Substance Abuse Treatment For Persons With Co-Occurring Disorders

A Treatment Improvement Protocol

TIP 42

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

CO-OCCURRING DISORDERS

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at http://www.kap.samhsa.gov.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA/CSAT's mission to improve treatment of substance use disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. We are grateful to all who have joined with us to contribute to advances in the substance abuse treatment field.

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Executive Summary

For purposes of this TIP, *co-occurring disorders* refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have co-occurring disorders have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders. A diagnosis of co-occurring disorders (COD) occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder. Many may think of the typical person with COD as having a severe mental disorder combined with a severe substance use disorder, such as schizophrenia combined with alcohol dependence. However, counselors working in addiction agencies are more likely to see persons with severe addiction combined with mild- to moderate-severity mental disorders; an example would be a person with alcohol dependence combined with a depressive disorder or an anxiety disorder. Efforts to provide treatment that will meet the unique needs of people with COD have gained momentum over the past 2 decades in both substance abuse treatment and mental health services settings.

Throughout this TIP, the term "substance abuse" refers to both substance abuse and substance dependence (as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision* [DSM-IV-TR] [American Psychiatric Association 2000]) and encompasses the use of both alcohol and other psychoactive substances. Though unfortunately ambiguous, this term was chosen partly because the lay public, politicians, and many substance abuse treatment professionals commonly use "substance abuse" to describe any excessive use of any addictive substance. Readers should attend to the context in which the term occurs to determine the range of possible meanings; in most cases, however, the term refers to all substance use disorders described by the DSM-IV. It should be noted, however, that although nicotine dependency is recognized as a disorder in DSM-IV, an important difference between tobacco addiction and other addictions is that tobacco's chief effects are medical rather than behavioral, and, as such, it is not treated as substance abuse in this TIP. Nonetheless, because of the high numbers of

the COD population addicted to nicotine as well as the devastating health consequences of tobacco use, nicotine dependency is included as an important cross-cutting issue for people with substance use disorders and mental illness.

Terms for mental disorders may have somewhat different lay and professional definitions. For example, while most people might become depressed or anxious briefly around a life stress, this does not mean that they have a "mental disorder" as is used in this text. Because the DSM-IV is the national standard for definitions of mental disorders, it is used in this TIP. In certain States, however, only certain trained professionals "officially" can diagnose either a mental or substance use disorder.

In the late 1970s, practitioners began to recognize that the presence of substance abuse in combination with mental disorders had profound and troubling implications for treatment outcomes. This growing awareness has culminated in today's emphasis on the need to recognize and address the interrelationship of these disorders through new approaches and appropriate adaptations of traditional treatment. In the decades from the 1970s to the present, substance abuse treatment programs typically reported that 50 to 75 percent of their clients had COD, while corresponding mental-health settings cited proportions of 20 to 50 percent. During the same period of time, a body of knowledge has evolved that clarifies the treatment challenges presented by the combination of substance use and mental disorders and illuminates the likelihood of poorer outcomes for such clients in the absence of targeted treatment efforts.

The treatment and research communities have not been passive in the face of this challenge. Innovative strategies have emerged and been tested, and the treatment population has been defined more precisely. Findings have shown that many substance abuse treatment clients with less serious mental disorders do well with traditional substance abuse treatment methods, while those with more serious mental disorders need intervention modifications and additions to enhance treatment effectiveness and, in most instances, to result in successful treatment outcomes.

The Quadrants of Care, developed by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD), is a useful classification of *service coordination by severity* in the context of substance abuse and mental health settings. The NASADAD–NASMHPD four-quadrant framework provides a structure for fostering consultation, collaboration, and integration among drug abuse and mental health treatment systems and providers to deliver appropriate care to every client with COD. Although the material in this TIP relates to all four quadrants, the TIP is designed primarily to provide guidance for addiction counselors working in quadrant II and III settings. The four categories of COD are

- Quadrant I: Less severe mental disorder/less severe substance disorder
- Quadrant II: More severe mental disorder/less severe substance disorder
- Quadrant III: Less severe mental disorder/more severe substance disorder
- Quadrant IV: More severe mental disorder/more severe substance disorder

The American Society of Addiction Medicine (ASAM) also has developed a client placement system to facilitate effective treatment. The ASAM Patient Placement Criteria (ASAM PPC-2R) describe three types of substance abuse programs for people with COD: addiction only services, dual diagnosis capable, and dual diagnosis enhanced. This TIP employs a related system that classifies both substance abuse and mental health programs as basic, intermediate, and advanced in terms of their progress toward providing more integrated care. Further, counselors or other readers who use this TIP will have beginning, intermediate, or advanced backgrounds and experience in COD, and, therefore, different needs. The TIP is structured to meet the needs of addiction counselors with basic backgrounds as well as

the differing needs of those with intermediate and advanced backgrounds.

The integration of substance abuse treatment and mental health services for persons with COD has become a major treatment initiative. Integrated treatment coordinates substance abuse and mental health interventions to treat the whole person more effectively; the term refers broadly to any mechanism by which treatment interventions for COD are combined within a primary treatment relationship or service setting. As such, integrated treatment reflects the longstanding concern within substance abuse treatment programs for treating the whole person, and recognizes the importance of ensuring that entry into any one system can provide access to all needed systems.

As developed in the substance abuse treatment field, the recovery perspective acknowledges that recovery is a long-term process of internal change in which progress occurs in stages, an understanding critical to treatment planning. In preparing a treatment plan, the clinician should recognize that treatment takes place in different settings (e.g., residential and outpatient) over time, and that much of the recovery process typically occurs outside of, or following, treatment (e.g., through participation in mutual self-help groups). Practitioners often divide treatment into phases, usually including engagement, stabilization, primary treatment, and continuing care (also known as aftercare). Use of these phases enables the clinician (whether within the substance abuse or mental health treatment system) to apply coherent, stepwise approaches in developing and using treatment protocols.

This TIP identifies key elements of programming for COD in substance abuse treatment agencies; the paragraphs that follow provide an outline of these essential elements. While the needs and functioning of substance abuse treatment are accentuated, the elements described have relevance for mental health agencies and other service systems that seek to coordinate mental health and substance abuse services for their clients who need both.

Treatment planning begins with screening and assessment. The *screening process* is designed to identify those clients seeking substance abuse treatment who show signs of mental health problems that warrant further attention. Easy-to-use screening instruments will accomplish this purpose and can be administered by counseling staff with minimal preparation.

A *basic assessment* consists of gathering information that will provide evidence of COD and mental and substance use disorder diagnoses; assess problem areas, disabilities, and strengths; assess readiness for change; and gather data to guide decisions regarding the necessary level of care. Intake information consists of the following categories and items:

- *Background* is described by obtaining data on family; relevant cultural, linguistic, gender, and sexual orientation issues; trauma history; marital status; legal involvement and financial situation; health; education; housing status; strengths and resources; and employment.
- *Substance use* is established by age of first use, primary drugs used, patterns of drug use (including information related to diagnostic criteria for abuse or dependence), and past or current treatment. It is important to identify periods of abstinence of 30 days or longer to isolate the mental health symptoms, treatment, and disability expressed during these abstinent periods.
- *Psychiatric problems* are elaborated by determining both family and client histories of psychiatric problems (including diagnosis, hospitalization, and other treatments), current diagnoses and symptoms, and medications and medication adherence. It is important to identify past periods of mental health stability, determine past successful treatment for mental disorders, and discover the nature of substance use disorder issues arising during these stable periods. Identification of any current treatment providers enables vitally important information sharing and cooperation.
- *Integrated assessment* identifies the interactions among the symptoms of mental disor-

ders and substance use, as well as the interactions of the symptoms of substance use disorders and mental health symptoms. Integrated assessment also considers how all the interactions relate to treatment experiences, especially stages of change, periods of stability, and periods of crisis.

Diagnosis is an important part of the assessment process. The TIP provides a discussion of mental disorders selected from the DSM-IV-TR and the diagnostic criteria for each disorder. Key information about substance abuse and particular mental disorders is distilled, and appropriate counselor actions and approaches are recommended for the substance abuse treatment client who manifests symptoms of one or more of these mental disorders. The consensus panel recognizes that addiction counselors are not expected to diagnose mental disorders. The limited aims of providing this material are to increase substance abuse treatment counselors' familiarity with mental disorder terminology and criteria and to provide advice on how to proceed with clients who demonstrate the symptoms of these disorders.

The use of proper *medication* is an essential program element, helping clients to stabilize and control their symptoms, thereby increasing their receptivity to other treatment. Pharmacological advances over the past few decades have produced more effective psychiatric medications with fewer side effects. With the support of better medication regimens, many people with serious mental disorders who once would have been institutionalized, or who would have been too unstable for substance abuse treatment, have been able to participate in treatment, make progress, and lead more productive lives. To meet the needs of this population, the substance abuse treatment counselor needs better understanding of the signs and symptoms of mental disorders and access to medical support. The counselor's role is first to provide the prescribing physician with an accurate description of the client's behavior and symptoms, which ensures that proper medication is chosen, and then to assist the client in adhering to the medication regimen. The substance abuse counselor and program can, and often do, employ peers or the peer community to help and support individual efforts to follow prescription instructions.

Several other features complete the list of essential components of treatment for COD, including *enhanced staffing* that incorporates professional mental health specialists, psychiatric consultation, or an onsite psychiatrist (for assessment, diagnosis, and medication); *psychoeducational classes* (e.g., mental disorders and substance abuse, relapse prevention) that provide increased awareness about the disorders and their symptoms; onsite *double trouble groups* to discuss the interrelated problems of mental and substance use disorders, which will help to identify triggers for relapse; and participation in community-based *dual recovery mutual self-help groups*, which afford an understanding, supportive environment and a safe forum for discussing medication, mental health, and substance abuse issues.

Treatment providers are advised to view clients with COD and their treatment in the context of their culture, ethnicity, geographic area, socioeconomic status, gender, age, sexual orientation, religion, spirituality, and any physical or cognitive disabilities. The provider especially needs to appreciate the distinctive ways in which a client's culture may view disease or disorder, including COD. Using a model of disease familiar and culturally relevant to the client can help communication and facilitate treatment.

In addition to the essential elements described above, several well-developed and successful strategies from the substance abuse field are being adapted for COD. The TIP presents those strategies (briefly noted in the following paragraphs) found to have promise for effective treatment of clients with COD.

Motivational Interviewing (MI) is a client-centered, directive method for enhancing intrinsic motivation to change (by exploring and resolving ambivalence) that has proven effective in helping clients clarify goals and commit to change. MI has been modified to meet the spe-

cial circumstances of clients with COD, with promising results from initial studies to improve client engagement in treatment.

Contingency Management (CM) maintains that the form or frequency of behavior can be altered through the introduction of a planned and organized system of positive and negative consequences. It should be noted that many counselors and programs employ CM principles informally by rewarding or praising particular behaviors and accomplishments. Similarly, CM principles are applied formally (but not necessarily identified as such) whenever the attainment of a level or privilege is contingent on meeting certain behavioral criteria. Demonstration of the efficacy of CM principles for clients with COD is still needed.

Cognitive–Behavioral Therapy (CBT) is a general therapeutic approach that seeks to modify negative or self-defeating thoughts and behaviors, and is aimed at achieving change in both. CBT uses the client's cognitive distortions as the basis for prescribing activities to promote change. Distortions in thinking are likely to be more severe with people with COD who are, by definition, in need of increased coping skills. CBT has proven useful in developing these coping skills in a variety of clients with COD.

Relapse Prevention (RP) has proven to be a particularly useful substance abuse treatment strategy and it appears adaptable to clients with COD. The goal of RP is to develop the client's ability to recognize cues and to intervene in the relapse process, so lapses occur less frequently and with less severity. RP endeavors to anticipate likely problems, and then helps clients to apply various tactics for avoiding lapses to substance use. Indeed, one form of RP treatment, Relapse Prevention Therapy, has been specifically adapted to provide integrated treatment of COD, with promising results from some initial studies.

Because outpatient treatment programs are widely available and serve the greatest number of clients, it is imperative that these programs use the best available treatment models to reach the greatest possible number of persons with COD. In addition to the essential elements and the strategies described above, two outpatient models from the mental health field have been valuable for outpatient clients with both substance use and serious mental disorders: Assertive Community Treatment (ACT) and Intensive Case Management (ICM).

ACT programs, historically designed for clients with serious mental illness, employ extensive outreach activities, active and continuing engagement with clients, and a high intensity of services. ACT emphasizes multidisciplinary teams and shared decisionmaking. When working with clients who have COD, the goals of the ACT model are to engage them in helping relationships, assist them in meeting basic needs (e.g., housing), stabilize them in the community, and ensure that they receive direct and integrated substance abuse treatment and mental health services. Randomized trials with clients having serious mental and substance use disorders have demonstrated better outcomes on many variables for ACT compared to standard case management programs.

The goals of ICM are to engage individuals in a trusting relationship, assist in meeting their basic needs (e.g., housing), and help them access and use brokered services in the community. The fundamental element of ICM is a low caseload per case manager, which translates into more intensive and consistent services for each client. ICM has proven useful for clients with serious mental illness and co-occurring substance use disorders. (The consensus panel notes that direct translation of ACT and ICM models from the mental health settings in which they were developed to substance abuse settings is not self-evident. These initiatives likely must be modified and evaluated for application in such settings.)

Residential treatment for substance abuse occurs in a variety of settings, including long- (12 months or more) and short-term residential treatment facilities, criminal justice institutions, and halfway houses. In many substance abuse treatment settings, psychological disturbances have been observed in an increasing

proportion of clients over time; as a result, important initiatives have been developed to meet their needs.

The Modified Therapeutic Community (MTC) is a promising residential model from the substance abuse field for those with substance use and serious mental disorders. The MTC adapts the principles and methods of the therapeutic community to the circumstances of the client, making three key alterations: increased flexibility, more individualized treatment, and reduced intensity. The latter point refers especially to the conversion of the traditional encounter group to a conflict resolution group, which is highly structured, guided, of very low emotional intensity, and geared toward achieving self-understanding and behavior change. The MTC retains the central feature of TC treatment; a culture is established in which clients learn through mutual self-help and affiliation with the peer community to foster change in themselves and others. A series of studies has established better outcomes and benefit cost of the MTC model compared to standard services. A need for more verification of the MTC approach remains.

Because acute and primary care settings encounter chronic physical diseases in combination with substance use and mental disorders, treatment models appropriate to medical settings are emerging, two of which are described in the TIP. In these and other settings, it is particularly important that administrators assess organizational readiness for change prior to implementing a plan of integrated care. The considerable differences between the medical and social service cultures should not be minimized or ignored; rather, opportunities should be provided for relationship and team building.

Within the general population of persons with COD, the needs of a number of specific subgroups can best be met through specially adapted or designed programs. These include persons with *specific disorders* (such as bipolar disorder) and *groups with unique requirements* (such as women, the homeless, and clients in the criminal justice system). The two categories often overlap; for example, a number of recovery models are emerging for women with substance use disorders who are survivors of trauma, many of whom have posttraumatic stress disorder. The TIP highlights a number of promising approaches to treatment for particular client groups, while recognizing that further development is needed, both of disorder-specific interventions and of interventions targeted to the needs of specific populations.

Returning to life in the community after residential placement is a major undertaking for clients with COD, and relapse is an ever-present danger. Discharge planning is important to maintain gains achieved through residential or outpatient treatment. Depending on program and community resources, a number of continuing care (aftercare) options may be available for clients with COD who are leaving treatment. These options include mutual self-help groups, relapse prevention groups, continued individual counseling, psychiatric services (especially important for clients who will continue to require medication), and ICM to continue monitoring and support. A carefully developed discharge plan, produced in collaboration with the client, will identify and relate client needs to community resources, ensuring the supports needed to sustain the progress achieved in treatment.

During the past decade, dual recovery mutual self-help approaches have been developed for individuals affected by COD and are becoming an important vehicle for providing continued support in the community. These approaches apply a broad spectrum of personal responsibility and peer support principles, often employing 12-Step methods that provide a planned regimen of change. The clinician can help clients locate a suitable group, find a sponsor (ideally one who also has COD and is at a late stage of recovery), and become comfortable in the role of group member.

Continuity of care refers to coordination of care as clients move across different service systems and is characterized by three features:

consistency among primary treatment activities and ancillary services, *seamless transitions* across levels of care (e.g., from residential to outpatient treatment), and *coordination* of present with past treatment episodes. Because both substance use and mental disorders typically are long-term chronic disorders, continuity of care is critical; the challenge in any system of care is to institute mechanisms to ensure that all individuals with COD experience the benefits of continuity of care.

The consensus panel recognizes that the role of the client (the consumer) with COD in the design of, and advocacy for, improved services should continue to expand. The consensus panel recommends that program design and development activities of agencies serving clients with COD continue to incorporate consumer and advocacy groups. These groups help to further the refinement and responsiveness of the treatment program, thus enhancing clients' self-esteem and investment in their own treatment.

All good treatment depends on a trained staff. The consensus panel underscores the importance of creating a supportive environment for staff and encouraging continued *professional development*, including skills acquisition, values clarification, and competency attainment. An organizational commitment to staff development is necessary to implement programs successfully and to maintain a motivated and effective staff. It is essential to provide consistently high-quality and supportive supervision, favorable tuition reimbursement and release time policies, appropriate pay and health/retirement benefits, helpful personnel policies that bolster staff well-being, and incentives or rewards for work-related achievements.

Together, these elements help create the infrastructure needed for quality service.

The consensus panel supports and encourages the development of a unified substance abuse and mental health approach to co-occurring disorders. Recognizing that *system integration* is difficult to achieve and that the need for improved COD services in substance abuse treatment agencies is urgent, the panel recommends that, at this stage, the emphasis be placed on assisting the substance abuse treatment system in the development of *increased internal capability* to treat individuals with COD effectively. A parallel effort should be undertaken in the mental health system, with the two systems continuing to work cooperatively on services to individual clients.

Much has been accomplished in the field of COD in the last 10 years, and the knowledge acquired is ready for broader dissemination and application. The importance of the transfer and application of knowledge and technology has likewise become better understood. The consensus panel emphasizes the need for new government initiatives that improve services by promoting innovative technology transfer strategies using material from this TIP and from other resources (e.g., the Substance Abuse and Mental Health Services Administration's [SAMHSA's] *Report to Congress on the Treatment and Prevention of Co-Occurring Substance Abuse and Mental Disorders* and SAMHSA's Center for Mental Health Service's *Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit*) are adapted and shaped to the particular program context and circumstances.

1 Introduction

In This Chapter…

The Evolving Field of Co-Occurring Disorders

Important Developments That Led to This TIP

Organization of This TIP

Overview

Over the past few decades, practitioners and researchers increasingly have recognized the link between substance abuse and mental disorders. Treatment Improvement Protocol (TIP) 9, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse* (Center for Substance Abuse Treatment [CSAT] 1994*a*), answered the treatment field's need for an overview of diagnostic criteria, assessment, psychopharmacology, specific mental disorders, and the need for linkage between the mental health services system and substance abuse treatment system.

Subsequent to TIP 9, research has provided a more in-depth understanding of co-occurring substance use and mental disorders—how common they are, the multiple problems they create, and the impact they have on treatment and treatment outcome. As knowledge of co-occurring disorders (COD) continues to evolve, new challenges arise: How do we treat specific populations such as the homeless and those in our criminal justice system? What is the role of housing? What about those with specific mental disorders such as posttraumatic stress disorder? Where is the best locus for treatment? Can we build an integrated system of care? The main purpose of this TIP is to provide addiction counselors and other practitioners with this state-of-the-art information on the rapidly advancing field of co-occurring substance use and mental disorders.

Following a discussion of the evolving field of co-occurring disorders, this chapter addresses the developments that led to this TIP. It then describes the scope of this TIP (both what is included and what is excluded by design), its intended audience, and the basic approach that has guided the selection of strategies, techniques, and models highlighted in the text. The organization of the TIP is laid out for the reader, with the components of each chapter and appendix described in an effort to help users of the TIP quickly locate subjects of immediate interest.

The Evolving Field of Co-Occurring Disorders

Today's emphasis on the relationship between substance use and mental disorders dates to the late 1970s, when practitioners increasingly became aware of the implications of these disorders, when occurring together, for treatment outcomes. The association between depression and substance abuse was particularly striking and became the subject of several early studies (e.g., Woody and Blaine 1979). In the 1980s and 1990s, however, both the substance abuse and mental health communities found that a wide range of mental disorders were associated with substance abuse, not just depression (e.g., De Leon 1989; Pepper et al. 1981; Rounsaville et al. 1982*b*; Sciacca 1991). During this period, studies conducted in substance abuse programs typically reported that 50 to 75 percent of clients had *some type of* co-occurring mental disorder (although not usually a severe mental disorder) while studies in mental health settings reported that between 20 and 50 percent of their clients had a co-occurring substance use disorder. (See Sacks et al. 1997*b* for a summary of studies and Compton et al. 2000 for a more recent study.)

The multiple studies reflect the extent to which COD constitutes a clinical concern. At the same time, however, these studies varied in that they (1) were conducted in an array of settings and on a range of sample sizes from 68 to 20,291, (2) used different measures and criteria for determining a disorder, and (3) reported on different time periods (i.e., either lifetime or current, or both). This diversity in reporting can produce differing estimates and suggests a need to address the broad range of survey and analytic strategies used to generate estimates. Further work to clarify the type, severity, and clinical significance of co-occurring disorders can contribute to an improved understanding of the phenomenon and treatment. Nevertheless, it is important that, in spite of those differences, there is a consistency in reporting significant rates of disorder across all studies.

Researchers not only found a link between substance abuse and mental illness, they also found the dramatic impact the complicating presence of substance abuse may have on the course of treatment for mental illness. One study of 121 clients with psychoses found that those with substance abuse problems (36 percent) spent twice as many days in the hospital over the 2 years prior to treatment as clients without substance abuse problems (Crome 1999; Menezes et al. 1996). These clients often have poorer outcomes, such as higher rates of HIV infection, relapse, rehospitalization, depression, and suicide risk (Drake et al. 1998*b*; Office of the Surgeon General 1999).

Researchers also have clearly demonstrated that substance abuse treatment for clients with co-occurring mental illness and substance use disorders can be beneficial—even for clients with serious mental symptoms. For example, the National Treatment Improvement Evaluation Study (NTIES) found marked reductions in suicidality the year following substance abuse treatment compared to the year prior to treatment for both male and female clients and nonabused women. Suicide attempts declined about four fifths for both the 3,037 male clients and the 1,374 female clients studied (Karageorge 2001). Many clients in traditional substance abuse treatment settings who had mild to moderate mental disorders were found to do well with traditional substance abuse treatment methods (Hser et al. 2001; Hubbard et al. 1989; Joe et al. 1995; Simpson et al. 2002; Woody et al. 1991). However, modifications designed to address mental disorders may further enhance treatment effectiveness and can be essential for people with severe mental disorders. This TIP will discuss the modifications and approaches practitioners have found to be helpful. For examples, see the sections on suicide assessment and intervention in chapter 8 and appendix D.

Just as the field of treatment for substance use and mental disorders has evolved to become more precise, so too has the terminology used to describe people with both substance use and mental disorders. The term *co-occurring disorders* replaces the terms *dual disorder* or *dual diagnosis*. These latter terms, though used commonly to refer to the combination of substance use and mental disorders, are confusing in that they also refer to other combinations of disorders (such as mental disorders and mental retardation). Furthermore, the terms suggest that there are only two disorders occurring at the same time, when in fact there may be more. For purposes of this TIP, *co-occurring disorders* refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have co-occurring disorders have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders. A diagnosis of co-occurring disorders occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder. (See chapter 2 for more discussion of terminology used in this TIP.)

New models and strategies are receiving attention and encouraging treatment innovation (Anderson 1997; De Leon 1996; Miller 1994*a*; Minkoff 1989; National Advisory Council [NAC] 1997; Onken et al. 1997; Osher and Drake 1996). Reflecting the increased interest in issues surrounding effective treatment for this population, the American Society of Addiction Medicine (ASAM) added substantial new sections on clients with COD to an update of its patient placement criteria. These sections refine criteria both for placing clients with COD in treatment and for establishing and operating programs to provide services for such clients (ASAM 2001).

In another important development, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) began surveying its members about effective treatment of clients with COD in their States (Gustafson et al. 1999). In addition, NASADAD has joined with the National Association of State Mental Health Program Directors (NASMHPD) (NASMHPD-NASADAD 1999, 2000) and other collaborators in a series of national efforts designed to

- Foster improvement in treatment by emphasizing the importance of knowledge of both mental health and substance abuse treatment when working with clients for whom both issues are relevant.
- Provide a classification of treatment settings to facilitate systematic planning, consultations, collaborations, and integration.
- Reduce the stigma associated with both disorders and increase the acceptance of substance abuse and mental health concerns as a standard part of healthcare information gathering.

Researchers have clearly demonstrated that substance abuse treatment of clients with co-occurring mental illness and substance use disorders can be beneficial.

These efforts are slowly changing the way that the public, policymakers, and substance abuse counselors view mental illness. Still, stigma attached to mental illness remains. One topic worth mentioning is the public perception that people with mental illness are dangerous and pose a risk of violence. However, studies have shown that the public's fear is greater than the actual risk, and that often, people with mental disorders are not particularly violent; it is when substance abuse is added that violence can ensue. For example, Steadman et al. (1998) found that substance abuse symptoms significantly raised

the rate of violence in both individuals with mental illness and those without mental illness. This research adds support to the importance of treating both mental illness and substance abuse.

In recent years, dissemination of knowledge has been widespread. Numerous books and hundreds of articles have been published, from counseling manuals and instruction (Evans and Sullivan 2001; Pepper and Massaro 1995) to database analysis of linkage among treatment systems and payors (Coffey et al. 2001). Several annual "dual diagnosis" conferences emerged. One of the most long-standing is the annual conference on The Person With Mental Illness and Substance Abuse, hosted by MCP Hahnemann University (now Drexel University), which began in 1988.

In spite of these developments, individuals with substance use and mental disorders commonly appear at facilities that are not prepared to treat them. They may be treated for one disorder without consideration of the other disorder, often "bouncing" from one type of treatment to another as symptoms of one disorder or another become predominant. Sometimes they simply "fall through the cracks" and do not receive needed treatment. This TIP captures the current state-of-the-art treatment strategies to assist counselors and treatment agencies in providing appropriate services to clients with COD.

