorder did not exist before the alleged negligent prescribing of an abusable substance, for example, diet pills; in a health care worker whose behavior has raised questions as to whether or not he or she is impaired and needs substance abuse treatment; in a parent trying to obtain or retain custody; or in a law enforcement or security worker who is responsible for a weapon and who

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in someway has gotten his or her supervisor's attention relative to a possible alcohol or drug problem. A specific example of the latter type to be returned to below was a 38-year-old, male, law enforcement officer who had become intoxicated at a national convention and confronted members of a rival agency. His superiors were informed leading them to wonder if alcoholism was behind the confrontation and if they could continue to allow him to carry a weapon safely; a psychiatric evaluation ensued. As with all of the evaluations here, the person being evaluated has a vested interest in not having an alcohol- or drug-related problem diagnosed, and it is the task of the evaluator to conduct an adequately comprehensive and objective evaluation to determine if such a psychoactive substance use disorder is present or to be able to say with adequate medical certainty that such a disorder is not present.

The evaluations under discussion here are not generally ones relative to whether or not *any* alcohol or drug use has occurred. There are settings in which any substance use of particular kinds is a significant problem, such as a truck driver, air traffic controller, or member of the armed forces with a confirmed positive urine test for marijuana on a random check while on duty. In these cases the issues may be quite different from the ones to be discussed herein, in which it is not a question of documenting a single occasion of psychoactive substance use, but examining to see if there is a pattern of continuing or intermittent use amounting to a diagnosis of psychoactive substance abuse or dependence; such a latter evaluation requires a comprehensive, corroborated examination looking for the criteria for primarily an alcohol or drug abuse or dependence diagnosis. Depending on the way the evaluation problem presents itself, other psychoactive substance use diagnoses may also be of concern, such as the presence of or a history of psychoactive substance-related withdrawal, delirium, or dementia; in a presentation of this length these other psychoactive substance-related disorders can only be briefly mentioned (see Table 1; for additional details see Ref *1*, pp. 123-163).

The main, forensically relevant abusable substances are alcohol; amphetamines and similar stimulants; cocaine; *Cannabis;* hallucinogens such as lysergic acid diethylamine (LSD) and mescaline; inhalants such as glue and paint thinners; opioids such as codeine and heroin; phencyclidine (PCP) and related substances; sedatives, hypnotics, and anxiolytics; and substances not otherwise classified, such as anticholinergics, nitrous oxide, ether, and amyl- or butyl-nitrite.

To exclude, or make, a psychoactive substance abuse or dependence disorder diagnosis, it is necessary to start with appropriate criteria, and those from DSM III-R are used herein [*1*, pp. 166-169]. Although the case examples to be discussed were examined using the DSM III criteria of 1980, the conclusions would have been the same using DSM III-R criteria.

TABLE 1—*Psychoactive substance use disorders.*

1. Abuse
2. Dependence
3. Intoxication
4. Withdrawal
5. Delirium
6. Dementia
7. Amnestic disorder
8. Delusional disorder
9. Hallucinosis
10. Mood disorder
11. Anxiety disorder
12. Personality disorder
13. Alcohol idiosyncratic intoxication
14. Organic mental disorder not otherwise specified, for example, to anticholinergics

The Evaluation

How to examine for the specific criteria and other aspects of a psychoactive substance abuse or dependence disorder will now be discussed, with emphasis on the more objective information for such a disorder. As with all evaluations, good clinical judgment must be used in deciding how much detail to pursue in various parts of the evaluation and in considering how important a particular piece of information is. The goal of the evaluation is to be able to say when it is over that the examination has been as comprehensive and careful as necessary, and that the evaluator can testify with adequate medical (clinical) certainty that there is or is not a psychoactive substance use disorder; the evaluation will also have been thorough enough to make other psychiatric and important medical diagnoses as required.

Presenting Problem

The presenting problem will provide general guidelines for the type of examination, records required, who needs to be interviewed, and so forth. In practice, some of the presenting problem information will often come in an initial phone call, sometimes from an attorney. This initial contact provides an occasion to advise about needed information for the evaluation, for example, the need to interview others than the examinee and the need for medical and other records (see below).

