4

Assessment I: Detection, Classification, and Functional Assessment

Assessment is the cornerstone of effective treatment. In order to treat clients with dual disorders, clinicians need first to be able to identify the possible signs of substance abuse, and to conduct more detailed follow-up assessments to determine whether these clients meet the diagnostic criteria for substance use disorders. Clinicians must have the tools for evaluating the specific nature of their clients substance abuse, including their patterns of substance use, the context in which they occur, their functional significance, and the role that substances play in the clients lives. Finally, clinicians need to be able to formulate coherent, specific, and realistic treatment plans based on these evaluations. The steps of assessment are not static activities that occur in a fixed sequence. Rather, the process of assessment is ongoing and continuous throughout the course of all work with clients with a dual disorder.

In this chapter and the next, we present the necessary ingredients for conducting a comprehensive assessment of substance abuse in clients with severe mental illness. We begin this chapter with an overview of the assessment process, which we organize into a model comprising five steps: detection, classification, functional assessment, functional analysis, and treatment planning. We next describe common problems clinicians encounter when assessing substance use disorders in clients with severe mental illness. Awareness of these potential obstacles, and of strategies for overcoming them, is critical to conducting an accurate assessment. We then provide a detailed description of the first three steps of assessment (detection, classification, and functional assessment), and introduce clinicians to specific instruments and assessment forms that are contained in Appendix C. In Chapter 5, we complete the last two steps of assessment (functional analysis and treatment planning). Throughout both chapters, we make recommendations for how to integrate the assessment process into the ongoing day-to-day activities of individual clinicians and treatment teams caring for clients with dual disorders.

AN OVERVIEW OF THE ASSESSMENT PROCESS

Assessment is an ongoing process that is interwoven with treatment. Assessment begins at the earliest point of contact with the client, during the engagement stage, when a therapeutic relationship is being established between the client and clinician. It continues through the relapse prevention stage, when a sustained remission of substance abuse has been achieved and attention has turned to improving other areas of functioning. Information regarding a client s substance abuse and functional adjustment is gathered throughout the treatment process, along with evidence regarding the effects of interventions (or lack thereof). Treatment plans are then modified accordingly.

As mentioned above, the assessment of substance use disorders in persons with severe mental illness can be conceptualized as a five-step process (see Figure 4.1). Each step has a unique goal, specific assessment instruments, and various strategies available to clinicians for achieving that goal.

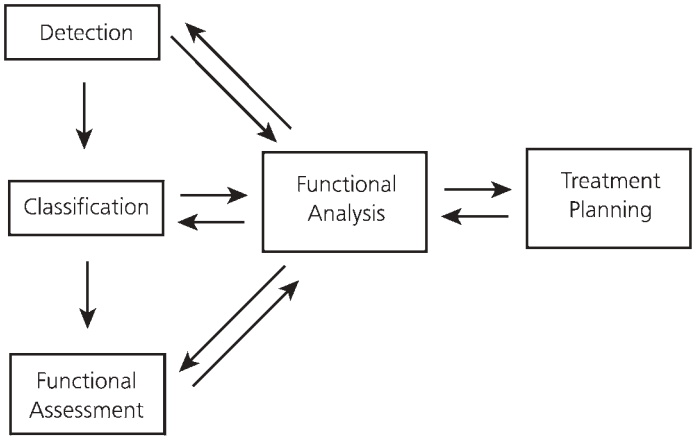

FIGURE 4.1. The five steps of assessing substance use disorders in clients with severe mental illness: detection, classification, functional assessment, functional analysis, and treatment planning. Treatment planning involves continuous feedback from the other four steps of assessment.

1. *Detection*. The first step of assessment is detection. Its goal is to identify clients who are experiencing problems related to substance abuse. Because the consequences of untreated substance abuse are so devastating, and because substance abuse is frequently unrecognized in clients with severe mental illness, it is preferable to cast a wide net and to be overinclusive rather than underinclusive in identifying these clients.

2. *Classification*. The second step is to classify the nature of those substance use problems by determining whether they meet *Diagnostic and Statistical Manual of Mental Disorders* (DSM) criteria for a substance use disorder. Classification involves evaluating whether clients use of alcohol or drugs has led to *substance abuse* (i.e., substance use that results in negative social, role-related, or legal consequences) or *substance dependence*, including *nonphysiological (psychological) dependence* (i.e., excessive involvement in using substances to the point where other important activities are given up) or *physiological dependence* (i.e., development of physical tolerance to substances and/or withdrawal symptoms following cessation, leading to increased use to achieve desired effects). Clients who meet DSM criteria for a substance use disorder are in need of further dual-disorder assessment (described below); those who use substances without experiencing negative consequences should be educated and monitored, as their vulnerability to developing substance use problems in the future is high (Drake & Wallach, 1993).

3. *Functional assessment*. After a client has been determined to have a substance use disorder, the next step is to conduct a functional assessment of the client s adjustment, with a special focus on the role played by substance use in the client s life. The goal of the functional assessment is to obtain a comprehensive understanding of the client s adjustment across a range of different life domains, including psychiatric symptoms, physical health and safety, psychosocial functioning, and substance use. Specific needs related to substance abuse and other domains are identified during this assessment, as well as client strengths, which can be capitalized upon in developing treatment plans. As part of the functional assessment, the clinician obtains a thorough description of the client s pattern of substance use, including history of substance abuse and treatment, types, amounts, and situations in which substances are used, possible motives and consequences (both positive and negative) of substance use, and motivation to address substance abuse problems.

4. *Functional analysis*. When the clinician has obtained a description of the client s substance use behavior and functioning in other domains, the next step of assessment is to synthesize this information into a functional analysis. The goal of the functional analysis is to develop an understanding of the role played by substance use in the client s life, and to identify factors that may contribute to maintaining ongoing substance abuse and pose obstacles to achieving sobriety (or that pose a risk for relapse in clients not actively using substances). The functional analysis recognizes that a client often uses substances to meet particular needs (e.g., socialization, coping), even in the face of negative consequences, and that effective substance abuse treatment may require finding other ways for the client to meet these needs (e.g., improving social skills, finding alternative socialization outlets, developing better coping strategies).

5. *Treatment planning*. The final step in assess-

ment is to develop a treatment plan that addresses the problems and goals identified in the previous steps. In developing such a plan, the clinician needs to determine the client s most pressing needs and select strategies for addressing them (e.g., services to address housing and medical needs); the clinician must also articulate longer-range goals that are the major focus of treatment, and indicate the steps and methods for achieving these. Reducing substance use and achieving sobriety (or preventing relapses, for clients who have recently attained sobriety) are generally long-term goals in clients with dual disorders. Effective treatment plans for addressing these goals need to take into account clients motivation to address their substance abuse, as well as factors identified in the functional analysis that may be obstacles to achieving or maintaining sobriety (e.g., a substance-abusing peer group, poor skills for coping with persistent symptoms). As treatment is provided, the success of interventions can be evaluated. Treatment plans are then modified in a continuous feedback loop based on ongoing assessment and refinements (or modifications) of the functional analysis.

