



Enhancing concurrent capability:
A toolkit for managers and staff

Comprehensive assessment

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Introduction

How was this toolkit chapter created?

The content of this chapter is based on a literature review called *Assessment of Concurrent Disorders* (Alberta Health Services, 2012) and discussions within Addiction and Mental Health (AMH) to identify the needs regarding assessment for concurrent disorders. In addition, further research was consulted to identify concrete implementation and practice issues.

The Comprehensive Assessment Chapter Subgroup Committee reviewed each draft of this toolkit chapter and provided feedback. We would like to acknowledge the hard work of this committee. Their suggestions and direction have greatly contributed to this chapter.

We are committed to matching the toolkit content to the needs of the people who will be using it. We welcome any feedback, questions, or suggestions for content additions or revisions. We wish to learn from the experiences at the front line, so please let us know how well this toolkit works for you by emailing us at concurrent.disorders@albertahealthservices.ca

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What you will learn in this chapter

Instead of having a chapter that focuses on all the different assessment instruments, we chose to focus on the common processes and approaches for comprehensive assessment. As with the other chapters in this toolkit, we have tried to keep the main part of the chapter brief. There is detailed information available in the Appendices where you can read about topics of further interest to you. Throughout the chapter, you'll find suggested activities and you can find team activities in *Appendix 2: Team activities*.

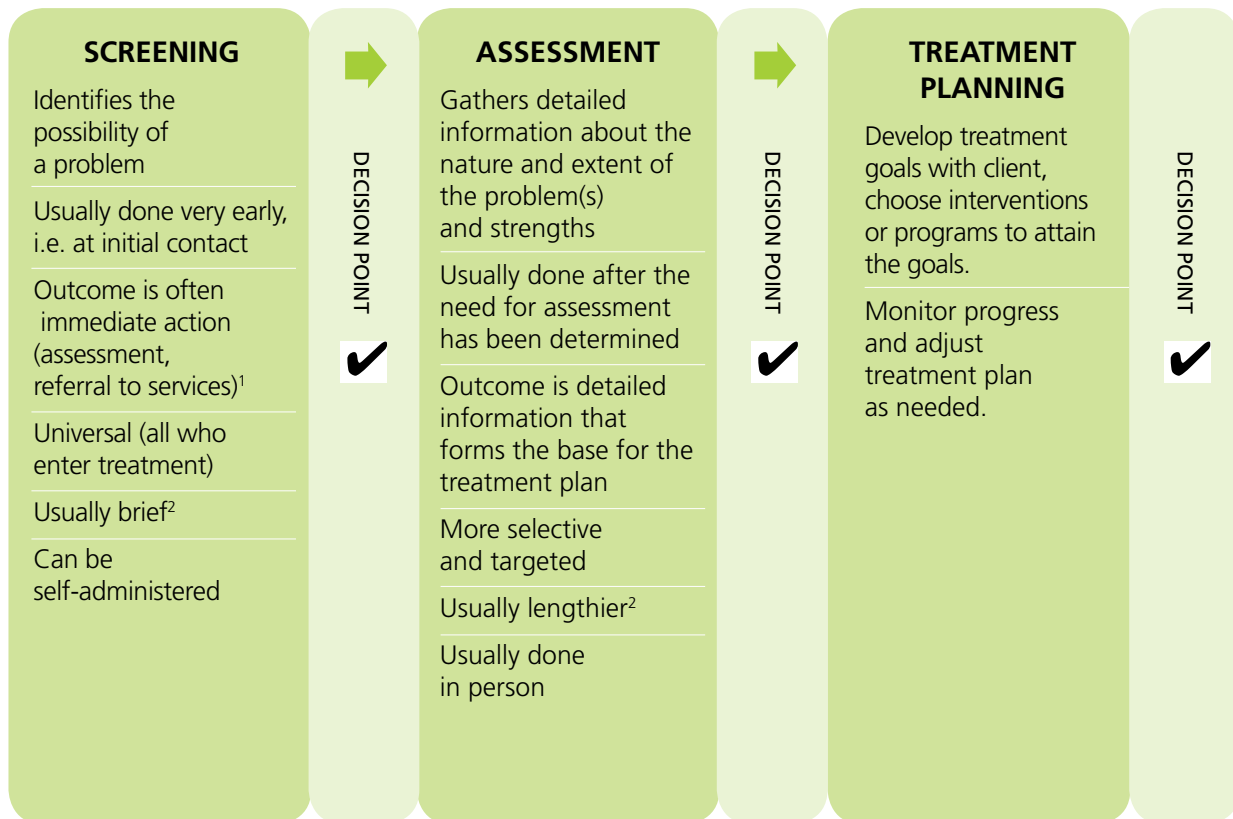
The following topics are covered in this chapter:

- Assessment as part of clinical decision-making
- How to build engagement during assessment
- Procedural factors in assessment and tips for making the process more effective
- Challenges to comprehensive assessment

Clinical decision-making: Assessment

As discussed in the *Standard Approach to Screening* chapter, screening, assessment and treatment planning can overlap yet they have unique qualities and follow a progressive timeline. The sequencing of the three activities makes sense—each process builds on the other process as shown below. Between each process is a decision point where the clinician, in collaboration with the client, decides what to do next.

Clinical Decision-Making Process

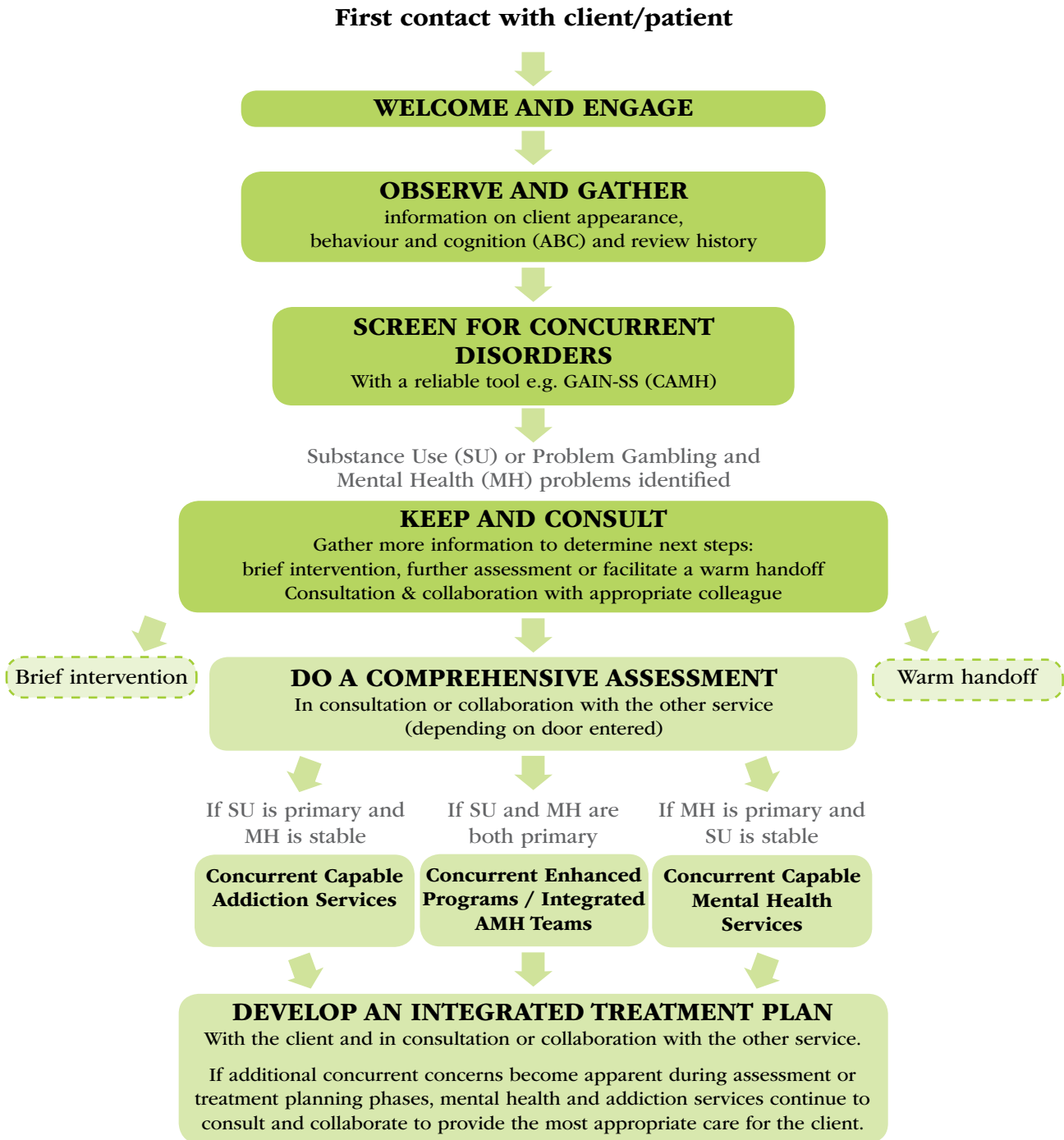


¹ While assessment may identify immediate needs, it is usually more concerned with longer-term treatment planning and service co-ordination.

² Some assessment tools may actually be briefer than some screening tools if the assessment tool focuses only on specific disorders, and the screening tool is multidimensional in its coverage.

Where assessment fits in

The Standard Approach to Concurrent Capable Practice outlines a six-step process for concurrent disorders practice. It shows where assessment fits into the larger picture as illustrated below:



Comprehensive assessment

What is comprehensive assessment?

- *Comprehensive assessment* is a process where both mental health and addiction issues are assessed at the same time and in the context of each other.
- Comprehensive assessment involves assessing for two interacting issues. It is the work of understanding the interaction between the disorders (and the interaction over time) that makes assessment comprehensive. These interactions are not always linear cause-and-effect, but are dynamic, fluid and change over time.

Benefits of comprehensive assessment

In the Screening chapter, we reviewed the benefits of screening for concurrent disorders. These benefits apply to comprehensive assessment as well. The benefits include:

- improved client outcomes
- improved follow-through
- better match to appropriate treatment
- improved client satisfaction
- earlier intervention
- better use of valuable resources
- better organizational planning
- common language and increased co-operation between systems

A note on definitions

What do we call “assessment for concurrent disorders?” The term *integrated assessment* is the most common phrasing, yet we feel it does not fully describe assessment in a concurrent capable system. In looking to the future, we are using the term *comprehensive assessment* to describe a process that is inclusive of all strengths and problems that our clients bring through our doors.