History of Presenting Problem

This part of the evaluation requires a careful description of the presenting situation that is leading to the evaluation, and a review of the person's acknowledged lifetime alcohol and drug use and recent use beginning several months before the episode in question. It is then necessary to review the major areas in which substance use problems can occur; all of these potential problem areas can provide external, objective information with less chance for bias than from the information obtained directly from the person being examined.

Personal-psychological problems—Here one needs to inquire about symptoms that can be associated with substance misuse, including concentration or memory problems, blackouts and hallucinations such as can be associated with LSD or PCP intoxication, or alcohol or sedative-hypnotic-anxiolytic withdrawal. One also needs to ask about participation in violence to others and suicide attempts, and ask about suspicious and other paranoid-type behavior that can be associated with the use of cocaine and other stimulants. Inquiry can also be made about the degree to which the person may have failed to achieve his or her potential in work or education and try to determine if such a failure may be substance use related. Inquiry can also be made about past attempts to cut down or control substance use and how much the person thinks about using, that is, has a persistent desire for or preoccupation with use. The examiner also needs to inquire for evidence of psychiatric diagnoses with an increased association with substance misuse, especially affective disorders, posttraumatic stress disorder (PTSD), organic mental syndromes, and antisocial and borderline personality disorders. (Some of these areas of inquiry will allow for external corroboration, as discussed below.)

Family and Other Relationship Problems—As appropriate, the examinee is asked about problematic areas in relationships with parents, siblings, spouse(s) or significant others, and children looking for abusive and exploitive relationships and multiple spousal significant other relationships. The evaluation should inquire about possible poor relationships with children and about troubled children, looking for the types of problems in children that can be secondary to alcohol or drug use or both in a parent, for example, problems in school, drug problems, and so forth. As much of this history as necessary and feasible needs to be corroborated, keeping in mind that those who can provide the corroboration may be afraid of saying certain things and/or may have a vested interest in the outcome of the evaluation,

for example, in helping the family member keep his or her job. To facilitate objectivity, these corroborative interviews should be conducted without the examinee present. These interviews should begin with appropriate supportive comments about how it may be awkward for the interviewee to say certain things, about the interviewer's desire to try to obtain help for any alcohol/drug problem in the examinee if indicated, and so forth.

While observing the emotions and other psychological aspects of the reactions accompanying the verbal responses, family members and significant others can be asked a series of questions from more open-ended and general to more specific ones. For a spouse or significant other this can begin with how the relationship with the examinee started, what attracted them to each other, why they decided to marry or live together or continued dating, on to areas of disagreements in their relationship and how these are settled. If there is a denial of any disagreements in the relationship it will raise questions about the overall veracity of the responses. The spouse or significant other can also be asked such specific questions as the degree and type of alcohol/drug use she or he is aware of by the examinee, whether she or he worries about the alcohol/drug use of the examinee, whether she or he has ever called in to work for the examinee when the examinee was ill after a weekend of drinking or drugging, if she or he has ever been verbally or physically abused, and how the children, if any, are treated, and, if appropriate, whether there is any child abuse.

The spouse/significant other can also be asked if either parent in her or his family had an alcohol or drug problem, and if so, its characteristics, if the parent ever recovered, and so on. Children often feel responsible for parental alcohol/drug problems and may grow up trying "to rescue" a spouse from his or her alcohol/drug problem, a pattern the examiner should keep in mind. Also, it is appropriate to review the spouse/significant other's own alcohol and drug use history and current use and consider this information in evaluating the overall data; for example, it would be an unusual relationship where a female spouse had a significant alcohol or drug problem but the male examinee used little or no alcohol or drugs.

When indicated and feasible more than one family member can be interviewed and the interviews compared; these different family members might be the spouse and a child or the spouse and a parent. In one malpractice case in which an issue was the presence or absence of a substance use disorder before treatment with the physician in question, the spouse knew only a little of the examinee's history before treatment by the physician and also appeared to have an "axe to grind" regarding the physician, whereas the parent who was interviewed could provide more background information and was embarassed by the current drug abuse problems of their child and tended to downplay it. By having the two family member interviews it was easier to put together a picture of the examinee more consistent with the remainder of the examination data.