The five steps of assessment, including their goals, instruments, and strategies, are summarized in Table 4.1. These steps are most effectively accomplished when they are the products of a team effort, involving all individuals who provide services to the client (e.g., case manager,

TABLE 4.1. Overview of the Five Steps of Assessment: Goals, Instruments, and Strategies

Step	Goals	Instruments	Strategies
Detection	To identify clients who may be experiencing problems related to substance abuse.	The Dartmouth Assessment of Lifestyle Instrument (DALI)	• Cast a wide net; assume that substance abuse is likely. • Explore past use of substances before current use. • Use lab tests to screen for substance use. • If use is detected, screen for presence of negative consequences.
Classification	To determine which, if any, DSM diagnoses apply to the client.	Alcohol Use Scale Revised (AUS-R) Drug Use Scale Revised (DUS-R)	• Complete AUS-R and DUS-R every 6 months. • Rate worst period of use. • Base ratings on team consensus. • Tap multiple sources of information. • Stick to evidence and get more information when needed.
Functional assessment	To gather information about the client s adjustment across different domains of functioning and his or her pattern of substance use.	Functional Assessment Interview Drug/Alcohol Time-Line Follow-Back Calendar (TLFBC)	• Obtain information about background, psychiatric illness and treatment, physical health and safety, psychosocial adjustment, substance use. • Use all sources of information. • Assess the client s range of different needs. • Identify client s strengths. • Update functional assessment every 6 months.
Functional analysis	To identify factors that maintain substance abuse, interfere with sobriety, or pose a risk of relapse.	Payoff Matrix Functional Analysis Summary	• Use information obtained from functional assessment. • Explore possible motives for using substances and costs of giving them up (e.g., reduced socialization, self-medication, pleasure/leisure, structure). • View identified motives and costs as working hypotheses, not facts. • Update/modify Payoff Matrix every 6 months.
Treatment planning	To develop an integrated treatment plan that addresses substance abuse and mental illness through concurrent treatment.	Substance Abuse Treatment Scale Revised (SATS-R) Individual Dual-Disorder Treatment Plan Individual Treatment Review	• First address pressing needs. • Evaluate client motivation to address substance abuse. • Identify treatment goals and target behaviors. • Select interventions for achieving goals. • Choose measures to monitor outcomes of goal setting. • Follow up and modify treatment plans at least every 6 months.

psychiatrist, nurse, therapist), led by a single clinician. The clinician who takes the lead in conducting and coordinating the assessment obtains and consolidates information from all available sources (e.g., other team members, records, client self-reports, collateral reports); convenes regular meetings with the treatment team (or treatment providers) to discuss and reach a consensus regarding each step of assessment; documents each of the steps; and monitors follow-up of treatment plans, including periodic revision of the functional analysis and treatment plan. Although one individual is charged with spearheading the assessment process for a client, taking a team-based approach increases the likelihood that treatment providers will act in concert with one another, due to shared endorsement of the problems at hand and of the most promising treatment approach.

Assessment can take place anywhere, depending on where the client is and how involved the client is with the treatment team. At the engagement stage of treatment, assessment often begins in community locations convenient for the client, such as the home, a coffee shop, a local park, or a homeless shelter. For clients who have experienced psychiatric relapses, physical illnesses, or legal problems as a result of their dual disorders, the first steps of assessment may take place in an institutional setting (e.g., a psychiatric or general hospital, an emergency room, or a local jail or prison). For clients who are engaged in psychiatric services, but whose substance abuse has not been carefully evaluated, the earliest steps of assessment may occur at a mental health center, day treatment program, or vocational rehabilitation program.

The time required to complete the assessment process is partly dependent on the ease with which a client can be engaged by a clinician. For most clients, the detection and classification steps can be completed over 1 2 weeks. The functional assessment step often requires more time to complete typically 2 3 weeks, although even longer periods may be required for clients who are minimally engaged in treatment and who have very limited contact with their primary clinician. The steps of functional analysis and treatment planning are less dependent upon client availability, and they can be completed in 1 2 weeks. Overall, it is best if the entire assessment process, including the treatment plan, can be completed within 4 6 weeks of initial contact with the client. Although the time required to complete this process is substantial, this investment is well spent, and it is an integral part of treatment. As clinicians spend time with clients learning about their substance use and abuse, functioning, and goals, clients become engaged in treatment, and a therapeutic relationship emerges. This relationship is critical to pursuing targeted goals, and thus serves the ends of treatment.

COMMON ASSESSMENT PROBLEMS

The assessment of substance use disorders in persons with severe mental illness is complicated by eight common problems (Carey & Correia, 1998; Drake, Rosenberg, & Mueser, 1996; Shaner et al., 1998). We highlight and discuss these problems here, and we suggest strategies for dealing with these issues. Awareness of these problems is helpful to clinicians in completing the detection and classification steps of assessment.

Failure to Take a Proper History

The most significant obstacle to assessing substance abuse in clients with psychiatric disorders is the failure to take a proper history of the clients use of alcohol and drugs. Numerous studies have demonstrated that in routine clinical practice, clinicians are often unaware which of their clients use or abuse alcohol or drugs (Ananth et al., 1989; Barbee, Clark, Craqanzano, Heintz, & Kehoe, 1989; Drake et al., 1990; Galletly, Field, & Prior, 1993; Shaner et al., 1993). The most common reason for this is that clinicians simply fail to ask clients about their use of substances. Although not all clients are willing to discuss this subject freely, some are quite direct in acknowledging substance use and discussing the consequences of their use. It is often helpful to begin examining this topic with a discussion about a client s past substance use, and then to move gradually toward more recent use. Talking about past use first can help reduce client defensiveness, which is naturally likely to be greater when discussions focus immediately on current substance use. Of greatest importance, clinicians should know that if they do not ask their clients about substance use, most will not spontaneously divulge this information and it may not otherwise emerge.

Denial and Minimization

It is 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 deny that they have an illness or minimize the extent of their disability. Therefore, it is not surprising that denial and minimization about both the amount of substance use and its consequences are pervasive in clients with dual disorders. Rather than directly confronting clients about denial or minimization, clinicians should expect these reactions, and strive toward the long-term goal of developing a trusting relationship with open, honest dialogue. In addition, clinicians must actively seek other sources of information about clients substance use,

such as reports of family members and significant others. Accurate assessment requires an ongoing process in order to overcome these barriers.