Important Developments That Led to This TIP

Important developments in a number of areas pointed to the need for a revised TIP on co-occurring disorders. Among the factors that contributed to the need for this document are the availability of significant data on the prevalence of COD, the emergence of new treatment populations with COD (such as people who are homeless, people with HIV/AIDS, and persons in the criminal justice system), and changes in treatment delivery (including an increasing number of programs serving persons with COD). The following section provides a summary of data relevant to each of these key areas.

The Availability of Prevalence and Other Data

Prevalence and other data on COD have established the scope and impact of the problem, and the need for appropriate treatment and services. Four key findings are borne out by prevalence and other available data, each of which is important in understanding the challenges of providing effective treatment to this population.

(1) COD are common in the general adult population, though many individuals with COD go untreated.

National surveys suggest COD are common in the adult population. For example, the National Survey on Drug Use and Health (NSDUH) reports that in 2002, 4 million adults met the criteria for both serious mental illness (SMI) and substance dependence and abuse. NSDUH information is based on a sample of 67,500 American civilians aged 12 or older in noninstitutionalized settings (Office of Applied Studies [OAS] 2003*b*). The NSDUH defined SMI as having at some time during the past year a diagnosable mental, behavioral, or emotional disorder that met the criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV) (American Psychiatric Association 1994) and resulted in functional impairment that substantially interfered with or limited one or more major life activities. The NSDUH classification scheme was not diagnosis specific, but function specific. Results from the survey are highlighted below.

- SMI is highly correlated with substance dependence or abuse. Among adults with SMI in 2002, 23.2 percent were dependent on or abused alcohol or illicit drugs, while the rate among adults without SMI was only 8.2 percent. Among adults with substance depen-

dence or abuse, 20.4 percent had SMI; the rate of SMI was 7 percent among adults who were not dependent on or abusing a substance.

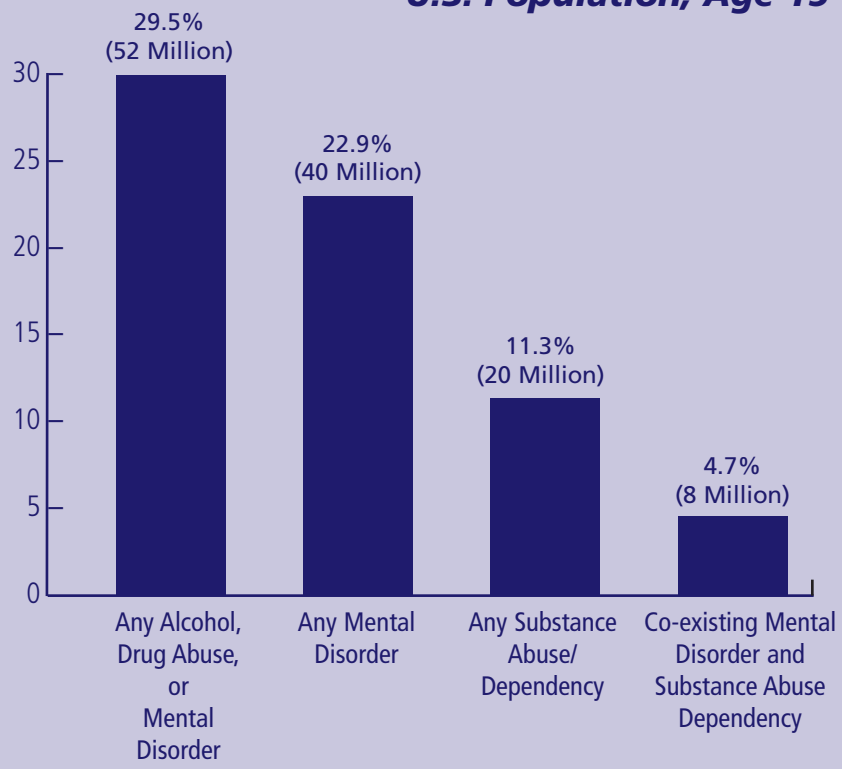
- Among adults who used an illicit drug in the past year, 17.1 percent had SMI in that year, while the rate was 6.9 percent among adults who did not use an illicit drug. Conversely, among adults with SMI, 28.9 percent used an illicit drug in the past year while the rate was 12.7 percent among those without SMI (OAS 2003*b*).
- SMI was correlated with binge alcohol use (defined as drinking five or more drinks on the same occasion on at least one day in the past 30 days). Among adults with SMI, 28.8 percent were binge drinkers, while 23.9 percent of adults with no SMI were binge drinkers.

Earlier, the National Comorbidity Study (NCS) reported 1991 information on mental disorders and substance abuse or dependence in a sample of 8,098 American civilians aged 15 to 54 in noninstitutionalized settings. Figure 1-1 shows estimates from the NCS of the comparative number of any alcohol, drug abuse, or mental disorder (52 million), any mental disorder (40 million), any substance abuse/dependence disorder (20 million), and both mental disorder and substance abuse/dependence (8 million) in the past year.

In a series of articles derived from the NCS, Kessler and colleagues give a range of estimates related to both the lifetime and 12-month prevalence of COD (Kessler et al. 1994, 1996*a*, *b*, 1997). They estimate that 10 million Americans of all ages and in both institutional and noninstitutional settings have COD in any given year. Kessler et al.

Figure 1-1

Persons With Alcohol, Drug Abuse, or Mental Disorder in the Past Year (See Endnote[1]) U.S. Population, Age 15 to 54, 1991



Source: Kessler et al. 1994. Table 2 and unpublished data from the survey.

also estimate the lifetime prevalence of COD (not shown in Figure 1-1, which relates only the prevalence in the past 12 months) (1996*a*, p. 25) as follows: "…51 percent of those with a lifetime addictive disorder also had a lifetime mental disorder, compared to 38 percent in the ECA." (The ECA—Epidemiologic Catchment Area study—predated the NCS study; this National Institute of Mental Health study of 20,291 people was representative of the total U.S. community and institutional populations [Regier et al. 1990]).

Comparative figures for individuals with COD whose addictive disorders involve alcohol versus drugs are also available. Fifty-three percent of the respondents with lifetime *alcohol* abuse or dependence also had one or more lifetime mental disorders. For respondents with lifetime *illicit drug* abuse/dependence, 59 percent also had a lifetime mental disorder, and 71 percent of those with lifetime illicit drug abuse/ dependence had alcohol abuse or dependence over their lifetime (Office of the Inspector General 1995).

> Research suggests that the likelihood of seeking treatment is strongly increased in the presence of at least one co-occurring condition.

A recent first report from the National Comorbidity Survey Replication, conducted between February 2001 and December 2002 (Kessler and Walters 2002), provides more precise information on rates of specific disorders. For example, rates of major depressive disorder were reported at 6.6 percent in the general population in the last year, or an estimated number between 13.1 and 14.2 million people (Kessler et al. 2003*b*). Additional data from a new and expanded NCS survey are now available (e.g., Breslau et al. 2004*a*, *b*; Kessler 2003; Kessler et al. 2003*a*; see also the Web site www.hcp.med.harvard.edu/ncs).

Research suggests that the likelihood of seeking treatment is strongly increased in the presence of at least one co-occurring condition. The National Longitudinal Alcohol Epidemiologic Study (NLAES)—a nationwide household survey of 42,862 respondents aged 18 or older conducted by the National Institute on Alcohol Abuse and Alcoholism—reveals that a large increase in treatment for an alcohol disorder and a drug disorder occurs when there is a co-occurring "major depressive disorder" (Grant 1997). NCS data suggest that people with more than two disorders are more likely to receive treatment than those with "only" two. People with three or more diagnosable conditions were the most likely to be severely impaired and to require hospitalization (NAC 1997).

While people with co-occurring disorders are more likely to seek treatment, research consistently shows a gap between the number of people who are identified in a survey as having a disorder and the number of people receiving any type of treatment. Even of those with three or more disorders, a troubling 60 percent never received any treatment (Kessler et al. 1994; NAC 1997). Based on NLAES data, Grant (1997, p. 13) notes that one of the most interesting results of the survey is the "sheer number of respondents with alcohol and drug use disorders missing from the treated population. Only 9.9 percent and 8.8 percent of the respondents classified with past-year alcohol and drug use disorders, respectively, sought treatment."

(2) Some evidence supports an increased prevalence of people with COD and of more programs for people with COD.

NASADAD conducts voluntary surveys of State Alcohol and Drug Abuse Agencies and produces the State Alcohol and Drug Abuse Profile (SADAP) reports. In 1996, NASADAD asked the States to describe any special pro-

grams in their States for clients with COD and to provide any available fiscal year (FY) 1995 statistics on the number of "dually diagnosed" clients treated (Gustafson et al. 1997). Forty-one States plus Palau, Puerto Rico, and the U.S. Virgin Islands responded. About 3 years later, 31 States responded to a request for detailed statistics on the number of persons admitted in FYs 1996 and 1997 to programs for treatment of COD (Gustafson et al. 1999). In general, examination of SADAP State profiles for information related to COD suggests about a 10 percent increase since the NASADAD survey in both the number of people with COD entering treatment and in the number of programs in many States over that 3-year period (Gustafson et al. 1999).

The 2002 National Survey of Substance Abuse Treatment Services (N-SSATS) indicated that about 49 percent of 13,720 facilities nationwide reporting substance abuse services offered programs or groups for those with COD (OAS 2003*a*). However, only 38 percent of the 8,292 responding facilities that focused primarily on substance abuse offered such COD programming. Sixty-three percent of the 1,126 responding mental health services that offered substance abuse services offered COD programs or groups. About 70 percent of the 3,440 facilities that have a mix of mental health and substance abuse treatment services offer COD programs or groups.

Still it must be kept in mind that of all the approximately 1.36 million clients in treatment for substance use disorders in 2002, about 68 percent were treated in facilities whose primary focus was substance abuse services and 23 percent were treated in facilities whose focus was a mix of both mental health and substance abuse services. Only 4 percent of these individuals were in facilities whose primary focus was the provision of mental health services.

(3) Rates of mental disorders increase as the number of substance use disorders increases, further complicating treatment.

In their analysis of data from a series of studies supported by the National Institute on Drug Abuse, the Drug Abuse Treatment Outcome Study (DATOS), Flynn et al. (1996) demonstrate that the likelihood of mental disorders rises with the increasing number of substance dependencies. Participating clients were assessed according to DSM-III-R criteria (*Diagnostic and Statistical Manual for Mental Disorders*, 3d edition revised) for lifetime antisocial personality, major depression, generalized anxiety disorder, and/or any combination of these disorders.

DATOS was a national study of clients entering more than 90 substance abuse treatment programs in 11 metropolitan areas, mainly during 1992 (Flynn et al. 1997). Of the initial intake sample of 10,010 clients, 7,402 completed an intake and a clinical assessment interview and met DSM-III-R criteria for dependence on alcohol, cocaine, and/or heroin. Figure 1-2 (p. 8) shows a general trend of increase in the rates of DSM-III-R lifetime antisocial personality disorder, major depression, and generalized anxiety disorder as the number of substance dependencies involving alcohol, heroin, and cocaine increases (except for the relationship between alcohol dependence only and major depression and generalized anxiety). Since the use of multiple drugs is common in those with substance use disorders, treatment is further complicated for these people by the greater incidence of mental disorders that accompanies multiple drug use.

(4) Compared to people with mental or substance use disorders alone, people with COD are more likely to be hospitalized. Some evidence suggests that the rate of hospitalization for people with COD is increasing.

According to Coffey and colleagues, the rate of hospitalization for clients with both a mental and a substance use disorder was more than 20 times the rate for substance-abuse–only clients and five times the rate for mental-

Figure 1-2

Rates of Antisocial Personality, Depression, and Anxiety Disorder by Drug Dependency (%). Taken From the Drug Abuse Treatment Outcome Study (DATOS)

Drug dependency	Antisocial personality	Major depression	Generalized anxiety
Alcohol only	34.7	17.8	5.5
Heroin only	27	7	2
Heroin and alcohol	46.3	13.2	3.2
Cocaine only	30.4	8.4	2.7
Cocaine and alcohol	47	13.6	4.7
Cocaine and heroin	44	10.8	2.2
Cocaine, heroin, and alcohol	59.8	17.1	6.3
Overall	39.3	11.7	3.7

Source: Flynn et al. 1996; data are from the NIDA-supported DATOS study.

disorder–only clients (Coffey et al. 2001). This estimate is based on an analysis of the CSAT/Center for Mental Health Services (CMHS) Integrated Data Base Project, in which a team studied information from the mental health, substance abuse, and Medicaid agencies in Delaware, Oklahoma, and Washington. Using a broad coding for health policy research to study discharges between 1990–1995 from community hospitals nationwide, Duffy (2004, p. 45) estimated that clients classified as having both a substance-related disorder and a mental disorder significantly "…increased from 9.4 to 17.22 per 10,000 population …" with the 35–45 year age group increasing the most among the 7 age groups studied from childhood to 65 or older.

Treatment Innovation for Other Populations With COD

Further treatment innovation has been required to meet the needs and associated problems of other treatment populations with high rates of COD such as people who are homeless, those in the criminal justice system, persons living with HIV/AIDS and other infectious diseases (e.g., hepatitis), and those with trauma and posttraumatic stress disorder (PTSD).

Homeless populations

Data on the increasing rates of co-occurring mental and substance use disorders in homeless populations are now available (North et al. 2004). North and colleagues estimate that rates of co-occurring Axis I and substance use disorders among females who are homeless increased from 14.3 percent in 1990 to 36.7

percent in 2000 and that rates among men who are homeless increased from 23.2 percent in 1990 to 32.2 percent in 2000.

North and colleagues also compared data collected in their 2000 study with estimates from ECA data collected in the early 1980s. They found that alcohol and drug use for both males and females rose considerably over the 2 decades. In 2000, 84 percent of the men who were homeless and 58 percent of the women who were homeless had a substance use disorder (North et al. 2004). The article reports an increase in bipolar disorder from 1990 to 2000 and an increase in major depression from 1980 to 2000. (Major depression accounted for the majority of all Axis I non-substance disorders.) The authors also noted that non-Axis I antisocial personality disorder (APD) appeared to change little from 1980 to 2000, with 10 to 20 percent of women who were homeless and 20 to 25 percent of men who were homeless receiving APD diagnoses in both time periods (North et al. 2004).

The increased prevalence of COD among people who are homeless and the need to provide services to this growing population has led to treatment innovations and research on service delivery. One of the main challenges is how to engage this group in treatment. CMHS's Access to Community Care and Effective Services and Supports initiative, which supported programs in nine States over a 5-year period, indicated the effectiveness of integrated systems, including the value of street outreach (Lam and Rosenheck 1999; Rosenheck et al. 1998). Both systems integration and comprehensive services, such as Assertive Community Treatment (ACT) and Intensive Case Management (ICM), were seen as essential and effective (Integrating Systems of Care 1999; Winarski and Dubus 1994). (See chapter 6 for a discussion of these approaches.)

Offenders

The Bureau of Justice Statistics estimates that "at midyear 1998, an estimated 283,800 mentally ill offenders were incarcerated in the Nation's prisons and jails" (Ditton 1999, p. 1). Surveys by the Bureau found that "16 percent of State prison inmates, 7 percent of Federal inmates, and 16 percent of those in local jails reported either a mental condition or an overnight stay in a mental hospital" (Ditton 1999). In addition, an estimated 547,800 probationers—16 percent—said they had had a mental condition or stayed overnight in a mental hospital at some point in their lifetime (Ditton 1999).

The Office of National Drug Control Policy (ONDCP) emphasized that "the fastest and most cost-effective way to reduce the demand for illicit drugs is to treat chronic, hard core drug users" (ONDCP 1995, p. 53). These "hard core users" are in need of COD services. The NTIES study reported that, when given the choice to rate their desire for certain services as "not important," "somewhat important," or "very important," 37 percent of a population that was predominantly criminal-justice–involved rated mental health services as "very important" (Karageorge 2000).

The substance abuse treatment and mental health services communities have been called on to provide, or assist in providing, treatment to these individuals. This requires the integration of substance abuse treatment and mental health services and the combination of these approaches with those that address criminal thinking and behavior, while attending to both public health and public safety concerns.

HIV/AIDS and infectious diseases

The association between psychological dysfunction and a tendency to engage in high-risk behaviors (Joe et al. 1991; Simpson et al. 1993) suggests that it is important to integrate HIV/AIDS prevention and treatment with

substance abuse treatment and mental health services for the COD population. Advances in the treatment of HIV/AIDS (such as antiretroviral combination therapy, including protease inhibitors) and the improved outcomes resulting from such therapies potentially will extend the survival of those with HIV/AIDS and co-occurring disorders. This will extend their requirement for continued mental health and substance abuse services. For persons with COD who also have HIV/AIDS or other infectious diseases (e.g., hepatitis C), primary medical care should be integrated with COD treatment. To be successful, this treatment should include an emphasis on treatment adherence (see chapter 7 for one such model).

Trauma and PTSD

Many persons with substance use disorders have experienced trauma, often as a result of abuse. A significant number of them have the recognized mental disorder known as PTSD. Recent studies have demonstrated strong connections between trauma and addictions, including the possibility that childhood abuse plays a part in the development of substance use disorders (Anderson et al. 2002; Brady et al. 2000; Chilcoat and Breslau 1998*b*; Jacobsen et al. 2001). Although substance abuse treatment clinicians have counseled these clients for years, new treatment strategies for PTSD and trauma have expanded treatment options (see chapter 8 and appendix D). The forthcoming TIP *Substance Abuse Treatment and Trauma* will explore these issues in depth (CSAT in development *d*).

Changes in Treatment Delivery

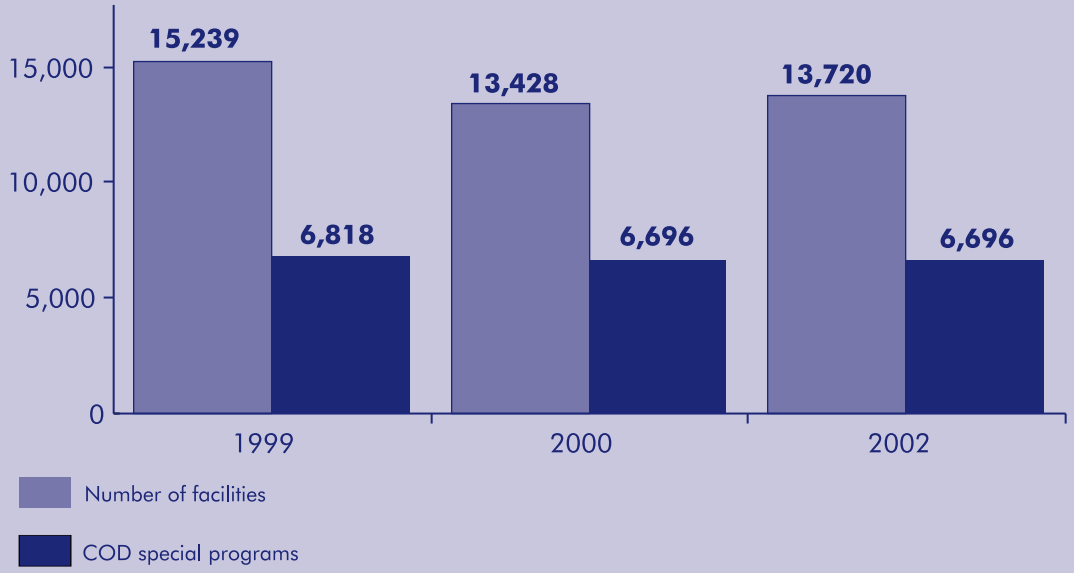
The substance abuse treatment field has recognized the importance of COD programming. In 1995, only 37 percent of the substance use disorder treatment programs reporting data to the Substance Abuse and Mental Health Services Administration (SAMHSA) offered COD programming. By 1997, this percentage had increased to almost half (data not shown).

According to 2002 N-SSATS data, the number of programs for COD peaked in 1999, followed by a slight decline in 2000 that remained constant in 2002. This tracked the number of substance use disorder treatment providers, which also peaked in 1999. In 1999, there were 15,239 substance abuse treatment programs reporting to SAMHSA; in 2000, there were 13,428; in 2002, there were 13,720 (OAS 2003*a*). Figure 1-3 shows that the number of programs for people with COD decreased slightly from 1999 to 2000, from 6,818 to 6,696, but remained constant in 2002 at 6,696 (OAS 2003*a*). However, the ratio between the total number of substance abuse treatment programs and those offering COD programming has been relatively stable since 1997, increasing slightly from 44.7 percent in 1999 to 49.9 percent in 2000, and then remaining roughly constant at 48.8 percent in 2002.

An important consideration for the public mental health and substance abuse delivery systems is the recognition that not all people with emotional problems are candidates for care within the public mental health system. Because many States prioritize the funding of mental health slots by providing access to those who meet the criteria for the most severe and persistent mental illnesses, it is important for treatment providers to recognize the criteria that their State jurisdiction uses to provide care. For example, a treatment program may be aware that a person has psychological symptoms signifying stress, a diagnosable mental disorder, a serious mental disorder, a severe and persistent mental disorder, or, finally, a severe and persistent mental disorder with disability. From the point of view of the behavioral healthcare delivery system, these distinctions are important. In a State that restricts the use of its Federal community mental health services dollars to those with severe and persistent mental illness, a person not meeting the criteria for that condition may not be eligible for mental health services.

Figure 1-3

Substance Abuse Treatment Facilities Offering Special Programs for Clients With COD: 1999–2002[1]



[1]Survey reference dates were October 1 for 1999 and 2000 and March 29, 2002. See appendix C of source for changes in the survey base, methods, and instruments that affect analysis of trends over time.

Source: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, UFDS Survey, 1996–1999; National Survey of Substance Abuse Treatment Services (N-SSATS), 2000 and 2002.

If a client/consumer has a primary substance abuse problem and a "non-eligible" mental disorder—that is, a disorder that cannot by regulation or law be treated in a public mental health program—then all providers should be aware of this. The difference between ideal care and available care is critical to the utility of this TIP. Furthermore, during periods of financial difficulty, the prospect of additional resources being created to address complex problems is not likely. Thus, an integrated care framework is preferred in this TIP. An integrated framework recognizes that quality evidence-based individualized care can be provided within a behavioral health delivery system using existing resources and partnerships.

Advances in Treatment

Advances in the treatment of COD, such as improved assessments, psychological interventions, psychiatric medications, and new models and methods, have greatly increased available options for the counselor and the client.

"No wrong door" policy

The publication of *Changing the Conversation* (CSAT 2000*a*) signaled several fundamental advances in the field. Of particular importance is the principle of "no wrong door." This principle has served to alert treatment providers that the healthcare delivery system, and each provider within it, has a responsibility to address the range of client

needs wherever and whenever a client presents for care. When clients appear at a facility that is not qualified to provide some type of needed service, those clients should carefully be guided to appropriate, cooperating facilities, with followup by staff to ensure that clients receive proper care. The evolution of the *Changing the Conversation* paradigm signals a recognition that recovery is applicable to all people in need of substance abuse services: to the client with psychiatric problems in the substance abuse treatment delivery system, the client with substance abuse problems in the traditional mental health services delivery system, or the client with co-occurring behavior problems in a traditional physical health delivery system. Every "door" in the healthcare delivery system should be the "right" door.

> Treatment approaches are emerging with demonstrated effectiveness in achieving positive outcomes for clients with COD.

Mutual self-help for people with COD

Based on the Alcoholics Anonymous model, the mutual self-help movement has grown to encompass a wide variety of addictions. Narcotics Anonymous and Cocaine Anonymous are two of the largest mutual self-help organizations for chemical addiction; Recoveries Anonymous and Schizophrenics Anonymous are the best known for mental illness. Though these typically are referred to as "self-help" groups, this TIP adopts the term "mutual self-help" because it is more descriptive of the way most participants see these groups—as a means of both helping themselves and supporting each other in achieving specific personal goals.

Mutual self-help programs, which include but are not limited to 12-Step groups, apply a broad spectrum of personal responsibility and peer support principles, usually including 12-Step methods that prescribe a planned regimen of change. In recent years, mutual self-help groups that have been adapted to clients with COD have become increasingly available. A more extensive discussion of these dual recovery mutual self-help programs can be found in chapter 7.

Integrated care as a priority for people with severe and persistent mental illness

For those with severe and persistent mental illness, integrated treatment, as originally articulated by Minkoff (1989), emphasized the correspondence between the treatment models for mental illness and addiction in a residential setting. The model stressed a parallel view of recovery, concomitant treatment of mental illness and substance abuse, application of treatment stages, and the use of strategies from both the mental health and substance abuse treatment fields. During the last decade, integrated treatment has continued to evolve, and several models have been described (Drake and Mueser 1996*b*; Lehman and Dixon 1995; Minkoff and Drake 1991; Solomon et al. 1993).

For the purposes of this TIP, *integrated treatment* refers more broadly to any mechanism by which treatment interventions for COD are combined within the context of a primary treatment relationship or service setting. Integrated treatment is a means of coordinating substance abuse and mental health interventions to treat the whole person more effectively. In a review of mental health center-based research for clients with serious and persistent mental illness, Drake and colleagues (1998*b*) concluded that comprehensive, integrated treatment, "especially when delivered for 18 months or longer, resulted in significant reductions of substance abuse and, in some cases, in substantial rates of remission, as well as reductions in hospital use and/or improvements in other outcomes" (p.

601). Several studies based in substance abuse treatment centers addressing a range of COD have demonstrated better treatment retention and outcome when mental health services were integrated onsite (Charney et al. 2001; McLellan et al. 1993; Saxon and Calsyn 1995; Weisner et al. 2001).

An integrated care framework supports the provision of some assessment and treatment wherever the client enters the treatment system, ensures that arrangements to facilitate consultations are in place to respond to client issues for which a provider does not have in-house expertise, and encourages all counselors and programs to develop increased competency in treating individuals with COD. Several States have received Community Action Grants from SAMHSA to develop comprehensive continuous integrated systems of care. It is especially important that appropriate substance abuse and mental health services for clients with COD be designed specifically for the substance abuse treatment system—a system that addresses a wide range of COD, not mainly those with severe and persistent mental illness. This subject is explored in chapter 3, and some approaches to integrated treatment in substance abuse treatment settings are examined in chapter 3 and chapter 6.