Work and Leisure Problems—Here one inquires about decreasing job performance or lack of appropriate promotions; absenteeism, especially after weekends; disciplinary proceedings in work settings; work injuries; and multiple jobs whether or not the person has quit or been terminated. Depending on the overall evaluation picture, the examiner will usually want to check with at least the current employer for corroboration. Leisure is included in this area of inquiry to cover persons who do not work, for example, retired or disabled people; with such a person one should ask how his or her time is spent looking for problems or behaviors that may be alcohol- or drug-related, for example, the retired, healthy person who "doesn't have time" to visit his children or do certain household chores and so forth.

Medical Problems—One needs to inquire about substance-related medical problems, considering the possible medical problems most related to the main substance(s) in question in the evaluation. Medical problems can occur in four general substance use-related ways, namely during intoxication, by chronic use, from withdrawal, and from ignoring general medical care because of substance use or preoccupation. Regarding intoxication, the main areas of inquiry relate to injuries from accidents, fights, or suicide attempts [*2*]. The possible medical problems from the chronic use of alcohol alone are extensive (see Ref *3*), but include

alcohol-related gastritis, otherwise unexplained chest pain, peripheral neuropathy, and dementia. Snorting of cocaine can be associated with nasal problems, free-base cocaine or extensive marijuana smoking can be associated with chronic pharyngitis or bronchitis, and any intravenous drug use can be associated with hepatitis or infection with the human immunodeficiency virus (HIV). Women should be asked about their gestation history, with attention to spontaneous abortions, low birth weight infants, drug addicted newborns, and children with retardation and/or other evidence of the fetal alcohol syndrome.

The most common withdrawal problems are nausea and vomiting from alcohol withdrawal and tremors, seizures, and delirium from withdrawal from alcohol or any sedative-hypnotic-anxiolytic. There is also the possible history of a narcotic withdrawal syndrome and of a "crash" (acute depressive episode) secondary to stopping chronic cocaine or other stimulant use. Among the more common aggravations of general health problems from substance preoccupation and use are poorly controlled diabetes mellitus or hypertension from alcohol excess or poor dental care from the same cause or from cocaine or opioid use with their analgesic effects.

All possibly relevant prior medical (and psychiatric) records should be obtained to look for the above and other substance use-related medical problems, including relevant laboratory test findings (see below). Incidental negative recent laboratory evaluations obtained in the course of medical evaluations for nonsubstance-related reasons are particularly helpful in showing the lack of expected findings if the person met the criteria for substance abuse or especially dependence, especially for chronic, extensive, alcohol use which has such pervasive medical effects. Conversely, someone with multiple episodes of treatment for injuries will raise a suspicion for possible psychoactive substance misuse with multiple episodes of problematic intoxication [*2*].

Legal Problems—A full legal history should be taken and corroborated as necessary, with particular attention to driving while intoxicated/driving while under the influence (DWI/DUI) offenses, assaults, charges for possession or sales of controlled substances, and any other possible substance use-related offenses. Current or prior members of the armed forces should be asked about disciplinary proceedings against them while in the service, with consideration of whether these might be substance use related.

Past History

Besides prior medical and psychiatric treatment history, the inquiry about past history should include any substance use treatment or attendance at such peer support groups as Alcoholics Anonymous or Narcotics Anonymous. Although this has not been the case in any of the author's clinical experience for these types of evaluations, it is possible that the examinee acknowledges that there has been a prior substance use disorder that is claimed to have been in clear remission at the time of the circumstances leading to the evaluation.

Family Background

Inquiry into the family background will look for the possibility of increased alcohol/drug use in the person being examined because of a genetic or environmental background for same, that is, parental alcoholism. Also of interest in learning about the family background will be the presence or absence of substance use problems in siblings. Certain family settings are also associated with a decreased chance for substance use problems, for example, alcoholism in traditional Jewish families.