Confusion about the Effects of Substance Use

In the general population, substance abuse is defined in terms of its effects on a person s ability to work, the quality of social relationships, negative effects on health, and use of substances in dangerous situations (e.g., driving while intoxicated). However, even in the absence of active substance 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 dual-diagnosis population.

Substance use disorders in clients with severe mental illness can be identified by exploring the interactions between substance use and the course of mental illness. Although mental illness may cause impairments in a number of different areas, substance use often exacerbates these problems, resulting in even worse functioning. Familiarity with a client s pattern of substance use and the course of severe mental illness can help a clinician discern the effects of substance use on the client s functioning. In addition, when active substance use coexists with a range of other psychosocial impairments, the clinician should assume that these impairments are related to the client s substance abuse until proven otherwise.

The Primary–Secondary Distinction

When working with clients with a dual diagnosis, clinicians often want to know which disorder is primary and which is secondary. In discussions of substance use disorders and comorbid anxiety and depressive disorders, the primary secondary distinction refers to the question of which disorder comes first, with the assumption that the earlier-onset disorder often causes the disorder that follows (Mueser, Drake, & Wallach, 1998; Schuckit, 1983; Schuckit, Zisook, & Mortola, 1985). Conventional wisdom holds that 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.

There are several difficulties with attempting to distinguish which disorder is primary and which is secondary. First, it is notoriously difficult (and often impossible) to determine the effects of two mutually interacting disorders while both disorders are currently active (Lehman et al., 1994). Attempts to disentangle the causes and the effects of the different disorders are usually unsuccessful and frequently futile. Second, 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 (Cornelius et al., 1997; Mason, Kocsis, Ritvo, & Cutler, 1996; McGrath et al., 1996). Third, trying to disentangle primary from secondary disorders requires the assumption that, indeed, one disorder *is* primary and another *is* secondary. Such an assumption is often incorrect, and the designation of one disorder as primary and another as secondary is more of an arbitrary distinction than one based on their true causal relationships. Rather than attempting to determine which disorder is primary and which is secondary, we encourage clinicians to view both disorders as primary, and to assess and treat both disorders simultaneously.

Cognitive, Psychotic, and Mood-Related Distortions

Severe mental illnesses are characterized by their effects on mental processes and mood. Cognitive impairments (e.g., poor attention and memory problems), hallucinations or delusions, and problems with moods (e.g., depression and mania) may compromise the validity of clients self-reports about their substance use. However, clinicians concerns over the validity of client self-reports often result in prematurely rejecting reports that are valid. In fact, there is abundant evidence that reliable and valid reports of substance abuse can be obtained from clients with severe mental illness (Mueser, Drake, & Wallach, 1998).

An individual client s cognitive impairments or psychiatric symptoms may interfere with his or her ability to report accurately about substance use and its consequences. However, the presence of symptoms or cognitive deficits alone does not mean that a client s self-reports are not valid. To evaluate the validity of a client s self-reports, a clinician needs to gather as much information as possible about substance use, its consequences, and other areas of functioning, in order to develop a comprehensive clinical picture of the client. The apparent consistency (or lack of it) among the client s reports of substance use, reports about other areas of func-

tioning, and information obtained from other sources provides the necessary basis for judging whether cognitive, psychotic, or mood-related distortions are compromising the validity of the client s reports of substance use and its consequences.

History of Sanctions

Legal sanctions against drug use are a potent disincentive for persons with drug use disorders to provide an honest account of their use to treating clinicians. This obstacle to open dialogue also exists in persons with severe mental illness. In addition, efforts to restrict the access of clients with dual disorders to their disability income can act as a further deterrent to their willingness to talk about their substance use with clinicians. Clinicians need to be aware of these disincentives, in order to create a therapeutic relationship with their clients that is free of concerns over the legal sanctions associated with the clients use of substances.

With respect to the abuse of illicit drugs, clients need to know when clinicians are, and when they are not, working in collaboration with law enforcement officials. Whether or not a clinician is actively working with people in the criminal justice system is usually determined by who employs the clinician and how a client has come into contact with dual-disorder treatment providers. When close collaboration with law enforcement authorities exists, clinicians may be required to report clients use of substances to these authorities, and such reporting requirements need to be discussed openly with clients. In general, it is easier to develop an open and honest working relationship with a client when information about his or her substance abuse can be kept confidential and need not be reported to people other than the immediate treatment team. In such a therapeutic context, the client learns that he or she is free to discuss substance use without fear or sanctions; this permits a more open dialogue concerning the relative merits and disadvantages of continued substance use. However (as discussed in more detail in Chapter 17), even when a clinician does work for or in close collaboration with law enforcement, a strong working alliance can be formed with a client provided that the clinician informs the client about the bounds of confidentiality.

A good relationship between the clinician and client also entails discussion of control over the client s finances, and the role of the clinician in determining the client s access to his or her money. Financial payeeships, in which a clinician or someone else controls the client s money, are useful early in dual-disorder treatment for limiting access to substances (Rosen et al., 2002), but they can also create tension in the therapeutic relationship. As discussed in Chapter 17, a clinician s honesty about the conditions under which a client can gain access to his or her money, and the steps necessary for the client to regain control over finances, are critical to establishing a good relationship in which the clinician can work together with the client toward the goal of removing these financial restrictions.

Premotivational State

As we discuss later in this chapter, many clients with dual disorders are not motivated to address their substance use problems and consequently are difficult to involve in the assessment process. It is helpful for clinicians to recognize that lack of motivation to work on substance abuse is common in the early stages of dual-diagnosis treatment, and that it need not be an obstacle to engaging clients and beginning the assessment process. Recognizing that most clients early in treatment are in a premotivational state can help clinicians lower their expectations for cooperation in the assessment process, and encourage them to work on understanding how clients perceive their own problems and goals. If assessment is approached as a desire to understand clients as they are, without prejudice or preconceived agendas for change, most clients will be able to participate with growing cooperation.

Different Norms for Substance Use Disorders

Clinicians often fail to recognize substance abuse in their clients with severe mental illness because of different norms for substance use disorders between these clients and the general population. Persons who develop substance use disorders in the general population frequently use large quantities of alcohol and drugs, leading to physiological dependence and health consequences (e.g., liver and circulatory problems due to alcohol abuse, or infections due to injection drug use). In contrast, individuals with severe mental illness frequently experience significant negative consequences with mild to moderate quantities of substance use (Cohen & Klein, 1970; Crowley et al., 1974; Lehman et al., 1994), and because of their moderate use, they are less likely to develop physical dependence (Corse et al., 1995; Drake et al., 1990; Test et al., 1989). Similarly, clients with dual disorders are less likely to use injection drugs on a regular basis than are individuals in the general population who develop drug use disorders. Therefore, applying the same standards for substance abuse from the general population to individuals with severe mental illness can result in failing to identify significant numbers of clients with dual disorders. To avoid this, 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.