Development of effective approaches, models, and strategies

Treatment approaches are emerging with demonstrated effectiveness in achieving positive outcomes for clients with COD. These include a variety of promising treatment approaches that provide comprehensive integrated treatment. Successful strategies with important implications for clients with COD also include interventions based on addiction work in contingency management, cognitive–behavioral therapy, relapse prevention, and motivational interviewing. These strategies are discussed in chapter 5. In fact, it is now possible to identify "guiding principles" and "fundamental elements" for COD treatment in COD settings that are common to a variety of approaches. These are discussed at length in chapter 3 and chapter 6, respectively. Specific program models that have proven effective for the COD population with serious mental illness include ACT and the Modified Therapeutic Community. ICM also has proven useful in treating clients with COD. See chapter 6 for a discussion of these models.

Pharmacological advances

Pharmacological advances over the past decade have produced antipsychotic, antidepressant, anticonvulsant, and other medications with greater effectiveness and fewer side effects (see appendix F for a listing of medications). With the support available from better medication regimens, many people who once would have been too unstable for substance abuse treatment, or institutionalized with a poor prognosis, have been able to lead more functional lives. To meet the needs of this population, the substance abuse treatment counselor needs both greater understanding of the signs and symptoms of mental illness and greater capacity for consultation with trained mental healthcare providers. As substance abuse treatment counselors learn more about mental illness, they are better able to partner with mental health counselors to design effective treatment for both types of disorders. Such partnerships benefit mental health agencies as well, helping them enhance their ability to treat clients with substance abuse issues.

Increasingly, substance abuse treatment counselors and programs have come to appreciate the importance of providing medication to control symptoms as an essential part of treatment. The counselor has an important role in describing client behavior and symptoms to ensure that proper medication is prescribed when needed. The peer community also is a powerful tool that can be employed to support and monitor medication adherence. Support from mutual self-help groups can include learning about the effects of med-

ication and learning to accept medication as part of recovery. Monitoring involves clients learning from and reflecting on their own and others' reactions, thoughts, and feelings about the ways medications affect them, both positively as symptoms are alleviated, and negatively as unwanted side effects may occur.

Some Recent Developments

Since the consensus panel for this TIP was convened, there have been several important developments in the field of co-occurring disorders. Following is a description of the most recent developments in the field.

National Registry of Effective Programs and Practices

To help its practice and policymaking constituents learn more about evidence-based programs, SAMHSA's Center for Substance Abuse Prevention created the National Registry of Effective Programs and Practices (NREPP), a resource to review and identify effective programs derived primarily from existing scientific literature, effective programs assessed by other rating processes, SAMHSA, and solicitations to the field. When co-occurring disorder treatment programs are submitted for NREPP consideration, teams of scientists review the programs based on four criteria: (1) co-occurring disorders programs, (2) psychopharmacological programs, (3) workplace programs, and (4) general substance abuse prevention and treatment programs. Evaluation is based on methodological quality (a program's overall rigor and substantive contribution) and appropriateness (dissemination capability, cultural sensitivity, and consumer involvement to inform a total rating that describes a program's readiness for adoption and replication). Programs that demonstrate a commitment to complete assessment and comprehensive services receive priority. For programs that target persons with serious mental disorders, priority is given to approaches that integrate substance abuse treatment and mental health services. Targeted techniques and strategies are also eligible for NREPP review. For more detailed information about NREPP, see http://www.nrepp.samhsa.gov.

Co-Occurring Disorders State Incentive Grants

The Co-Occurring Disorders State Incentive Grants (COSIG) (funded through SAMHSA's CSAT and CMHS) provide funding to the States to develop or enhance their infrastructure to increase their capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with COD. COSIG uses the definition of co-occurring disorders from this TIP (see the beginning of this chapter). It supports infrastructure development and services across the continuum of COD, from least severe to most severe, but the emphasis is on people with less severe mental disorders and more severe substance use disorders, and on people with more severe mental disorders and less severe substance use disorders (i.e., quadrants II and III—see chapter 2 for a description of the four quadrants). COSIG is appropriate for States at any level of infrastructure development. COSIG also provides an opportunity to evaluate the feasibility, validity, and reliability of the proposed co-occurring performance measures for the future Performance Partnership Grants. Some States and communities throughout the country already have initiated system-level changes and developed innovative programs that overcome barriers to providing services for individuals of all ages who have COD. The COSIG program reflects the experience of States to date. For more information, see www.samhsa.gov.

Co-Occurring Center for Excellence

As a result of the pressing need to disseminate and support the adoption of evidence- and consensus-based practices in the field of

COD, SAMHSA established the Co-Occurring Center for Excellence (COCE) in 2003. COCE provides SAMHSA and the field with key resources needed to disseminate knowledge and increase adoption of evidence-based practices in the systems and programs that serve people with COD. The COCE mission is to

- *Transmit* advances in substance abuse and mental health treatment that address all levels of mental disorder severity and that can be adapted to the unique needs of each client.
- *Guide* enhancements in the infrastructure and clinical capacities of the substance abuse and mental health service systems.
- *Foster* the infusion and adoption of evidence-based treatment and program innovation into clinical practice.

To guide its work, COCE has developed a framework that locates the key topics in COD along three dimensions: services and service systems, infrastructure, and special populations. Services and service systems include providers and the services they offer; the nature and structure of the organizations and systems in which services are delivered; and the interrelationships among various providers, organizations, and systems. Infrastructure includes the wide variety of national, State, and local policies, programs, and resources that support, facilitate, catalyze, and otherwise contribute to the work of service providers and service systems. Special populations identifies groups who may require special services, settings, or accommodations to reap the full benefit of COD-related services. At this time, the core products and services of the COCE are envisioned as technical assistance and training, a Web site (www.coce.samhsa.gov), meetings and conferences, and future COCE products and services.

Report to Congress on the Prevention and Treatment of Co-Occurring Substance Use Disorders and Mental Disorders

In response to a Congressional mandate, in December 2002 the Department of Health and Human Services provided Congress with a comprehensive report on treatment and prevention of co-occurring substance abuse and mental disorders. The report emphasizes that people with co-occurring disorders can and do recover with appropriate treatment and support services. It also finds there are many long-standing systemic barriers to appropriate treatment and support services for people with co-occurring disorders, including separate administrative structures, eligibility criteria, and funding streams, as well as limited resources for both mental health services and substance abuse treatment. The report identifies the need for various Federal and State agencies, providers, researchers, recovering persons, families, and others to work together to create a system in which both disorders are addressed as primary and treated as such. It also outlines a 5-year blueprint for action to improve the opportunity for recovery by increasing the availability of quality prevention, diagnosis, and treatment services for people with co-occurring disorders. To access the full report, see www.samhsa.gov/reports/congress2002/index.html.

As substance abuse treatment counselors learn more about mental illness, they can better partner with mental health counselors to design effective treatment for both disorders.

Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit

Known simply as the "tool kit," and developed by the Psychiatric Research Center at New Hampshire-Dartmouth under the leadership of Robert E. Drake, M.D., Ph.D., this resource package specifically targets clients with COD who have SMI and who are seeking care through mental health services available in their community. The six evidence-based practices described in the tool kit are collaborative psychopharmacology, ACT, family psychoeducation, supported employment, illness management and recovery, and integrated dual disorders treatment (substance use and mental illness). Using materials germane to a variety of audiences (i.e., consumers, family members/caregivers, mental health program leaders, public mental health authorities, and practitioners/clinical supervisors), the tool kit articulates a flexible basic plan that allows materials to be used to implement best practices to their maximum effect. The tool kit is being produced under a contract with SAMHSA's CMHS and through a grant from The Robert Wood Johnson Foundation (CMHS in development).

The TIP is structured to meet the needs of the addiction counselor with a basic background as well as the differing needs of those with intermediate and advanced backgrounds.

Organization of This TIP

Scope

The TIP attempts to summarize for the clinician the state-of-the-art in the treatment of COD in the substance abuse and mental health fields. It contains chapters on terminology, assessment, and treatment strategies and models, as well as recommendations for treatment, research, and policy planning.

The primary concern of this TIP is co-occurring substance use (abuse and dependence) and mental disorders, even though it is recognized that this same vulnerable population also is subject to many other physical and social ills. The TIP includes important work on nicotine dependence, a somewhat large and separate body of work that admittedly does need further integration into the general field of COD. Nicotine dependency is treated here as an important cross-cutting issue. Finally, although the TIP does address several specific populations (i.e., homeless, criminal justice, and women), it does this briefly and does not describe programs specifically for adolescents or for such specialized populations as new Asian and Hispanic/Latino immigrants. At the same time, the authors fully recognize, and the TIP states, that all COD treatment must be culturally relevant.

Audience

The primary audience for this TIP is substance abuse treatment clinicians and counselors, many, but not all, of whom possess certification in substance abuse counseling or related professional licensing. Some may have credentials in the treatment of mental disorders or in criminal justice services. The TIP is structured to meet the needs of the addiction counselor with a basic background as well as the differing needs of those with intermediate and advanced backgrounds. Another equally important audience for the TIP is mental health staff. Secondary audiences include educators, researchers, primary care providers, criminal

justice staff, and other healthcare and social service personnel who work with people with COD.

Approach

The TIP uses three criteria for inclusion of a particular strategy, technique, or model: (1) definitive research (i.e., evidence-based treatments), (2) well-articulated approaches with empirical support, and (3) consensus panel agreement about established clinical practice. The information in this TIP derives from a variety of sources, including the research literature, conceptual writings, descriptions of established program models, accumulated clinical experience and expertise, government reports, and other available empirical evidence. It is a document that reflects the current state of clinical wisdom in the treatment of clients with COD.

The TIP keeps two questions in the forefront:

1. What does the clinician need to know?
2. How can the information be conveyed in a manner that makes it readily accessible?

Guidance for the Reader

This TIP is both a resource document and a guide on COD that contains both up-to-date knowledge and instructive material. It includes selected literature reviews, synopses of many COD treatment approaches, and some empirical information. The scope of the work in this field generated a complex and extensive document that is probably best read by chapter or section. It contains text boxes, case histories, illustrations, and summaries to synthesize knowledge that is grounded in the practical realities of clinical cases and real situations. A special feature throughout the TIP—"Advice to the Counselor"—provides the TIP's most direct and accessible guidance for the counselor. Readers with basic backgrounds, such as addiction counselors or other practitioners, can study the Advice to the Counselor boxes first for the most immediate practical guidance. In particular, the Advice to the Counselor boxes provide a distillation of what the counselor needs to know and what steps to take, which can be followed by a more detailed reading of the relevant material in the section or chapter.

The chair and co-chair of the TIP consensus panel plan to continue working with providers and treatment agencies, and encouraging others to do likewise, to translate the concepts and methods of the TIP into other useable tools specifically shaped to the needs and resources of each agency and situation. It is the hope of the consensus panel that the reader will come away with increased knowledge, encouragement, and resources for the important work of treating persons with COD.

Organization

The TIP is organized into 9 chapters and 14 appendices. Subject areas addressed in each of the remaining chapters and appendices are as follows:

Chapter 2. Definitions, terms, and classification systems for co-occurring disorders

This chapter reviews terminology and classifications related to substance use, clients, treatment, programs, and systems for clients with COD. Key terms used in the TIP and in the field are defined to help the reader understand the framework and language used in this TIP and how this language relates to other terminology and classifications that are familiar to the reader. The main classification systems currently in use in the field are presented.

Chapter 3. Keys to successful programming

The chapter begins with a review of some guiding principles in treatment of clients with COD, and key challenges to establishing services in substance abuse treatment settings are highlighted. This section also presents a system for

classifying substance abuse treatment programs to determine an appropriate level of services and care. The chapter describes some service delivery issues including access, assessment, integrated treatment, comprehensive services, and continuity of care. Finally, critical issues in workforce development are discussed, including values, competencies, education, and training.

Chapter 4. Assessment

This chapter reviews the key principles of assessment, selected assessment instruments, and the assessment process. The chapter also addresses the specific relationship of assessment to treatment planning.

Chapter 5. Strategies for working with clients with co-occurring disorders

This chapter presents guidelines for developing a successful therapeutic relationship with individuals who have COD. It describes specific techniques for counselors that appear to be the most successful in treating clients with COD and introduces guidelines that are important for the successful use of all these strategies.

Chapter 6. Traditional settings and models

The chapter begins by addressing essential programming for clients with COD that can readily be offered in most substance abuse treatment settings. Overarching considerations in effective treatment for this population, regardless of setting, are reviewed. Practices are highlighted that have proven effective for the treatment of persons with COD in outpatient and residential settings. The chapter also highlights several distinctive models.

Chapter 7. Special settings and specific populations

This chapter addresses issues related to providing treatment to clients with COD in acute care and other medical settings, as well as the need to sustain these programs. Because of the critical role mutual self-help groups play in recovery, several dual recovery mutual self-help groups that address the specific concerns of clients with COD are described. Resources available through advocacy groups are highlighted. Finally, the chapter discusses the need to address the particular needs of people with COD within three key populations: homeless persons, criminal justice populations, and women.

Chapter 8. A brief overview of specific mental disorders and cross-cutting issues

With the permission of American Psychiatric Publishing, Inc. (APPI), the consensus panel has taken the opportunity to present to the substance abuse treatment audience basic information contained in the *Diagnostic and Statistical Manual for Mental Disorders, 4th edition, Text Revised* (DSM-IV-TR). The chapter updates material that was presented on the major disorders covered in TIP 9 (i.e., personality disorders, mood disorders, anxiety disorders, and psychotic disorders) and adds other mental disorders with particular relevance to COD that were not covered in TIP 9 (i.e., attention deficit/hyperactivity disorder, PTSD, eating disorders, and pathological gambling). Suicidality and nicotine dependency are presented as cross-cutting issues. The consensus panel is pleased that APPI has allowed this liberal use of its materials to help foster the co-occurring disorders field and positive interchange between the substance abuse treatment and mental health services fields.

The chapter contains key information about substance abuse and the particular mental disorder, highlighting advice to the counselor to help in working with clients with those disorders. A relevant case history accompanies each disorder in this chapter. This chapter is meant to function as a "quick reference" to help the substance abuse treatment counselor understand the mental disorder diagnosis and

its implications for treatment planning. Appendix D contains a more extensive discussion of the same disorders.

Chapter 9. Substance-induced disorders

This chapter provides information on mental disorder symptoms caused by the use of substances. It outlines the toxic effect of substances and provides an overview of substance-induced symptoms that can mimic mental disorders.

Appendices

Appendix A. Bibliography

Appendix A contains the references cited in this TIP and other resources used for background purposes but not specifically cited.

Appendix B. Acronyms

Appendix B contains a key to all the acronyms used in this TIP.

Appendix C. Glossary of terms

This appendix contains the definitions of terms used in this TIP, with the exception of terminology related to specific mental disorders discussed in chapter 8 and appendix D. For these specialized terms, the reader is advised to consult a medical dictionary.

Appendix D. Specific mental disorders: Additional guidance for the counselor

Clients with COD entering treatment often have several disorders, each of which is associated with a growing body of knowledge and range of treatment options. This appendix is meant to serve substance abuse treatment counselors and programs as a resource and training document that provides more extensive information on individual mental disorders than could be included in chapter 8. Although most readers will not read the entire appendix at one time, this mental disorder-oriented section is included so that a counselor who is working with a new client with one or more of these disorders can have detailed information readily available.

Appendix E. Emerging models

In this appendix, the reader can find descriptions of several recent models of care for persons with COD that were (or are being) evaluated under initiatives funded by SAMHSA's CSAT. Though selective and based primarily on available information from recent SAMHSA initiatives, it is hoped that these models will suggest ways in which readers working with a variety of client types and symptom severities in different settings can improve their capacities to assess and treat these clients.

Appendix F. Common medications for disorders

Because medication is such an important adjunct to treatment, this appendix offers a brief review of key issues in pharmacologic management. A table of common medications for various disorders follows this discussion, with comments on the effects of these medications and their implications for addiction counselors and treatment. This material is taken from the Pharmacological Management section of TIP 9 (CSAT 1994*a*, pp. 91–94), followed by the complete text of *Psychotherapeutic Medications 2004: What Every Counselor Should Know* (Mid-America Addiction Technology Transfer Center 2004).

Appendix G. Screening and assessment instruments

A list of selected screening and assessment tools referenced in chapter 4, along with key information on the use of each instrument, appears in this appendix. As a full review of these instruments was beyond the scope of this TIP, readers are urged to review the literature to determine their reliability, validity, and utility, and to gain an understanding of their applicability to specific situations.

Appendix H. Sample screening instruments

This appendix offers two screening instruments available for unrestricted use:

- The Mental Health Screening Form-III
- The Simple Screening Instrument for Substance Abuse

Appendix I. Selected resources of training

Here the reader finds some of the most readily available and well-used sources of training in substance abuse treatment, mental health services, and co-occurring disorders.

Appendix J. Dual recovery mutual self-help programs and other resources for consumers and providers

This appendix provides a brief description and contact information for several mutual self-help groups discussed in the TIP.

Appendix K. Confidentiality

This appendix provides a brief description of the Federal Alcohol and Drug Confidentiality Law and Regulations (42 C.F.R. Part 2) and the Health Insurance Portability and Accountability Act of 1996.

[1]"These estimates are from the National Comorbidity Survey. The survey was based on interviews administered to a probability sample of the noninstitutionalized U.S. civilian population. The NCS sample consisted of 8,098 respondents, age 15 to 54 years. This survey was conducted from September 1990 to February 1992. DSM-III-R criteria were used as the basis for assessing disorders in the general population. A random sample of initial nonrespondents was contacted further and received a financial incentive to participate. A nonresponse weight was used to adjust for the higher rates of [alcohol, drugs, or mental (ADM) disorders] found in the sample of initial nonresponders. The Composite International Diagnostic Interview was modified to eliminate rare diagnoses in the age group studied and to add probes to improve understanding and motivation. The 'substance abuse/dependence' category includes drugs and alcohol. 'Any ADM disorder' includes the following: affective, anxiety, substance abuse/dependence, nonaffective psychosis, and antisocial personality disorders. 'Affective disorders' include major depressive episode, manic episode, and dysthymia. Anxiety disorders include panic disorder, agoraphobia, social phobia, simple phobia, and generalized anxiety disorder. Antisocial personality was assessed only on a lifetime basis. Nonaffective psychoses include schizophrenias, delusional disorder, and atypical psychoses. Substance abuse/dependence includes both abuse of and dependence on alcohol and other drugs" (SAMHSA 1998, p. 7).

2 Definitions, Terms, and Classification Systems for Co-Occurring Disorders

In This Chapter…

Terms Related to Substance Use Disorders

Terms Related to Mental Disorders

Terms Related to Clients

Terms Related to Treatment

Terms Related to Programs

Terms Related to Systems

Overview

This chapter reviews and defines many of the terms that are applied commonly to co-occurring substance use and mental disorders (COD). Discussion points include how different terms have emerged, the contexts in which various classification systems are likely to be used, and why many of the specific terms and classification systems used throughout this TIP were chosen.

After a review of basic terminology related to substance use (including the distinction between abuse and dependence) and a brief description of mental disorders, the chapter discusses terms related to clients. A key point is the importance of using person-centered terminology as a way of acknowledging each client's individuality. The chapter notes the many terms that may be used to describe co-occurring disorders, reviews the terms related to treatment and programs, and concludes with an overview of terms that describe the systems of care within which treatment occurs and programs operate.

The addiction counselor should be aware that the terminology and classifications introduced in this chapter, though important and useful, were developed by different groups for different purposes. Therefore, these terms do not necessarily form a seamless picture or work smoothly together. Nevertheless, they are useful and appropriate when used in the intended context. The reader who becomes conversant with these terms and classifications will find it easier to navigate the discussion of treatment issues (chapter 3) and to follow the TIP's narrative.

Finally, this chapter contains brief Advice to the Counselor boxes, which readers with basic backgrounds, such as addiction counselors or other practitioners, can refer to for the most immediate practical guidance. (For a full listing of these boxes see the table of contents.)

Terms Related to Substance Use Disorders

Substance abuse and substance dependence are two types of substance use disorders and have distinct meanings. The standard use of these terms derives from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV) (American Psychiatric Association [APA] 1994). Produced by the APA and updated periodically, DSM-IV is used by the medical and mental health fields for diagnosing mental and substance use disorders. This reference provides clinicians with a common language for communicating about these disorders. The reference also establishes criteria for diagnosing specific disorders.

Substance abuse, as defined in DSM-IV-TR (4th edition, Text Revision; APA 2000), is a "maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances" (APA 2000, p. 198). Individuals who abuse substances may experience such harmful consequences of substance use as repeated failure to fulfill roles for which they are responsible, legal difficulties, or social and interpersonal problems. It is important to note that the chronic use of an illicit drug still constitutes a significant issue for treatment even when it does not meet the criteria for substance abuse specified in the text box below.

For individuals with more severe or disabling mental disorders, as well as for those with developmental disabilities and traumatic brain injuries, even the threshold of substance use that might be harmful (and therefore defined as abuse) may be significantly lower than for individuals without such disorders. Further-more, the more severe the disability, the lower the amount of substance use that might be harmful.

Substance dependence is more serious than abuse. This maladaptive pattern of substance use includes such features as increased tolerance for the substance, resulting in the need for ever-greater amounts of the substance to achieve the intended effect; an obsession with securing the substance and with its use; or persistence in using the substance in the face of serious physical or mental health problems. See the text box on page 23 for more information.

Criteria for a Diagnosis of Substance Abuse

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Source: APA 2000, p. 199.

Criteria for a Diagnosis of Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
   b. Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for the substance (refer to the DSM-IV-TR, Criteria A and B of the criteria sets for withdrawal from the specific substances).
   b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or mental health problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

Source: APA 2000, p. 197.

The term *substance abuse* has come to be used informally to refer to both abuse and dependence. Substance abuse treatment professionals commonly use the term "substance abuse" to describe any excessive use of addictive substances, whether the substance is alcohol or another drug. By and large the terms "substance dependence" and "addiction" have come to mean the same thing, though there is debate about the interchangeable use of these terms. When only those who are diagnosed as dependent are referenced, the specific term will be used.

Terms Related to Mental Disorders

The standard use of terms for non-substance use mental disorders, like the terms for substance use disorders, derive from the DSM-IV-TR (APA 2000). These terms are used throughout the medical and mental health fields for diagnosing mental disorders. As with substance use disorders, this reference provides clinicians with a common language for communicating about these disorders. The reference also establishes criteria for diagnosing specific disorders. (See chapter 1, Figure 1-2 for an overview of the association between specific mental disorders and substance use disorders.)

The following section provides a brief introduction to some (not, by any means, all) of these disorders and offers advice to the addiction counselor and other practitioners for working with clients with these disorders. The consensus panel recognizes that addiction counselors are not expected to diagnose mental disorders. Clinicians in the substance abuse treatment field, however, should familiarize themselves with the mental disorders that co-occur with substance use disorders and/or that mimic symptoms of substance use disorders, particularly withdrawal or intoxication. The aim of providing this material is only to increase substance abuse treatment counselors' familiarity with the mental disorders terminology and criteria necessary to provide advice on how to proceed with clients who demonstrate these disorders. (See chapter 8 and appendix D for more complete material on mental disorders co-occurring with substance use disorders.)

Personality Disorders

These are the disorders most commonly seen by the addiction counselor and in quadrant III substance abuse treatment settings (see Figure 2-1 for a depiction of the four quadrants). Individuals with personality disorders have symptoms and personality traits that are enduring and play a major role in most, if not all, aspects of the person's life. These individuals have personality traits that are persistent and cause impairment in social or occupational functioning or cause personal distress. Symptoms are evident in their thoughts (ways of looking at the world, thinking about self or others), emotions (appropriateness, intensity, and range), interpersonal functioning (relationships and interpersonal skills), and impulse control.

Personality disorders are listed in the DSM-IV under three distinct areas, referred to as "clusters." The clusters are listed below with the types of symptoms or traits seen in that category. The specific personality disorders included in each cluster also are listed. For personality disorders that do not fit any of the specific disorders, the diagnosis of "personality disorder not otherwise specified" is used.

Cluster A: Hallmark traits of this cluster involve *odd or eccentric behavior.* It includes *paranoid*, *schizoid*, and *schizotypal* personality disorders.

Cluster B: Hallmark traits of this cluster involve *dramatic, emotional, or erratic behavior.* It includes *antisocial, borderline, histrionic*, and *narcissistic* personality disorders.

Cluster C: Hallmark traits of this cluster involve *anxious, fearful behavior.* It includes *avoidant, dependent,* and *obsessive-compulsive* personality disorders.

The prevalence of co-occurring substance abuse and antisocial personality disorder is high (Flynn et al. 1997). In fact, much of substance abuse treatment is targeted to those with antisocial personality disorders and substance abuse treatment alone has been especially effective for these disorders. Below is an Advice to the Counselor box on working with clients who have antisocial personality disorder; similar and more detailed advice boxes can be found throughout the TIP.

Advice to the Counselor: Antisocial Personality Disorders

- Confront dishonesty and antisocial behavior directly and firmly.
- Hold clients responsible for the behavior and its consequences.
- Use peer communities to confront behavior and foster change.

Psychotic Disorders

The common characteristics of these disorders are symptoms that center on prob-

lems of thinking. The most prominent (and problematic) symptoms are delusions or hallucinations. Delusions are false beliefs that significantly hinder a person's ability to function. For example, a client may believe that people are trying to hurt him, or he may believe he is someone else (a CIA agent, God, etc.). Hallucinations are false perceptions in which a person sees, hears, feels, or smells things that aren't real (i.e., visual, auditory, tactile, or olfactory).

Psychotic disorders are seen most frequently in mental health settings and, when combined with substance use disorders, the substance disorder tends to be severe. Clients with psychotic disorders constitute what commonly is referred to as the serious and persistent mentally ill population. Increasingly, individuals with serious mental illness are present in substance abuse treatment programs (Gustafson et al. 1999).

Drugs (e.g., cocaine, methamphetamine, or phencyclidine) can produce delusions and/or hallucinations secondary to drug intoxication. Furthermore, psychotic-like symptoms may persist beyond the acute intoxication period.