Physical Examination

The physical examination needs particularly to look for evidence of intoxication and withdrawal and of complications from substance use (see Ref *3*), with special attention to the

possible physical findings from the main substance(s) under consideration. The examination should include looking for evidence of injuries and sites of intravenous (or subcutaneous) injections, with attention to the fact that virtually any site may be used for injection depending on where veins (or skin) are accessible and the desire to conceal use. In brief, other areas of emphasis include pupillary size and reflexes, nystagmus and conjunctivitis, nasal mucosal injury, pharyngitis from cocaine and marijuana smoking, hepatomegaly from alcohol- or drug-related liver damage, spider nevi or collateral abdominal circulation from alcoholism, and alcoholic neurological damage including peripheral neuropathy or cerebral or cerebellar damage.

Mental Examination

On the mental status examination other than looking for evidence of intoxication or withdrawal, the examination should evaluate the person's reactions to the discussion of alcohol and drug use and examine as necessary for evidence of the full range of substance-related disorders (Table 1), for example, for dementia that could be secondary to chronic alcohol use. The mental status exam will also help the examiner find or exclude the general psychiatric conditions with an increased association with substance use problems as discussed above, particularly affective disorders, PTSD, and antisocial and borderline personality disorders.

Laboratory Evaluation

There are many abnormal laboratory tests associated with substance use problems and primarily only the main ones will be mentioned here [*4–6*]; the relevant tests should be performed at the time of the evaluation, and prior medical records should be examined for these tests for possible laboratory abnormalities.

Standard tests for liver damage (serum glutamic-oxaloacetic transaminase [SGOT], serum glutamic-pyruvic transaminase [SGPT], alkaline phosphatase, and so on) should be performed. Among the most sensitive and specific of these if there is no other chronic disease is gamma-glutamyltranspeptidase (GGT) [*4,5*]. In examining for alcohol misuse, red blood cell mean corpuscular volume (MCV) [*4,6*] is one of the best tests because of chronic alcohol use interfering with folate handling in red blood cell production; both MCV and GGT can remain elevated for weeks after chronic, heavy alcohol use has ceased [*7*]. When indicated, tests for hepatitis and HIV should also be conducted because of their high association with intravenous (IV) drug use. If dementia is suspected, a computed tomography (CT) scan of the brain can be helpful, and an electrocardiogram (EKG) can show alcohol- or other substance-related cardiac arrhythmias.

While none of these tests are specific for a substance use disorder, negative results can lower one's index of suspicion while positive results raise it. This is especially true for heavy alcohol use and hepatic enzyme and MCV testing where research has been more extensive [*4–7*]. But otherwise unexplained hepatitis B or HIV positivity would also significantly raise one's suspicion for an IV-type drug problem.

Direct examinations for alcohol in serum or breath should be done if at all relevant, and urine should be examined for alcohol and the standard abusable drugs. There are certain psychoactive substances that will not be detected on some of the usual, more routine urine testing methods, and this includes fentanyl, the preferred substance of some substance using anesthesiologists [*8*]. Such urines must be collected under direct visual supervision and with adequately careful handling, and positive findings should be confirmed by a second method. When required, chain of custody procedures will be necessary and the confirmatory method will have to meet vigorous standards [*9,10*]; nonetheless, false positives (and false negatives) will still occur (even a .02% error rate will produce 20 erroneous tests per 100 000 testings). Repeated serum, breath, and urine testings add diagnostic certainty and credibility, especially when some of these testings are done or have been done unexpectedly.

The significance of a positive alcohol or drug finding in body fluids will depend on the substance in question, when found to be positive, and sometimes its concentration. This subject is too extensive for review here [*11,12*], but briefly, drugs vary over a wide range in how long they remain in the body, with, for example, even large amounts of alcohol being gone by about 24 h, whereas even limited marijuana use can be detected in urine for a few days and chronic, extensive use can be detected even two and three weeks after usage has stopped. Futhermore, the relationship between a positive serum or urine test and intoxication and impairment, for example in a work setting, also varies with the substance, its concentration, and when detected. Barring such complications as chronic cerebral damage from alcohol or drug use or a withdrawal syndrome, the usual effects of alcohol or drugs are generally gone within hours or a day or so at most, even though a drug may persist in the body. This nonetheless means that even fairly low-level weekend recreational use of, for example, marijuana, can be detected in the urine a few days into the workweek when there may be no clinically detectable impairment in work performance. For certain employees this detection may nevertheless be a problem in their employment, for example, in an air traffic controller who may as a result of such a positive test still face suspension from work until a drug treatment program is completed.