We have now reviewed some of the most common problems associated with the assessment of substance use disorders in persons with severe mental illness. A summary of these problems and of strategies for overcoming them is provided in Table 4.2. We next describe the first three steps of assessment: detection, classification, and functional assessment.

DETECTION

The goal of detection is to identify clients with severe mental illness who may be experiencing problems related to substance use. At this step in the assessment process, it is important not to miss any such clients. Clinicians must cast a wide net and be willing to identify some clients for whom subsequent assessment will reveal that substance use is not currently a problem. Mistakenly identifying a client as experiencing negative consequences from substance use is a more acceptable error than failing to identify a client with an active substance use disorder.

During the detection step, clinicians need to maintain a high index of suspicion ; that is, they must recognize that persons with severe mental illness are prone to substance use problems, and that it is possible for any such client to have a substance use disorder. This index of suspicion can be increased for the clients who are most likely to develop such disorders. Table 4.3 provides a summary of the demographic, history, and clinical characteristics that increase the risk of substance use disorders in persons with severe mental illness. The presence of each of these factors increases the chances that the client has a substance use disorder in an additive fashion. See Chapter 1 for more information about these correlates.

Exploring past use of substances before discussing current use can help identify those clients most likely to have current problems. Use of laboratory tests, such as breath, saliva, urine, blood, or hair analysis, can aid in the identification of clients using different substances (Galletly et al., 1993; McPhillips et al., 1997), although such assessment methods can only be used effectively with clients who are engaged in treatment. Drug and alcohol screening should be performed during all hospital admissions and emergency room visits, and should be considered with other routine laboratory testing at times of concern about substance use.

One strategy for identifying clients with a dual disorder is to use a self-report screening instrument. Numerous screening instruments have been developed for the detection of alcohol and drug use disorders in the general population, such as the Michigan Alcoholism Screening Test (Selzer, 1971), the Drug Abuse Screening Test (Skinner, 1982), the Cut Down on Drinking, Annoyed, Guilt, and Eye-Opener Test (Mayfield, McCleod, & Hall, 1974), and the Tolerance, Worry, Eye-Opener, Amnesia, and Cut Down on Drinking Test (Russell, Martier, & Sokol, 1991). A common problem

TABLE 4.2. Common Obstacles to Assessment, and Solutions

Obstacle	Solution
Failure to take a proper history	Ask clients directly about substance use and its consequences, beginning with past use.
Denial and minimization	Expect denial and minimization, and tap additional sources of information about clients substance abuse.
Confusion about effects of substance use	Explore associations between substance use and course of psychiatric illness; if a client uses substances, assume that problems in functioning are at least partly related to substance use.
The primary secondary distinction	View both substance abuse and mental illness as primary disorders (and neither as secondary).
Cognitive, psychotic, and mood-related distortions	Be aware of possible distortions without ruling out all client self-reports; seek out other sources of information about a client s substance abuse.
History of sanctions	Openly discuss the clinician s legal responsibilities, the client s concerns about legal issues, and control over the client s finances.
Premotivational state	Recognize that low motivation is common early in dual-diagnosis treatment, and actively seek to engage the client.
Different norms for substance use disorders	Remember that clients may experience adverse consequences to much lower amounts of alcohol and drug use than people with no psychiatric illness; the quantity of substance use is less important than the consequences of use.

TABLE 4.3. Demographic, History, and Clinical Correlates of Substance Abuse

Characteristic	Correlate with substance abuse
Demographic	
Gender	Male
Age	Young
Education	Low
Marital status	Not married
History	
Family history of substance use disorder	Present
Conduct disorder in childhood	Present
Premorbid social functioning	Good
Trauma and posttraumatic stress disorder	Present
Clinical	
Antisocial personality disorder in adulthood	Present
Medication and psychosocial treatment compliance	Poor
Violent/disruptive behavior	High
Depression	High
Suicidality	High
Legal system involvement	High
Homelessness	Present

with these instruments is that they were developed for the general population and often lack strong predictive utility for identifying substance use disorders in persons with severe mental illness (Dyson et al., 1998; Maisto, Carey, Carey, Gordon, & Gleason, 2000; Wolford et al., 1999). An exception to this is the Alcohol Use Disorders Identification Test (Saunders, Aasland, Babor, De La Fuente, & Grant, 1993), which has shown good sensitivity and specificity in detecting alcohol use disorders in persons with severe mental illness (Maisto et al., 2000; Seinen, Dawe, Kavanagh, & Bahr, 2000). However, most substance abuse screening instruments for the general population are of limited utility for a psychiatric population.

In order to facilitate substance abuse screening in persons with severe mental illness, we and our colleagues have developed an instrument tailored specifically to this population, the Dartmouth Assessment of Lifestyle Instrument (DALI; Rosenberg et al., 1998). The DALI is a brief, 18-item instrument that can be administered by interview, as a self-report questionnaire, or on computer; it requires less than 5 minutes to administer and score. A copy of the DALI and scoring instructions are provided in Appendix C (see Form C.1). Because the DALI was developed for a population of clients with severe mental illness, it has high sensitivity and specificity for the detection of recent substance use disorders, especially alcohol, cannabis, and cocaine use disorders. A positive score on the DALI indicates a high probability (80 90%) that the client meets DSM criteria for a recent substance use disorder. The DALI can be very useful in detecting substance use disorders, especially if the clinician is not familiar with the client.

If clients have been identified as using alcohol or drugs, or if they score positive on the DALI, they should be further assessed for any of the common negative consequences of substance abuse in persons with severe mental illness. Clinicians should use all sources of information available in evaluating the presence of these negative consequences. A list of the common consequences of substance abuse in clients with psychiatric disorders is provided in Table 4.4.

TABLE 4.4. Common Consequences of Substance Use in Persons with Severe Mental Illness

- 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)

CLASSIFICATION

The goal of classification is to determine which, if any, specific DSM diagnoses for substance use disorders a client currently meets. Classifying substance use disorders is necessary for communicating the nature and severity of the disorders to other clinicians, and for monitoring the effects of treatment. Evaluating whether a client s substance use problem has improved over the course of treatment has important implications both for program evaluation and determining the need for, and nature of, subsequent treatment.