Schizophrenia

This is one of the most common of the psychotic disorders and one of the most destructive in terms of the effect it has on a person's life. Symptoms may include the following: hallucinations, delusions, disorganized speech, grossly disorganized or catatonic behavior, social withdrawal, lack of interest, and poor hygiene. The disorder has several specific types depending on what other symptoms the person experiences. In the paranoid type there is a preoccupation with one or more delusions or frequent auditory hallucinations. These often are experienced as threatening to the person. In the disorganized type there is a prominence of all of the following: disorganized speech, disorganized behavior, and flat or inappropriate affect (i.e., emotional expression).

Advice to the Counselor: Psychotic Disorders

- Screen for psychotic disorders and refer identified clients for further diagnostic evaluation.
- Obtain a working knowledge of the signs and symptoms of the disorder.
- Educate the client and family about the condition.
- Help the client detect early signs of its re-occurrence by recognizing the symptoms associated with the disorder.

Mood Disorders

The disorders in this category include those where the primary symptom is a disturbance in mood, where there may be inappropriate, exaggerated, or a limited range of feelings or emotions. Everyone feels "down" sometimes, and everybody experiences feelings of excitement or emotional pleasure. However, when a client has a mood disorder, these feelings or emotions are experienced to the extreme. Many people with substance use disorders also have a co-occurring mood disorder and tend to use a variety of drugs in association with their mood disorder. There are several types of mood disorders, including depression, mania, and bipolar disorder.

Depression. Instead of just feeling "down," the client might not be able to work or function at home, might feel

Advice to the Counselor: Mood and Anxiety Disorders

- Differentiate between mood disorders, commonplace expressions of depression, and depression associated with more serious mental illness.
- Conduct careful and continuous assessment since mood symptoms may be the result of substance abuse and not an underlying mental disorder.
- Combine addiction counseling with medication and mental health treatment.

suicidal, lose his or her appetite, and feel very tired or fatigued. Other symptoms can include loss of interest, weight changes, changes in sleep and appetite, feelings of worthlessness, loss of concentration, and recurrent thoughts of death.

Mania. This includes feelings that are toward the opposite extreme of depression. There might be an excess of energy where sleep is not needed for days at a time. The client may be feeling "on top of the world," and during this time, the client's decisionmaking process might be significantly impaired and expansive and he may experience irritability and have aggressive outbursts, although he might think such outbursts are perfectly rational.

Bipolar. A person with bipolar disorder cycles between episodes of mania and depression. These episodes are characterized by a distinct period of abnormally elevated, expansive, or irritable mood. Symptoms may include inflated self-esteem or grandiosity, decreased need for sleep, being more talkative than usual, flight of ideas or a feeling that one's thoughts are racing, distractibility, increase in goal-directed activity, excessive involvement in pleasurable activities that have a high potential for painful consequences (sexual indiscretions, buying sprees, etc.). Excessive use of alcohol is common during periods of mania.

Anxiety disorders. As with mood disorders, anxiety is something that everyone feels now and then, but anxiety disorders exist when anxiety symptoms reach the point of frequency and intensity that they cause significant impairment. In addiction treatment populations, the most common anxiety syndrome seen is that associated with early recovery, which can be a mix of substance withdrawal and learning to live without the use of drugs or alcohol. This improves with time and addiction treatment. However, other anxiety disorders that may occur, but need particular assessment and treatment, are social phobia (fear of appearing or speaking in front of groups), panic disorder (recurrent panic attacks that usually last a few hours, cause great fear, and make it hard to breathe), and posttraumatic stress disorders (which cause recurrent nightmares, anxiety, depression, and the experience of reliving the traumatic issues).

Terms Related to Clients

Person-Centered Terminology

In recent years, consumer advocacy groups have expressed concerns related to how clients are classified. Many take exception to terminology that seems to put them in a "box" with a label that follows them through life, that does not capture the fullness of their identities. A person with COD also may be a mother, a plumber, a pianist, a student, or a person with diabetes, to cite just a few examples. Referring to an individual as a person who has a specific disorder—a person with depression rather than "a depressive," a person with schizophrenia rather than "a schizophrenic," or a person who uses heroin rather than "an addict"—is more acceptable to many clients because it implies that they have many characteristics besides a stigmatized illness, and therefore that they are not defined by this illness.

Terms for Co-Occurring Disorders

Many terms have been used in the field to describe the group of individuals who have COD (most of these terms do not reflect the "people-first" approach used in this TIP). Some of these terms represent an attempt to identify which problem or disorder is seen as primary or more severe. Others have developed in the literature in order to argue for setting aside funding for special services or to identify a group of clients who may benefit from certain interventions. These terms include

- MICA—mentally ill chemical abuser. This acronym is sometimes seen with two As (MICAA) to signify mentally ill chemically addicted or affected. There are regional differences in the meaning of this acronym. Many States use it to refer specifically to persons with serious mental disorders.
- MISA—mentally ill substance abuser.
- MISU—mentally ill substance using.
- CAMI—chemically abusing mentally ill, or chemically addicted and mentally ill.
- SAMI—substance abusing mentally ill.
- MICD—mentally ill chemically dependent.
- Dually diagnosed.
- Dually disordered.
- Comorbid disorders.
- ICOPSD—individuals with co-occurring psychiatric and substance disorders.

While all of these terms have their uses, many have developed connotations that are not helpful or that have become too broad or varied in interpretation to be useful. For example, "dual diagnosis" also can mean having both mental and developmental disorders. Readers who hear these terms should not assume they all have the same meaning as COD and should seek to clarify the client characteristics associated with a particular term. Readers also should realize that the term "co-occurring disorder" is not inherently precise and distinctive; it also may become distorted by popular use, with other conditions becoming included within the term. The issue here is that clients/consumers may have a number of health conditions that "co-occur," including physical health problems. Nevertheless, for the purpose of this TIP, co-occurring disorders refers to substance use disorders and mental disorders.

Some clients' mental health problems may not fully meet the strict definition of co-occurring substance use and mental disorders criteria for diagnoses in DSM-IV categories. However, many of the relevant principles that apply to the treatment of COD also will apply to these individuals. Careful assessment and treatment planning to take each disorder into account will still be important. Suicidal ideation is an excellent example of a mental health symptom that creates a severity problem, but alone doesn't necessarily meet criteria for a formal DSM-IV condition since suicidality is a symptom and not a diagnosis. Substance-induced suicidal ideation can produce catastrophic consequences. Some individuals may exhibit symptoms that could indicate the existence of COD but could also be transitory; for example, substance-induced mood swings, which can mimic bipolar disorder, or amphetamine-induced hallucinations or paranoia, which could mimic schizophrenia. Depending on the severity of their symptoms, these individuals also may require the full range of services needed by those who meet the strict criterion of having both conditions independently, but generally for acute periods until the substance-induced symptoms resolve.

Terms Related to Treatment

Levels of Service

The American Society of Addiction Medicine's Patient Placement Criteria (ASAM PPC-2R) (ASAM 2001) envisions treatment as a continuum within which there are five levels of care. These levels of care are as follows:

- Level 0.5: Early Intervention
- Level I: Outpatient Treatment
- Level II: Intensive Outpatient/Partial Hospitalization Treatment
- Level III: Residential/Inpatient Treatment
- Level IV: Medically Managed Intensive Inpatient Treatment

Each level of care includes several levels of intensity indicated by a decimal point. For example, Level III.1 refers to "Clinically Managed Low-Intensity Residential

Treatment." A client who has COD might be appropriately placed in any of these levels of service.

Substance abuse counselors also should be aware that some mental health professionals may use another system, the Level of Care Utilization System for Psychiatric and Addiction Services. This system also identifies levels of care, including

- Level 1: Recovery Maintenance Health Management
- Level 2: Low Intensity Community Based Services
- Level 3: High Intensity Community Based Services
- Level 4: Medically Monitored Non-Residential Services
- Level 5: Medically Monitored Residential Services
- Level 6: Medically Managed Residential Services

These levels, like the ASAM levels, use a variety of specific dimensions to describe a client in order to determine the most appropriate placement (see the section in chapter 4, "Assessment Step 5," for more information about these dimensions).

Quadrants of Care

The quadrants of care are a conceptual framework that classifies clients in four basic groups based on relative symptom severity, not diagnosis.

- Category I: Less severe mental disorder/ less severe substance disorder
- Category II: More severe mental disorder/ less severe substance disorder
- Category III: Less severe mental disorder/ more severe substance disorder
- Category IV: More severe mental disorder/ more severe substance disorder (National Association of State Mental Health Program Directors [NASMHPD] and National Association of State Alcohol and Drug Abuse Directors [NASADAD] 1999)

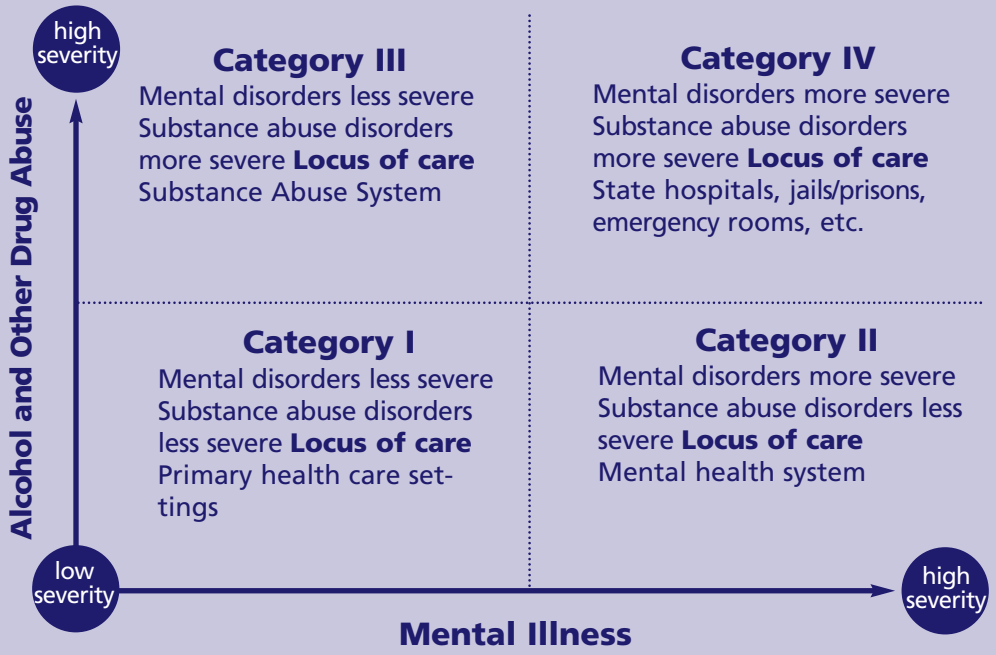
For a more detailed description of each quadrant, see Figure 2-1 and text box on p. 30.

The quadrants of care were derived from a conference, the National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders, which was supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) and two of its centers—the Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services—and co-sponsored by NASMHPD and NASADAD. The quadrants of care is a model originally developed by Ries (1993) and used by the State of New York (NASMHPD and NASADAD 1999; see also Rosenthal 1992).

The four-quadrant model has two distinct uses:

- To help conceptualize an individual client's treatment and to guide improvements in system integration (for example, if the client has acute psychosis and is known to the treatment staff to have a history of alcohol dependence, the client will clearly fall into Category IV—that is, severe mental disorder and severe substance use disorder). However, the severity of the client's needs, diagnosis, symptoms, and impairments all determine level of care placement.
- To guide improvements in systems integration, including efficient allocation of resources. The NASMHPD–NASADAD National Dialogue recognized that currently "there is no single locus of responsibility for people with COD. The mental health and substance abuse treatment systems operate independently of one another, as separate cultures, each with its own treatment philosophies, administrative structures, and funding mechanisms. This lack of coordination means that neither consumers nor providers move easily among service settings" (NASMHPD and NASADAD 1999, p. ii).

Figure 2-1
Level of Care Quadrants



Although the chapters of this TIP are not organized around the four-quadrant framework, most of the material in chapters 3 through 7 is directed primarily to addiction counselors working in quadrant III settings and other practitioners working in quadrant II settings.

Interventions

Intervention refers to the specific treatment strategies, therapies, or techniques that are used to treat one or more disorders. Interventions may include psychopharmacology, individual or group counseling, cognitive–behavioral therapy, motivational enhancement, family interventions, 12-Step recovery meetings, case management, skills training, or other strategies. Both substance use and mental disorder interventions are targeted to the management or resolution of acute symptoms, ongoing treatment, relapse prevention, or rehabilitation of a disability associated with one or more disorders, whether that disorder is mental or associated with substance use.

Integrated Interventions

Integrated interventions are specific treatment strategies or therapeutic techniques in which interventions for both disorders are combined in a single session or interaction, or in a series of interactions or multiple sessions. Integrated interventions can include a wide range of techniques. Some examples include

- Integrated screening and assessment processes
- Dual recovery mutual self-help meetings
- Dual recovery groups (in which recovery skills for both disorders are discussed)
- Motivational enhancement interventions (individual or group) that address issues related to both mental health and substance abuse or dependence problems

Level of Care Quadrants

Quadrant I: This quadrant includes individuals with low severity substance abuse and low severity mental disorders. These low severity individuals can be accommodated in intermediate outpatient settings of either mental health or chemical dependency programs, with consultation or collaboration between settings if needed. Alternatively, some individuals will be identified and managed in primary care settings with consultation from mental health and/or substance abuse treatment providers.

Quadrant II: This quadrant includes individuals with high severity mental disorders who are usually identified as priority clients within the mental health system and who also have low severity substance use disorders (e.g., substance dependence in remission or partial remission). These individuals ordinarily receive continuing care in the mental health system and are likely to be well served in a variety of intermediate level mental health programs using integrated case management.

Quadrant III: This quadrant includes individuals who have severe substance use disorders and low or moderate severity mental disorders. They are generally well accommodated in intermediate level substance abuse treatment programs. In some cases there is a need for coordination and collaboration with affiliated mental health programs to provide ongoing treatment of the mental disorders.

Quadrant IV: Quadrant IV is divided into two subgroups. One subgroup includes individuals with serious and persistent mental illness (SPMI) who also have severe and unstable substance use disorders. The other subgroup includes individuals with severe and unstable substance use disorders and severe and unstable behavioral health problems (e.g., violence, suicidality) who do not (yet) meet criteria for SPMI. These individuals require intensive, comprehensive, and integrated services for both their substance use and mental disorders. The locus of treatment can be specialized residential substance abuse treatment programs such as modified therapeutic communities in State hospitals, jails, or even in settings that provide acute care such as emergency rooms (see chapter 7 for an example in an emergency room setting).

- Group interventions for persons with the triple diagnosis of mental disorder, substance use disorder, and trauma, or which are designed to meet the needs of persons with COD and another shared problem such as homelessness or criminality
- Combined psychopharmacological interventions, in which an individual receives medication designed to reduce cravings for substances as well as medication for a mental disorder

Integrated interventions can be part of a single program or can be used in multiple program settings.

Episodes of Treatment

An individual with COD may participate in recurrent episodes of treatment involving acute stabilization (e.g., crisis intervention, detoxification, psychiatric hospitalization) and specific ongoing treatment (e.g., mental-health–supported housing, mental-health day treatment, or substance abuse residential treatment). It is important to recognize the reality that clients engage in a series of treatment episodes, since many individuals with COD progress gradually through repeated involvement in treatment.

Integrated Treatment

Integrated treatment refers broadly to any mechanism by which treatment interventions for COD are combined within the context of a

primary treatment relationship or service setting. Integrated treatment is a means of actively combining interventions intended to address substance use and mental disorders in order to treat both disorders, related problems, and the whole person more effectively.

Culturally Competent Treatment

One definition of cultural competence refers to "the capacity of a service provider or of an organization to understand and work effectively with the cultural beliefs and practices of persons from a given ethnic/racial group" (Castro et al. 1999, p. 504). Treatment providers working with individuals with COD should view these clients and their treatment in the context of their language, culture, ethnicity, geographic area, socioeconomic status, gender, age, sexual orientation, religion, spirituality, and any physical or cognitive disabilities. For a full discussion of cultural issues in treatment for persons with substance use disorders, see the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT in development *a*).

Cultural factors that may have an impact on treatment include heritage, history and experience, beliefs, traditions, values, customs, behaviors, institutions, and ways of communicating. The client's culture may include distinctive ways of understanding disease or disorder, including mental and substance use disorders, which the provider needs to understand. Referencing a model of disease that is familiar to the client can help communication and enhance treatment. The counselor acquires cultural knowledge by becoming aware of the cultural factors that are important to a particular ethnic group or client.

Cultural competence may be viewed as a continuum on which, through learning, the provider increases his or her understanding and effectiveness with different ethnic groups. Various researchers have described the markers on this continuum (Castro et al. 1999; Cross 1988; Kim et al. 1992). The continuum moves from cultural destructiveness, in which an individual regards other cultures as inferior to the dominant culture, through cultural incapacity and blindness to the more positive attitudes and greater levels of skill described below:

- *Cultural sensitivity* is being "open to working with issues of culture and diversity" (Castro et al. 1999, p. 505). Viewed as a point on the continuum, however, a culturally sensitive individual has limited cultural knowledge and may still think in terms of stereotypes.
- *Cultural competence*, when viewed as the next stage on this continuum, includes an ability to "examine and understand nuances" and exercise "full cultural empathy." This enables the counselor to "understand the client from the client's own cultural perspective" (Castro et al. 1999, p. 505).
- *Cultural proficiency* is the highest level of cultural capacity. In addition to understanding nuances of culture in even greater depth, the culturally proficient counselor also is working to advance the field through leadership, research, and outreach (Castro et al. 1999, p. 505).

It is important to remember that clients, not counselors, define what is culturally relevant to them. It is possible to damage the relationship with a client by making assumptions, however well intentioned, about the client's cultural identity. For example, a client of Hispanic origin may be a third-generation United States citizen, fully acculturated, who feels little or no connection with her Hispanic heritage. A counselor who assumes this client shares the beliefs and values of many Hispanic cultures would be making an erroneous generalization. Similarly, it is helpful to remember that all of us represent multiple cultures. Clients are not simply African–American, white, or Asian. A client who is a 20-year-old African-American man from the rural south may identify, to some extent, with youth, rural south, or African-American cul-

tural elements—or may, instead, identify more strongly with another cultural element, such as his faith, that is not readily apparent. Counselors are advised to open a respectful dialog with clients around the cultural elements that have significance to them.

Integrated Counselor Competencies

A counselor has integrated competencies if he or she has the specific attitudes, values, knowledge, and skills needed to provide appropriate services to individuals with COD in the context of his or her actual job and program setting.

Just as other types of integration exist on a continuum, so too does integrated competency. Some interventions and/or programs require clinicians only to have basic competency in welcoming, screening, assessing, and identifying treatment needs of individuals with COD. Other interventions, programs, or job functions (e.g., those of supervisory staff) may require more advanced integrated competency. The more complex or unstable the client, the more formal mechanisms are required to coordinate the various staff members working with that client in order to provide effective integrated treatment.

A number of service delivery systems are moving toward identification of a required basic level of integrated competency for all clinicians in the mental health and substance abuse treatment systems. Many States also are developing curricula for initial and ongoing training and supervision to help clinicians achieve these competencies. Other State systems (e.g., Illinois) have created career ladders and certification pathways to encourage clinicians to achieve higher levels of integrated competency and to reward them for this achievement. (See chapter 3 for a full discussion of counselor competencies.)

Terms Related to Programs

A program is a formally organized array of services and interventions provided in a coherent manner at a specific level or levels of care in order to address the needs of particular target populations. Each program has its own staff competencies, policies, and procedures. Programs may be operated directly by public funders (e.g., States and counties) or by privately funded agencies. An individual agency may operate many different programs. Some agencies operate only mental health programs, some operate only substance abuse treatment programs, and some do both. An individual, licensed healthcare practitioner (such as a psychiatrist or psychologist) may offer her or his own integrated treatment services as an independent practitioner.

Key Programs

Mental health-based programs

A mental health program is an organized array of services and interventions with a primary focus on treating mental disorders, whether by providing acute stabilization or ongoing treatment. These programs may exist in a variety of settings, such as traditional outpatient mental health centers (including outpatient clinics and psychosocial rehabilitation programs) or more intensive inpatient treatment units.

Many mental health programs treat significant numbers of individuals with COD. Programs that are more advanced in treating persons with COD may offer a variety of interventions for substance use disorders (e.g., motivational interviewing, substance abuse counseling, skills training) within the context of the ongoing mental health treatment.

Substance abuse treatment programs

A substance abuse treatment program is an organized array of services and interventions with a primary focus on treating substance use disorders, providing both acute stabilization and ongoing treatment.

Substance abuse treatment programs that are more advanced in treating persons with COD may offer a variety of interventions for mental disorders (e.g., psychopharmacology, symptom management training) within the context of the ongoing substance abuse treatment.

Program Types

The ASAM PPC-2R (ASAM 2001) describes three different types of programs for people with COD:

- *Addiction only services.* This term refers to programs that "either by choice or for lack of resources, cannot accommodate patients who have mental illnesses that require ongoing treatment, however stable the illness and however well-functioning the patient" (ASAM 2001, p. 10).
- *Dual diagnosis capable (DDC)* programs are those that "address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning" (ASAM 2001, p. 362). Even where such programs are geared primarily to treat substance use disorders, program staff are "able to address the interaction between mental and substance-related disorders and their effect on the patient's readiness to change—as well as relapse and recovery environment issues—through individual and group program content" (ASAM 2001, p. 362).
- *Dual diagnosis enhanced* programs have a higher level of integration of substance abuse and mental health treatment services. These programs are able to provide primary substance abuse treatment to clients who are, as compared to those treatable in DDC programs, "more symptomatic and/or functionally impaired as a result of their co-occurring mental disorder" (ASAM 2001, p. 10). Enhanced-level services "place their primary focus on the integration of services for mental and substance-related disorders in their staffing, services and program content" (ASAM 2001, p. 362).

See chapter 3 for a discussion of program terminology proposed by the consensus panel that works well for both the substance abuse and mental health fields (i.e., "basic," "intermediate," and "advanced") and for a crosswalk of this terminology with the ASAM program types.

> A system is a means of organizing a number of different treatment programs and related services to implement a specific mission and common goals.

Terms Related to Systems

For the purposes of this TIP, a system is a means of organizing a number of different treatment programs and related services to implement a specific mission and common goals. A basic example of a system is SAMHSA. Single State Agencies are systems that organize statewide services. There may also be county, city, or local systems in various areas.

A system executes specific functions by providing services and related activities. It is often, but not always, a government agency. Systems may be defined according to a number of different characteristics: a section of government, a geographic entity, or a payor (e.g., the Medicaid system of care).

Systems work with other systems in a variety of ways and with different degrees of integration. The primary systems with which people with COD interact are the substance abuse treatment and mental health services systems. Other systems that frequently come into play are health care, criminal justice, and social services. Systems are usually the entities that determine funding, standards of care, licensing, and regulation.

Substance Abuse Treatment System

The substance abuse treatment system encompasses a broad array of services organized into programs intended to treat substance use disorders (including illegal substances, such as marijuana and methamphetamine, and legal substances, such as alcohol for adults over 21 years of age). It also includes services organized in accord with a particular treatment approach or philosophy (e.g., methadone treatment for opioid dependence or therapeutic communities). A system may be defined by a combination of administrative leadership (e.g., through a designated director of substance abuse treatment services), regulatory oversight (e.g., all programs that have substance abuse treatment licenses), or funding (e.g., all programs that receive categorical substance abuse funding, or, more rarely, bill third-party payors for providing substance abuse services).

In most substance abuse treatment systems, the primary focus is on providing distinct treatment episodes for the acute stabilization, engagement, active treatment, ongoing rehabilitation of substance use disorders, and relapse prevention. More intensive services are almost invariably targeted to the treatment of substance dependence. The primary focus of intervention is abstinence from illicit drugs for those who use illicit drugs and from alcohol for those who use alcohol excessively.

Mental Health Service System

The mental health service system includes a broad array of services and programs intended to treat a wide range of mental disorders. Like the substance abuse treatment system, the coherence of the mental health system is defined by a combination of administrative leadership (e.g., through a designated director of mental health services), regulatory oversight (e.g., all programs which have mental health licenses), and funding (e.g., all programs which receive categorical mental health funding or that primarily bill third party payors for providing mental health services).

In most mental health systems, services are provided for a wide range of mental disorders; however, in many publicly financed mental health programs, the priority is on acute crisis intervention and stabilization and on the provision of ongoing treatment and rehabilitative services for individuals identified as having SPMI. Typically, the mental health system identifies a cohort of priority clients (identified by a State's definition of SPMI) for which it assumes continuing responsibility, often by providing continuing case management, psychiatric rehabilitation services, and/or housing support services.

Interlinking Systems

Depending on the life area affected at a given moment, individuals with COD may present themselves at different venues. For example, a person who experiences an array of problems in addition to the COD—such as homelessness, legal problems, and general medical problems—may first be seen at a housing agency or medical clinic. Historically, the distinctive boundaries maintained between systems have impeded the ability of individuals with COD to access needed services (Baker 1991; Schorske and Bedard 1989).

Intersystem linkages are essential to a comprehensive service delivery system. Fundamental to effective linkage is the collaboration between substance abuse treatment and mental health

systems, because they are the primary care systems for persons with COD. The coordination of these systems enhances the quality of services by removing barriers that impede access to needed services. For example, access to care and quality of care have been impeded historically by the failure to address issues of language and culture. Intersystem coordination can lead to cohesive and coordinated delivery of program and services, where the burden is not on the individual to negotiate services and the system's resources are used more effectively. The criminal justice system now plays a central role in the delivery of treatment for both mental health and substance use disorders, especially for those persons with COD, so it is important to ensure coordination with this system as well. Community health centers and other primary health providers also play critical roles in substance use disorder treatment and mental health treatment.

Comprehensive Continuous Integrated System of Care

The Comprehensive Continuous Integrated System of Care model (CCISC) is a model to bring the mental health and substance abuse treatment systems (and other systems, potentially) into an integrated planning process to develop a comprehensive, integrated system of care. The CCISC is based on the awareness that COD are the expectation throughout the service system. The entire system is organized in ways consistent with this assumption. This includes system-level policies and financing, the design of all programs, clinical practices throughout the system, and basic clinical competencies for all clinicians. This model derives from the work of the SAMHSA Managed Care Initiative Consensus Panel on developing standards of care for individuals with COD (Center for Mental Health Services 1998; Minkoff 2001*a*). CCISCs are grounded in the following assumptions:

- The four-quadrant model is a valid model for service planning.
- Individuals with COD benefit from continuous, integrated treatment relationships.
- Programs should provide integrated primary treatment for substance use and mental disorders in which interventions are matched to diagnosis, phase of recovery, stage of change, level of functioning, level of care, and the presence of external supports and/or contingencies.