Psychological Testing

When indicated, appropriate psychological testing should be obtained. The Minnesota Multiphasic Personality Inventory test (MMPI) with its validity scales can help in a general assessment of psychopathology and of the examinee's test-taking veracity and attitude, for example, if he or she is excessively trying to present a favorable impression. Such special MMPI scales as the McAndrew Alcoholism Scale may be of some use, but its validity is uncertain [*13*]. Neuropsychological testing can help in assessing for possible alcohol-related brain damage.

Conclusions from Evaluation

At the conclusion of the evaluation, which has included appropriate laboratory and other corroborative data, the examiner should be able to conclude and testify with adequate medical certainty whether or not there is sufficient evidence for a psychoactive substance abuse or dependence or other substance disorder diagnosis. The evaluation will, of course, also allow other diagnoses to be made as indicated, and some of these examinees may show such problems as personality disorders or other diagnoses that have contributed to their being evaluated for a possible substance-related disorder. In reporting the findings and conclusions, the main limitations of the evaluation should be reported, for example, whether all prior relevant medical records have been reviewed, if interviewed family members appeared afraid to be interviewed, and so forth. At times the examination will still be inconclusive even after a careful, comprehensive evaluation, and the examiner needs to so state. Whether the degree of medical certainty in the conclusions is satisfactory for the desired purpose of the evaluation will depend on various things, including the possible consequences of an erroneous conclusion; for example, more risk and uncertainty is likely more acceptable in a custody case dispute than in a weapon-carrying inner-city police officer or control room member of a nuclear missile crew.

Case Vignettes

Case A

By way of illustration of the above material, the 38-year-old, law enforcement officer previously mentioned will be returned to first. Soon after the incident of intoxication at a na-

tional convention, the officer was seen for an evaluation at a community mental health center, where a diagnosis of alcohol dependence was made. In view of a 10-year, very favorable, work history and of the serious job consequences of the alcohol dependence diagnosis, the officer sought and his superiors granted him a second evaluation. As part of his second evaluation details of his disciplinary problems were obtained, his superiors and spouse were interviewed, and the mental health center records were obtained.

When interviewed the examinee admitted fairly regular but not heavy drinking of beer without other psychoactive substance use. No evidence could be found from his history of significant and repeated problems that could be related to alcohol or drug use, and his medical, laboratory, and mental status exam failed to detect any such problems. He did acknowledge that when the "presenting problem" began and his supervisors thought that he had an alcohol problem that he began to wonder himself if he did. It also became clear that he had a strong need for approval from his supervisors. His supervisors denied knowledge of any significant problems that could be explicitly related to alcohol or drug use other than the recent episode of intoxication and poor judgment at the law enforcement convention and a similar episode many years previously. His wife denied any possible alcohol- or drug-related problems in her husband, but she was worried about his current work problems and acknowledged some concerns about the five dollars or so he spent weekly on beer in view of their tight finances, including expenses for a child with severe chronic illness. Psychological testing revealed generally fairly honest testing responses with some defensiveness and rigidity and mild to moderate distress related to the current problems at work. There was no evidence of organic dysfunction in the psychological testing.

The conclusions of the evaluation were that the examinee did not have an alcohol- or drug-related disorder nor any other diagnosible psychiatric or medical condition. He did have some current distress and personality rigidity, neither amounting to a diagnosis, and he was offered the option of short-term psychotherapy to help with the current distress. A copy of the evaluation findings and conclusions was sent to his employer, along with suggestions—not recommendations—for possible treatment; alcohol treatment was not recommended or suggested. The examinee chose not to obtain the suggested treatment and his superiors did not insist on it.

On a recent follow-up inquiry with the employer one and a half years after the initial evaluation, it was learned that after the evaluation report was received the examinee had immediately been returned to full-duty status, including carrying a weapon, and he was said to currently be "doing real well." He was reported as appreciative that his supervisors had worked with him on the work problems and he had responded very favorably to the support. The examinee was also said to have done very well on some recent difficult cases, underscoring his general high quality of work performance.