In addition, the term concurrent “disorder” assumes that a disorder has been diagnosed. That is one end of the continuum, but we often work with people who have not received an official diagnosis, or their symptoms may not be at a level severe enough to warrant a diagnosis, but they still have problems and concerns with both mental health and addiction. In this document, the term concurrent disorder refers to the entire continuum of challenges faced by people who present with issues in both mental health and addiction.

For more detailed information on these benefits, please see the *Standard Approach to Screening* chapter, pages 28-31.

You're already assessing

As with screening, you are probably already doing assessments for your service area, whether it's mental health or addiction. Comprehensive assessment means building on the knowledge and expertise you already have about assessment.

For example, Addiction Services has implemented province-wide standardized assessment using the Substance and Gambling Addiction Assessment (SAGAA) and the Substance and Gambling Addiction Assessment for Youth (SAGAA-Y) which includes screening for mental health issues. It provides the foundation for concurrent capable practice as the interview can be expanded to include full assessment of mental health issues.

Similarly, professionals in traditionally mental health settings may be using instruments such as the Structured Clinical Interview for DSM Disorders (SCID-I), Minnesota Multiphasic Personality Inventory (MMPI-2), Personality Assessment Inventory (PAI), etc. These instruments include substance use diagnosis/screening and can form the basis for more detailed exploration.

Common ground

Comprehensive assessment will be a key component as AHS moves towards concurrent capability. Fortunately, there is a lot of common ground to build from. The best practice research on assessment for concurrent disorders fits well with Alberta Health Service’s values and with the latest evidence on what contributes to treatment outcome. This is shown in the chart below:

AHS values	Practice recommendations from concurrent disorder research (AHS, 2012)	Factors that contribute to treatment outcome (by % they contribute) (Duncan et al., 2010)*
Respect	Empathy	Alliance (38-54%)**
Engagement	Person-centred	Therapist effects (46-69%)
Accountability	Motivation and treatment readiness	Expectancy/placebo effects (+30%)
Transparency	Identify strengths and supports	Feedback effects (15-31%)
Safety	Cultural sensitivity	Model/Technique (8%).
Learning	Trauma and PTSD sensitivity	
Performance	Universal access (“no wrong door”)	
	An ongoing process	

* These factors account for *treatment* outcomes only. Treatment accounts for about 13% of client outcomes—the other 87% is from client/extratherapeutic factors (Duncan et al., 2010).

** The percentages do not add up to 100% due to the variability of results across studies. That is why ranges are given for each factor.

Want more information?

For more details on Alberta Health Service’s values, see the website at <http://www.albertahealthservices.ca/190.asp>

For more details on practice recommendations from concurrent disorder research, check out *Appendix 3: Best and promising practices for integrated assessment*. It’s a list of best and promising practices for comprehensive assessment as identified in the literature review *Assessment of Concurrent Disorders* (Alberta Health Services, 2012). For even more details, you can read the literature review too!

For more details on the factors that contribute to treatment outcome, check out the book *Heart and Soul of Change*. There’s a good overview chapter and detailed chapters on each factor. It’s listed in the *References* section (Duncan et al., 2010).

It's not just the tool, it's the process

We often think of assessment in terms of instruments and tools. And there are hundreds (if not thousands!) of them. It can be overwhelming to compare and evaluate all these instruments. As discussed above, different sites in AMH may use different assessment instruments that meet their requirements and those of their clients. So instead of having a chapter that focuses on all the different assessment instruments, we are going to focus on the common processes and approaches for comprehensive assessment.

Tools for concurrent disorder assessment

There are few tools for comprehensive assessment. In the absence of integrated tools, a combination of tools is often used to achieve a concurrent capable approach. The literature review *Assessment of Concurrent Disorders* (Alberta Health Services, 2012) identified three concurrent disorder assessment tools and another tool being used as part of a system transformation:

Psychiatric Research Interview for Substance and Mental Disorders (PRISM)

A semi-structured diagnostic interview designed to deal with the problems of psychiatric diagnosis when subjects/patients drink heavily or use drugs. The PRISM assesses DSM-IV Axis I and Axis II disorders. The PRISM was used in the development of DSM-5 criteria for substance use related disorders, but it is unclear at the time of writing if it will be updated for the DSM-5. [Details at www.columbia.edu/~dsh2/prism](http://www.columbia.edu/~dsh2/prism).

Global Appraisal of Individual Needs Initial (GAIN-I)

Includes sections covering background, substance use, physical health, risk behaviors and disease prevention, mental and emotional health, environment and living situation, legal, and vocational. Within these sections are questions that address problems, services, client attitudes and beliefs, and the client's desire for services. [Details at www.gaincc.org/GAINI](http://www.gaincc.org/GAINI).

Strengths Assessment (Rapp and Goscha)

This tool includes seven life domains: daily living situation, financial/insurance, vocational/educational, social supports, health, leisure/recreational, and spirituality. A copy of the tool with a full description is in the book *The Strengths Model: A Recovery-Oriented Approach to Mental Health Services* by Rapp and Goscha (2011).

Ontario Common Assessment of Need (OCAN)

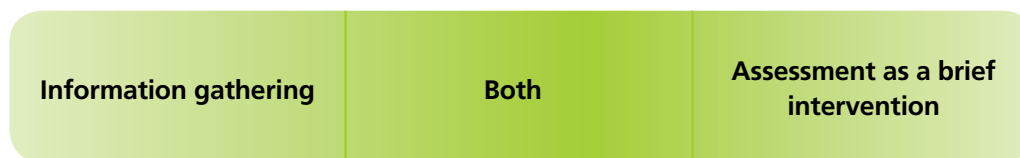
OCAN is a tool, but it is also part of a larger process of Ontario's transformation towards a recovery-based, integrated addiction and mental health system with an "every door is the right door" philosophy. It is a standardized, consumer-led decision-making tool that assesses client needs in 22 domains. Each need is rated as Met, Unmet or No Need. [Details at www.ccim.on.ca/CMHA/OCAN/default.aspx](http://www.ccim.on.ca/CMHA/OCAN/default.aspx).

The art of assessment

Just as with screening, there is the technical side of assessment and there is the “art” side. The art of assessment is to gather the needed information while building rapport and engagement with clients. It is also good science—the best practice recommendations from the research for concurrent disorder assessment emphasize the *process* of assessment—the interpersonal and procedural factors. As with screening, the way in which assessment is done is more important than the tools and instruments used.

Information or therapeutic?

One way to think about assessment is that it can range on a continuum from pure information gathering to being a therapeutic intervention as illustrated below:



On one end of the continuum is assessment as a purely information gathering activity. The clinician asks questions and the client passively answers them. This is the type of assessment technique that has been called the “assessment trap” by Miller and Rollnick (2012).

On the other end of the continuum are brief interventions centred around conducting an assessment using a variety of instruments and sharing the results with the client in a way that encourages change. In these brief interventions, assessment is not a precursor to treatment, it *is* the treatment. Examples of these interventions are Therapeutic Assessment (Finn, 2007) and Motivational Enhancement Therapy (Miller, 1992).

The “assessment trap”

The authors of Motivational Interviewing (an evidence-based practice) identify an assessment trap in their list of things that can interfere with engagement.

Many workers and agencies fall into the assessment trap, as though it were necessary to know a lot of information before being able to help. The structure of an assessment-intensive session is clear: the interviewer asks the questions and the client answers them. This quickly places the client in a passive and one-down role. ...When client change is the desired outcome, an expert-driven information-in, answer-out model is seldom effective (Miller and Rollnick, 2012).

Most of the time, we are probably somewhere in the middle of the continuum combining information gathering with therapeutic efforts. For example, when a Solution-focused or Motivational Interviewing approach is combined with assessment. What makes assessment therapeutic is engaging clients throughout the assessment. In other words, making clients active participants regardless of what tool or instrument is being used.

The process of assessment

This section will look at the interpersonal and procedural factors with some practical tips you can use in your work. The interpersonal factors centre around the relationship you form with clients and whether they are engaged in the assessment process. The procedural factors identified in the research are presented as a *Practical approach to comprehensive assessment*.

The topics below were identified and discussed in the literature review Assessment of Concurrent Disorders (AHS, 2012). For more detailed discussion of the evidence and best practice research, please refer to this document.

<p>Interpersonal factors: Engagement</p>	<p>Procedural factors: A practical approach to comprehensive assessment</p>
<p>Person-centred Empathy Motivation and treatment readiness Identification of strengths and supports Cultural sensitivity Trauma and PTSD</p>	<p>Universal access (“no wrong door”) Areas to assess Interaction effects Purposeful assessment An ongoing process Assessment using multiple methods</p>

Interpersonal factors: Engagement

As with screening, a key task in the comprehensive assessment process is engagement. An expert consensus panel (Center for Substance Abuse Treatment, 2005) determined that the first step in the comprehensive assessment process is to engage the client in an empathic, welcoming manner and build rapport to facilitate open disclosure of information. This matches AHS's Standard Approach to Concurrent Capability where the first (and on-going) task is welcoming and engaging.

The following guidelines are recommended practices to foster engagement as identified in the literature review on comprehensive assessment (Alberta Health Services, 2012) and other sources as indicated. For each guideline, some practical tips are given.

< | suggested activity | >

Introducing the assessment can go a long way to promote engagement, but sometimes it can be forgotten. The *Standard Approach to Screening* chapter in this toolkit has more information on introducing a tool which also applies to assessment. See pages 19-21 for some ideas and a guide to writing your own introduction.

Person-centred

The assessment process should be person-centred in order to fully motivate and engage clients in the assessment and treatment process. *Person-centred* means that clients' perceptions of their problem(s) and the goals they wish to accomplish are central to assessment and the resulting recommendations (Center for Substance Abuse Treatment, 2005).

Practical tips

Many psychiatric clients don't identify with having a specific psychiatric illness (e.g. schizophrenia), and addiction clients may also reject labels (e.g. alcoholic, addict), but are nevertheless willing to acknowledge some problem areas or difficulties in their lives (Miller et al., 2011). Rather than trying to convince clients about having a disorder, clinicians should

seek to understand how clients perceive their own difficulties and strive to emulate client language when discussing problems to develop and maximize rapport (Mueser et al., 2003).

A practical framework for involving clients in the assessment process is “Elicit-Provide-Elicit.” This framework is from Motivational Interviewing (Miller and Rollnick, 2012) and involves first eliciting from clients what they would like to know, permission to share feedback, etc. Clinicians provide the information and then elicit what the client thinks of the information, what it means to him or her, etc.

One way to check if clients felt their perceptions were understood and their goals were met is to ask clients for feedback at the end of the assessment meeting. You can do this informally or use an already-developed system. There are two feedback systems with empirical support (OQ Measures, Lambert, 2010, and the Partners for Change Outcome Measurement System, Duncan and Miller, 2008). These systems can result in dramatic increases in client improvement rates and decreases in treatment failures (American Psychological Association Interdivisional Task Force on Evidence-Based Therapy Relationships, 2011).