This model has been identified by SAMHSA as an exemplary practice and is at various stages of implementation in a number of States. States in various stages of implementing the CCISC model include Alabama, Alaska, Arizona, Maine, Maryland, Massachusetts, Montana, and New Mexico, as well as the District of Columbia. Regional projects are underway in Florida, Louisiana, Michigan, Oregon, Texas, and Virginia.

3 Keys to Successful Programming

In This Chapter…

Guiding Principles

Delivery of Services

Improving Substance Abuse Treatment Systems and Programs

Workforce Development and Staff Support

Overview

Many treatment agencies may recognize the need to provide quality care to persons with co-occurring disorders (COD), but see it as a daunting challenge beyond their resources. Programs that already have incorporated some elements of integrated services and want to do more may lack a clear framework for determining priorities. As programs look to improve their effectiveness in treating this population, what should they consider? How could the experience of other agencies inform their planning process? Are resources available that could help turn such a vision into reality? This chapter is designed both to help agencies that want to design programs for their clients with COD and to assist agencies that are trying to improve existing ones.

The chapter begins with a review of guiding principles derived from proven models, clinical experience, and the growing base of empirical evidence. Building on these guiding principles, the chapter turns to the core components for effective service delivery. It suggests that the provider needs to address in concrete terms the challenges of providing access, assessment, appropriate level of care, integrated treatment, comprehensive services, and continuity of care. This section provides guidance relevant to designing processes that are appropriate for this population within each of these key areas.

The chapter then moves onto a discussion of strategies for agencies that want to improve established systems, beginning with the too-familiar issue of how to access funding—a major hurdle for most, if not all, substance abuse treatment agencies. This portion of the chapter also gives an example of how one collaborative project crosses agency lines to share resources among a variety of partners and ensure continuity of care. The chapter then discusses difficulties of achieving equitable resource allocations for a venture of this nature, and highlights efforts to integrate research and practice.

Finally, the critical issues in workforce development are discussed, for without a well-prepared staff, the needs of these often-challenging clients cannot be met—regardless of what other systemic changes are made. The chapter describes the attitudes and values needed to successfully treat these clients, required competencies, paths to professional development for those who wish to increase their skills in treating clients with COD, and ways of avoiding staff burnout and reducing turnover—an especially pressing concern for providers who work closely with this demanding population.

Guiding Principles

The consensus panel developed a list of guiding principles to serve as fundamental building blocks for programs that offer services to clients with COD (see Figure 3-1). These principles derive from a variety of sources: conceptual writings, well-articulated program models, a growing understanding of the essential features of COD, elements common to separate treatment models, clinical experience, and available empirical evidence. These principles may be applied at both a program level (e.g., providing literature for people with cognitive impairments) or at the individual level (e.g., addressing the client's basic needs).

In identifying these principles, the TIP consensus panel recognizes that there are a number of carefully elaborated protocols to guide treatment for individuals with COD, including principles identified by Drake and colleagues (1993) and by the Center for Mental Health Services Managed Care Initiative Panel (1998), as well as the assumptions that underlie the model Comprehensive Continuous Integrated Systems of Care described in chapter 2. The principles suggested in this chapter are consistent with these protocols, but reflect the specific focus of the consensus panel on how best to provide COD treatment in substance abuse treatment agencies. (However, the principles apply equally well to the treatment of COD in mental health agencies.)

The following section discusses each of the six principles in turn, highlighting the related field experience that underlies each one.

Employ a Recovery Perspective

There are two main features of the recovery perspective: It acknowledges that recovery is a long-term process of internal change, and it recognizes that these internal changes proceed through various stages. (See De Leon 1996 and Prochaska et al. 1992 for a detailed description. Also see chapter 5 of this TIP for a discussion of the recovery perspective as a guideline for practice.)

The recovery perspective is applicable to clients who have COD. It generates at least two main principles for practice:

Figure 3-1

Six Guiding Principles in Treating Clients With COD

1. Employ a recovery perspective.
2. Adopt a multi-problem viewpoint.
3. Develop a phased approach to treatment.
4. Address specific real-life problems early in treatment.
5. Plan for the client's cognitive and functional impairments.
6. Use support systems to maintain and extend treatment effectiveness.

Develop a treatment plan that provides for continuity of care over time. In preparing this plan, the clinician should recognize that treatment may occur in different settings over time (i.e., residential, outpatient) and that much of the recovery process typically occurs outside of or following treatment (e.g., through participation in mutual self-help groups and through family and community support, including the faith community). It is important to reinforce long-term participation in these continuous care settings.

Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the co-occurring disorder recovery process. Whether within the substance abuse treatment or mental health services system, the clinician is advised to use sensible stepwise approaches in developing and using treatment protocols. In addition, markers that are unique to individuals—such as those related to their cultural, social, or spiritual context—should be considered. It is important to engage the client in defining markers of progress meaningful to the individual and to each stage of recovery.

Adopt a Multi-Problem Viewpoint

People with COD generally have an array of mental health, medical, substance abuse, family, and social problems. Most are in need of substantial rehabilitation and habilitation (i.e., initial learning and acquisition of skills). Treatment should address immediate and long-term needs for housing, work, health care, and a supportive network. Therefore, services should be comprehensive to meet the multidimensional problems typically presented by clients with COD.

Develop a Phased Approach to Treatment

Many clinicians view clients as progressing though phases (Drake and Mueser 1996*a*; McHugo et al. 1995; Osher and Kofoed 1989; Sacks et al. 1998*b*). Generally, three to five phases are identified, including engagement, stabilization, treatment, and aftercare or continuing care. These phases are consistent with, and parallel to, stages identified in the recovery perspective. As noted above, use of these phases enables the clinician (whether within the substance abuse treatment or mental health services system) to develop and use effective, stage-appropriate treatment protocols. (See chapter 5 for a discussion of how to use motivational enhancement therapy appropriate to the client's stage of recovery. Also see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [Center for Substance Abuse Treatment (CSAT) 1999*b*]).

Address Specific Real-Life Problems Early in Treatment

The growing recognition that co-occurring disorders arise in a context of personal and social problems, with a corresponding disruption of personal and social life, has given rise to approaches that address specific life problems early in treatment. These approaches may incorporate case management and intensive case management to help clients find housing or handle legal and family matters. It may also be helpful to use specialized interventions that target important areas of client need, such as money management (e.g., Conrad et al. 1999) and housing-related support services (e.g., Clark and Rich 1999). Psychosocial rehabilitation, which helps the client develop the specific skills and approaches she needs to perform her chosen roles (e.g., student, employee, community member) also is a useful strategy for addressing these specific problems (Anthony 1996; Cnaan et al. 1990).

Solving such problems often is an important first step toward achieving client engagement in continuing treatment. Engagement is a critical part of substance abuse treatment generally and of treatment for COD specifically, since remaining in treatment for an adequate length of time is essential to achieving behavioral change.

Plan for the Client's Cognitive and Functional Impairments

Services for clients with COD, especially those with more serious mental disorders, must be tailored to individual needs and functioning. Clients with COD often display cognitive and other functional impairments that affect their ability to comprehend information or complete tasks (CSAT 1998*e*; Sacks et al. 1997*b*). The manner in which interventions are presented must be compatible with client needs and functioning. Such impairments frequently call for relatively short, highly structured treatment sessions that are focused on practical life problems. Gradual pacing, visual aids, and repetition often are helpful. Even impairments that are comparatively subtle (e.g., certain learning disabilities) may still have significant impact on treatment success. Careful assessment of such impairments and a treatment plan consistent with the assessment are therefore essential.

Use Support Systems To Maintain and Extend Treatment Effectiveness

The mutual self-help movement, the family, the faith community, and other resources that exist within the client's community can play an invaluable role in recovery. This can be particularly true for the client with COD, as many clients with COD have not enjoyed a consistently supportive environment for decades. In some cultures, the stigma surrounding substance use or mental disorders is so great that the client and even the entire family may be ostracized by the immediate community. Furthermore, the behaviors associated with active substance use may have alienated the client's family and community. The clinician plays a role in ensuring that the client is aware of available support systems and motivated to use them effectively.

Mutual self-help

Based on the Alcoholics Anonymous model, the mutual self-help movement has grown to encompass a wide variety of addictions. Narcotics Anonymous and Cocaine Anonymous are two of the largest mutual self-help organizations for substance use disorders; Recoveries Anonymous and Schizophrenics Anonymous are among the best known for mental illness. Personal responsibility, self-management, and helping one another are the basic tenets of mutual self-help approaches. Such programs apply a broad spectrum of personal responsibility and peer support principles, usually including 12-Step methods that prescribe a planned regimen of change (see Peyrot 1985 for the history, structure, and approach of Narcotics Anonymous, representative of 12-Step approaches in general). However, in the past clients with COD felt that either their mental health or their substance use issues could not be addressed in a single-themed mutual self-help group; that has changed.

Mutual self-help principles, highly valued in the substance abuse treatment field, are now widely recognized as important components in the treatment of COD. Mutual self-help groups may be used as an adjunct to primary treatment, as a continuing feature of treatment in the community, or both. These groups not only provide a vital means of support during outpatient treatment, but also are used commonly in residential programs such as therapeutic communities. As clients gain employment, travel, or relocate, mutual self-help meetings may become the most easily accessible means of providing continuity of care. For a more extensive discussion of dual recovery mutual self-help programs applicable to persons with COD, see chapter 7.

Building community

The need to build an enduring community arises from three interrelated factors—the persistent nature of COD, the recognized effectiveness of mutual self-help principles, and the importance of client empowerment. The therapeutic community (TC), modified mutual self-help programs for COD (e.g., Double Trouble in Recovery), and the client consumer movement all reflect an understanding of the critical role clients play in their own recovery, as well

as the recognition that support from other clients with similar problems promotes and sustains change.

Reintegration with family and community

The client with COD who successfully completes treatment must face the fragility of recovery, the toxicity of the past environment, and the negative impact of previous associates who may encourage drug or alcohol use and illicit or maladaptive behaviors. There is a need for groups and activities that support change. In this context it is important that these clients receive support from family and significant others where that support is available or can be developed. There is also the need to help the client reintegrate into the community through such resources as religious, recreation, and social organizations. (See chapter 6 for a discussion of continuing care issues in treatment.)

Delivery of Services

While the guiding principles described above serve as the fundamental building blocks for effective treatment, ensuring effective treatment requires attention to other variables. This section discusses six core components that form the ideal delivery of services for clients with COD. These include:

1. Providing access
2. Completing a full assessment
3. Providing an appropriate level of care
4. Achieving integrated treatment
5. Providing comprehensive services
6. Ensuring continuity of care

Providing Access

"Access" refers to the process by which a person with COD makes initial contact with the service system, receives an initial evaluation, and is welcomed into services that are appropriate for his or her needs.

Access occurs in four main ways:

1. Routine access for individuals seeking services who are not in crisis
2. Crisis access for individuals requiring immediate services due to an emergency
3. Outreach, in which agencies target individuals in great need (e.g., people who are homeless) who are not seeking services or cannot access ordinary routine or crisis services
4. Access that is involuntary, coerced, or mandated by the criminal justice system, employers, or the child welfare system

Treatment access may be complicated by clients' criminal justice involvement, homelessness, or health status. CSAT's "no wrong door" policy should be applied to the full range of clients with COD, and programs should address obstacles that bar entry to treatment for either the mental or substance use disorders. (See chapter 7 for recommendations on removing systemic barriers to care and the text box on p. 42 for more on CSAT's "no wrong door" policy.)

> It is important that clients receive support from family and significant others where that support is available or can be developed.

Completing a Full Assessment

While chapter 4 provides a complete description of the assessment process, this section highlights several important features of assessment that must be considered in the context of effective service delivery. Assessment of individuals with COD involves a combination of the following:

- Screening to detect the possible presence of COD in the setting where the client is first seen for treatment
- Evaluation of background factors (family, trauma history, marital status, health, education and work history), mental disorders, substance abuse, and related medical and psychosocial problems (e.g., living circumstances, employment, family) that are critical to address in treatment planning
- Diagnosis of the type and severity of substance use and mental disorders
- Initial matching of individual client to services (often, this must be done before a full assessment is completed and diagnoses clarified; also, the client's motivation to change with regard to one or more of the co-occurring disorders may not be well established)
- Appraisal of existing social and community support systems
- Continuous evaluation (that is, re-evaluation over time as needs and symptoms change and as more information becomes available)

The challenge of assessment for individuals with COD in any system involves maximizing the likelihood of the identification of COD, immediately facilitating accurate treatment planning, and revising treatment over time as the client's needs change.

Providing an Appropriate Level of Care

Clients enter the treatment system at various levels of need and encounter agencies with varying capacity to meet those needs. Ideally, clients should be placed in the level of care appropriate to the severity of both their substance use disorder and their mental illness.

The American Society of Addiction Medicine's (ASAM) classification is one standard way of identifying programs that offer the needed services. As described in chapter 2, ASAM describes programs' ability to address COD as "addiction only services," "dual diagnosis capable," and "dual diagnosis enhanced."

Making "No Wrong Door" a Reality

CSAT's "no wrong door" policy states that effective systems must ensure that an individual needing treatment will be identified and assessed and will receive treatment, either directly or through appropriate referral, no matter where he or she enters the realm of services (CSAT 2000*a*). The consensus panel strongly endorses this policy.

The focus of the "no wrong door" imperative is on constructing the healthcare delivery system so that treatment access is available at any point of entry. A client with COD needing treatment might enter the service system by means of primary healthcare facilities, homeless shelters, social service agencies, emergency rooms, or criminal justice settings. Some clients require the creation of a "right door" for treatment entry—for example, mobile outreach teams who can access clients with COD who are unlikely to knock on the door of any treatment facility.

The "no wrong door" approach has five major implications for service planning:

1. Assessment, referral, and treatment planning for all settings must be consistent with a "no wrong door" policy.
2. Creative outreach strategies may be needed to encourage some people to engage in treatment.
3. Programs and staff may need to change expectations and program requirements to engage reluctant and "unmotivated" clients.
4. Treatment plans should be based on clients' needs and should respond to changes as they progress through stages of treatment.
5. The overall system of care needs to be seamless, providing continuity of care across service systems. This can only be achieved through an established pattern of interagency cooperation or a clear willingness to attain that cooperation.

While recognizing ASAM's contribution, the consensus panel suggests an alternative classification system: basic, intermediate, advanced, or fully integrated. As conceived by the consensus panel

- A *basic* program has the capacity to provide treatment for one disorder, but also screens for the other disorder and can access necessary consultations.
- A program with an *intermediate* level of capacity tends to focus primarily on one disorder without substantial modification to its usual treatment, but also explicitly addresses some specific needs of the other disorder. For example, a substance abuse treatment program may recognize the importance of continued use of psychiatric medications in recovery, or a psychiatrist could provide motivational interviewing regarding substance use while prescribing medication for mental disorders.
- A program with an *advanced* level of capacity provides integrated substance abuse treatment and mental health services for clients with COD. Several program models of this sort are described in chapter 6. Essentially, these programs address COD using an integrated perspective and provide services for both disorders. This usually means strengthening substance abuse treatment in the mental health setting by adding interventions such as mutual self-help and relapse prevention groups. It also means adding mental health services, such as psychoeducational classes on mental disorder symptoms and groups for medication monitoring, in substance abuse treatment settings. Collaboration with other agencies may add to the comprehensiveness of services.
- A program that is *fully integrated* actively combines substance abuse and mental health interventions to treat disorders, related problems, and the whole person more effectively.

The suggested classification has several advantages. For one, it avoids the use of the term "dual diagnosis" (instead of COD) and allows a more general, flexible approach to describing capacity without specific criteria. In addition, the recommended classification system conceptualizes a bidirectionality of movement where either substance abuse or mental health agencies can advance toward more integrated care for clients with COD, as shown in Figure 3-2 (p. 44).

Figure 3-2 depicts a model of basic, intermediate (COD capable), and advanced (COD enhanced) programming within mental health services and substance abuse treatment systems. The idea of integrated COD treatment is shown in the center. For the purpose of this TIP, both mental health and substance abuse treatment providers may be conceived of as beginning, intermediate, or advanced in terms of their progress toward the highest level of capacity to treat persons with COD.

It should also be recognized that not all services want or need to be fully integrated, since many clients do not need a full array of services. (See Figure 2-1 in chapter 2.) In Figure 3-2, the middle box—fully integrated—refers to a system that has achieved an integrated setting in which staff, administration, regulations, and funding streams are fully integrated.

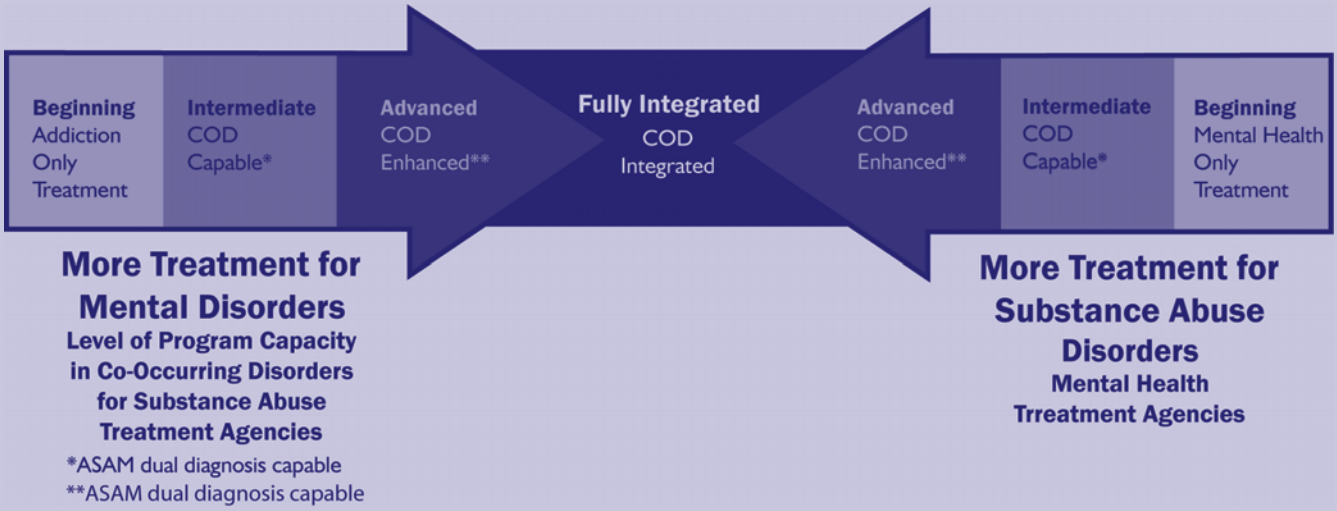
Achieving Integrated Treatment

The concept of integrated treatment for persons with severe mental disorders and substance use disorders, as articulated by Minkoff (1989), emphasized the need for correlation between the treatment models for mental health services and substance abuse treatment in a residential setting. Minkoff's model stressed the importance of well-coordinated, stage-specific treatment (i.e., engagement, primary treatment, continuing care) of substance use and mental disorders, with emphasis on dual recovery goals as well and the use effective treatment strategies from both the mental health services and the substance abuse treatment fields.

During the last decade integrated treatment continued to evolve. Several successful treatment models have been described for addiction settings (Charney et al. 2001; McLellan et al.

Figure 3-2

Levels of Program Capacity in Co-Occurring Disorders



1993; Saxon and Calsyn 1995; Weisner et al. 2001), including the addition of psychiatric and mental health services to methadone treatment (Kraft et al. 1997; Woody et al. 1983), and a modified therapeutic community for providing integrated care to persons with COD (De Leon 1993*b*; Guydish et al. 1994; Sacks 2000; Sacks et al. 1997*a*, *b*, 1998*a*, 2002). Likewise, the literature also describes numerous models for mental health settings (CSAT 1994*a*; Drake and Mueser 1996*b*; Lehman and Dixon 1995; Minkoff and Drake 1991; Zimberg 1993). Figure 3-3 illustrates one vision of a comprehensive, fully integrated approach to treatment for persons with severe mental disorders and substance use disorders from the mental health literature. However, as noted in the following section, programs may be integrated in a variety of ways.

The literature from both the substance abuse and mental health fields has evolved to describe integrated treatment as a unified treatment approach to meet the substance abuse, mental health, and related needs of a client. It is the preferred model of treatment.

Integrated treatment can occur on different levels and through different mechanisms. For example:

- One clinician delivers a variety of needed services.
- Two or more clinicians work together to provide needed services.
- A clinician may consult with other specialties and then integrate that consultation into the care provided.
- A clinician may coordinate a variety of efforts in an individualized treatment plan that integrates the needed services. For example, if someone with housing needs was not accepted at certain facilities, the clinician might work with a State-level community-housing program to find the transitional or supported housing the client needs.
- One program or program model (e.g., modified TC or Assertive Community Treatment) can provide integrated care.
- Multiple agencies can join together to create a program that will serve a specific population. For example, a substance abuse treatment program, a mental health center, a local

housing authority, a foundation, a county government funding agency, and a neighborhood association could join together to establish a treatment center to serve women with COD and their children.

Integrated treatment also is based on positive working relationships between service providers. The National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors' (NASADAD) four-quadrant category framework described in chapter 2 provides a useful structure for fostering consultation, collaboration, and integration among systems and providers to deliver appropriate care to every client with COD (see chapter 2, Figure 2-1). According to the NASMHPD–NASADAD (1999) framework

- *Consultation* refers to the traditional types of informal relationships among providers—from referrals to requests for exchanging information and keeping each other informed. The framework calls for particular attention to the consultation relationship during identification, engagement, prevention, and early intervention activities.
- *Collaboration* is essential when a person who is receiving care in one treatment setting also requires services from another provider. Collaboration is distinguished from consultation on the basis of the formal quality of collaborative agreements, such as memoranda of understanding or service contracts, which document the roles and responsibilities each party will assume in a continuing relationship. For example, parties must ensure that they can share information without violating Federal Law 42 C.F.R. Part 2 on confidentiality (see appendix K for more information). This will require the client to give written authorization for release of information to all providers.
- *Integration* denotes "those relationships among mental health and substance abuse providers in which the contributions of professionals in both fields are moved into a single treatment setting and treatment regimen" (p. 15).

Figure 3-3
A Vision of Fully Integrated Treatment for COD

- The client participates in one program that provides treatment for both disorders.
- The client's mental and substance use disorders are treated by the same clinicians.
- The clinicians are trained in psychopathology, assessment, and treatment strategies for both mental and substance use disorders.
- The clinicians offer substance abuse treatments tailored for clients who have severe mental disorders.
- The focus is on preventing anxiety rather than breaking through denial.
- Emphasis is placed on trust, understanding, and learning.
- Treatment is characterized by a slow pace and a long-term perspective.
- Providers offer stagewise and motivational counseling.
- Supportive clinicians are readily available.
- 12-Step groups are available to those who choose to participate and can benefit from participation.
- Neuroleptics and other pharmacotherapies are indicated according to clients' psychiatric and other medical needs.

Source: Adapted from Drake et al. 1998*b*, p. 591.

For the purposes of this TIP, integration is seen as a continuum. Depending on the needs of the client and the constraints and resources of particular systems, appropriate degrees and means of integration will differ.

Providing Comprehensive Services

People with COD have a range of medical and social problems—multidimensional problems that require comprehensive services. In addition to treatment for their substance use and mental disorders, these clients often require a variety of other services to address other social problems and stabilize their living conditions. Treatment providers should be prepared to help clients access a broad array of services, including life skills development, English as a second language, parenting, nutrition, and employment assistance.

McLellan and colleagues have shown the need for wraparound services to address difficult-to-treat public-sector clients, not all of whom were diagnosed with COD (Gould et al. 2000; McLellan et al. 1997). Two areas of particular value, highlighted below, are housing and work.

Housing

The high proportion of homelessness among clients with COD has focused attention on the importance of providing housing for people with COD and of integrating housing into treatment. Approaches vary from those that provide housing at the point of entry into the service system combined with case management and supportive services (Tsemberis and Asmussen 1999), to those that provide housing as a reward contingent on successful completion of treatment (Milby et al. 1996; Schumacher et al. 1995), or as part of a continuing care strategy that combines housing and continuing care services (Sacks et al. 1998*a*, 2003*a*).

Addressing housing needs requires an ongoing relationship with housing authorities, landlords, and other housing providers. Groups and seminars that discuss housing issues also may be necessary to help clients with COD transition from residential treatment to housing. Another effective strategy for easing the transition has been organizing and coordinating housing tours with supportive housing programs. Finally, relapse prevention efforts are essential, since substance abuse generally disqualifies clients from public housing in the community.

Work

Vocational rehabilitation has long been one of the services offered to clients recovering from mental disorders and, to some degree, to those recovering from substance use disorders. However, in the past clients often were expected first to maintain a period of abstinence. As a result of this policy, people with serious mental disorders often were underserved, if served at all (CSAT 2000*c*). For people with COD, Blankertz and colleagues contend that, "work can serve as a rehabilitative tool and be an integral part of the process of stabilizing the mental illness and attaining sobriety" (Blankertz et al. 1998, p. 114).

The fact is that many individuals with COD are unemployed. However, it is unreasonable to expect employers to tolerate employees who are actively using alcohol on the job or who violate their drug-free workplace policies. Therefore, if work is to become an achievable goal for individuals with COD, vocational rehabilitation and substance abuse treatment must be closely integrated into mental health rehabilitation (Blankertz et al. 1998). For more information about incorporating vocational rehabilitation into treatment, see TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT 2000*c*).

Ensuring Continuity of Care

Continuity of care implies coordination of care as clients move across different service systems (e.g., Morrissey et al. 1997). Since both substance use and mental disorders frequently are long-term conditions, treatment for persons with COD should take into consideration rehabilitation and recovery over a significant period of time. Therefore, to be effective, treatment must address the three features that characterize continuity of care:

- *Consistency* between primary treatment and ancillary services
- *Seamlessness* as clients move across levels of care (e.g., from residential to outpatient treatment)
- *Coordination* of present and past treatment episodes

It is important to set up systems that prevent gaps between service system levels and between clinic-based services and those outside the clinic. The ideal is to include outreach, employment, housing, health care and medication, financial supports, recreational activities, and social networks in a comprehensive and integrated service delivery system.