In classifying substance use disorders, the DSM distinguishes between substance abuse and substance dependence. *Substance abuse* refers to a pattern of substance use that results in significant problems in one or more areas of functioning (such as social relationships, legal status, or role functioning), or the use of substances in hazardous situations (such as driving). *Substance dependence* refers to the use of substances that meets the criteria for either nonphysiological (psychological) dependence or physiological dependence. *Nonphysiological (psychological) dependence* is a syndrome characterized by excessive involvement in using substances, as indicated by such behaviors as repeated unsuccessful attempts to cut down on substance use, giving up important activities to use substances, or spending large amounts of time obtaining and using substances. *Physiological dependence* is a syndrome in which persistent substance use results in the development of physical tolerance to the effects of the substance (requiring greater amounts of the substance to achieve the same desired effects), withdrawal symptoms following cessation of substance use, and substance use to decrease or avoid withdrawal symptoms. If a client meets criteria for either nonphysiological or physiological dependence, he or she is classified as having substance dependence. The specific signs and symptoms of DSM-defined substance abuse and dependence, including both nonphysiological and physiological dependence, are summarized in Table 4.5.

It is common for clients with dual disorders to develop nonphysiological (psychological) dependence on drugs or alcohol, despite relatively moderate amounts of use. Clients with severe mental illness often have limited social outlets and recreational activities, and substance use may fill a vacuum in this area, resulting in psychological dependence. As we have reviewed before, physical dependence on alcohol and drugs is less common among clients with dual disorders than among people in the general population with substance use disorders, due to the high sensitivity of clients with severe mental illness to the effects of psychoactive substances.

In order to classify substance use disorders in clients with dual disorders, we recommend the Alcohol Use Scale Revised (AUS-R) and the Drug Use Scale Revised (DUS-R) (Drake et al., 1990; Mueser, Drake, et al., 1995). These scales are provided in Appendix C. The AUS-R (Form C.2) and the DUS-R (Form C.3) both include a 5-point, behaviorally anchored scale that corresponds to the client s use of alcohol or drugs over the past 6 months. In each instrument, the 5-point rating scale is preceded by a number of items that reflect the DSM criteria for substance abuse and dependence, and/or that enable clinicians to identify specific negative consequences associated with clients substance use. The answers to these items provide the basis for the 1 5 rating. A rating of 1 corresponds to no use of (abstinence from) that substance over the past 6 months. A rating of 2 corresponds to substance use over the past 6 months without evidence for substance abuse or dependence. A rating of 3 corresponds to meeting criteria for substance abuse, but not substance dependence. A rating of 4 means that the client meets DSM criteria for substance

TABLE 4.5. Signs and Symptoms of DSM-Defined Substance Abuse and Dependence

Substance abuse	Substance dependence
Substance use resulting in the following:	Nonphysiological (psychological) dependence
Problems with social relationships	Use of more of a substance than intended
Problems with role functioning	Repeated unsuccessful attempts to reduce use
Legal problems	Giving up important activities to use substances
Substance use in hazardous situations (e.g., driving)	Spending excessive time obtaining substances
	Continued substance use despite awareness of having a problem
	Physiological dependence
	Physical tolerance to substance (need for increased amounts, or lessened effects with use of same amounts)
	Withdrawal symptoms after cessation of substance use
	Substance use to decrease withdrawal symptoms

dependence (either nonphysiological or physiological). Finally, a rating of 5 means that in addition to meeting criteria for substance dependence, the client s substance use has been so severe over the past 6 months that it has resulted in significant institutionalization, such as repeated hospitalizations, emergency room visits, or time spent incarcerated. Recommendations for completing the AUS-R and DUS-R are provided below.

1. *Complete the scales every 6 months*. We encourage clinicians to complete the AUS-R and DUS-R every 6 months on all of their clients, in order to track substance use disorders in those known to have them and to identify emergent cases of these as soon as possible. Periodic evaluations of substance use help clinicians to remember its importance and, when present, to incorporate dual-disorder treatment into service planning.

2. *Rate the worst period of substance use over the last 6 months*. Clinician ratings should correspond to the client s *worst* period of substance use over the last 6 months, rather than to the client s most recent use of substances or average substance use over the 6-month time period. Ratings are made of the most severe period of substance use for two reasons. First, clients often minimize their recent substance use problems, so that focusing on the past 1 or 2 months could lead to an overly optimistic assessment. Second, the worst period of substance use over the past 6 months has important clinical implications for the treatment of dual disorders. Clients who have met criteria for either substance abuse or substance dependence within the past 6 months, but who have recently experienced improvements in their substance use, remain at very high risk for relapse in the forthcoming months. Therefore, basing their substance use ratings on the worst period ensures that this high risk for relapse is taken into account in planning treatment.

3. *Base ratings on team consensus*. Rather than a client s primary clinician alone being responsible for rating the client s substance use, it is best if ratings are made following a discussion with the entire treatment team so that they reflect a consensus of team members, rather than the opinion of just one clinician. A major advantage of using team consensus is that it requires team members to share their views and to reach an agreement about the nature and extent of a client s substance use problems. Reaching a consensus about a client s substance abuse or dependence increases the team s ability to act in concert with one another in their work with the client, thereby minimizing possible conflicts and maximizing the chances that the substance use disorder will be an agreed-upon target of intervention.

4. *Tap multiple sources of information*. Clinician ratings of substance use should be based on all available sources of information, including client self-reports, direct observations of clinicians and other treatment providers, reports by significant others (e.g., family members), medical records, and laboratory tests (e.g., urine screens). These multiple sources of information are combined to arrive at substance use ratings that best summarize the accumulated evidence.

5. *Stick to the evidence and gather more information when needed*. Sometimes a clinician knows that a client uses substances, but the effects of this substance use are unclear. When classifying clients substance use behavior, clinicians should not assume that clients experience negative consequences from their substance use when there is no supporting evidence. Rather, when clinicians are aware of clients substance use but negative consequences are unknown, they need to gather additional information in order to arrive at an objective appraisal of the clients substance use problems. In the absence of evidence indicating negative consequences, clinicians should not classify clients as meeting criteria for either substance abuse or substance dependence on the AUS-R or DUS-R.