There is a lot more to the E-P-E framework than outlined here (including listening for and strengthening language that favours change). For more information on the E-P-E framework, see Miller et al. (1992) and Miller and Rollnick (2012) listed in the *References* section.

Empathy

It turns out Carl Rogers was right. Empathy (one of his three critical conditions for client-centred counselling) turns out to be an evidence-based practice and is foundational to a good relationship (Center for Substance Abuse Treatment, 2005; American Psychological Association Interdivisional Task Force on Evidence-Based Therapy Relationships, 2011).

Rogers (1980) defined empathy as: “the therapist’s sensitive ability and willingness to understand the client’s thoughts, feelings and struggles from the client’s point of view. [It is] this ability to see completely through the client’s eyes, to adopt his frame of reference....It means entering the private perceptual world of the other” (p. 142).

Practical tips

A key skill of empathy is reflective listening (Rogers, 1980). Assessment is usually a questioning activity. After you ask a question, try to reflect the client's answer (especially the underlying meaning or feeling, in other words, a *complex* reflection). This will communicate that you are trying to understand their point of view, it will clarify misunderstandings and it will encourage clients to say more.

Empathy is easier said than done. It's easy to forget to be empathic when feeling pressured to get paperwork done. It helps to know your assessment instruments well—what information is required and where it is entered on the paper form (or on the computer screen). This can free you to use a conversational approach with clients. Using reflective listening allows clients to tell their story in their own way instead of following the order of questions on an assessment form. You will likely get the same (or more) information with increased engagement. When you know your forms well, you can enter information in this less linear way.

> | suggested activity | <

By yourself, or with your team, think of ways to make assessment more conversational in tone. How can you rephrase closed questions into open questions? For what types of assessment information is it more important to be empathic? How can you remain empathic with all clients?

Motivation and treatment readiness

A consistent recommendation for the assessment of people with concurrent disorders is to evaluate their motivation for change, including the stage of change and/or the person's stage in the treatment process (Health Canada, 2002).

Many individuals with concurrent disorders have real-life barriers to participation in treatment services and to vocational and educational achievement. They can be demoralized by financial, service-related, or other barriers, or by their own limitations that affect employment,

interpersonal relationships and emotional well-being (Peters et al., 2008). For these reasons, assessment and treatment planning for concurrent disorders should address an individual's motivation and readiness for treatment. Motivation has been found to be an important predictor of treatment compliance, dropout, and outcome (Miller et al., 2011).

To these recommendations of assessing 'stage of change' and/or 'stage of treatment motivation,' is added the importance of assessing both these intrinsic motivational factors and the more extrinsic pressures to seek help. Tailoring the treatment plan for people with concurrent disorders based on client stage and motivation is one of the key principles of an integrated treatment plan as defined by Mueser and colleagues, and is a good example of how the assessment information must be linked to the treatment plan (Health Canada, 2002).

Practical tips

Framing assessment as a way of understanding where clients are at without any pressure to change can be effective with clients who are not ready for change. Make sure you introduce yourself and the assessment process. Tell clients why they are being asked the questions, what will be done with them, that you will share the results as feedback and that you won't pressure them to do something they don't want to do. Emphasize that when the assessment is complete, the client will decide what to do from there (and that you can help with that process).

Pushing people to change before they are ready is a surefire way to decrease engagement (and increase drop-outs!). Recognize that clients may not be ready to take action on either mental health or addiction issues or they might be ready to look at one and not the other. Identifying the stage of change for each issue can help you (and clients!) keep track of each issue, monitor shifts for each and choose appropriate strategies.

Many people with chronic concurrent disorders are too busy surviving to really think about their disorders. It can be a powerful experience for clients to sit down with a caring listener and take an in-depth look at their life and where they want to go. Motivational Interviewing approaches used during assessment can result in increased motivation (Miller and Rollnick, 2012). Clients can move a stage or two of change when assessment is done in an engaging, client-centred manner.

Clients may not be ready for treatment itself or for getting help. Treatment readiness is sometimes overlooked by assuming that because clients are attending appointments, they are ready to start and actively participate in treatment. You may need to assess stage of change and build motivation for seeking help and treatment before beginning the assessment process.

Identification of strengths and supports

The Center for Substance Abuse Treatment (2005) expert consensus panel concluded that all comprehensive assessment must include some specific attention to the individual's current strengths, skills, and supports, both in relation to general life functioning, and in relation to his or her ability to manage either mental or substance use disorders. This often provides a more positive approach to treatment engagement than focusing exclusively on deficits that need to be corrected.

Practical Tips

A prerequisite for affirming client strengths is to notice them. Be watchful for skills, talents, accomplishments, successes, etc. When you notice strengths, affirm them to clients and reinforce it when clients do acknowledge their strengths.

Clients may not see their strengths. Reframing is a good skill for showing clients that what they see as failures or deficits can actually be strengths. For example, "I've tried so many times and failed" can be reframed as "Even though you haven't succeeded yet, you're really determined."

Noticing strengths and then putting them into practice is not as simple as it sounds. It requires an underlying mindset that in many ways is the polar opposite of the deficit view. There are some great resources for learning more about strengths-based approaches:

- There is now a wing of psychology called Positive Psychology that studies strengths and well-being. The home website has some great resources and ideas for working with strengths as well as a variety of online measures of strengths. It can be found at www.ppc.sas.upenn.edu.
- One of the founders of Positive Psychology developed a positive counterpart to the DSM which lists and classifies strengths rather than deficits. It's called *Character Strengths and Virtues: A Handbook and*

Classification (Peterson and Seligman, 2004). It can help give you a language of strengths.

- A longer read is the book *The Strengths Model: A Recovery-Oriented Approach to Mental Health Services* (Rapp and Goscha, 2011). It offers an in-depth look at strengths-based approaches including the history and rationale, an overview of the empirical base and even a chapter on assessment!
- You might already be using strengths-based approaches (e.g. Solution Focused Therapy, Motivational Interviewing, Narrative Therapy, Strengths-based Case Management).

At the larger level...

Strengths-based approaches are being implemented in community development to create change in the larger environment, particularly in reducing poverty (which will help our clients!).

Asset-based Community Development (ABCD) founded by John McKnight and John Kretzman is a widely used approach. More information can be found at www.abcdinstitute.org.

An innovative and successful approach to help low-income families move out of poverty is the Family Independence Initiative (FII). FII is a radically different (i.e. strengths-based) approach than the usual system. More information can be found at www.fiinet.org.

< | suggested activity | >

By yourself, or with your team, think of the strengths, resources, resiliencies, talents and knowledge your clients have. Make a list and add to it when you notice or observe a new strength. When you begin to feel discouraged about clients, look at your list (or better yet, keep it posted where you can see it).

⇒ Controversy ⇐ **problems with problems**

Assessments, whether for diagnosis or case formulation and treatment planning purposes, have been criticized for only looking at “the Ds”—deficits, diagnosis, dysfunction and delinquency, particularly in the absence of client strengths and resiliencies. Even when assessment instruments include a strengths section, it is often relegated to the background as diagnostic/deficit constructs take precedence (Rapp and Goscha, 2011).

Traditional behavioral health services have been based on a narrow and acute medical model that perceives mental illnesses and addictions as diseases that can be treated and cured. While this approach works effectively for many people, for many others it primarily serves to add additional weight to their already heavy burdens. In this case, providers have had an unfortunate tendency to overlook the remaining and co-existing areas of health, assets, strengths, and competencies that the person continues to have at his or her disposal—what remains ‘right’ with people (Connecticut Department of Mental Health and Addiction Services, 2006, p. 50).

There is substantial evidence that focusing only on deficits and problems may negatively affect treatment outcomes:

Therapist effects

It is well known in the research that some clinicians get better outcomes than others. What is not as clear is why they do. There is some evidence that clinicians who get better outcomes focus on strengths more than less successful clinicians and they do so right from the start of therapy (Gassman and Grawe, 2006).

It matters what clients talk about

Research from Motivational Interviewing has found that treatment outcomes can be predicted from client language. When clients are talking about their desire, reason, ability, need and commitment to change, they are more likely to change. The opposite holds true as well—when clients talk about problems and why they can’t or won’t change, the problems can be strengthened (Moyers et al., 2007).

Hope and expectancy

In addition, one of the most powerful predictors of treatment outcome is hope and expectancy (accounting for over 30% of treatment outcome).

Focusing on the assessment and treatment of deficits, aberrations, and symptoms—what is “wrong” with people—has led to a tremendous sense of hopelessness and despair among both clients and the behavioral health practitioners who serve them (Connecticut Department of Mental Health and Addiction Services, 2006, p. 50).

The strengths movement

The past emphasis on the D’s has led to a movement towards strengths-based assessment and treatment. One promising practice uses a strengths-based assessment instrument that includes none of the D’s. In this approach, assessment is an ongoing and integral part of services. This strengths-based approach achieved equal or better outcomes when compared to traditional, problem-based treatment (Rapp and Goscha, 2011).

See *Appendix 2: Team activities* for an exercise called *What are you asking for?* and an activity called *The Ds Debate*.

Cultural sensitivity

Assessment approaches for concurrent disorders should consider influences of ethnicity, social class, gender, sexual orientation, race, disability status, socioeconomic level, and religious and spiritual affiliation (Hienz et al., 1999). “An important component of a person-centred assessment is the continual recognition that culture plays a significant role in determining the client’s view of the problem and the treatment” (Center for Substance Abuse Treatment, 2005, p. 73).

Practical tips

Cultures vary widely in terms of how they view the causes of mental illness and addiction, from spirit possession (e.g. by malevolent ancestors) to characterological or genetic flaws or weakness of the person. Therefore, some cultures have very powerful stigmas against those who suffer from mental health or addiction problems. Stigma can inhibit clients’ willingness to acknowledge the existence of a problem (to themselves and to others) and to disclose their symptoms. These factors can also limit clients’ ability or willingness to participate in any form of treatment, including pharmacological and/or psychosocial interventions.

Culture also influences how clients view appropriate treatment. Psychotropic medications may be rejected in favour of alternative biological agents (e.g. herbs in traditional Chinese medicine). In addition, many cultures do not include concepts such as “talk therapy.” Explore these issues openly and honestly from a place of genuine curiosity. Explore with clients how they themselves and, when relevant, how other people from their cultural background view these issues. Elicit information on how they might deal with these apparently contradictory ways of viewing personal challenges.