Empirical evidence related to continuity of care

Evidence for the benefits of ensuring continuity of care comes from multiple sources. In one study of criminal justice populations not specifically identified as having COD, Wexler and colleagues (1999) found that at 3 years post-treatment only 27 percent of those prison program completers who also completed an aftercare program were returned to custody. In contrast, about three-fourths of the subjects in all other study groups were returned. Similar findings have been reported by Knight and colleagues (1999). Although selection bias exists in these studies for entry into aftercare, the long-term outcomes suggest the critical role of aftercare in maintaining positive treatment effects in the criminal justice population.

A study of homeless clients with COD provided further evidence (again with selection bias into aftercare) that aftercare is crucial to positive treatment outcomes. In this study, clients who lived in supported housing after residing in a modified therapeutic community demonstrated reductions in antisocial behavior occurring during the residential modified therapeutic community program and stabilizing during supported housing, while increases in prosocial behavior were largely incremental and continuous throughout both the residential and supported housing programs (Sacks et al. 2003*a*).

> Continuity of care implies coordination of care as clients move across different service systems.

Organizing continuity of care

In organizing continuity of care—a high-priority aspect of any treatment plan for a client with COD—the substance abuse treatment agency must carefully consider and strive to overcome systemic barriers. It is important to recognize that the public mental health and substance abuse treatment systems have evolved in different ways, and these differing histories must be recognized as collaborative ventures are formed.

Community mental health centers were created to be relatively comprehensive in nature, but have not been funded to deliver comprehensive services. Furthermore, there are wide variations in the types of mental disorders that publicly funded mental health centers are permitted to treat; many restrict their services to those in acute crisis or who have serious and persistent mental illnesses, such as schizophrenia, bipolar affective disorder, or major depression. Many States explicitly prevent public mental health programs from

treating those with primary substance use disorders.

Substance abuse treatment programs exist within a variety of organizational structures. Many of them are stand-alone substance abuse treatment programs, several are part of comprehensive drug treatment agencies, some are affiliated with hospitals, some are located within hospitals, many have evolved as part of the criminal justice system, some exist in community mental health settings, and still others are faith-based programs. Many substance abuse treatment programs are the last refuge of the most underserved populations (e.g., the homeless).

The different organizational structures and settings in which services occur influence the ease or difficulty of providing a service delivery network that is integrated, comprehensive, and continuous. Many of the larger drug treatment agencies are to be commended for developing state-of-the-art programming for COD, and some smaller programs also have extended themselves to serve this population. Nevertheless, the strains imposed by organizational and system constraints should be recognized. As substance abuse treatment agencies continue to develop their capabilities for treating clients with COD, the consensus panel recommends that groups of providers organize themselves into coherent systems of care that enable them to provide comprehensive services.

An example of a collaborative that promotes the development of a local infrastructure in support of co-occurring treatment is the Co-Occurring Collaborative of Southern Maine. The Collaborative's ways of working, accomplishments, and the critical elements for success identified at the close of Figure 3-4 may well inspire others to weave similar structures, crossing agency boundaries to better serve shared clients.

Improving Substance Abuse Treatment Systems and Programs

Critical challenges face substance abuse treatment systems and programs that are intent on improving care for clients with COD. One of the most critical of these is how to organize a system that will provide continuity of care for these clients, who, as noted previously, often have multifaceted needs and require long-term treatment plans. Another, of course, is how to access funding for program improvement. When treatment providers from different systems cooperate, equitable allocation of funds also becomes an issue. Finally, at every level there is the problem of how best to integrate research and practice to give clients the benefit of the proven treatment strategies. This section addresses each of these major concerns in turn.

Assessing the Agency's Potential To Serve Clients With COD

Every agency that already is treating or planning to treat clients with COD should assess the current profile of its clients, as well as the estimated number and type of potential new clients in the community. It also must consider its current capabilities, its resources and limitations, and the services it wants to provide in the future.

Programs should consider performing a needs assessment to determine the prevalence of COD in their client population, the demographics of those clients, and the nature of the disorders and accompanying problems they present. These data help create a picture of client needs that can be useful not only to the agency itself, but also to other systems of care at various levels. All levels of government demand some form of needs assessment from provider agencies. Block grant requirements from the Federal government require a statewide needs assessment. In turn, States look to regional and county groups to perform a needs assessment

Figure 3-4

The Co-Occurring Collaborative of Southern Maine

The Co-Occurring Collaborative of Southern Maine, a 501(c)(3) nonprofit corporation, is an alliance of member agencies, consumers, and family members in Cumberland County in southern Maine. Formed in 1992 through a State initiative on COD, the Collaborative provided the umbrella structure for a demonstration grant from The Bingham Program and The Robert Wood Johnson Foundation. It received additional support from Maine's Office of Substance Abuse and Maine's Medicaid Program for a project comparing the efficacy of integrated and coordinated care. The Collaborative has continued its work beyond the 3-year demonstration grant with funding from the Maine Office of Substance Abuse, becoming an integral part of the community's efforts to address COD. In 1998, the Collaborative formalized its structure by becoming a Maine nonprofit corporation.

The number of member agencies has expanded from an initial dozen to more than 30, including consumer groups, family groups, and mental health, substance abuse, criminal justice, HIV, and public health service providers. Each member agency has an identified liaison who serves as the bridge between the Collaborative and the agency. Each member agency formally commits through a memorandum of understanding to do the following:

1. Support the Collaborative's mission.
2. Examine and make changes to the services and organizational structures to support improved service provision for persons with COD.
3. Exchange information, share resources, and alter activities to enhance the capacities of all agencies to improve services for persons with COD.
4. Participate actively in, and share responsibility for, the Collaborative.

The Collaborative structure provides a mechanism for cross-agency and cross-disciplinary communication, coordination, training and education, creative interagency problemsolving, resource development for co-occurring recovery capacity, and advocacy. The Collaborative's accomplishments to date include

- Promoting dual competence expectations in the workforce
- Obtaining grants and collaborating on grant submission
- Expanding consumer, family, and provider partnerships
- Developing the mutual self-help option of dual recovery
- Supporting diversion planning from the criminal justice system
- Supporting the creation of an Assertive Community Treatment team for individuals with COD
- Creating a community service consultation team
- Supporting transfer of knowledge to develop new clinical models for treatment of persons with personality and substance use disorders

To achieve success in forging a collaborative structure, the following were found to be critical elements:

- Inviting all relevant agencies to participate and air their concerns
- Nurturing one-to-one relationships among service providers across service sectors
- Creating and maintaining a shared knowledge base and a common vision
- Collaboration, support, and empowerment
- Early and frequent successes
- Encouraging participation in planning and decisionmaking
- Clarifying roles and process
- Ensuring ongoing consumer and family participation
- Conducting periodic self-review
- Having visionary, consistent, and effective leadership

focused on the local level. Local needs assessment information feeds back to the State level and is used to develop a statewide picture that, in turn, is provided to higher-level funding authorities. The data generated through needs assessments also can be used to demonstrate need in support of grant proposals for increasing service capacity prepared by the treatment agency.

It is important to determine what changes need to be made with respect to staff, training, accreditation, and other factors to provide effective services for clients with COD. The agency also should know what resources and services are already available within their local and State systems of care before deciding what services to provide. This assessment of community capacity and the resulting decisionmaking process should involve all stakeholders in the program. Whatever changes the provider decides to make will require an active commitment from all levels of staff as well as from members of the community, advocacy groups, and other interested parties.

The various classification systems described previously can be used to identify missing levels of care and gaps in specific services. Such tools permit clinicians to relate program services to clients' needs for specific activities. They also enable planners to identify gaps in the current system of care and then to design programs that address these gaps. Figure 3-5 provides a list of domains and questions to guide agencies in assessing their potential to serve clients with COD. In doing so, it is assumed that each agency will use the best approach to each task that is possible, given its level of resources. It may, for example, need to use estimates rather than precise data in some instances.

Accessing Funding

System components and financing principles

Both mental health services and substance abuse treatment systems must face the challenge of obtaining funding that supports programming for clients with COD. For substance abuse treatment agencies, which are seeing more clients with COD and clients with more serious COD, it often is difficult to obtain funds to provide needed screening, assessment, specialized mental health service enhancement, and case management.

Developing a comprehensive system of care for people with COD requires committed leadership, joint planning, and the willingness and ability to find creative solutions to difficult problems. Financing a comprehensive system of care requires no less a commitment of time, creativity, and expertise. The process of continuing dialog between NASMHPD and NASADAD has identified key system development components and financing principles shown in Figure 3-6 (p. 52). Like the conceptual framework, these components and principles represent a set of flexible guidelines that can be adapted for use in any State or community.

Each of the six financing principles is a critical element of success and is described below:

1. *Plan To Purchase Together.* It has been found that "in most successful demonstration programs for people with co-occurring disorders, the State mental health agency and the State alcohol and drug abuse agency jointly planned and purchased services" (NASMHPD and NASADAD 2000, pp. 19–20).
2. *Define the Population.* Individuals with COD may fall into any of the four quadrants. Program services must target populations based on the severity of their mental or substance use disorders, among other considerations. However, it is important to keep in mind that due to the illegality of drug use denying services to those whose current condition is not severe may increase the severity of problems associated with that drug use, increasing severity by producing arrests, job loss, and conflicts with the child welfare system.
3. *Secure Financing.* The following section of this chapter will provide some suggestions on this challenging and often complex task.

Figure 3-5
Assessing the Agency's Potential To Serve Clients With COD

1. Describe the profile of current clients with COD and any potential changes anticipated.
   - Estimate the prevalence of persons with COD among the agency's clients. (One of the screening tools recommended in chapter 4 may be appropriate for this purpose.)
   - What are the demographics of persons with COD?
   - What functional problems do they have?
   - Are there clients with COD who seek care at the agency who are referred elsewhere? What is the profile of these clients?
2. Identify services needed by clients.
   - What services are needed by existing and potential clients?
3. Identify and assess resources available to meet client needs.
   - What services are immediately available to the program?
   - What services could be added within the program?
   - What services are available from the community that would enhance care?
   - How well are outside agencies meeting clients' needs?
4. Assess resource gaps.
   - What resources are needed to enhance treatment for persons with COD?
   - What can your agency, specifically, do to enhance its capacity to serve these clients?
5. Assess capacity.
   - Realistically assess the capacity of your agency to address these resource gaps.
6. Develop a plan to enhance capacity to treat clients with COD.
   - How can the skills of existing staff be increased?
   - Can additional expertise be accessed through consulting agreements or similar arrangements?
   - What additional programs or services can be offered?
   - What sources of funding might support efforts to enhance capacity?

4. *Purchase Effective Services.* It is important to purchase services that research has shown to be effective. Unfortunately, COD research tends to focus on those with serious mental disorders. As a result, guidance on which strategies are most cost-effective in treating persons with less serious mental disorders and co-occurring substance use disorders is not readily available.
5. *Purchase Performance.* NASMHPD and NASADAD strongly recommend performance-based contracts that focus on outcomes. "A program's effectiveness should be judged not only by how many people it serves or units of service it delivers, but rather by the level of real change it helps bring about in the lives of consumers who have co-occurring mental health and substance use disorders" (NASMHPD and NASADAD 2000).
6. *Evaluate and Improve.* It is essential to evaluate performance. Findings help providers revise protocols to get better

Figure 3-6

Financing a Comprehensive System of Care for People With COD

Key System Development Components

- Provide Leadership/Build Consensus
- Identify Resources
- Develop New Models/Train Staff
- Decide on Outcomes
- Evaluate Program

Financing Principles

- Plan To Purchase Together
- Define the Population
- Secure Financing
- Purchase Effective Services
- Purchase Performance
- Evaluate and Improve

Source: NASMHPD and NASADAD 2000, p. 19.

results and give them a vital two-way channel for communicating with key stakeholders (NASMHPD and NASADAD 2000).

Federal funding opportunities

Federal funding opportunities include a variety of grants from diverse agencies. In its efforts to enhance services, the Substance Abuse and Mental Health Services Administration (SAMHSA) is currently emphasizing the use of strategies that have been demonstrated to be effective in research ("science to service").

Other Federal agencies such as the National Institutes of Health (NIH), including the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the National Institute of Mental Health (NIMH), emphasize funds for research and likely will provide only modest funds for treatment—typically in conjunction with research projects. Overall, SAMHSA will focus on working with States and helping communities use the latest research findings to implement effective treatment and prevention programs, while NIH institutes will conduct research on best practices in substance abuse treatment, prevention, and mental health services. The reader can determine what funding opportunities are currently available by visiting funder Web sites (e.g., SAMHSA's Web site at www.samhsa.gov, NIDA's Web site at www.nida.nih.gov, NIAAA's Web site at www.niaaa.nih.gov, and NIMH's Web site at www.nimh.nih.gov).

Although SAMHSA and NIH probably will remain the main Federal funding sources for initiatives related to people with COD, other Federal agencies also may provide funding opportunities. Examples of such Federal agencies include the Health Resources and Services Administration within the U.S. Department of Health and Human Services, the U.S. Department of Justice, the U.S. Department of Labor, and so on. The reader can determine what funding opportunities are currently available by visiting the Web sites of these agencies or by searching the Catalog of Federal Domestic Assistance Web site (www.cfda.gov), which provides a database of all Federal programs available to State and local governments (including the District of Columbia); federally recognized Indian tribal governments; Territories (and possessions) of the United States; domestic public, quasi-public, and private profit and nonprofit organizations and institutions; specialized groups; and individuals.

State funding opportunities

Administrators or treatment professionals should be familiar with the funding mechanisms in their State. Information is also avail-

able through the National Association of State Alcohol/Drug Abuse Directors (www.nasadad.org) and the National Association of State Mental Health Program Directors (www.nasmhpd.org).

Private funding opportunities

Foundation matching funds can be used to leverage change within a system in specific areas and increasingly should be explored in the area of COD treatment. For example, Robert Wood Johnson Foundation funding has driven improved access to primary care within addiction services.

A wide variety of funding initiatives exist in health care, including in the area of substance abuse treatment. Eligibility and procedures for getting funding will vary depending on the specific foundation. The best procedure is to use the Web site of the Foundation Center (www.fdncenter.org) to identify a possible funder, then call or write to ask for information on its current funding interests and application procedures. The Web site allows visitors to search profiles of more than 65,000 private and community foundations. The Foundation Center also produces a CD-ROM version of its database and print publications containing information on grants. Among the many foundations that have a broad interest in this field are the Ittleson Foundation, Inc., the van Ameringen Foundation, the Trull Foundation, the Carlisle Foundation, the Mary Owen Border Foundation, and the Chevron Corporation.

For the most part, private funding provides an opportunity to enhance existing larger programs with a specific "add-on" service, such as employment counseling or a substance abuse prevention group for children of people who abuse substances. Programs can be significantly strengthened through the aggressive pursuit of available grants and by combining several funding opportunities. Treatment providers seeking funding should not overlook the possibility that major businesses operating in their geographic area may have charitable foundations that could be tapped for promising program initiatives.

Attaining Equitable Allocation of Resources

It is recognized that the acquisition of adequate program resources is both a challenging and essential task. Moreover, though a number of advances have been made in recent years in the treatment of people with COD, systems of care across the country often have not improved accordingly. For example, while programs are now working to treat COD in an integrated manner, mental health services and substance abuse treatment still are funded separately. This can cause programs to spend significantly increased amounts of time in administrative tasks needed to acquire funds for a client's treatment through multiple streams. Also, payors in many places continue to fund treatment using an acute care model, even though treatment providers recognize that clients can present with long-term disorders.

In addition to the amount of money spent on COD, it is important to address issues of efficiency. One study of the expenditures on COD found that annual spending per client with COD in 1997 was $5,000 to $11,000 (depending on the State), which is nearly twice as high as clients with mental disorders only and nearly four times as high as clients with substance use disorders only.

Clients with COD compared to clients with a single diagnosis receive more treatment services of the major types—hospital inpatient, residential, and outpatient services. While clients with COD do not remain in the hospital as long as clients with mental disorders only, they do stay longer in residential treatment than clients with single diagnoses.

Clients with COD have higher outpatient expenses. Those expenses are 40 to over 100 percent higher than those of clients with mental disorders only, and 200 to over 300 percent higher than those of clients with substance use

disorders only. The average amount spent for outpatient treatment is $2,700 to $4,600 per client with COD.

In addressing COD, it is also important to look at medication costs when addressing the issue of equitable allocation of resources. In the three States reviewed, the estimated costs for those with mental disorders only and with COD was about $400 to $600 per person per year. However, clients with substance use disorders only generally do not get prescription medication therapy; their medication spending range was $100 to $200.

> To be effective, resources must be used to implement the evidence-based practices most appropriate to the client population and the program needs.

When looking at the existing allocation of resources for clients with COD and the demographics of covered clients, the three-State estimated study found that they are more likely to be adults over the age of 18 and are more likely to be male, but less likely to be minorities, than are clients with single diagnoses. They are also more likely to be the exclusive responsibility of mental health or substance abuse agencies rather than Medicaid's total responsibility; across the three States, 40 to 84 percent of clients with COD receive services only from mental health or substance abuse agencies.

The Expenditures on Treatment of Co-Occurring Mental and Substance Use Disorders reference study involved only three States: Delaware, Oklahoma, and Washington. However, the data presented raise the issue of efficiency and effectiveness rather than cost. For those with more serious mental illness, strategies that are more efficient may make the better use of the larger amounts spent on those with COD, rather than creating disturbances in the existing system by forcing the shifting of resources from the treatment of those with either substance use disorders or mental disorders only.

Ultimately, we are challenged not only to advocate on behalf of our own programs and clients, but for systemic change. Effective advocacy will help ensure that resources are allocated in a manner that takes appropriate cognizance of the needs of our clients and the complexity of the treatment field for clients with COD. However, in any advocacy caution against unintended consequences must be taken; with the de-institutionalization of patients hospitalized for severe and persistent mental illnesses, the expected reallocation of funds did not occur as expected.

Any savings that could come from integrated treatment must not be diverted into general revenues. Any efficiencies that result from more effective treatment of those without COD, but with mental disorders or substance use disorders alone, should be invested into integrated treatment. Any transformation of the existing system of care that results in a decrease in access to substance abuse treatment for those without COD will only create stresses in the criminal justice, workplace, and child welfare systems.

Integrating Research and Practice

To be effective, resources must be used to implement the evidence-based practices most appropriate to the client population and the program needs. The importance of the transfer of knowledge and technology has come to be well understood. Conferences to explore "bridging the gap" between research and field practice are now common.

Although not specific to COD, these efforts have clear implications for our attempts to share knowledge of what is working for clients

with COD. As emphasized in the 1998 report by Lamb and colleagues, *Bridging the Gap Between Research and Practice*, there is a need for, and value in, "enhancing collaborative relationships between the drug abuse research community and the world of community-based treatment programs" (Lamb et al. 1998, p. v). Brown (1998) has underscored the fundamental importance of making research relevant to practice, emphasizing the need for new government initiatives that focus on interpersonal contacts to achieve organizational change and that promote technology transfer as a significant area of investigation.

Several recent government initiatives highlight this effort and are described in *Changing the Conversation* (CSAT 2000*a*). They include

- Practice Improvement Collaboratives (SAMHSA/CSAT)
- Clinical Trials Network Program (NIH/NIDA)
- Improving the Delivery of Alcohol Treatment and Prevention Services (NIH/NIAAA)
- Evidence-based Practice Centers (Agency for Healthcare Research and Quality)
- The Addiction Technology Transfer Centers (SAMHSA/CSAT)
- The Knowledge Application Program (SAMHSA/CSAT)
- Researcher in Residence Program (NIH/NIAAA)

CSAT's Practice Improvement Collaboratives

Knowledge exchange is one of the most critical elements in efforts to move best practices in substance abuse treatment to community programs working on the front lines of substance abuse interventions. Formerly known as the Practice/Research Collaboratives, the Practice Improvement Collaboratives program—designed, in part, to achieve this goal—supports the development of collaborations among a broad spectrum of substance abuse treatment organizations (including, but not limited to, community-based treatment organizations, units of government, colleges, universities, and other public research entities). Key objectives of the program include the following:

- To develop and sustain community involvement in, and commitment to, practice improvement in the delivery of substance abuse treatment services.
- To improve the quality of substance abuse treatment through the adoption of evidence-based practices in community-based treatment organizations.
- To identify successful methods and models for implementing evidence-based practices in community-based treatment organizations.

Workforce Development and Staff Support

This section focuses on some key issues providers face in developing a workforce able to meet the needs of clients with COD. These include

- The attitudes and values providers must have to work successfully with these clients
- Essential competencies for clinicians (basic, intermediate, and advanced)
- Opportunities for continuing professional development
- Ways to avoid burnout and reduce turnover—common problems for any substance abuse treatment provider, but particularly so for those who work with clients who have COD

The consensus panel underscores the importance of an investment in creating a supportive environment for staff that encourages professional development to include skill acquisition, values clarification, training, and competency attainment equal to an investment in new COD program development. An organizational commitment to both is necessary for successful implementation of programs. Examples of staff

support may include standards of practice related to consistent high-quality supervision, favorable tuition reimbursement and release time policies, helpful personnel policies related to bolstering staff wellness practices, and incentives or rewards for work-related achievement, etc. Together these elements help in the creation of needed infrastructure for quality of service.

Attitudes and Values

Attitudes and values guide the way providers meet client needs and affect the overall treatment climate. They not only determine how the client is viewed by the provider (thereby generating assumptions that could either facilitate or deter achievement of the highest standard of care), but also profoundly influence how the client feels as he or she experiences a program. Attitudes and values are particularly important in working with clients with COD since the counselor is confronted with two disorders that require complex interventions.

The essential attitudes and values for working with clients with COD shown in Figure 3-7 are adapted from Technical Assistance Publication 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (Center for Substance Abuse Treatment 1998*a*). The consensus panel believes these attitudes and values also are consistent with the attitudes and values of the vast majority of those who commit themselves to the challenging fields of substance abuse treatment and mental health services.

Clinicians' Competencies

Clinicians' competencies are the specific and measurable skills that counselors must possess. Several States, university programs, and expert committees have defined the key competencies for working with clients with COD. Typically, these competencies are developed by training mental health and substance abuse treatment counselors together, often using a case-based approach that allows trainees to experience the insights each field affords the other.

One challenge of training is to include culturally sensitive methods and materials that reflect consideration for the varying levels of expertise and background of participants. The consensus panel recommends viewing competencies as basic, intermediate, and advanced to foster continuing professional development of all counselors and clinicians in the field of COD. This classification does not crosswalk with the program classification system using the same terminology illustrated in Figure 3-2 (p. 44) and is derived from various sources. Clearly, the sample competencies listed within each category cannot be completely separated from each other (e.g., competencies in the "basic" category may require some competency in the "intermediate" category). Some of the categorizations may be debatable, but the grouping within each category reflects, on the whole, different levels of clinician competency.

Providers in the field face unusual challenges and often provide effective treatment while working within their established frameworks. In fact, research studies previously cited have established the effectiveness of substance abuse treatment approaches in working with persons who have low- to moderate-severity mental disorders. Still, the classification of competencies supports continued professional development and promotes training opportunities.

Basic competencies

Every substance abuse treatment and mental health service program should require counselors to have certain basic skills. In keeping with the principle that there is "no wrong door," the consensus panel recommends that clinicians working in substance abuse treatment settings should be able to carry out the mental-health–related activities shown in Figure 3-8 (p. 58).

Figure 3-7

Essential Attitudes and Values for Clinicians Who Work With Clients Who Have COD

- Desire and willingness to work with people who have COD
- Appreciation of the complexity of COD
- Openness to new information
- Awareness of personal reactions and feelings
- Recognition of the limitations of one's own personal knowledge and expertise
- Recognition of the value of client input into treatment goals and receptivity to client feedback
- Patience, perseverance, and therapeutic optimism
- Ability to employ diverse theories, concepts, models, and methods
- Flexibility of approach
- Cultural competence
- Belief that all individuals have strengths and are capable of growth and development (added by consensus panel)
- Recognition of the rights of clients with COD, including the right and need to understand assessment results and the treatment plan

Intermediate competencies

Intermediate competencies encompass skills in engaging substance abuse treatment clients with COD, screening, obtaining and using mental health assessment data, treatment planning, discharge planning, mental health system linkage, supporting medication, running basic mental disorder education groups, and implementing routine and emergent mental health referral procedures. In a mental health unit, mental health providers would exhibit similar competencies related to substance use disorders. The consensus panel recommends the intermediate level competencies shown in Figure 3-9 (p. 59), developed jointly by the New York State Office of Mental Health and the New York State Office of Alcohol and Substance Abuse Services.

Advanced competencies

At the advanced level, the practitioner goes beyond an awareness of the addiction and mental health fields as individual disciplines to a more sophisticated appreciation for how co-occurring disorders interact in an individual. This enhanced awareness leads to an improved ability to provide appropriate integrated treatment. Figure 3-10 (p. 60) gives examples of advanced skills.

Continuing Professional Development

The consensus panel is aware that many providers in the substance abuse treatment and mental health services fields have performed effectively the difficult task of providing services for clients with COD, until recently without much guidance from an existing body of knowledge or available systematic approaches. The landscape has changed and a solid knowledge base is now available to the counselor, although that knowledge typically is scattered through many journals and reports. This TIP makes an effort to integrate the available information. Counselors reading this TIP can review their own knowledge and determine what they need to continue their professional development.