FUNCTIONAL ASSESSMENT

The goals of the functional assessment are to develop an in-depth understanding of the client s adjustment across a broad range of life domains (e.g., living situation, social relationships), and to gather specific information about the client s substance use behavior (e.g., patterns of use, high-risk situations). The functional assessment is the most information-intensive part of the assessment process, since it involves gathering information not only about the client s substance use, but also about other areas of functioning. This is necessary because effective treatment of dual disorders requires a comprehensive assessment of needs related to both the mental illness and the substance use disorder. As the clinician gathers information about the client s functioning over multiple life domains, including a detailed description of the circumstances under which the client uses substances, he or she works like a detective to identify and evaluate the possible interactions between the two disorders, including how each disorder may worsen the other. This information plays a critical role in the next step of assessment, functional analysis (see Chapter 5), in which the clinician arrives at a formulation concerning the most important factors that contribute to the client s substance abuse or that pose a risk for relapse.

CASE EXAMPLE

Over the course of conducting the functional assessment of Jim, a 24-year-old man with schizoaffective disorder, the clinician learned that he drank large amounts of alcohol three to five times per week typically averaging 10 15 drinks per episode and sometimes more, mostly with friends. According to Jim, his alcohol use helped him socialize with friends; in addition, drinking gave him temporary relief from his hallucinations, depression, and anxiety, and helped him get to sleep at night. However, Jim also indicated that although drinking gave him a temporary escape from his problems, he had struggled a great deal with depression since he began drinking heavily. He reported frequent suicidal ideation, several serious suicide attempts, and numerous hospitalizations. Jim said that he felt discouraged by his persistently depressed mood, and added that he hated going into the hospital, where he felt isolated from his friends and his inability to escape his painful feelings.

The functional assessment is best conducted over a series of meetings with the client, with additional information collected from family and friends, other treatment providers, and medical records. Information can be obtained during informal or formal meetings with the client, with discussion paced and intermingled with case management according to the client s comfort and need. When the clinician has recently established a relationship with the client, these discussions serve to develop and strengthen the therapeutic alliance between the two.

The Functional Assessment Interview is contained in Appendix C (Form C.4). The interview is divided into five main areas, as well as two sections titled Goals and Strengths, covering the core topics of comprehensive assessment: background information, psychiatric illness, physical health and safety, psychosocial adjustment, and substance use. Guidelines for completing each section of the interview are provided below.

Background Information

The first section of the interview is straightforward and requires little elaboration. One area of potential importance in this section concerns clients who have children, especially women (Miller & Finnerty, 1996). Many such women experience difficulties managing their relationships and responsibilities with their mates and children. As a consequence of their dual disorders, these women often experience strained relationships with their partners and children, and lose custody of their children (Brunette & Dean, 2002). Issues of lost motherhood are critical to these mothers (Fox, 1999). Helping mothers with dual disorders improve their relationships with their children, and potentially regain their parenting roles, are important goals that can contribute to their motivation to work on their substance abuse problems (Schwab, Clark, & Drake, 1991).

Psychiatric Illness

Information obtained about the client s psychiatric disorder includes the diagnosis, characteristic symptoms, and medication, as well as the client s understanding of the illness and its treatment. The purpose of this part of the evaluation is not to conduct a comprehensive assessment of the psychiatric disorder (which presumably has been conducted as part of the client s mental health treatment); rather, it is to summarize the information most critical to developing a treatment plan that addresses both the mental illness and the substance abuse. Some of the information in this section can be gleaned from the client s medical records (e.g., diagnosis, psychiatric history, medications), with other information obtained directly from the client (e.g., understanding of illness, symptoms).

When a clinician is inquiring about a client s understanding of the psychiatric illness, it is important not to attempt to persuade the client that he or she has a specific disorder. Many psychiatric clients deny having a specific psychiatric illness (e.g., schizophrenia), but are nevertheless willing to acknowledge some problem areas or difficulties in their lives. For example, some clients agree that they have problems with their nerves or that they are vulnerable to stress, while resisting the idea that their problems are due to a diagnosable psychiatric condition. Other clients may even deny having any problems at all. Knowledge about and sensitivity to alternative cultural interpretations of mental illness are important. For example, *espiritsmo* in Puerto Rican culture is a system of beliefs involving the interactions between the invisible spirit world and the visible world, in which spirits can attach themselves to persons (Morales-Dorta, 1976). Spirits are hierarchically ordered in terms of their moral perfection, and the practice of espiritismo is guided by helping individuals who are spiritually ill achieve higher levels of this perfection. Troubled persons are not identified as sick, nor are they blamed for their difficulties; in some cases, symptoms such as hallucinations may be interpreted favorably as signs that the person is advanced in his or her spiritual development, resulting in some prestige (Comas-D az, 1981).

Regardless of the client s level of insight into his or her psychiatric disorder, most clients can be engaged

and helped to work on addressing problems or achieving goals, and (eventually) toward reducing substance abuse. Rather than trying to convince the client about having a psychiatric disorder, the clinician should seek to understand how the client perceives his or her own difficulties, and strive to emulate the client s language when discussing problems in order to develop and maximize rapport. Thus treatment plans need to correspond to the client s view of the world and personal goals.

Similarly, when exploring the client s understanding of medication and treatment of the psychiatric illness, the clinician should avoid attempting to correct or educate the client; the focus should be kept instead on evaluating the client s perceptions. Exploring the client s perceptions about the value of medication, problems with side effects, and concerns about the interactions between medication and substances can provide important information for treatment planning. For example, one side effect of antipsychotic medications is *akathisia*, an uncomfortable inner feeling of restlessness that is often accompanied by pacing (Bermanzohn & Siris, 1992; Raskin, 1972). Some clients do not take their medication regularly because of akathisia, while others may use alcohol and other substances to cope with this side effect (Duke et al., 1994). Recognition of akathisia as a troubling side effect in the functional assessment could result in modifications during treatment planning, such as changes in the dosage or type of medication used to treat the psychiatric disorder, or the development of more effective coping strategies for dealing with the side effect.

The clinician needs to have a detailed understanding of the client s primary psychiatric symptoms in order to effectively integrate treatment of mental health and substance abuse problems. The Functional Assessment Interview identifies the most common psychiatric symptoms in clients with severe mental illness, including mood problems (depression, anxiety, anger); sleep disturbances; cognitive impairment; apathy and anhedonia (lack of pleasure); and hallucinations and delusions. This list of symptoms is not comprehensive, and a more detailed assessment of particular symptoms can be useful.

There are numerous semistructured psychiatric rating scales for more comprehensively evaluating symptoms in persons with severe mental illness. These include the Brief Psychiatric Rating Scale (Lukoff, Nuechterlein, & Ventura, 1986), the Positive and Negative Syndrome Scale (Kay, Opler, & Fiszbein, 1987), and the Scale for the Assessment of Negative Symptoms (Andreasen, 1984; Mueser, Sayers, Schooler, Mance, & Haas, 1994). There are also self-report scales that can be administered to clients, such as the Brief Symptom Inventory (Derogatis, 1993), the Beck Depression Inventory (Beck, Steer, & Garbin, 1988), the Beck Anxiety Inventory (Beck & Steer, 1990), and the Posttraumatic Stress Disorder Checklist (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). If the clinician does not have expertise in the assessment of psychiatric symptoms, it may be helpful to work with other members of the client s treatment team who have more skills in this area, such as the client s psychiatrist. For example, the clinician can meet with the client and the psychiatrist to review the client s current symptoms.