The Center for Substance Abuse Treatment (2005) recommends the following practices to address cultural issues in comprehensive assessment:

- Mental health symptoms may be expressed quite differently by individuals of different cultural or ethnic backgrounds and may be misinterpreted if cultural norms are not well understood or if there is insufficient follow-up to assess the full meaning of unusual self-reported symptoms. Ensure you are aware of clients' cultural norms.
- Treatment staff should actively explore expectations and beliefs that may have been shaped by experiences of racism and discrimination, and should be cautious in determining how these affect the process of assessment.
- Some individuals may not be fully candid during assessment interviews because their cultural affiliation does not condone self-disclosure of problems to those outside the immediate family. Self-disclosure may also be inhibited among individuals who have experienced discrimination from people who share the culture or ethnicity of the staff person conducting the assessment interview. This is an engagement issue. You may have to spend more time building rapport and trust before exploring areas that require significant self-disclosure.
- Language barriers can also influence the outcome of assessment interviews. Take your time to understand and verify what clients are saying if there are language barriers. If necessary, work through an interpreter.
- Some individuals may find they do not fit into the treatment culture (either substance abuse or mental health treatment culture). Clinicians should explore client comfort with treatment settings and cultures before referring clients to treatment.

> | *suggested activity* | <

By yourself, or with your team, identify what cultural and ethnic groups you work with most often. Think about the ways in which assessment is influenced by cultural issues.

In what ways do the cultures you work with respond to assessment?

What can you do to make assessment more "culturally friendly?"

Trauma and PTSD

There is a high prevalence of trauma in individuals with concurrent disorders. Trauma may include early childhood physical, sexual, or emotional abuse; experiences of rape or interpersonal violence as an adult; and traumatic experiences associated with political oppression, as might be the case in refugee or other immigrant populations (Center for Substance Abuse Treatment, 2005).

The assessment approach must be sensitive to the possibility that clients have suffered previous traumatic experiences that may interfere with their ability to trust the clinician.

The assessment approach must include trauma-informed approaches and the recognition that trauma may interfere with one's ability to engage and follow through with treatment recommendations. A client's perspective of safety, relationships, identity of self and others may be altered as a result of trauma. Trauma-informed service involves understanding, anticipating, and responding to issues, expectations, and special needs that are often present in survivors of trauma. At minimum, this includes reducing the risk of re-traumatization.

Practical tips

Clinicians who observe guardedness on the part of clients should consider the possibility of trauma and try to promote safety in the interview through providing support and gentleness, rather than trying to “break through” evasiveness that erroneously might look like resistance or denial. All questioning should avoid “retraumatizing” clients (Center for Substance Abuse Treatment, 2005).

Ask about a person's trauma history respectfully and be prepared to listen. It can help to let clients know you are aware of the prevalence and effects of trauma.

- For example, “I know these things can be hard to talk about, but there is growing evidence that violence and abuse can affect a person's health and create difficulties during health care encounters...

Lots of information on trauma-informed practice and links to other trauma websites can be found by AHS staff on the Intranet site

A good resource with practical information and tips for clinicians is *The Trauma-informed Toolkit* (2008) by Clinic Community Health Centre in Winnipeg. The full resource is listed in the *References* section with the website where you can download it.

you don't have to discuss this with me if you don't want to...but if you do, I can work with you to ensure you are comfortable when you see me and to get the support/assistance you need.”

Shift focus from asking “What is wrong with you?” type of questions to asking “What happened to you?” (Rosenburg, 2011). Some questions could be:

- “What has happened to you?”
- “How have you tried to deal or cope with it?”
- “How can you and I work together to further your goals for healing and recovery?”

Depending on the assessment instruments and processes used at your site, you might ask about past and current traumatic experiences as part of assessment. Use a trauma-informed approach regardless of whether a person discloses trauma or not.

If a client chooses to disclose history related to trauma, Schachter et al. (2009) suggest the following effective trauma-informed responses (their guide is for all health care practitioners and can be downloaded from the website listed in the References):

- 1. Accept the information.** Clients need to know that their health care professional has heard them, has accepted the information, and believes children are never responsible for abuse. When survivors disclose their history of abuse, it is usually because they hope that something positive will come from it. If clinicians do not respond, survivors may interpret the silence as an indication of lack of interest, which may deter them from mentioning it again. Moreover, they may stop seeing that particular clinician or, in the extreme, avoid all health services.
- 2. Express empathy and caring.** Survivors also want to know that their clinicians care about them. Simple statements of empathy and concern can convey both compassion and interest.
- 3. Clarify confidentiality.** Health care professionals do not have a legal obligation to report past child abuse disclosed by an adult, unless, in disclosing his or her own experience, a client identifies a child who may be currently in need of protection (e.g. if a male patient who was abused by a family member tells the practitioner he has reason to believe that the same perpetrator is continuing to abuse children).

- 4. Acknowledge the prevalence of abuse.** Understandably, many survivors feel very isolated and alone in their experience. Having health care professionals demonstrate awareness about the prevalence and long term effects of childhood trauma normalizes the experience for survivors and may reduce their sense of shame. For example, a clinician might say, “We know that as many as one in three women and one in seven men are survivors of childhood sexual abuse. It is sad to realize that so many children have suffered in this way.”
- 5. Validate the disclosure.** Health care professionals must validate the courage it took for the client to disclose, and communicate that they believe the client. Visible distress needs to be acknowledged (e.g. “I see that this is painful [distressing, disturbing] for you right now. What can I do to help?” or “It’s okay if it takes more than one visit to explore this”). Failure to validate the survivor’s experience, silence, or judgmental comments can be shaming and contribute to a reticence to disclose in the future.
- 6. Address time limitations.** Time pressures are one of the biggest impediments to disclosure. If clients disclose a history of abuse and the health care professional can spend only a few minutes with them afterward, it is important that the time constraints are communicated in a way that will not leave survivors feeling dismissed or that they have done something wrong by disclosing (e.g. “Thank you for telling me about being abused. I can only imagine how difficult things have been for you. I have another patient waiting—do you want to book a longer appointment later this week?”).
- 7. Offer reassurance.** Because individuals who have disclosed have shared some very personal information, they may feel vulnerable and exposed—both at the time of the disclosure and during future encounters with the health care professional to whom they have disclosed. To minimize this sense of vulnerability, health care professionals can reassure survivors that they commend the courage it took to talk about past trauma and that the information that has been shared will be useful in providing appropriate health care.

- 8. Collaborate to develop an immediate plan for self-care.** Some survivors identified unsettled feelings or flashbacks of their trauma as an immediate after-effect of disclosure. Accordingly, health care professionals should caution individuals who have just disclosed to be prepared for these feelings. They should then work with survivors to make a specific plan for self-care (e.g. “Sometimes talking about past abuse stirs up upsetting memories. Tell me what you can do to look after yourself if this happens to you”).
- 9. Recognize that action is not always required.** Survivors who have just disclosed may not necessarily expect clinicians to do anything except to be present with them in the moment. While it is important to ask survivors if there is anything they want in relation to their disclosure, it may be preferable to identify a later time for discussion about what actions (if any) the survivors want from the health care professional.
- 10. Ask whether this is the client’s first disclosure.** By asking “Have you talked with anyone else about this?” health care professionals can get a sense of whether the survivor has previously taken any steps to address the trauma. An answer of “No, I have never told anyone before today,” as compared to “Well, my counsellor knows and suggested that I tell you,” can help clinicians to shape their next response. It may also help them learn what supports clients have in place and what they may need.

What NOT to do after a disclosure

- Conveying pity (e.g. “Oh, you poor thing”).
- Offering simplistic advice (e.g. “Look on the bright side” or “Put it behind you” or “Get over it” or “Don’t dwell in the past”).
- Overstating or dwelling on the negative (e.g. “A thing like that can ruin your whole life”).
- Smiling (while you may hope that your smile conveys compassion, a neutral or concerned expression is more appropriate).
- Touching the survivor without permission even if you intend it as a soothing gesture.
- Interrupting (let the individual finish speaking).
- Minimizing or ignoring the individual’s experience of trauma, the potential impact of the trauma, or the decision to disclose (e.g. “How bad could it be?” or “I know a woman that this happened to and she became an Olympic gold medalist” or “Let’s just concentrate on your schizophrenia” or “What does that have to do with anything?”).
- Asking intrusive questions that are not pertinent to the treatment or consultation.
- Disclosing your own history of abuse.
- Giving the impression that you know everything there is to know on the subject.

If you think that you have inadvertently responded to the disclosure in an inappropriate way, or if the client’s feedback (verbal or nonverbal) suggests a negative reaction to their initial responses, you should immediately clarify the intended message and check for further reaction.

> | team activity | <

See *Appendix 2: Team activities* for a comprehensive assessment checklist which includes the above interpersonal factors.

Challenges to engagement

From the pioneers

The developers of one of the few integrated treatment approaches (Mueser et al., 2003) identified a number of challenges they encountered when trying to integrate assessment for concurrent disorders:

Clients have different views

Clients may see their mental disorders or addiction issues differently from their helpers. Mueser et al. (2003) found it was common for individuals with substance use disorders to deny or minimize the negative effects of their substance use on their lives. In a similar fashion, individuals with severe mental illness often don't believe that they have an illness or minimize the extent of their disability.

- The issue of denial or minimization is also discussed below in the section called *Accuracy of self-reported use and symptoms*.
- The authors recommend that rather than directly confronting clients about what the helper might call denial or minimization, clinicians should expect these reactions and strive toward the long-term goal of developing a trusting relationship with open, honest dialogue. Seeing issues through the eyes of the client can go a long way to promoting engagement and is fundamental to client-centred care.

History of sanctions

Clients may be reluctant to disclose illegal drug use for fear of legal difficulties, particularly if they have a corrections history. In some cases, financial arrangements may be compromised by substance abuse, for example, a trustee taking over management of a client's money. Clients may be reluctant to disclose problems with money management if they fear they will lose control of their money. Clients may also fear losing their children if they disclose too much information.

Premotivational state

We've already seen that motivation and treatment readiness are an engagement issue. The pioneers found that it was a major issue and that many clients with concurrent disorders were not motivated to address one or both of the disorders, which made assessment more difficult.

- Some tips for this challenge have already been discussed in the section called *Motivation and treatment readiness*.

Accuracy of self-reported use and symptoms

Reliability of self-reported substance use or mental health symptoms is an issue when assessing for the purpose of diagnosis/description. People with concurrent disorders may not fully disclose their substance use or mental health symptoms for many reasons. In the research, this is called denial or minimization. Rather than framing this issue as one of psychological defenses called “denial” or “minimization,” it is more productive to understand what is going on for clients that may impact disclosure.