At the time of this writing, Arizona, Connecticut, Illinois, New Mexico, New York,

Figure 3-8

Examples of Basic Competencies Needed for Treatment of Persons With COD

- Perform a basic screening to determine whether COD might exist and be able to refer the client for a formal diagnostic assessment by someone trained to do this.
- Form a preliminary impression of the nature of the disorder a client may have, which can be verified by someone formally trained and licensed in mental health diagnosis.
- Conduct a preliminary screening of whether a client poses an immediate danger to self or others and coordinate any subsequent assessment with appropriate staff and/or consultants.
- Be able to engage the client in such a way as to enhance and facilitate future interaction.
- De-escalate the emotional state of a client who is agitated, anxious, angry, or in another vulnerable emotional state.
- Manage a crisis involving a client with COD, including a threat of suicide or harm to others. This may involve seeking out assistance by others trained to handle certain aspects of such crises; for example, processing commitment papers and related matters.
- Refer a client to the appropriate mental health or substance abuse treatment facility and follow up to ensure the client receives needed care.
- Coordinate care with a mental health counselor serving the same client to ensure that the interaction of the client's disorders is well understood and that treatment plans are coordinated.

and Pennsylvania have developed consensus guidelines that define the competencies substance abuse treatment counselors should have to claim expertise in this area. Others are in the process of identifying mechanisms for licensing or certifying expertise in COD. Counselors may check with their States' certification bodies to determine whether training leading to formal credentials in counseling persons with co-occurring disorders is available. Appendix I identifies some resources counselors can use to enhance their professional knowledge and development.

Education and training

Discipline-specific education

Staff education and training are fundamental to all substance abuse treatment programs. Although there have been improvements in the past decade, there are still very few university-based programs that offer a formal curriculum on COD. Numerous observers have commented on the lack of adequate discipline-based training for professionals in the substance abuse treatment field (Brown 1996; Galanter 1989; Miller and Brown 1997).

Many professional organizations are promoting the development of competencies and practice standards for intervening with substance abuse problems, including the Council on Addictions of the American Psychiatric Association; the American Academy of Addiction Psychiatry; the American Osteopathic Academy of Addiction Medicine; American Psychological Association; the American Society of Addiction Medicine; the Association for Medical Education and Research on Substance Abuse; the American Association of Obstetricians and Gynecologists; the Alcohol, Tobacco and Other Addictions Section of the National Association of Social Workers; and the International Nurses Society on Addictions. They are also specifically encouraging faculty members to enhance their knowledge in this area so they can better prepare their students to meet the needs of clients with COD. The consensus panel encourages all such organizations to identify standards and competencies for their member-

ship related to COD and to encourage the development of training for specific disciplines.

Since the consequences of both addiction and mental disorders can present with physical or psychiatric manifestations, it is equally important for medical students, internal medicine and general practice residents, and general psychiatry residents to be educated in the problems of COD. Too few hours of medical education are devoted to the problems of addiction and mental disorders. Since pharmacologic therapies play a critical role in the treatment of those with COD, it is important to have adequately trained physicians who can manage the medication therapies for those clients.

Continuing education and training

Many substance abuse treatment counselors learn through continuing education and facility-sponsored training. Continuing education and training involves participation in a variety of courses and workshops from basic to advanced level offered by a number of training entities (see appendix I). The strength of continuing education and training courses and workshops is that they provide the counselor with the opportunity to review and process written material with a qualified instructor and other practitioners.

Continuing education is useful because it can respond rapidly to the needs of a workforce that has diverse educational backgrounds and experience. To have practical utility, competency training must address the day-to-day issues that counselors face in working with clients with COD. The educational context must be rich with information, culturally sensitive, designed for adult students, and must include examples and role models. It is optimal if the instructors have extensive experience as practitioners in the field. Figure 3-11 (p. 61) provides an example description for one of many possible continuing education courses in this dynamic field.

Continuing education is essential for effective provision of services to people with COD, but it is not sufficient in and of itself. Counselors must have ongoing support, supervision, and opportunity to practice new skills if they are to truly integrate COD content into their practice.

Figure 3-9

Six Areas of Intermediate-Level Competencies Needed for the Treatment of Persons With COD

- ***Competency I:*** **Integrated Diagnosis of Substance Abuse and Mental Disorders.** Differential diagnosis, terminology (definitions), pharmacology, laboratory tests and physical examination, withdrawal symptoms, cultural factors, effects of trauma on symptoms, staff self-awareness
- ***Competency II:*** **Integrated Assessment of Treatment Needs.** Severity assessment, lethality/risk, assessment of motivation/readiness for treatment, appropriateness/treatment selection
- ***Competency III:*** **Integrated Treatment Planning.** Goal-setting/problemsolving, treatment planning, documentation, confidentiality,[1] legal/reporting issues, documenting issues for managed care providers
- ***Competency IV:*** **Engagement and Education.** Staff self-awareness, engagement, motivating, educating
- ***Competency V:*** **Early Integrated Treatment Methods.** Emergency/crisis intervention, knowledge and access to treatment services, when and how to refer or communicate
- ***Competency VI:*** **Longer Term Integrated Treatment Methods.** Group treatment, relapse prevention, case management, pharmacotherapy, alternatives/risk education, ethics, confidentiality,[1] mental health, reporting requirements, family interventions

[1]Confidentiality is governed by the Federal "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations (42 C.F.R. Part 2) and the Federal "Standards for Privacy of Individually Identifiable Health Information" (45 C.F.R. Parts 160 and 164).

Figure 3-10

Examples of Advanced Competencies in the Treatment of Clients With COD

- Use the current edition of criteria from the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (American Psychiatric Association 2000) to assess substance-related disorders and Axis I and Axis II mental disorders.
- Comprehend the effects of level of functioning and degree of disability related to both substance-related and mental disorders, separately and combined.
- Recognize the classes of psychotropic medications, their actions, medical risks, side effects, and possible interactions with other substances.
- Use integrated models of assessment, intervention, and recovery for persons having both substance-related and mental disorders, as opposed to parallel treatment efforts that resist integration.
- Apply knowledge that relapse is not considered a client failure but an opportunity for additional learning for all. Treat relapses seriously and explore ways of improving treatment to decrease relapse frequency and duration.
- Display patience, persistence, and optimism.
- Collaboratively develop and implement an integrated treatment plan based on thorough assessment that addresses both/all disorders and establishes sequenced goals based on urgent needs, considering the stage of recovery and level of engagement.
- Involve the person, family members, and other supports and service providers (including peer supports and those in the natural support system) in establishing, monitoring, and refining the current treatment plan.
- Support quality improvement efforts, including, but not limited to consumer and family satisfaction surveys, accurate reporting and use of outcome data, participation in the selection and use of quality monitoring instruments, and attention to the need for all staff to behave respectfully and collaboratively at all times.

Source: Adapted from Minkoff 1999.

Cross-training

Cross-training is the simultaneous provision of material and training to more than one discipline at a time (e.g., substance abuse and social work counselors; substance abuse counselors and corrections officers). Counselors who have primary expertise in either substance abuse or mental health will be able to work far more effectively with clients who have COD if they have some degree of cross-training in the other field. The consensus panel recommends that counselors of either field receive at least basic level cross-training in the other field to better assess, refer, understand, and work effectively with the large number of clients with COD. Cross-trained individuals who know their primary field of training well, and also have an appreciation for the other field, provide a richness of capacity that cannot be attained using any combination of personnel familiar with one system alone.

When training is offered in this manner, interaction and communication between the counselors from each discipline is facilitated. This helps to remove barriers, increase understanding, and promote integrated work. Cross-training is particularly valuable for staff members who will work together in the same program. Consensus panel members have found cross-training very valuable in mental health, substance abuse, and criminal justice settings.

Program orientation and ongoing supervision

Orientation. Staff education and training have two additional components: (1) a statement of program orientation that clearly presents the mission, values, and aims of service delivery, and (2) strong, ongoing supervision. The orientation can use evidence-based initiatives as well as promising practices. Successful program orientation for working with clients with COD will equip staff members with skills and decisionmaking tools that will enable them to provide optimal services in real-world environments.

Supervision. Many agree that relational skills are requisite for staff working in COD programs (Gerber and Basham 1999; Martino et al. 2000; Miller 2000*b*), skills that are best learned though direct supervision. Active listening, interviewing techniques, the ability to summarize, and the capacity to provide feedback are all skills that can be best modeled by a supervisor. Strong, active supervision of ongoing cases is a key element in assisting staff to develop, maintain, and enhance relational skills.

National training resources

Training resources. Curricula and other forms of educational materials are available through Addiction Technology Transfer Centers (ATTCs), universities, State entities, and private consultants. These materials can help enhance the ability of substance abuse treatment counselors to work with clients who have mental disorders, as well as to enable mental health personnel to improve their efforts with persons with substance use disorders. ATTCs offer workshops, courses, and online remote location courses. (See appendix I for training sources.)

Figure 3-11

Treatment Planning and Documentation Issues for Mental and Substance Use Disorders

Description

This course provides an opportunity for participants to review the principles of collaborative treatment planning, including working from a comprehensive assessment; identifying and mutually setting long- and short-term goals; identifying steps for accomplishing goals, the persons responsible for collaborative treatment planning, and a defined timeline; and reviewing and altering such plans when necessary. Progress tracking is reviewed, including how to write clear and concise notes, and the principles for their review. This course focuses on effective treatment principles and the practices of writing and reviewing plans.

Course Objectives

By the end of this course, participants will be able to

- Review the principles and processes that support thorough and accurate assessment and diagnosis, including strengths-based interviewing skills and cultural diversity issues.
- Examine each step in treatment/service planning, its rationale, and the similarities and differences in service and treatment planning.
- Describe the importance of the person with COD having active involvement and real choice in all post-acute treatment planning processes (and some means for incorporating these features in acute care settings).
- Identify means of writing brief and useful progress notes that support movement toward positive outcomes.
- Discuss means of using progress notes with the person as a useful piece of the ongoing treatment/service process.

Source: Supplied by consensus panelist Donna McNelis, Ph.D.

Listservs and discussion lists. There are a number of e-mail listservs and Internet discussion groups on the topic of COD (e.g., *Co-Occurring Dialogues, The Dual Diagnosis Listserv, The Dual Diagnosis Bulletin Board, The Dual Diagnosis Pages: Colleagues List,* and *MIDAS: A Discussion Group*). These online communication networks offer members the opportunity to post suggestions or questions to a large number of people at the same time. Listservs are generally geared more toward professionals and are more closely monitored. Discussion groups usually are open to anyone, and may not be monitored closely. (See appendix I for more detailed descriptions of the listservs and discussion groups mentioned above.)

COD certification in health disciplines

The disciplines of medicine and psychology have recognized subspecialties in COD with a defined process for achieving a certificate in this area. Figure 3-12 summarizes current information on certification by discipline.

Avoiding Burnout and Reducing Staff Turnover

Burnout

Often, substance abuse and mental health clinicians are expected to manage growing and more complex caseloads. "Compassion fatigue" may occur when the pressures of work erode a counselor's spirit and outlook and begin to interfere with the counselor's personal life (see TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* [CSAT 2000*d*], p. 64.) Assisting clients who have COD is difficult and emotionally taxing; the danger of burnout is considerable. It is especially important that program administrators maintain awareness of the problem of burnout and the benefits of reducing turnover. It is vital that staff feel that program administrators are interested in their well-being in order to sustain morale and esprit de corps.

To lessen the possibility of burnout when working with a demanding caseload that includes clients with COD, the consensus panelists for TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*d*, p. 64) suggest that program directors and supervisors assist counselors to

- Work within a team structure rather than in isolation.
- Build in opportunities to discuss feelings and issues with other staff who handle similar cases.
- Develop and use a healthy support network.
- Maintain the caseload at a manageable size.
- Incorporate time to rest and relax.
- Separate personal and professional time.

Most important, supervision should be supportive, providing guidance and technical knowledge.

Farmer (1995) found that much of the perceived stress among substance abuse treatment counselors was attributable to workload factors and factors relating to management—for example, authoritarian and controlling management styles that allow staff too little autonomy and command over their own work. Performance goals should be realistic and clearly understood. Supervision should be not only a means of ensuring standards of practice, but also a way of encouraging and enabling professional growth.

Grosch and Olsen (1994) suggest that when professionals begin to exhibit signs of boredom or malaise, varying the nature of the job is a helpful strategy. This can be accomplished via a negotiated dialog with the supervisor that is initiated by a staff member who requests an opportunity to try new or differing activities.

Some programs have proactively addressed the issue of burnout among staff to help staff

Figure 3-12 Certification in Health Professions	
Health Profession	**Certification in Co-Occurring Disorders**
Physicians	Physicians from any specialty, including primary care, psychiatry, and internal medicine can become certified by ASAM. Psychiatrists can receive added qualifications in Addiction Psychiatry through the formal American College of Graduate Medical Education Board Certification process or through the American Academy of Addiction Psychiatry. Osteopathic physicians from any specialty can receive addiction qualifications though the American Osteopathic Association. www.asam.org www.aaap.org www.http://www.osteopathic.org
Psychologists	Psychologists may achieve a "Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders" through the American Psychological Association's College of Professional Psychology. (As of January 1, 2011, APA stopped offering this certificate but continues to support the credential for previously certified psychologists; see http://www.apapracticecentral.org/ce/courses/index.aspx.)
Social Workers	The Alcohol, Tobacco and Other Addictions Section of the National Association of Social Workers offers a curriculum leading to a certificate of specialty in addiction. www.naswdc.org/

morale, improve care, and reduce turnover in their program. Pavillon International, an addiction treatment residential program in North Carolina, proactively addresses burnout by placing high values on staff well-being; routinely discussing well-being issues; providing activities such as retreats, weekend activities, yoga, and other healing activities at the work site; and creating a network of ongoing support.

Turnover

The issue of staff turnover is especially important for staff working with clients with COD because of the limited workforce pool and the high investment of time and effort involved in developing a trained workforce. It matters, too, because of the crucial importance of the treatment relationship to successful outcomes. Rapid turnover disrupts the context in which recovery occurs. Clients in such agencies may become discouraged about the possibility of being helped by others.

Turnover sometimes results from the unique professional and emotional demands of working with clients with COD. On the other hand, most providers in this area are unusually dedicated and find the work to be rewarding. Figure 3-13 (p. 64) provides some methods for reducing staff turnover.

Conclusion: Workforce Development

In concluding this section on workforce development, the consensus panel strongly encourages counselors to acquire the competencies needed to work effectively with clients who have COD. The difficulty of juggling a high and demanding workload and the desire for contin-

ued professional development should be recognized and accommodated. To the extent possible, education and training efforts should be customized—in terms of content, schedule, and location—to meet the needs of the counselors in the field. That is, bring the training to the counselor. Agency and program administrators, including both line-level and clinical supervisors, are urged to demonstrate support and encouragement for the continuing education and training of the workforce, as well as develop COD competencies themselves. Rewards can include both salary and advancement tied to the counselor's efforts to increase his or her effectiveness in serving clients with COD, as demonstrated by job performance. Naturally, non-counselor clinicians working in primary care settings, community mental health centers, or private mental health offices also should enhance their knowledge of alcohol

Figure 3-13
Reducing Staff Turnover in Programs for Clients With COD

To decrease staff turnover, whenever possible, programs should

- Hire staff members who have familiarity with both substance abuse and mental disorders and have a positive regard for clients with either disorder.
- Hire staff members who are critically minded and can think independently, but who are also willing to ask questions and listen, remain open to new ideas, maintain flexibility, work cooperatively, and engage in creative problemsolving.
- Provide staff with a framework of realistic expectations for the progress of clients with COD.
- Provide opportunities for consultation among staff members who share the same client (including medication providers).
- Ensure that supervisory staff members are supportive and knowledgeable about issues specific to clients with COD.
- Provide and support opportunities for further education and training.
- Provide structured opportunities for staff feedback in the areas of program design and implementation.
- Promote sophistication about, and advocacy for, COD issues among administrative staff, including both those in decisionmaking positions (e.g., the director and clinical director) and others (e.g., financial officers, billing personnel, and State reporting monitors).
- Provide a desirable work environment through adequate compensation, salary incentives for COD expertise, opportunities for training and for career advancement, involvement in quality improvement or clinical research activities, and efforts to adjust workloads.

4 Assessment

In This Chapter…

Screening and Basic Assessment for COD

The Assessment Process

Overview

This chapter consists of three parts: (1) an overview of the basic screening and assessment approach that should be a part of any program for clients with co-occurring disorders (COD); (2) an outline of the 12 steps to an ideal assessment, including some instruments that can be used in assessing COD; and (3) a discussion of key considerations in treatment matching.

Ideally, information needs to be collected continuously, and assessments revised and monitored as the client moves through recovery. A comprehensive assessment as described in the main section of this chapter leads to improved treatment planning, and it is the intent of this chapter to provide a model of optimal process of evaluation for clients with COD and to encourage the field to move toward this ideal. Nonetheless, the panel recognizes that not all agencies and providers have the resources to conduct immediate and thorough screenings. Therefore, the chapter provides a description of the initial screening and the basic or minimal assessment of COD necessary for the initial treatment planning.

A basic assessment covers the key information required for treatment matching and treatment planning. Specifically, the basic assessment offers a structure with which to obtain

- Basic demographic and historical information, and identification of established or probable diagnoses and associated impairments
- General strengths and problem areas
- Stage of change or stage of treatment for both substance abuse and mental health problems
- Preliminary determination of the severity of the COD as a guide to final level of care determination

Note that medical issues (including physical disability and sexually transmitted diseases), cultural issues, gender-specific and sexual orientation issues, and legal issues always must be addressed, whether basic or more comprehensive assessment is performed. The consensus panel assumes

that appropriate procedures are in place to address these and other important issues that must be included in treatment planning. However, the focus of this chapter, in keeping with the purpose of this TIP, is on screening and assessment related to COD.

Screening and Basic Assessment for COD

This section provides an overview of the screening and assessment process for COD. In carrying out these processes, counselors should understand the limitations of their licensure or certification authority to diagnose or assess mental disorders. Generally, however, collecting assessment information is a legitimate and legal activity even for unlicensed providers, provided that they do not use diagnostic labels as conclusions or opinions about the client. Information gathered in this way is needed to ensure the client is placed in the most appropriate treatment setting (as discussed later in this chapter) and to assist in providing mental disorder care that addresses each disorder.

In addition, there are a number of circumstances that can affect validity and test responses that may not be obvious to the beginning counselor, such as the manner in which instructions are given to the client, the setting where the screening or assessment takes place, privacy (or the lack thereof), and trust and rapport between the client and counselor. Throughout the process it is important to be sensitive to cultural context and to the different presentations of both substance use and mental disorders that may occur in various cultures.

The following *Advice to the Counselor* section gives an overview of the basic "do's and don'ts" for assessing for COD. Detailed discussions of these important screening/assessment and cultural issues are beyond the scope of this TIP. For more information on basic screening and assessment information, see chapters 4 and 5 in Evans and Sullivan (2001), National Institute on Drug Abuse (NIDA) (1994), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (Allen and Wilson 2003). For information on cultural issues, see the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT] in development *a*).

Screening

Screening is a formal process of testing to determine whether a client does or does not warrant further attention at the current time in regard to a particular disorder and, in this context, the possibility of a co-occurring substance use or mental disorder. The screening process for COD seeks to answer a "yes" or "no" question: Does the substance abuse (or mental health) client being screened show signs of a possible mental health (or substance abuse) problem? Note that the screening process does not necessarily identify what kind of problem the person might have or how serious it might be, but determines whether or not further assessment is warranted. A screening process can be designed so that it can be conducted by counselors using their basic counseling skills. There are seldom any legal or professional restraints on who can be trained to conduct a screening.

Screening processes always should define a protocol for determining which clients screen positive and for ensuring that those clients receive a thorough assessment. That is, a professionally designed screening process establishes precisely how any screening tools or questions are to be scored and indicates what constitutes scoring positive for a particular possible problem (often called "establishing cut-off scores"). Additionally, the screening protocol details exactly what takes place after a client scores in the positive range and provides the necessary standard forms to be used to document both the results of all later assessments and that each staff member has carried out his or her responsibilities in the process.

So, what can a substance abuse treatment counselor do in terms of screening? All counselors can be trained to screen for COD. This screening often entails having a client respond to a specific set of questions, scoring those questions according to how the counselor was trained, and then taking the next "yes" or "no" step in the process depending on the results and the design of the screening process. In substance abuse treatment or mental health service settings, every counselor or clinician who conducts intake or assessment should be able to screen for the most common COD and know how to implement the protocol for obtaining COD assessment information and recommendations. For substance abuse treatment agencies that are instituting a mental health screening process, appendix H reproduces the Mental Health Screening Form-III (Carroll and McGinley 2001). This

Advice to the Counselor: Do's and Don'ts of Assessment for COD

1. *Do* keep in mind that assessment is about getting to know a person with complex and individual needs. Do not rely on tools alone for a comprehensive assessment.
2. *Do* always make every effort to contact all involved parties, including family members, persons who have treated the client previously, other mental health and substance abuse treatment providers, friends, significant others, probation officers as quickly as possible in the assessment process. (These other sources of information will henceforth be referred to as collaterals.)
3. *Don't* allow preconceptions about addiction to interfere with learning about what the client really needs (e.g., "All mental symptoms tend to be caused by addiction unless proven otherwise"). Co-occurring disorders are as likely to be underrecognized as overrecognized. Assume initially that an established diagnosis and treatment regime for mental illness is correct, and advise clients to continue with those recommendations until careful reevaluation has taken place.
4. *Do* become familiar with the diagnostic criteria for common mental disorders, including personality disorders, and with the names and indications of common psychiatric medications. Also become familiar with the criteria in your own State for determining who is a mental health priority client. Know the process for referring clients for mental health case management services or for collaborating with mental health treatment providers.
5. *Don't* assume that there is one correct treatment approach or program for any type of COD. The purpose of assessment is to collect information about multiple variables that will permit individualized treatment matching. It is particularly important to assess stage of change for each problem and the client's level of ability to follow treatment recommendations.
6. *Do* become familiar with the specific role that your program or setting plays in delivering services related to COD in the wider context of the system of care. This allows you to have a clearer idea of what clients your program will best serve and helps you to facilitate access to other settings for clients who might be better served elsewhere.
7. *Don't* be afraid to admit when you don't know, either to the client or yourself. If you do not understand what is going on with a client, acknowledge that to the client, indicate that you will work with the client to find the answers, and then ask for help. Identify at least one supervisor who is knowledgeable about COD as a resource for asking questions.
8. Most important, *do* remember that empathy and hope are the most valuable components of your work with a client. When in doubt about how to manage a client with COD, stay connected, be empathic and hopeful, and work with the client and the treatment team to try to figure out the best approach over time.

instrument is intended for use as a rough screening device for clients seeking admission to substance abuse treatment programs. (Note that while the consensus panel believes that this instrument is useful, it has received limited validation [Carroll and McGinley 2001].)

Basic Assessment

While both screening and assessment are ways of gathering information about the client in order to better treat him, assessment differs from screening in the following way:

- Screening is a process for evaluating the possible presence of a particular problem.
- Assessment is a process for defining the nature of that problem and developing specific treatment recommendations for addressing the problem.

A basic *assessment* consists of gathering key information and engaging in a process with the client that enables the counselor to understand the client's readiness for change, problem areas, COD diagnosis(es), disabilities, and strengths. An assessment typically involves a clinical examination of the functioning and well-being of the client and includes a number of tests and written and oral exercises. The COD diagnosis is established by referral to a psychiatrist, clinical psychologist, or other qualified healthcare professional. Assessment of the client with COD is an ongoing process that should be repeated over time to capture the changing nature of the client's status. Intake information consists of

1. Background—family, trauma history, history of domestic violence (either as a batterer or as a battered person), marital status, legal involvement and financial situation, health, education, housing status, strengths and resources, and employment
2. Substance use—age of first use, primary drugs used (including alcohol, patterns of drug use, and treatment episodes), and family history of substance use problems
3. Mental health problems—family history of mental health problems, client history of mental health problems including diagnosis, hospitalization and other treatment, current symptoms and mental status, medications, and medication adherence

In addition, the basic information can be augmented by some objective measurement, such as that provided in the University of Rhode Island Change Assessment Scale (URICA) (McConnaughy et al. 1983), Addiction Severity Index (ASI) (McLellan et al. 1992), the Mental Health Screening Form-III (Carroll and McGinley 2001), and the Symptom Distress Scale (SDS) (McCorkle and Young 1978) (see appendices G and H for further information on selected instruments). It is essential for treatment planning that the counselor organize the collected information in a way that helps identify established mental disorder diagnoses and current treatment. The text box on page 71 highlights the role of instruments in the assessment process.

Careful attention to the characteristics of past episodes of substance abuse and abstinence with regard to mental health symptoms, impairments, diagnoses, and treatments can illuminate the role of substance abuse in maintaining, worsening, and/or interfering with the treatment of any mental disorder. Understanding a client's mental health symptoms and impairments that persist during periods of abstinence of 30 days or more can be useful, particularly in understanding what the client copes with even when the acute effects of substance use are not present. For any period of abstinence that lasts a month or longer, the counselor can ask the client about mental health treatment and/or substance abuse treatment—what seemed to work, what did the client like or dislike, and why? On the other hand, if mental health symptoms (even suicidality or hallucinations) resolve in less than 30 days with abstinence from substances, then these symptoms are most likely substance induced and the best treatment is maintaining abstinence from substances.

The counselor also can ask what the mental health "ups and downs" are like for the client. That is, what is it like for the client

when he or she gets worse (or "destabilizes")? What—in detail—has happened in the past? And, what about getting better ("stabilizing")—how does the client usually experience that? Clinician and client together should try to understand the specific effects that substances have had on that individual's mental health symptoms, including the possible triggering of psychiatric symptoms by substance use. Clinicians also should attempt to document the diagnosis of a mental disorder, when it has been established, and determine diagnosis through referral when it has not been established. The consensus panel notes that many, if not most, individuals with COD have well-established diagnoses when they enter substance abuse treatment and encourages counselors to find out about any known diagnoses.

Treatment Planning

A comprehensive assessment serves as the basis for an individualized treatment plan. Appropriate treatment plans and treatment interventions can be quite complex, depending on what might be discovered in each domain. This leads to another fundamental principle:

- There is no single, correct intervention or program for individuals with COD. Rather, the appropriate treatment plan must be matched to individual needs according to these multiple considerations.

The following three cases illustrate how the above factors help to generate an integrated treatment plan that is appropriate to the needs and situation of a particular client.

Case 1: Maria M.

The client is a 38-year-old Hispanic/Latina woman who is the mother of two teenagers. Maria M. presents with an 11-year history of cocaine dependence, a 2-year history of opioid dependence, and a history of trauma related to a longstanding abusive relationship (now over for 6 years). She is not in an intimate relationship at present and there is no current indication that she is at risk for either violence or self-harm. She also has persistent major depression and panic treated with antidepressants. She is very motivated to receive treatment.