Case B

A military police officer came to the attention of his superiors after he had hidden the weapon of a man under his command "to teach him a lesson" about always knowing where his weapon was. Since this was a second questionable incident within a few months period of time, his superior chastised him and threatened a demotion at a morning meeting with the officer. During this meeting the officer became very apprehensive and broke down tearfully, in part fearing for his job, but also because he was under considerable personal stress, and a demotion would mean a cut in salary and his finances were barely scraping along in a new marriage after an expensive divorce. Because of the emotional breakdown, his superiors had him seen by a company physician, who detected the odor of alcohol on his breath, eventually leading to an evaluation with the author. After a comprehensive evaluation as above, it was found that the patient drank several drinks one or two nights per week, occasionally to intoxication, and had done so late the night before the morning meeting with his superiors. Nonetheless, the conclusion of the evaluation was that the officer did not have a substance abuse

disorder and that he could return to full-duty status. Work counseling was recommended to help the officer deal more appropriately with his subordinates, and he and his new wife were given suggestions on how they could more effectively deal with the stresses in their marriage other than by the degree of drinking that the officer had been doing.

Follow-up with the officer's superior more than a year after the original evaluation found that the officer was doing well and there had been no new disciplinary episodes or concerns over his drinking.

Case C

In a criminal case a health professional had forged prescriptions to obtain narcotics, which behavior had been detected by a suspicious pharmacist. This led to reporting the matter to legal authorities and to an initial evaluation that diagnosed a drug abuse disorder and recommended inpatient substance abuse treatment. The health professional was then referred through his attorney for a "second opinion."

This second evaluation proceeded as earlier described with obtaining prior medical records and interviewing and examining the patient and obtaining psychological testing; since he did not live close to family members and did not have a long-term "significant other," no such persons were interviewed. The medical records showed some half-dozen episodes over the previous year of presenting to area hospitals for complaints of acute pain of various kinds, generally treated with narcotic injections; a somatic basis was found for some of the episodes. These hospital visits had begun after the stress of a marital breakup and large financial indebtedness associated with beginning his professional practice.

The evaluation found him to be an uninsightful, narcissistic person who could not accept the "weakness" that he was having major problems handling the stresses in his life, stresses that were also aggravating a predisposition to migraine headaches. He was handling the stresses with somatization, and using the rare episodes of presenting at hospitals to obtain narcotics for his headaches, which headaches he had also been loath to acknowledge to others because he considered them an example of being unable to manage his life. The forged prescriptions, of which only three occasions were discovered and all for only a few tablets of narcotics, were ostensibly used to treat his headaches. The evaluation also found that the patient had had fleeting suicidal thoughts, which he acknowledged hesitantly.

The conclusion of the evaluation, nonetheless, was that in view of the infrequency of the drug use and its limited nature, a substance use disorder was not diagnosed, but other psychiatric diagnoses were made. He was recommended for psychotherapy and biofeedback for his headaches, which recommendations were partly followed.

Follow-up inquiry with a probation counsellor over a year later found that the patient's general functioning was considerably improved, including his headaches, there was no known evidence of an alcohol or drug problem, and there were no new legal difficulties.

Case D

Contrary to the above examples, a physician did not avoid a drug abuse diagnosis in spite of his adamant initial denials. An evaluation was requested by his attorney after the physician, an anesthesiologist, had come to the attention of his superiors because of drug-recording irregularities in medical records. As the evaluation proceeded and material from the employer was examined, the evidence of narcotic recording irregularities grew, as did documented evidence of such peculiarities in the physician's behavior as appearing to be asleep around the operating room. A urine screening for drugs detected an unknown substance. There were then threats to attempt to suspend or remove his medical license if he did not enter treatment. At this early point in the evaluation process it was becoming more clinically certain that the physician had a substance use disorder, and although he continued his ver-

bal denials of having such a disorder, he entered an alcohol/drug treatment program. (No follow-up is available on this case.)

Conclusion

In appropriate cases in forensic psychiatric contexts it is possible to do a comprehensive, corroborated evaluation and conclude with adequate medical certainty on the basis of the evaluation that the person evaluated does not have a psychoactive substance use disorder. In some cases, in spite of the examinee's denials, such a diagnosis will be the reasonable clinical conclusion. In other cases the examiner will only be able to conclude that the evaluation was inconclusive.

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