- It might be better to frame disclosure as a safety issue—clients do not feel safe enough to disclose. Safety is an engagement issue and it might take time to develop enough trust to make disclosure more comfortable.
- Clients may not remember all their symptoms or substance use. Mental disorders and substance abuse can directly affect memory and impair the ability to connect the links between substance use and symptoms.
- Clients are usually honest but they have a different perspective than clinicians. From clients' perspective, their use may not be that bad compared to their past use or the people in their life—the same goes for their mental health symptoms. What is normal in one context may not appear to be normal in the world of treatment.
- The tendency to provide socially desirable responses can impact disclosure. If there are sanctions/penalties for disclosing substance use (e.g. revoking parole), clients may choose not to disclose. The opposite is also true—if there are rewards for disclosing (e.g. entry into treatment), clients may even make their use/symptoms sound worse.

There is evidence of lower reliability of self-reported past or current psychiatric disorders among drug abusing versus non-drug-abusing individuals. There is also lower reliability of self-reported alcohol and drug use and consequences among people with severe mental illness, which is made worse by fluctuations in acute symptoms, cognitive impairment and mental status (Health Canada, 2002).

Practical tips

Suggestions for improving the accuracy and reliability of self-reported substance use and related problems by people with concurrent disorders include (from Carey and Correia, 1998; Health Canada, 2002; Peters et al., 2008):

- Establish a good rapport before asking for a lot of details.
 - Provide a supportive interview setting to promote disclosure of sensitive clinical information.
 - Compile self-report information in a non-judgmental manner and in a relaxing setting. The interview should be prefaced by a clear articulation of the limits of confidentiality.
 - Examine non-intrusive information first (e.g. background information). After rapport has been established, proceed to address substance abuse issues. Gather mental health information last, as this information tends to be the most stigmatizing and difficult to disclose.
 - Frame questions to normalize different substance use patterns (e.g. “Many people have experimented with drugs. Have you ever had any experiences with.....?”)
 - Use motivational interviewing techniques to enhance accurate self-reporting.
 - Reduce institutional factors that can affect responses. Individuals may anticipate negative consequences related to self-disclosure of mental health or substance abuse symptoms. Alternatively, symptoms may be feigned or exaggerated if an individual believes that this will lead to more favorable placement or treatment.
 - Wait to use self-report instruments until mental health symptoms have stabilized and the individual is not intoxicated or in withdrawal.
 - The timing of the diagnostic interview may affect the reliability and validity of the results, and diagnoses made early in treatment may need to be revised as more information becomes available over time.
 - Use multiple assessment methods and conduct multiple assessments over time.
-

Use of collateral information

One of the strongest recommendations made by experts in the field is for assessment to include multiple sources of information (Health Canada, 2002). Whenever possible, interview and test results should be supplemented by collateral information obtained from family members, friends, housemates, and other informants who have close contact with the individual (Drake et al., 1993). This is especially important for family therapy or when significant others are part of a client’s treatment.

Seeking out (and using) information from others carries the risk of damaging engagement. If clients perceive that you do not believe them, are going “behind their back” or any other negative thoughts they may have about the use of outside information, your relationship can be damaged. Make sure you obtain consent to contact others and explain the reason for gathering the outside information (there better be a good reason!) and what benefit it can be to the client.

Check off the engagement challenges that apply to your work. For each, identify the way in which it impacts assessment and then strategies to respond to the challenge.

> | *suggested activity* | <

	How does it impact you?	Strategies
<input type="checkbox"/> Clients have different views		
<input type="checkbox"/> History of sanctions		
<input type="checkbox"/> Premotivational state		
<input type="checkbox"/> Accuracy of self-reported use and symptoms		
<input type="checkbox"/> Use of collateral information		
<input type="checkbox"/> Other:		
<input type="checkbox"/> Other:		

Procedural factors: A practical approach to comprehensive assessment

This section outlines some guidelines and tips that are procedural in nature. They were identified in the literature review *Assessment of Concurrent Disorders* (AHS, 2012).

Universal access (“no wrong door”)

A key concept in concurrent disorders is that of “no wrong door.” Clients should be able to have both mental health and addiction issues assessed without having to go back and forth between different services. This is why AHS is moving towards integrated services. After a screen indicates a possible concurrent disorder, whenever possible we will “Keep and consult” rather than just refer a client to another service.

Only when necessary will we refer with a “warm hand-off.” Continuity can be improved when clinicians assist and accompany clients and provide relevant information. In this way, clients are introduced to a new clinician and don’t have to tell their stories all over again. We call this a “warm hand off.”

Practical tip

Seek out your colleagues for assistance with decisions regarding assessment with clients who have concurrent disorders. If you are not confident in your skills to work with clients with respect to one of their disorders, ask for assistance!

What to assess

There is a lot of information that *could* be gathered during assessment.

Areas identified in the research for comprehensive assessment include:

- substance abuse
- mental health
- interaction of concurrent disorders
- medical issues/needs
- stage of change/motivation

Safety and risk

The safety of clients and yourself is your first priority. The *Observe and gather* step of the Standard Approach to Concurrent Capable Practice is where you first observe for safety/risk issues (and this observation is an on-going activity). You might also use a screening tool for this purpose. See the *Standard Approach to Screening* chapter, page 25 for more details.

- cultural and linguistic needs
- environment and social supports
- strengths
- client background (Alberta Health Services, 2012).

What content to gather

Assessments commonly have long lists of questions to ask (see *Appendix 1: Content for integrated assessment* for recommended content for concurrent disorders). This list was put together from multiple sources and has 106 items of information that could be gathered. The Appendix also includes some suggestions for selecting what information to gather.

You are probably already assessing in most of these areas—the difference for comprehensive assessment is to gather information about both mental health and addictions for each area. Then you begin the challenge of sorting out the interaction effects. The interaction effects are key to comprehensive assessment and they are missed when assessment is not integrated.

< | team activity | >

Appendix 1: Content for integrated assessment includes an activity to identify, ahead of time, what information your team needs.

Interaction effects

The interaction effects can be difficult to sort out in an assessment. It is particularly important to examine the chronological history of the two disorders, including periods before the onset of drug and alcohol use, and during periods of abstinence such as jail, prison or hospitalization (Peters et al., 2008).

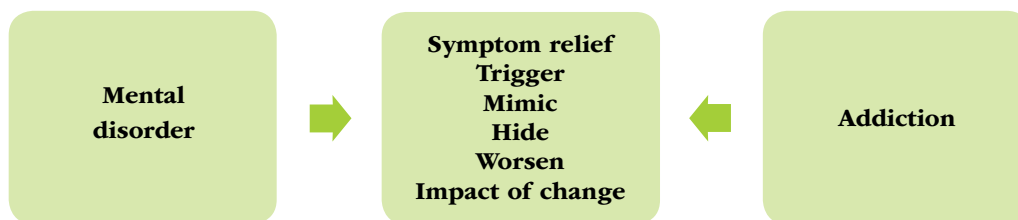
The interaction effects range on a continuum as shown below:

<p>No interaction</p> <p>Both disorders exist independently (both present, but their interactive effect is weak)</p>	<p>One-way interaction</p> <p>One disorder affects the other</p>	<p>Two-way interaction (“vicious circle”)</p> <p>One disorder leads to symptoms/effects in the other, which then add to the first one</p>
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It is possible, if not common, to find concurrent disorders that are largely independent of one another. That is, they are both present, but their interactive effect is weak (Skinner, 2005). It's more common that interaction effects are present and the combinations can be complex. Most start with a one-way interaction. Over time, the effects tend to feed into each other, sometimes leading to vicious circles of interaction.

Patterns of interaction

There are a number of interaction patterns as shown below.



Symptom relief

- Some people begin and continue to use substances to self-medicate symptoms of mental disorders (Central West Concurrent Disorders Network, 2012). For example, a person might use alcohol to reduce feelings of anxiety.
- Sometimes people turn to substance use to relieve or forget about the symptoms of mental disorders (Central West Concurrent Disorders Network, 2012).
- People may use substances to relieve the side effects of prescribed medications for mental disorders (National Institute on Drug Abuse, 2010).

Trigger

- Substance use may trigger mental health problems in people who would not otherwise have developed them. For example, cannabis use may precipitate psychotic symptoms in people who are already vulnerable (Hall and Degenhardt, 2000).
- The problems resulting from substance abuse can be risk factors for mental illness. For example, struggling with an addiction and its consequences affects mental health: moods, behaviours,

perceptions, coping strategies and social networks (Central West Concurrent Disorders Network, 2012).

- Conversely, mental health problems can act as risk factors for substance use problems. Mental disorders can precipitate substance use disorders. Most individuals with co-occurring disorders report that mental health symptoms preceded substance abuse (Peters et al., 2008).

Mimic

- Mental health symptoms or disorders are sometimes mimicked by the effects of alcohol and drug use (e.g. cocaine intoxication can cause auditory or visual hallucinations, methamphetamine psychosis can mimic schizophrenia) (Health Canada, 2002).
- Withdrawal from alcohol or drugs can cause psychiatric symptoms and mimic psychiatric syndromes. Cessation of substance use following the development of tolerance and physical dependence causes an abstinence phenomenon with clusters of psychiatric symptoms that can also resemble psychiatric disorders (Ries, 2007).

Hides

- Alcohol and drug use may mask or hide mental health symptoms or disorders (e.g. alcohol intoxication may mask underlying symptoms of depression).
- Acute mental illness can hide substance abuse symptoms (e.g. depression symptoms can hide alcohol abuse).
- Persons with severe mental illness are frequently underemployed or unemployed, experience significant problems with their interpersonal relationships, have health problems, and do not drive cars. The overlap between the core impairments of severe mental illness and the common consequences of substance abuse can make assessing the effects of substance use more difficult in the concurrent disorder population (Mueser et al., 2003).

Worsens

- Alcohol and drug abuse can make symptoms of a mental health problem worse. Substance abuse may sharply increase symptoms of mental illness or trigger new symptoms.
- Individuals with some mental disorders may be particularly

vulnerable to substance use in amounts small enough that they would not normally be considered problem level (Peters et al., 2008).

- Although mental illness may cause impairments in a number of different areas, substance use often exacerbates these problems, resulting in even worse functioning (Mueser et al., 2003).
- Alcohol and drug abuse also interact with medications such as antidepressants, anti-anxiety pills, and mood stabilizers, making them less effective or increasing their effects.
- Using substances can make people forget to take their medications; if this happens, the mental health symptoms may come back (“relapse”) or get worse (Central West Concurrent Disorders Network, 2012).
- Relapses with one disorder can trigger or affect relapse in the other disorder.