Physical Health and Safety

A careful evaluation of physical health should be conducted, because clients with severe mental illness often neglect their health. In addition, the consequences of substance abuse, both direct and indirect, may include a range of health problems. Examples of the direct effects of substance abuse on health include the effects of alcohol on liver functioning (which in severe cases can interfere with the client s ability to metabolize psychotropic medications), and the risk of infectious diseases (e.g., hepatitis) resulting from injection or intranasal drug use with contaminated needles or straws. An example of the indirect effects of substance abuse on health is risky sexual behavior, such as unprotected sexual contact with multiple partners. Clients may engage in such behavior in exchange for drugs or money to support their substance use, because of lowered inhibitions and poor judgment following substance use, and/or because of increased vulnerability to victimization in substance abuse situations. Research indicates that clients with dual disorders are substantially vulnerable to such infectious diseases as hepatitis B, hepatitis C, sexually transmitted diseases, and HIV (M. P. Carey et al., 1999; Carey, Weinhardt, & Carey, 1995; Cournos & McKinnon, 1997; Grassi, Pavanati, Cardelli, Ferri, & Peron, 1999; Rosenberg, Goodman, et al., 2001; Rosenberg, Trumbetta, et al., 2001; see also Handout B.16 in Appendix B).

If health problems are not addressed, they can compromise the quality of the client s life and his or her ability to participate fully in treatment, as well as increase risk of premature mortality. Furthermore, failing to treat some health problems (such as sexually transmitted diseases) can have broader public health implications, including the spread of treatable and preventable diseases. Health issues are often some of the most pressing issues early in the treatment of clients with dual disorders. Diagnosing and treating diseases can help to solidify a good working alliance with a client. The clinician should be aware of the client s medical history from a chart review and available medical records. If the client has not had a physical examination conducted within the past year, one should be arranged.

Psychosocial Adjustment

Like the evaluation of the client s psychiatric illness, the assessment of psychosocial functioning is not intended to be comprehensive, but to provide an overview of the most critical components. Many different domains of functioning are covered in this section, including social relationships with family members and friends, leisure and recreational activities, work and education, financial matters, legal involvement, and spirituality. Much of the information about the client s psychosocial functioning may be available (or already known by the clinician) if the client is engaged and has been receiving treatment for his or her mental illness. In such cases, the assessment can be used to summarize information already collected and, if necessary, to update the most recent psychosocial assessment. If the client is new to the mental health system, has dropped out of treatment, or has received minimal services over the past several months, a more complete assessment should be undertaken.

There are several reasons why a careful assessment of clients psychosocial adjustment may inform dual-diagnosis treatment planning. First, problems in functioning may be due to substance abuse. For example, conflict with family members is a common consequence of substance abuse (Dixon et al., 1995; Kashner et al., 1991), and clients may be motivated to reduce or stop using substances in order to improve their family relationships. Second, the evaluation of psychosocial adjustment may yield clues about motivational factors that maintain a client s current use of substances, or that threaten a relapse. For example, if the client reports spending a great deal of time with a close circle of friends, the clinician may explore whether drug or alcohol use is a shared activity among these friends, and whether ongoing substance use serves to maintain these relationships (see the section on Substance Use, below, for more on assessing motivational factors).

Third, the evaluation of psychosocial adjustment may provide insights into the client s own strengths and into potential resources available in his or her social network. These strengths and resources can be capitalized upon when developing the treatment plan. For example, if a client expresses a strong desire to work, treatment can focus on securing competitive work and developing strategies for reducing the impact of substance use on getting or maintaining employment (see Chapter 18). If a client indicates strong religious or spiritual beliefs as many clients with dual disorders do (McDowell, Galanter, Goldfarb, & Lifshutz, 1996) it may be critical to incorporate these convictions into individual work (e.g., through motivational interviewing; see Chapter 7), and to identify others with similar beliefs in the community who may be sources of support and inspiration (e.g., members of churches or self-help groups; see Chapter 12). If a client s family ties are strong, involving the relatives at the earliest possible point will be an important part of the treatment plan (see Chapters 13 15).

Finally, comprehensive assessment of psychosocial functioning is critical if integrated treatment is to be successful in addressing the broad range of areas affected by mental illness, not only those affected by substance abuse. Improving psychosocial adjustment can help clients learn how to live a satisfying life without drugs or alcohol and build the foundation of recovery. This assessment serves to identify which areas need to be addressed in a client s treatment program.

Substance Use

The goals of the interview s fifth section are to obtain a detailed description of substance use behavior, to explore potential motivating factors for substance use, and to evaluate the client s insight and desire for change. It is best if the clinician has a good working relationship with the client at this point of the functional assessment, so that the direct focus on substance use will not be perceived by the client as threatening, and will lead to an honest, fruitful discussion. Therefore, the assessment of substance use may occur somewhat later than the other parts of the functional assessment, when the client is clearly engaged in treatment. However, the clinician is encouraged to attempt to complete the assessment within a month of initiating contact with the client, if possible.

Description of Substance Use

This section begins with obtaining a detailed description of the client s substance use. Within this part of the assessment, we suggest using the Drug/Alcohol Time-Line Follow-Back Calendar (TLFBC; Form C.5 in Appendix C) a version of a standard approach for evaluating the pattern of substance use over the past 6 months (Fals-Stewart, O Farrell, Freitas, McFarlin, & Rutigliano, 2000; Sobell, Maisto, Sobell, Copper, & Sanders, 1980). Many clients have difficulty accurately recalling their substance use over the past 6 months. In addition, it is common for clients to underreport their substance use over the most recent month. The clinician should be aware of these limitations in client self-reports, but not overly concerned. The most important information gathered during this assessment concerns the *pattern* of a client s substance use, including types of substances used, the approximate frequency and regularity of use, and the situations in which use most com-

monly occurs. The specific accuracy of the amounts of substances used is not central to understanding the client s substance use behavior. An example of a completed TLFBC is provided in Figure 4.2.