Impact of changing one disorder

- If clients experience problems directly linked to substance use, stopping or reducing use is likely to lead to improvement in mental health symptoms. On the other hand, if clients use substances to get relief from distressing mental states or from difficult situations, stopping their use could worsen their experience of distress (Skinner, 2005).

Vicious cycle of interaction

The above patterns can interact with each other and with risk factors for both addiction and mental disorders forming a vicious cycle. Common risk factors include: male gender, youthful offender status, low educational achievement, history of unstable housing or homelessness, history of legal difficulties and/or incarceration, suicidality, history of emergency room or acute care visits, high frequency of substance abuse relapse, antisocial or drug-using peers, poor relationships with family members, family history of substance use and/or mental disorders, poor adherence to treatment and history of disruptive behavior (Peters et al., 2008).



As the problems from both disorders multiply and interact with the risk factors and the social determinants of health, a vicious cycle can develop and result in increasing problems such as:

- relapse and rehospitalization
- financial problems
- family conflict
- housing instability and homelessness
- noncompliance with medication and psychosocial treatment
- violence
- victimization
- suicide
- legal problems and incarceration
- trading sex for drugs or money
- health problems
- health risk behaviors for infectious diseases (e.g. exchanging needles, unprotected sex) (Mueser et al., 2003)

Social determinants of health

The risk and protective factors for concurrent disorders reflect the social determinants of health. When we get frustrated with clients who are not making choices we'd like them to make, we sometimes blame the individual. However, there are factors larger than just the individual and that is where the social determinants of health come into play. The social determinants of health link health status to factors outside the control of the individual.

The primary factors that shape the health of Canadians are not medical treatments or lifestyle choices but rather the living conditions they experience. These conditions have come to be known as the social determinants of health. They include:

- | | |
|--------------------------------|--|
| Income and Income Distribution | Education |
| Unemployment and Job Security | Employment and Working Conditions |
| Early Childhood Development | Food Insecurity |
| Housing | Social Exclusion |
| Social Safety Network | Health Services |
| Aboriginal Status | Gender |
| Race | Disability (Mikkonen and Raphael, 2010). |

< | team activity | >

See *Appendix 2: Team activities* for a great exercise in developing a story about social determinants of health—AMH version.

There must be a purpose

Assessment should be purposeful. After an extensive review of the research on mental health assessment, Hunsley and Mash (2008) concluded that a discussion of evidence-based assessment strategies is impossible without first identifying the purpose of the assessment. They identified three purposes of assessment: diagnosis [and description], case formulation and treatment planning (we’ve simplified this to just treatment planning), and treatment monitoring and outcome. Each requires different content selection, methods and measures, and processes.

Administrative purposes

There can be another purpose for assessment: “Evidence-based assessment should support and guide treatment and intervention, but that is not always the case. In current practice, patient assessments are often used repeatedly to collect insurance and demographic information for administrative rather than treatment purposes” (Power et al., 2005, p. 7).

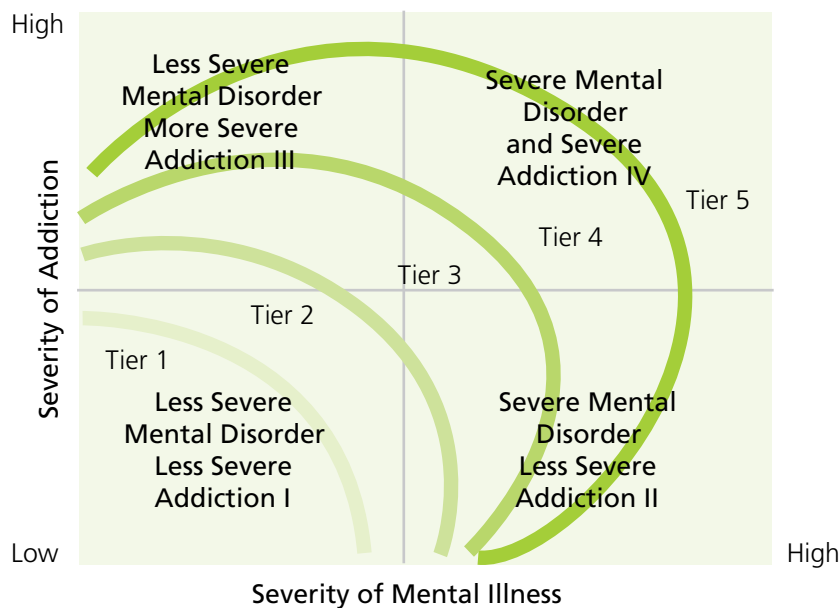
Diagnosis and description

Most of the research about mental health and addictions treatment is organized by diagnostic and descriptive categories. Diagnostic and descriptive information allows clinicians to consult relevant research on psychopathology, epidemiology, prognosis, and treatment.

Treatment planning

Treatment planning requires that clinicians gather information on client functioning, life history, and current life situation beyond what is necessary for diagnostic purposes (Hunsley and Mash, 2010). Comprehensive assessment can help place clients into appropriate AMH tiers of service based on the severity of their disorders as illustrated below or indicate when a warm handoff is appropriate.

Whenever possible we will “Keep and consult” rather than just refer a client to another service. Only when necessary will we refer with a warm hand-off.



Note: The quadrants of care model is a conceptual framework in common use to help guide improvements in individual care and system integration using existing treatment frameworks. There has been no formal clinical research to verify if the model improves care or improves outcomes (Center for Substance Abuse Treatment, 2005).

Treatment monitoring and outcome

Assessment data provides the “before and after” information that determines whether change (hopefully positive) has occurred as a result of treatment. It is also a pre-requisite for monitoring treatment as it progresses.

Treatment monitoring is part of ongoing assessment. By assessing how clients respond to treatment, you can alter and adapt treatment over time to meet client needs (which also change over time). With concurrent disorders, monitoring shifts in interaction effects can be key to successful treatment.

An ongoing process

One of the strongest recommendations made by experts in the field is for assessment to be conducted over more than one interview (Health Canada, 2002). There is an iterative relationship between assessment and treatment planning. Rather than being one-time events, treatment planning and assessment constitute a process of continual refinement and adaptation to changing client circumstances (Center for Substance Abuse Treatment, 2005).

Recovery planning

In addition to treatment planning, a newer shift in services may require the addition of recovery planning as a purpose. There is a movement underway in North America and Europe to shift from systems of treatment provision to systems of recovery (Sheedy and Whitter, 2009). The Mental Health Commission of Canada (2012) recently released its Mental Health Strategy for Canada which calls for a national recovery-oriented system. While an in-depth discussion of the shift to a recovery base is beyond the scope of this chapter, the implications for assessment are significant. The content of assessment changes when systems move to a recovery model.

There is extensive replicated evidence that regardless of whether clients are receiving an evidence-based practice, simply providing clinicians with accurate session by session feedback on client functioning and the client-counsellor alliance can result in dramatic increases in client improvement rates and decreases in treatment failures (American Psychological Association Interdivisional Task Force on Evidence-Based Therapy Relationships, 2011).

Mental and substance use disorders have a waxing and waning course and may manifest differently at different points in time (Peters et al., 2008, p. 20).

Mueser et al. (2003) identified several reasons for an on-going assessment process:

- Changes occur in a client's life and mental status over time; clinicians must actively seek current information rather than proceed on assumptions that might be no longer valid
- Recovery for one disorder will impact the other. These impacts must be monitored and treatment plans adjusted as needed.

- A longer assessment period is also required to formulate DSM-5 diagnoses. Significant periods of abstinence are required to establish DSM-5 criterion of disorders not due to substance use
- Client motivation for change can (and will) vary over time. Clients can move through different stages of change. As they do, treatment should change to match the stage.

Assessment using multiple methods

There is consensus in the literature that assessment includes gathering information in many ways, usually using a combination of instruments and interviews (Health Canada, 2002, Center for Substance Abuse Treatment, 2005). It is unlikely that one instrument will collect all the information required. Assessment methods may include (Health Canada, 2002, Center for Substance Abuse Treatment, 2005):

- a clinical examination of the functioning and well-being of the individual
- an in-depth interview
- standardized and/or specialized tests
- a social and treatment history
- a review of records (medical and psychiatric)
- a physical examination
- laboratory tests
- formal diagnosis using established systems such as the DSM-5
- interviews with friends and family (with consent)

Appendix 2: Team activities for a comprehensive assessment checklist which includes the above procedural factors.

Challenges to comprehensive assessment

From the pioneers

The developers of one of the few integrated treatment approaches (Mueser et al., 2003) identified a number of challenges they encountered when trying to integrate assessment for concurrent disorders:

Failure to take a proper history

Clinicians are often not aware of clients' substance abuse. The most common reason for this is that clinicians simply fail to ask clients about their use of substances and, if not asked, most clients will not disclose their substance use.

- The authors recommend starting with a discussion about a client's past substance use as it can help reduce client defensiveness, and then move gradually toward more recent use.

Different norms for substance use disorders

The norms for substance abuse typically involve large quantities of substances leading to major life problems. Clinicians need to be aware that persons with severe mental illness are likely to experience negative consequences from even low levels of alcohol or drug use. If clinicians only look for large quantity use levels, they may miss the impact that smaller quantities can have on the mental disorder.

Clinician resistance

Clinician resistance that can interfere with comprehensive assessment often originates in the historically separate treatment systems for addiction and mental health. Some mental health providers will not consider a person an appropriate candidate for mental health treatment until the substance abuse problem is under control.

Conversely, substance abuse treatment providers may require a client to have his or her mental illness stabilized before accepting him or her for substance abuse treatment.

System barriers

The addictions and mental health systems are often separate systems with their own values, treatment philosophies, and policies and procedures. Comprehensive assessment spans both systems and introduces implementation issues in both systems.

Lack of resources and funding are also a barrier to comprehensive assessment. The separate systems may already be at capacity and feel they're being asked to take on more than they can handle.

Sorting out the interaction effects

Concurrent disorder diagnosis requires sorting out the interaction effects which further complicates the task of diagnosis. Assessment content for concurrent diagnosis should help determine if the symptoms reflect a naturally occurring mental illness or result from psychoactive substance use. The DSM-5 recognizes this issue by requiring clarification if a disorder is substance induced.

Primary vs. secondary

An issue that has been the source of confusion and controversy in comprehensive assessment for the purpose of diagnosis is the debate between primary and secondary diagnoses. This distinction historically centred around which disorder occurred first—the earlier onset disorder would be declared primary. A common belief was that the earlier onset disorder caused the secondary disorder and “if the primary disorder is treated first, the secondary disorder will often go away automatically, and that it is futile to attempt to treat the secondary disorder until the primary one is successfully controlled” (Center for Substance Abuse Treatment, 2005).

The general consensus in the field is that the distinction based on age of onset is not useful and should not be used (Mueser et al., 2003; Minkoff, 2001; Center for Substance Abuse Treatment, 2005) for the following reasons:

- This distinction is not useful to differentiate whether the second disorder is independent from the first or to assess the relationship between both conditions (Torrens et al., 2006).

- Most clients enter treatment with both disorders in an active state. It is extremely difficult and often impossible to determine the effects of two mutually interacting disorders while both disorders are currently active (Lehman and Dixon, 1995). Shaner et al. (1998) found that it may not be possible to establish a DSM-IV (in use at the time of the study) diagnosis, even using state of the art measures and methods.
- Mueser et al. (2003) found that attempts to determine which disorder is primary or secondary often result in inadequate treatment of one or both disorders, resulting in poorer outcomes. For example, clinicians may decide to focus on treating the substance use disorder and to assume that the psychiatric disorder is secondary, with the belief that successful treatment will improve both disorders. As a result, the psychiatric disorder may be inadequately treated, interfering with effective treatment of the substance abuse as well.
- The primary/secondary split is artificial and does not necessarily reflect the complexity of the interaction patterns for concurrent disorders.

The expert consensus panel from the Center for Substance Abuse Treatment (2005) recommends that rather than attempting to determine which disorder is primary and which is secondary, clinicians are encouraged to view both disorders as primary, and to assess and treat both disorders simultaneously.

See *Appendix 2: Team activities* for an activity to identify: 1) challenges that impact your team and 2) strategies to deal with the challenges.

Conclusion

We hope you have found this chapter to be helpful. If you have any questions, comments or stories to share, please contact concurrent.
disorders@albertahealthservices.ca

The next steps in the concurrent capable treatment process are treatment planning and treatment itself. These are covered in detail in the next toolkit chapters.

APPENDIX 1

Content for comprehensive assessment

Perhaps the biggest (and as of now, unanswered by the research) question in assessment is what questions to ask. In other words, what do you need to know? For comprehensive assessment, this means determining content for two interacting disorders—not a simple task.

Too much information?

At this point in time, the research lends little to no guidance as to what information is needed to improve treatment and/or outcomes. The practice in the field has erred towards collecting a huge amount of information.

Since research has not provided definitive answers, assessment is predicated on a common-sense approach—collecting as much information as possible across multiple domains (Rawson et al., 2005, p. 194).

In the absence of empirically-guided content, the mental health and addiction fields have tended to drift towards this “shotgun” approach. Assessments commonly have long lists of questions to ask (see the list below).

Less is more

Given the lack of evidence for collecting vast amounts of information about clients, it might be wise to reverse the trend towards the shotgun approach and err on the side of less information.

Think ahead

It would make sense to determine ahead of time what content to gather in assessment. Unfortunately, this has not been the practice for most disorders. For example, there have been almost no attempts to determine in a prospective way which areas or domains should be the focus of assessment for anxiety disorders (Antony and Rowa, 2005).

Possible content for comprehensive assessment: The list

The following list includes items identified in Center for Substance Abuse Treatment (2005), Health Canada (2001), Mueser et al. (2003), and Peters et al. (2008). The items are sorted into categories and separated into current and historical timeframes. Unfortunately, there is no research at present that can inform the selection of content from this list (Alberta Health Services, 2012).

< | team activity | >

Give each team member a copy of the list below. Have all team members highlight the items they believe are needed to do their work. When finished, have the team compare their lists and develop a team list. Then compare the team list to the actual assessment content currently being gathered. Debrief and identify changes that could be made.

Area	Current	History
Substance abuse	<ul style="list-style-type: none"> • Primary drugs of abuse • Misuse of prescription drugs • Reasons for substance use • Context of substance use • Frequency, amount, and duration of use • Severity of use • Problems associated with use, including employment, family, legal, physical aggression and violence, and physical/medical problems or exacerbation of chronic medical or physical problems • Need for immediate withdrawal and stabilization in a detoxification program • Level of functioning 	<ul style="list-style-type: none"> • Periods of abstinence and how they were attained • Treatment history and response to/ compliance with treatment • Age of onset • Patterns of high and low use • Family history (including birth complications and in utero substance exposure) • History of withdrawal symptoms on discontinuation of the substance, especially a past history of seizures in alcohol withdrawal

	<ul style="list-style-type: none"> • Functional analysis (positive and negative consequences of substance use) 	
Mental health	<ul style="list-style-type: none"> • Current psychiatric symptoms • Current psychiatric medications and medication adherence • Identification of trauma-related disorders • Risk assessment • Severity of disorder and symptoms • Effect of symptoms on the person’s ability to maintain an independent living situation • Level of assistance, support, and resources the person needs to re-establish and maintain activities of daily living • Mental Status Examination (appearance and behavior, mood and affect, speech, thought process, thought content, cognition, insight and judgment) • Level of functioning 	<ul style="list-style-type: none"> • Client history of psychiatric problems • Treatment history and response to/compliance with treatment • History and patterns of hospitalizations • Family history of psychiatric problems • When possible, past psychiatric medications and medication adherence • Past trauma
Interaction of concurrent disorders	<ul style="list-style-type: none"> • Relationship between current substance use and mental health symptoms and functioning • Information about past and present successful and unsuccessful treatment efforts for each diagnosis • Identify substance-induced mental health symptoms 	<ul style="list-style-type: none"> • Chronological history of the two disorders, including periods before the onset of drug and alcohol use, and during periods of abstinence (including enforced abstinence while in jail, prison or hospital) • Historically, how the two conditions have interacted
Medical	<ul style="list-style-type: none"> • Current medical conditions and treatment, including identifying who is the primary care physician and date of last contact • Current medications • Health risk factors 	<ul style="list-style-type: none"> • Past medications • History of medical hospitalizations • History of head injury • History of injury and trauma • If a history of Attention-Deficit/Hyperactivity Disorder (AD/

	<ul style="list-style-type: none"> • HIV and Hepatitis C • Impaired cognition, IQ, FASD, neurological symptoms, developmental disabilities that interfere with ability to function independently and/or follow treatment recommendations • Presence of chronic pain • Chronic disease management • Physical disabilities 	<p>HD) is suspected, assessment should examine attention and concentration difficulties, hyperactivity and impulsivity, and the developmental history of childhood AD/HD symptoms</p>
<p>Stage of change/ motivation</p>	<ul style="list-style-type: none"> • Stage of change for each issue (precontemplation, contemplation, preparation, action, maintenance) • Salient incentives and goals for the individual • Client’s motivation, especially where current behavior or functioning support or conflict with values or major life goals • Cognitive appraisal of treatment and recovery, including motivation and readiness for treatment, self-efficacy, and expectancies related to substance use and use of medication • Client’s perceptions of problems and goals • Client areas of high motivation with either or both disorders 	<ul style="list-style-type: none"> • Past attempts at change and relapses (recycling)
<p>Cultural and linguistic needs</p>	<ul style="list-style-type: none"> • Racial and ethnic culture • Gender • Sexual orientation • Rural versus urban • How culture influences client’s understanding and approach to problems • Cultural identification (e.g. attachment to traditional cultural healing practices) 	<ul style="list-style-type: none"> • History of cultural identification

	<ul style="list-style-type: none"> • Cultural beliefs about mental and substance use disorders, treatment services and the role of treatment professionals • Abilities to adapt to treatment culture and to deal with conflict in these settings • Language ability, written and spoken, English as a second language • Reading and writing skill level, literacy level • Barriers to providing cultural and linguistic services • Cultures that have evolved around treatment of mental and/or substance use disorders (e.g. identification with 12-Step recovery culture; commitment to mental health empowerment movement) 	
<p>Environment and social supports</p>	<ul style="list-style-type: none"> • Family and peer relationships • Social interactions and lifestyle • Stability of social environment, including violence (victimization/victimizer) • Parenting situation • Presence or absence of continuing treatment relationships, particularly mental disorder treatment relationships beyond the single episode of care • Quality and safety of recovery environment • Effects of peer pressure to use drugs and alcohol • Adequacy and safety of the person’s current living situation 	<ul style="list-style-type: none"> • Family history • Prior experience with peer support groups • Trauma history and/or history of domestic violence

<p>Strengths (when listed separately)</p>	<ul style="list-style-type: none"> • Talents • Interests and aspirations • Skills • Personal characteristics • Areas of educational interest and literacy • Supportive relationships, peer, family, treatment, self-help, spiritual, and others • Interpersonal coping strategies, problem solving abilities, and communication skills • Recent successes • Ability to manage mental and substance use disorders • Vocational and educational accomplishments • Areas of particular capacity or motivation in relation to general life functioning (e.g. capacity to socialize, work, or obtain housing) 	<ul style="list-style-type: none"> • Past successes
<p>Client background</p>	<ul style="list-style-type: none"> • Presenting problem(s) • Criminal justice history and status • Employment/vocational status • Educational status • Vocational skills and training needs • Financial support and eligibility for entitlements • Resources and limitations affecting ability to participate in treatment (e.g. transportation problems, homelessness, child care needs) • Marital status • Socioeconomic status 	<ul style="list-style-type: none"> • History and chronology of events, acute and chronic stressors or difficulties, in the client’s words • Significant developmental, educational, family and social events • Vocational/employment history • Educational history

APPENDIX 2

Team activities

Possible content for comprehensive assessment: The list

In *Appendix 2: Content for comprehensive assessment*, there is a team activity that has team members take an in-depth look at the content of assessment as follows:

- Give each team member a copy of the content list (in Appendix 1). Have all team members highlight the items they believe are needed to do their work. When finished, have the team compare their lists and develop a team list. Then compare the team list to the actual assessment content currently being gathered. Debrief and identify changes that could be made.

What are you asking for?

Many assessment instruments and tools lean towards asking about problems much more than strengths. One of the problems with giving priority to problems is that it can be overwhelming and discouraging to both clients and clinicians. Client problems and deficits need to be balanced with their strengths and capabilities.

Let's take a look at *What are you asking for?*

1. Gather all assessment tools and instruments that your team uses.
2. For each question asked of clients, rate if it asks for a problem/deficit or strength/capability.
 - Have the team keep score. Literally count the number of each. The team can come up with its own scoring system—it can be as simple as a tally sheet or can be more complex. An example is shown below:

	Problem/deficit	Strength/capability
Question 1 _____	✓	
Question 2 _____		✓

3. When all items are rated, encourage a discussion of the results.
4. If needed, brainstorm ways that more strengths/capability information can be gathered.

“The Ds” Debate

There is a fair bit of controversy when people challenge the prevalence of “the Ds” (see the section on *Problems with problems*). This can be a fun activity to illuminate some beliefs about this issue.