Motives

After obtaining information about the client s pattern of substance use, the clinician probes for possible reasons for using substances. At this point, the clinician may have already identified possible motives for substance use, based on the previous review of the client s psychiatric illness, psychosocial adjustment, and apparent pattern of substance use. The clinician uses this information along with additional probe questions to explore these factors in greater detail. It should be noted that clients perceived reasons for using substances may not accurately reflect the true effects of the substances. In addition, motivational factors that clients are not aware of, or are unable to articulate, may nevertheless contribute to substance abuse. A client s perception of why he or she uses substances is only one type of information gathered by the clinician in attempting to understand motives for substance use; other sources of information include reports of significant others, reports of other treatment team members, and the clinician s own observations or hypotheses from other information obtained in the assessment. However, the client s perceptions of the reasons for using substances are often an important place to begin treatment.

Various motives are commonly associated with substance abuse in clients with mental illness (Addington & Duchak, 1997; Carey & Carey, 1995; Graham & Maslin, 2002; Mueser, Nishith, et al., 1995; Nishith, Mueser, Srsic, & Beck, 1997; Nishith, Resick, & Mueser, 2001; Noordsy et al., 1991; Test et al., 1989; Warner et al., 1994). In general, these reasons for substance use fall into four categories: self-medication; socialization; recreation; and sense of purpose, structure, or compulsion. Regarding *self-medication* motives, people with severe mental illness report using substances to alleviate troublesome symptoms (e.g., depression, anxiety, sleep disturbances, or auditory hallucinations), although substance use often worsens such symptoms in the long run. With respect to *socialization* motives, clients may have poor social skills or experience social stigma, resulting in difficulties establishing relationships with others; such difficulties may lead clients to develop relationships with more accepting and more marginalized social groups, such as persons with primary substance use disorders. Alternatively, some clients with dual disorders used substances with a peer group before they developed their mental illness, and they continue to use with these friends as a shared activity. Yet another socialization motive is that some clients report that using substances makes them feel less anxious or nervous in social settings.

Recreational motives for using substances are very common, as the effects of alcohol and drugs are usually quite rapid and predictable. The temptation to use substances simply for their pleasurable effects may be even greater in persons with severe mental illness than in the general population, as a way to combat the problem of boredom or anhedonia (lack of pleasure). Furthermore, clients often have limited money for engaging in other recreational pursuits, and the onset of their mental illness in late adolescence and early adulthood often interferes with the development of hobbies and other less harmful recreational activities. Finally, with respect to *sense of purpose, structure, or compulsion*, some clients develop severe substance dependence in which their addiction assumes a life of its own; feeding the addiction, and maintaining a routine that enables them to do so, become ends in their own right. All people have a need for meaning in their lives a sense of purpose, something to do with their time, and a reason to live. People get meaning from their lives in a variety of ways, including family, friends, work, sports, and other recreational pursuits. For some people who lack these outlets, addiction fills the void by providing something meaningful to do.

CASE EXAMPLE

Jerome had major depressive disorder and severe cocaine dependence. He began every day with a trip to the local subway, train, or bus station at 7:30 to 8:00 A.M., where he would panhandle for money until he had enough to buy several rocks of cocaine. Then he would go to a local crack house, where he would purchase some cocaine and use it there for the next couple of hours. Although Jerome described enjoying the feeling of cocaine, it was also clear that his addiction, including his routine (or compulsion) for obtaining and using cocaine, provided him with a meaningful structure for his daily life that was as important as the high itself.

Insight

In the final part of the substance use section of the interview, the clinician evaluates the client s awareness of negative consequences associated with substance use, insight into having a substance use problem, and motivation to work on substance abuse. Just as the clinician avoids debate when inquiring about the client s insight into his or her psychiatric illness, the clinician also does not try to persuade the client about having a substance use disorder. Since assessment typically occurs during

Drug/Alcohol Time-Line Follow-Back Calendar (TLFBC)

Client ID: _____ Date : ____/____/____

Instructions to interviewers: The TLFBC summarizes the current month and the previous 6 months of the client's substance use. Start by asking about alcohol use, month by month, and then ask about drug use. Focus on an estimation of monthly use and the pattern of use. (More detailed instructions follow the chart below.)

Ask: For each month—(1) How many days have you used alcohol (or drugs)? (2) What kind of alcohol (or drugs) did you use? (3) How much did you use each day (on those days you drank or used drugs)? (4) What is the total number of days in _____ (month) that you drank (or used any drug at all)?

Alcohol	**Current month** **1** (# days: 15)	**Previous month** **2** Aug	**Previous month** **3** July	**Previous month** **4** June	**Previous month** **5** May	**Previous month** **6** April	**Previous month** **7** March
Kind	beer	beer	beer	beer	beer →		
How much (per day)	6 pack per day →						
How often (days/month)	10 days	20 days	20 days	20 days →			
Total days/month alcohol used	10	20	20	20 →			
Drugs							
Kind (+ abused meds)	1) pot 2) cocaine	1) pot 2) cocaine	1) pot 2) cocaine 3) Klonopin	1) pot → 2) cocaine →			
How much (per day)	1) 1 joint/day 2) 1 gram/day	1) 1 joint/day 2) 1 gram/day	1) 1 joint/day 2) 1 gram/day 3) 12 extra/day	1) 1 joint/day → 2) 1 gram/day →			
How often (days/month)	1) 15 days 2) 2 days	1) 20 days 2) 3 days	1) 10 days 2) 3 days 3) 2 days	1) 20 days → 2) 10 days →			
Total days/month drugs used	15	20	12	25 →			

same pattern of use

FIGURE 4.2. Example of a completed Drug/Alcohol Time-Line Follow-Back Callendar (TLFBC).

the engagement stage, the clinician must nurture his or her relationship with the client by steering clear of debate, and focusing instead on understanding the role of substance use in the client s life.

SUMMARY

We have begun this chapter with an overview of the assessment process for clients with dual disorders, which we organize into five steps: detection, classification, functional assessment, functional analysis, and treatment planning. This is followed by a review of eight common problems with the assessment of substance use disorders in the dual-diagnosis population. These include the failure of clinicians to take a proper history of substance abuse; denial and minimization of substance use and related problems; confusion about the effects of substance use; the primary secondary distinction; distortions related to the mental illness (cognitive, psychotic, or mood-related); the history of legal sanctions against drug use; clients premotivational state; and different norms for substance use disorders in the severely mentally ill population compared to the general population. We have described strategies for dealing with and overcoming each of these common problems.

The reminder of the chapter has provided specific guidelines for the first three steps of assessment: detection, classification, and functional assessment. For each of these steps, we have made specific clinical recommendations and described instruments that are designed for clients with dual disorders. In the following chapter, we continue the discussion of assessment by providing recommendations and tools for conducting the last two assessment steps: functional analysis and treatment planning.

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