Form two teams and debate the following statement. One team argues in favour of the statement and the other team argues against it. Give the teams enough time to prepare their arguments. Be prepared for lively discussion!

Statement: “Deficit-oriented assessment has improved the assessment and treatment of a number of disorders but, at the same time, has created a negative bias, considered strengths as clinical peripheries or by-products, tended to reduce clients to diagnostic categories, and created a power differential, which could be counterproductive to clinical efficacy.” (From: Rashid, T. and Ostermann, R. F. (2009), Strength-based assessment in clinical practice. *J. Clin. Psychol.*, 65: 488–498. doi: 10.1002/jclp.20595).

Debrief questions:

After the debate, you can use the following questions to debrief:

- If deficit/strength approaches are on a continuum, where would each team member be? (You could put a scale on the floor or wall and have the group move to their own place on the continuum).
- Why did you choose that place on the continuum?

Social determinants of health: AMH version

One way to really see how the social determinants of health impact at the individual level is to tell a story. The deceptively simple story on the left side of the table below is from the Public Health Agency of Canada (<http://www.phac-aspc.gc.ca/ph-sp/determinants/#determinants>). It speaks to the complex set of factors or conditions that determine the level of health of every Canadian.

On the right side of the table, write a similar story, but for a client with concurrent disorders.

Public Health Agency of Canada's story	AMH's story
<p>Why is Jason in the hospital? Because he has a bad infection in his leg.</p> <p>But why does he have an infection? Because he has a cut on his leg and it got infected.</p> <p>But why does he have a cut on his leg? Because he was playing in the junk yard next to his apartment building and there was some sharp, jagged steel there that he fell on.</p> <p>But why was he playing in a junk yard? Because his neighborhood is kind of run down. A lot of kids play there and there is no one to supervise them.</p> <p>But why does he live in that neighborhood? Because his parents can't afford a nicer place to live.</p> <p>But why can't his parents afford a nicer place to live? Because his Dad is unemployed and his Mom is sick.</p> <p>But why is his Dad unemployed? Because he doesn't have much education and he can't find a job.</p> <p>But why ...?</p>	

Comprehensive assessment checklist

Interpersonal factors: Engagement

QUESTIONS	ALREADY DO THIS	COULD EASILY DO	THIS WILL TAKE TIME	THIS WILL BE HARD	COMMENTS AND REFLECTIONS
Are clients welcomed into the service and is the assessment process explained?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do staff introduce the assessment and each tool used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are clients' perceptions of their problems central to assessment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are the client's goals central to assessment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do clinicians use empathic approaches during assessment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is stage of change (Transtheoretical Model of Change) and motivation assessed for each area of assessment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are clinicians accepting and able to work with clients who are not ready to change (e.g. use methods such as Motivational Interviewing)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are client strengths and supports identified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are clinicians culturally sensitive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do clinicians use principles of trauma-informed care during assessment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do clinicians collect collateral information when appropriate with written consent from the client?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do clinicians have clear reasons for collecting collateral information and explain these reasons to the client?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Comprehensive assessment checklist

Procedural factors: A practical approach to comprehensive assessment

QUESTIONS	ALREADY DO THIS	COULD EASILY DO	THIS WILL TAKE TIME	THIS WILL BE HARD	COMMENTS AND REFLECTIONS
Do all sites have universal access (“no wrong door”) for assessment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do assessments gather only the information necessary for treatment planning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is administrative information separated from treatment information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are interaction effects included in the assessment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is a full history of all disorders gathered?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are the patterns of interaction identified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is information gathered on the role of social determinants of health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is the purpose of assessment clearly defined?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are all assessment activities in service to the defined purpose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is assessment an ongoing process?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are multiple methods used over time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Challenges (and solutions) to comprehensive assessment

Check the challenges that apply to your team and identify the ways it impacts your work. Then brainstorm strategies for each.

	How does it impact you?	Strategies
<input type="checkbox"/> Failure to take a proper history		
<input type="checkbox"/> Different norms for substance use disorders		
<input type="checkbox"/> Clinician resistance		
<input type="checkbox"/> System barriers (identify specific challenges) _____ _____ _____ _____		
<input type="checkbox"/> Sorting out the interaction effects		
<input type="checkbox"/> Primary vs. secondary		
<input type="checkbox"/> Other:		
<input type="checkbox"/> Other:		
<input type="checkbox"/> Other:		

APPENDIX 3

Best and promising practices for comprehensive assessment

The literature review *Assessment of Concurrent Disorders* (Alberta Health Services, 2012) found little empirical evidence that assessment contributes to improved outcomes. There are different types of evidence, ranging on a continuum from strong to weaker quality as shown in the diagram below:



From: Alberta Health Services KM Department, 2011.

While there is little empirical evidence, the Literature Review identified a number of Best and Promising Practices for comprehensive assessment. Most of the identified practices come from expert opinion, particularly from those who were the first to pilot integrated treatment for concurrent disorders. The experience of these “pioneers” in integrated treatment is invaluable.

The following is the summary of Best and Promising Practices from the literature review *Assessment of Concurrent Disorders* (Alberta Health Services, 2012, p. 46-48). They are sorted by category: Content, Methods and measures, and Process.

Best practices

Content

- Experts recommend a broad definition of concurrent disorders. If clients do not meet the official criteria for DSM-5 diagnosis, they should still be viewed as having a concurrent disorder (Center for Substance Abuse Treatment, 2005).
- Rather than look for a simple cause and effect relationship, expert consensus recommends looking for the complex interaction patterns unique to each person (Center for Substance Abuse Treatment, 2005).
- Diagnostic assessment must also consider the severity and chronicity of all disorders. Both severity and chronicity are negatively associated with treatment outcomes (Hunsley and Mash, 2010).
- After an extensive review of the research, the American Psychological Association Interdivisional Task Force on Evidence-Based Therapy Relationships (2011) found one of the empirically-supported elements of the client-clinician relationship was collecting client feedback. Implementing client feedback systems has been found to reduce drop-out, improve outcomes, reduce cost of care, decrease deterioration, and reduce hospitalizations and length of stay in mental health and addiction services (Lambert, 2010).
- A consistent recommendation for the assessment of people with concurrent disorders is to evaluate their motivation for change, including the stage of change and/or the person's stage in the treatment process (Health Canada, 2002).
- The Center for Substance Abuse Treatment (2005) expert consensus panel concluded that all assessment must include some specific attention to the individual's current strengths, skills, and supports, both in relation to general life functioning, and in relation to his or her ability to manage either mental or substance use disorders. This often provides a more positive approach to treatment engagement than does focusing exclusively on deficits that need to be corrected. This is no less true for individuals with serious mental disorders than it is for people with substance use disorders only.

Methods and measures

- There is consensus in the literature that assessment includes gathering information in many ways, usually using a combination of instruments and interviews (Health Canada, 2002, Center for Substance Abuse Treatment, 2005). It is unlikely that one instrument will collect all the information required.
- One of the strongest recommendations made by experts in the field is for assessment to include multiple sources of information (Health Canada, 2002). Whenever possible, interview and test results should be supplemented by collateral information obtained from family members, friends, housemates, and other informants who have close contact with the individual (Drake et al., 1993).
 - The recommendations for consulting other people for information to corroborate client-supplied information seems to come from correctional settings (Peters et al, 2008) or settings that deal with severe, cognitively impaired mental health clients (Mueser et al., 2003). It is unclear if this is necessary for clients whose cognition is not impaired, or whose treatment is not coerced.

Process

- One of the strongest recommendations made by experts in the field is for assessment to be conducted over more than one interview (Health Canada, 2002). There is an iterative relationship between assessment and treatment planning. Rather than being one-time events, treatment planning and assessment constitute a process of continual refinement and adaptation to changing client circumstances (Center for Substance Abuse Treatment, 2005).
- The assessment process should be person-centred in order to fully motivate and engage the client in the assessment and treatment process. Person-centred means that the client's perceptions of his or her problem(s) and the goals he or she wishes to accomplish are central to the assessment and to the recommendations that derive from it (Center for Substance Abuse Treatment, 2005).
- An expert consensus panel (Center for Substance Abuse Treatment, 2005) determined that the first step in the assessment process is to engage the client in an empathic, welcoming manner and build a

- rapport to facilitate open disclosure of information. They identified five key concepts that underlie effective engagement during the initial clinical contact: universal access (“no wrong door”), empathic detachment, person-centred assessment, cultural sensitivity, and trauma sensitivity. They also emphasized that engagement is a continual process as well as the first necessary step for assessment to take place.
- The assessment approach must be sensitive to the possibility that clients have suffered previous traumatic experiences that may interfere with their ability to be trusting of the counsellor. Clinicians who observe guardedness on the part of clients should consider the possibility of trauma and try to promote safety in the interview through providing support and gentleness, rather than trying to “break through” evasiveness that erroneously might look like resistance or denial. All questioning should avoid “retraumatizing” clients (Center for Substance Abuse Treatment, 2005).
 - Cultural sensitivity is also cited as a best practice for assessment. Assessment approaches for concurrent disorders should consider influences of ethnicity, social class, gender, sexual orientation, race, disability status, socioeconomic level, and religious and spiritual affiliation (Hienz et al., 1999). “An important component of a person-centred assessment is the continual recognition that culture plays a significant role in determining the client’s view of the problem and the treatment” (Center for Substance Abuse Treatment, 2005, p. 73).

Promising practices

Content

- Assessment has different purposes which require different content selection, methods and measures, and processes. A discussion of evidence-based assessment strategies is impossible without first identifying the purpose of the assessment (Hunsley and Mash, 2008).
- In addition to decreasing the number of assessment questions to only those needed, it would make sense to determine in advance what information would be useful and needed for each of the assessment purposes.
- Identifying and working with client strengths, rather than deficits, may lead to improved outcomes.
- The most consistent predictor of outcome has been the quality of the therapeutic relationship between therapist and the client. What may be more important than matching to therapy/treatment content is matching to the counsellor's therapeutic style. It may also be more important to tailor the treatment specifically to enhance the therapeutic relationship than to be consistent with a theoretical model of psychopathology (Beutler, 2000).

Methods and measures

- Ideographic [individual level] approaches are more applicable to the goals of case formulation and treatment planning, and treatment monitoring and outcomes [than to the goal of diagnosis]. Measures at this level are often self-monitoring forms and individualized scales for measuring treatment goals (e.g. goal attainment scales). For these purposes, psychometric characteristics such as reliability and validity may, at times, not be easily evaluated or even relevant (Hunsley and Mash, 2010).

Process

- Organizations need to develop and monitor assessment processes that encourage sound practice (Jensen-Doss and Hawley, 2010).

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