- ***Ideal Integrated Treatment Plan:*** The plan for Maria M. might include medication-assisted treatment (e.g., methadone or buprenorphine), continued antidepressant medication, 12-Step program attendance, and other recovery group support for cocaine dependence. She also could be

The Role of Assessment Tools

A frequent question asked by clinicians is

- What is the best (most valuable) assessment tool for COD?

The answer is

- There is no single gold standard assessment tool for COD. Many traditional clinical tools have a narrow focus on a specific problem, such as the Beck Depression Inventory (BDI) (Beck and Steer 1987), a list of 21 questions about mood and other symptoms of feeling depressed. Other tools have a broader focus and serve to organize a range of information so that the collection of such information is done in a standard, regular way by all counselors. The ASI, which is not a comprehensive assessment tool but a measure of addiction severity in multiple problem domains, is an example of this type of tool (McLellan et al. 1992). Not only does a tool such as the ASI help a counselor, through repetition, become adept at collecting the information, it also helps the counselor refine his or her sense of similarities and differences among clients. A standard mental status examination can serve a similar function for collecting information on current mental health symptoms. Despite the fact that there are some very good tools, no one tool is the equivalent of a comprehensive clinical assessment.

referred to a group for trauma survivors that is designed specifically to help reduce symptoms of trauma and resolve long-term issues.

Individual, group, and family interventions could be coordinated by the primary counselor from opioid maintenance treatment. The focus of these interventions might be on relapse prevention skills, taking medication as prescribed, and identifying and managing trauma-related symptoms without using. An appropriate long-term goal would be to establish abstinence and engage Maria in longer-term psychotherapeutic interventions to reduce trauma symptoms and help resolve trauma issues. On the other hand, if a local mental health center had a psychiatrist trained and licensed to provide Suboxone (the combination of buprenorphine and nalaxone), her case could be based in the mental health center.

Case 2: George T.

The client is a 34-year-old married, employed African-American man with cocaine dependence, alcohol abuse, and bipolar disorder (stabilized on lithium) who is mandated to cocaine treatment by his employer due to a failed drug test. George T. and his family acknowledge that he needs help not to use cocaine but do not agree that alcohol is a significant problem (nor does his employer). He complains that his mood swings intensify when he is using cocaine.

- ***Ideal Integrated Treatment Plan:*** The ideal plan for this man might include participation in outpatient addiction treatment, plus continued provision of mood-stabilizing medication. In addition, he should be encouraged to attend a recovery group such as Cocaine Anonymous or Narcotics Anonymous. The addiction counselor would provide individual, group, and family interventions. The focus might be on gaining the skills and strategies required to handle cocaine cravings and to maintain abstinence from cocaine, as well as the skills needed to manage mood swings without using substances. Motivational counseling regarding alcohol and assistance in maintaining medication (lithium) adherence also could be part of the plan.

Case 3: Jane B.

The client is a 28-year-old single Caucasian female with a diagnosis of paranoid schizophrenia, alcohol dependence, crack cocaine dependence, and a history of multiple episodes of sexual victimization. Jane B. is homeless (living in a shelter), actively psychotic, and refuses to admit to a drug or alcohol problem. She has made frequent visits to the local emergency room for both mental health and medical complaints, but refuses any followup treatment. Her main requests are for money and food, not treatment. Jane has been offered involvement in a housing program that does not require treatment engagement or sobriety but has refused due to paranoia regarding working with staff to help her in this setting. Jane B. refuses all medication due to her paranoia, but does not appear to be acutely dangerous to herself or others.

- ***Ideal Integrated Treatment Plan:*** The plan for Jane B. might include an integrated case management team that is either based in the shelter or in a mental health service setting. The team would apply a range of engagement, motivational, and positive behavioral change strategies aimed at slowly developing a trusting relationship with this woman. Engagement would be promoted by providing assistance to Jane B. in obtaining food and disability benefits, and using those connections to help her engage gradually in treatment for either mental disorders or addiction—possibly by an initial offer of help in obtaining safe and stable housing. Peer support from other

women also might be of value in promoting her sense of safety and engagement.

All of these cases are appropriate examples of integrated treatment. The purpose of the assessment process is to develop a method for gathering information in an organized manner that allows the clinician to develop an appropriate treatment plan or recommendation. The remainder of this chapter will discuss how this assessment process might occur, and how the information gathered leads to a rational process of treatment planning. In Step 12 of the assessment process, readers will find an expanded treatment plan for the three clients discussed above.

The Assessment Process

This chapter is organized around 12 specific steps in the assessment process. Through these steps, the counselor seeks to accomplish the following aims:

- To obtain a more detailed chronological *history* of past mental symptoms, diagnosis, treatment, and impairment, particularly before the onset of substance abuse, and during periods of extended abstinence.
- To obtain a more detailed description of *current* strengths, supports, limitations, skill deficits, and cultural barriers related to following the recommended treatment regimen for any disorder or problem.
- To determine *stage of change for each problem,* and identify external contingencies that might help to promote treatment adherence.

Note that although the steps appear sequential, in fact some of them could occur simultaneously or in a different order, depending on the situation. It is particularly important to identify and attend to any acute safety needs, which often have to be addressed before a more comprehensive assessment process can occur. Sometimes, however, components of the assessment process are essential to address the client's specific safety needs. For example, if a person is homeless, more information on that person's mental status, resources, and overall situation is required to address that priority appropriately. Finally, it must be recognized that while the assessment seeks to identify individual needs and vulnerabilities as quickly as possible to initiate appropriate treatment, assessment is an ongoing process: As treatment proceeds and as other changes occur in the client's life and mental status, counselors must actively seek current information rather than proceed on assumptions that might be no longer valid.

In the following discussion, validated assessment tools that are available to assist in this process are discussed with regard to their utility for counselors. There are a number of tools that are *required* by various States for use in their addiction systems (e.g., ASI [McLellan et al. 1992], American Society of Addiction Medicine (ASAM) Patient Placement Criteria [ASAM PPC-2R]). Particular attention will be given to the role of these tools in the COD assessment process, suggesting strategies to reduce duplication of effort where possible. It is beyond the scope of this TIP to provide detailed instructions for administering the tools mentioned in this TIP (with the exceptions of the Mental Health Screening Form-III [MHSF-III] and the Simple Screening Instrument for Substance Abuse [SSI-SA] in appendix H). Basic information about each instrument is given in appendix G, and readers can obtain more detailed information regarding administration and interpretation from the sources given for obtaining these instruments.

As a final point, this discussion primarily is directed toward substance abuse treatment clinicians working in substance abuse treatment settings, though many of the steps apply equally well to mental health clinicians in mental health settings. At certain key points in the discussion, particular information relevant to mental health clinicians is identified and described.

Assessment Step 1: Engage the Client

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 regarding mental health problems, substance use disorders, and related issues. The aim is to create a safe and nonjudgmental environment in which sensitive personal issues may be discussed. Counselors should recognize that cultural issues, including the use of the client's preferred language, play a role in creating a sense of safety and promote accurate understanding of the client's situation and options. Such issues therefore must be addressed sensitively at the outset and throughout the assessment process.

The consensus panel identified five key concepts that underlie effective engagement during the initial clinical contact: universal access ("no wrong door"), empathic detachment, person-centered assessment, cultural sensitivity, and trauma sensitivity. All staff, as well as substance abuse treatment and mental health clinicians, in any service setting need to develop competency in engaging and welcoming individuals with COD. It is also important to note that while engagement is presented here as the first necessary step for assessment to take place, in a larger sense engagement represents an ongoing concern of the counselor—to understand the client's experience and to keep him or her positive and engaged relative to the prospect of better health and recovery.

No wrong door

"No wrong door" refers to formal recognition by a service system that individuals with COD may enter a range of community service sites; that they are a high priority for engagement in treatment; and that proactive efforts are necessary to welcome them into treatment and prevent them from falling through the cracks. Substance abuse and mental health counselors are encouraged to identify individuals with COD, welcome them into the service system, and initiate proactive efforts to help them access appropriate treatment in the system, regardless of their initial site of presentation. The recommended attitude is as follows: *The purpose of this assessment is not just to determine whether the client fits in* my *program, but to help the client figure out where he or she fits in the system of care, and to help him or her get there.*

Twelve Steps in the Assessment Process

Step 1: Engage the client

Step 2: Identify and contact collaterals (family, friends, other providers) to gather additional information

Step 3: Screen for and detect COD

Step 4: Determine quadrant and locus of responsibility

Step 5: Determine level of care

Step 6: Determine diagnosis

Step 7: Determine disability and functional impairment

Step 8: Identify strengths and supports

Step 9: Identify cultural and linguistic needs and supports

Step 10: Identify problem domains

Step 11: Determine stage of change

Step 12: Plan treatment

Empathic detachment

Empathic detachment requires the assessing clinician to

- Acknowledge that the clinician and client are working together to make decisions to support the client's best interest
- Recognize that the clinician cannot transform the client into a different person, but can only support change that he or she is already making
- Maintain empathic connection even if the client does not seem to fit into the clinician's expectations, treatment categories, or preferred methods of working

In the past, the attitude was that the client with COD was the exception. Today, clinicians should be prepared to demonstrate responsiveness to the requirements clients with COD present. Counselors should be careful not to label mental health symptoms immediately as caused by addiction, but instead should be comfortable with the strong possibility that a mental-health condition may be present independently and encourage disclosure of information that will help clarify the meaning of any COD for that client.

Person-centered assessment

Person-centered assessment emphasizes that the focus of initial contact is not on filling out a form or answering several questions or on establishing program fit, but rather on finding out what the client wants, in terms of his or her perception of the problem, what he or she wants to change, and how he or she thinks that change will occur. Mee-Lee (1998) has developed a useful guide that illustrates the types of questions that might be asked in a person-centered assessment in an addiction setting (see Figure 4-1, p. 74). (It should be noted, however, that this is not a validated tool.) While each step in this decision tree leads to the next, the final step can lead back to a previous step, depending on the client's progress in treatment.

Answers to some of these important questions inevitably will change over time. As the answers change, adjustments in treatment strategies may be appropriate to help the client continue to engage in the treatment process.

Sensitivity to culture, gender, and sexual orientation

An important component of a person-centered assessment is the continual recognition that culture plays a significant role in determining the client's view of the problem and the treatment. (For a comprehensive discussion of culturally sensitive assessment strategies in addiction settings, see the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* [CSAT in development *a*]). With regard to COD, clinicians must remember that ethnic cultures may differ significantly in their approach to substance use disorders and mental disorders, and that this may affect how the client presents. In addition, clients may participate in treatment cultures (12-Step recovery, Dual Recovery Self-Help, psychiatric rehabilitation) that also may affect how they view treatment. Cultural sensitivity also requires recognition of one's own cultural perspective and a genuine spirit of inquiry into how cultural factors influence the client's request for help. (See also chapter 2 for a discussion of culturally competent treatment.)

During the assessment process, it is important to ascertain the individual's sexual orientation as part of the counselor's appreciation for the client's personal identity, living situation, and relationships. Counselors also should be aware that women often have family-related and other concerns that must be addressed to engage them in treatment, such as the need for child care. See chapter 7 of this TIP for a more extended consideration of women with COD as a population with specific needs. More information about women's issues is provided in the forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT in development *b*).

Figure 4-1
Assessment Considerations

Engagement:

- What does the client want?
- What is the treatment contract?
- What are the immediate needs?
- What are the multiaxial DSM-IV diagnoses?

Multidimensional severity/level of functioning profile:

- Identify which assessment dimensions are most severe to determine treatment priorities.
- Choose a specific priority for each medium/severe dimension.

What specific services are needed to address these priorities?

What "dose" or intensity of services is needed?

Where can these services be provided in the least intensive, but safe, level of care or site of care?

How will outcomes be measured?

What is the progress of the treatment plan and placement decision?

Source: Adapted from Mee-Lee 1998.

Trauma sensitivity

The high prevalence of trauma in individuals with COD requires that the clinician consider the possibility of a trauma history even before the assessment begins. Trauma may include early childhood physical, sexual, or emotional abuse; experiences of rape or interpersonal violence as an adult; and traumatic experiences associated with political oppression, as might be the case in refugee or other immigrant populations. This pre-interview consideration means that the approach to the client must be sensitive to the possibility that the client has suffered previous traumatic experiences that may interfere with his or her ability to be trusting of the counselor. Clinicians who observe guardedness on the part of the client 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" the client—see section on trauma screening later in this chapter and, for additional details, see the forthcoming TIP *Substance Abuse Treatment and Trauma* (CSAT in development *d*).

Assessment Step 2: Identify and Contact Collaterals (Family, Friends, Other Providers) To Gather Additional Information

Clients presenting for substance abuse treatment, particularly those who have current or past mental health symptoms, may be unable or unwilling to report past or present circumstances accurately. For this reason, it is recommended that all assessments include routine procedures for identifying and contacting any family and other collaterals who may have useful information to provide. Information from collaterals is valuable as a supplement to the client's own report in all of the assessment steps

listed in the remainder of this chapter. It is valuable particularly in evaluating the nature and severity of mental health symptoms when the client may be so impaired that he or she is unable to provide that information accurately. Note, however, that the process of seeking such information must be carried out strictly in accordance with applicable guidelines and laws regarding confidentiality[1] and with the client's permission.

Assessment Step 3: Screen for and Detect Co-Occurring Disorders

Because of the high prevalence of co-occurring mental disorders in substance abuse treatment settings, and because treatment outcomes for individuals with multiple problems improve if each problem is addressed specifically, the consensus panel recommends that

- All individuals presenting for substance abuse treatment should be screened routinely for co-occurring mental disorders.
- All individuals presenting for treatment for a mental disorder should be screened routinely for any substance use disorder.

The content of the screening will vary upon the setting. Substance abuse screening in mental health settings should

- Screen for acute safety risk related to serious intoxication or withdrawal
- Screen for past and present substance use, substance related problems, and substance-related disorders

Mental health screening has four major components in substance abuse treatment settings:

- Screen for acute safety risk: suicide, violence, inability to care for oneself, HIV and hepatitis C virus risky behaviors, and danger of physical or sexual victimization
- Screen for past and present mental health symptoms and disorders
- Screen for cognitive and learning deficits
- Regardless of the setting, all clients should be screened for past and present victimization and trauma.

Safety screening

Safety screening requires that early in the interview the clinician specifically ask the client if he or she has any immediate impulse to engage in violent or self-injurious behavior, or if the client is in any immediate danger from others. These questions should be asked directly of the client and of anyone else who is providing information. If the answer is yes, the clinician should obtain more detailed information about the nature and severity of the danger, the client's ability to avoid the danger, the immediacy of the danger, what the client needs to do to be safe and feel safe, and any other information relevant to safety. Additional information can be gathered depending on the counselor/staff training for crisis/emergency situations and the interventions appropriate to the treatment provider's particular setting and circumstances. Once this information is gathered, if it appears that the client is at some immediate risk, the clinician should arrange for a more in-depth risk assessment by a mental-health–trained clinician, and the client should not be left alone or unsupervised.

A variety of tools are available for use in safety screening:

- ASAM PPC-2R identifies considerations for immediate risk assessment and recommends follow up procedures (ASAM 2001).
- ASI (McLellan et al. 1992) and Global Appraisal of Individual Needs (GAIN) (Dennis 1998) also include some safety screening questions.
- Some systems use LOCUS (American Association of Community Psychiatrists [AACP] 2000*a*) as the tool to determine level of care for both mental disorders and addiction. One dimension of LOCUS specifically provides guides for scoring severity of risk of

[1]Confidentiality is governed by the Federal "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations (42 C.F.R. Part 2) and the Federal "Standards for Privacy of Individually Identifiable Health Information" (45 C.F.R. Parts 160 and 164).

harm. See Potential Risk of Harm on page 77.

None of these tools is definitive for safety screening. Clinicians and programs should use one of these tools only as a starting point, and then elaborate more detailed questions to get all relevant information.

Clinicians should not underestimate risk because the client is using substances actively. For example, although people who are intoxicated might only seem to be making threats of self-harm (e.g., "I'm just going to go home and blow my head off if nobody around here can help me"), all statements about harming oneself or others must be taken seriously. Individuals who have suicidal or aggressive impulses when intoxicated may act on those impulses; remember, alcohol and drug abuse are among the highest predictors of dangerousness to self or others—even without any co-occurring mental disorder. Determining which intoxicated suicidal client is "serious" and which one is not requires a skilled mental health assessment, plus information from collaterals who know the client best. (See chapter 8 and appendix D of this TIP for a more detailed discussion of suicidality.) In addition, it is important to remember that the vast majority of people who are abusing or dependent on substances will experience at least transient symptoms of depression, anxiety, and other mental symptoms. Moreover, it may not be possible, even with a skilled clinician, to determine whether an intoxicated suicidal patient is making a serious threat of self harm; however, safety is a critical and paramount concern. A more detailed discussion of each symptom subgroup is provided in appendix D. Safety screening conducted in mental health settings is highlighted in the text box below.

Screening for past and present mental disorders

Screening for past and present mental disorders has three goals:

1. To understand a client's history and, if the history is positive for a mental disorder, to alert the counselor and treatment team to the types of symptoms that might reappear so that the counselor, client, and staff can be vigilant about the emergence of any such symptoms.
2. To identify clients who might have a current mental disorder and need both an assessment to determine the nature of the disorder and an evaluation to plan for its treatment.

Safety Screening in Mental Health Settings

Evaluating safety considerations in mental health settings involves direct questioning of client and collaterals regarding current substance use and/or recent discontinuation of heavy use, along with past and present experiences of withdrawal. If clients obviously are intoxicated, they need to be treated with empathy and firmness, and provision needs to be made for their physical safety. If clients report that they are experiencing withdrawal, or appear to be exhibiting signs of withdrawal, use of formal withdrawal scales can help even inexperienced clinicians to gather information from which medically trained personnel can determine whether medical intervention is required. Such tools include the Clinical Institute Withdrawal Assessment (CIWA-Ar) (Sullivan et al. 1989) for alcohol withdrawal and the Clinical Institute Narcotic Assessment (CINA) (Zilm and Sellers 1978) for opioid withdrawal.

Mental health clinicians need to be aware that not all drugs have a physiological withdrawal associated with them, and it should not be assumed that withdrawal from any drug of abuse will require medical intervention. Only in the case of alcohol, opioids, sedative-hypnotics, or benzodiazepines is medical intervention likely to be required due to the pharmacological properties of the substance.

Potential Risk of Harm

- **Risk of Harm:** This dimension of the assessment considers a person's potential to cause significant harm to self or others. While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to care adequately for oneself, or from altered states of consciousness due to use of intoxicating substances. For the purpose of evaluation in this parameter, deficits in ability to care for oneself are considered only in the context of their potential to cause harm. Likewise, only behaviors associated with substance use are used to rate risk of harm, not the substance use itself. In addition to direct evidence of potentially dangerous behavior from interview and observation, other factors may be considered in determining the likelihood of such behavior such as past history of dangerous behaviors, ability to contract for safety, and availability of means. When considering historical information, recent patterns of behavior should take precedence over patterns reported from the remote past. Risk of harm may be rated according to the following criteria:

  Minimal risk of harm:

  (a) No indication of suicidal or homicidal thoughts or impulses, no history of suicidal or homicidal ideation, and no indication of significant distress.

  (b) Clear ability to care for self now and in the past.

  Low risk of harm:

  (a) No current suicidal or homicidal ideation, plan, intentions or serious distress, but may have had transient or passive thoughts recently or in the past.

  (b) Substance use without significant episodes of potentially harmful behaviors.

  (c) Periods in the past of self-neglect without current evidence of such behavior.

  Moderate risk of harm:

  (a) Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.

  (b) No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.

  (c) History of chronic impulsive suicidal/homicidal behavior or threats and current expressions do not represent significant change from baseline.

  (d) Binge or excessive use of substances resulting in potentially harmful behaviors without current involvement in such behavior.

  (e) Some evidence of self neglect and/or compromise in ability to care for oneself in current environment.

  Serious risk of harm:

  (a) Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.

  (b) History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from baseline.

  (c) Recent pattern of excessive substance use resulting in disinhibition and clearly harmful behaviors with no demonstrated ability to abstain from use.

  (d) Clear compromise of ability to care adequately for oneself or to be aware adequately of environment.

  Extreme risk of harm:

  (a) Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior without expressed ambivalence or significant barriers to doing so; or with a history of serious past attempts which are not of a chronic, impulsive, or consistent nature; or in presence of command hallucinations or delusions which threaten to override usual impulse control.

  (b) Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.

  (c) Extreme compromise of ability to care for oneself or to monitor adequately the environment with evidence of deterioration in physical condition or injury related to these deficits.

Source: AACP 2000*a*.

3. For clients with a current COD, to determine the nature of the symptoms that might wax and wane to help the client monitor the symptoms, especially how the symptoms improve or worsen in response to medications, "slips" (i.e., substance use), and treatment interventions. For example, clients often need help seeing that the treatment goal of avoiding isolation improves their mood—that when they call their sponsor and go to a meeting they break the vicious cycle of depressed mood, seclusion, dwelling on oneself and one's mood, increased depression, greater isolation, and so on.

A number of screening, assessment, and treatment planning tools are available to assist the substance abuse treatment team. For assessment of specific disorders and/or for differential diagnosis and treatment planning, there are literally hundreds of assessment and treatment planning tools. NIAAA operates a web-based service that provides quick information about alcoholism treatment assessment instruments and immediate online access to most of them, and the service is updated continually with new information and assessment instruments (www.niaaa.nih.gov/publications/Assesing%20Alcohol/index.pdf). NIDA has a publication from a decade ago (Rounsaville et al. 1993) that provides broad background information on assessment issues pertinent to COD and specific information about numerous mental health, treatment planning, and substance abuse tools. Of course, NIDA continues to explore issues related to screening and assessment. The mental health field contains a vast array of screening and assessment devices, as well as subfields devoted primarily to the study and development of evaluative methods. Almost all Substance Abuse and Mental Health Services Administration TIPs, which are available online (www.kap.samhsa.gov), have a section on assessment, many have appendices with wholly reproduced assessment tools or information about locating such tools, and TIPs 31, 16, 13, 11, 10, 9, 7, and 6 are centered specifically on assessment issues.

Advanced assessment techniques include assessment instruments for general and specific purposes and advanced guides to differential diagnosis. Most high-power assessment techniques center on a specific type of problem or set of symptoms, such as the BDI-II (Beck et al. 1996), the Beck Anxiety Inventory (BAI) (Beck et al. 1988), or the Hamilton Anxiety Scale (Hamilton 1959) or the Hamilton Rating Scale for Depression (Hedlung and Vieweg 1979). There are high-power broad assessment measures such as the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) (Butcher et al. 2001). However, such assessment devices typically are lengthy (the MMPI is more than 500 items), often require specific doctoral training to use, and can be difficult to adapt properly for some substance abuse treatment settings.

For both clinical and research activities, there are a number of well-known and widely used guides to the differential diagnostic process in the mental health field, such as the Structured Clinical Interview for Diagnosis (SCID). Again, the SCIDs involve considerable time and training, with a separate SCID for Axis I, Axis II, and dissociative disorders. Other broad high-power diagnostic tools are the Diagnostic Interview Schedule (DIS) and the Psychiatric Research Interview for Substance and Mental Disorders (PRISM), but these methods can require 1 to 3 hours and extensive training. These tools generally provide information beyond the requirements of most substance abuse treatment programs.

When using any of the wide array of tools that detect symptoms of mental disorders, counselors should bear in mind that symptoms of mental disorder can be mimicked by substances. For example, hallucinogens may produce symptoms that resemble psychosis, and depression commonly occurs during withdrawal from many substances. Even with well-tested tools, it can be difficult to distin-

guish between a mental disorder and a substance-related disorder without additional information such as the history and chronology of symptoms. In addition to interpreting the results of such instruments in the broader context of what is known about the client's history, counselors also are reminded that retesting often is important, particularly to confirm diagnostic conclusions for clients who have used substances.

The section below briefly highlights some available instruments available for mental health screening.

Mental Health Screening Form-III

The Mental Health Screening Form-III (MHSF-III) has only 18 simple questions and is designed to screen for present or past symptoms of most of the main mental disorders (Carroll and McGinley 2001). It is available to the public at no charge from the Project Return Foundation, Inc. and it is reproduced in its entirety in appendix H, along with instructions for its use and contact information (a Spanish form and instructions can be downloaded). The MHSF-III was developed within a substance abuse treatment setting and it has face validity—that is, if a knowledgeable diagnostician reads each item, it seems clear that a "yes" answer to that item would warrant further evaluation of the client for the mental disorder for which the item represents typical symptomatology.

On the other hand, the MHSF-III is only a screening device as it asks only one question for each disorder for which it attempts to screen. If a client answers "no" because of a misunderstanding of the question or a momentary lapse in memory or test-taking attitude, the screen would produce a "false-negative," where the client might have the mental disorder but the screen falsely indicates that the person probably does not have the disorder. In a journal article the MHSF-III is referred to as a "*rough* screening device" (Carroll and McGinley 2001, p. 35), and the authors make suggestions about its use, comments about its limitations, and review favorable validity and reliability data.

Mini-International Neuropsychiatric Interview

For a more complete screening instrument, the Mini-International Neuropsychiatric Interview (M.I.N.I.) is a simple 15- to 30-minute device that covers 20 mental disorders, including substance use disorders. Considerable validation research has accumulated on the M.I.N.I. (Sheehan et al. 1998).

> Counselors should bear in mind that symptoms of mental disorder can be mimicked by substances.

For each disorder the M.I.N.I. has an ordered series of about 6 to 12 questions, and it has a simple and immediate scoring procedure. For example, in terms of suicidality the M.I.N.I. contains questions about whether in the past month the client has

1. Thought about being better off dead or wishing to be dead (1 point)
2. Wanted to harm himself/herself (2 points)
3. Thought about suicide (6 points)
4. Attempted suicide (10 points)
5. Developed a suicide plan (10 points)

M.I.N.I. contains a sixth question asking if the client has ever attempted suicide (4 points). Scoring rates low current suicide risk as 1 to 5 points, moderate as 6 to 9 points, and high as 10 or more points.

The M.I.N.I. family consists of

- The M.I.N.I. (a low-power, broad screening device to see if the client requires further assessment)
- A two-page M.I.N.I. screen for research purposes or when time is limited
- The M.I.N.I. Plus (an expanded version of the M.I.N.I. designed specifically to determine whether symptoms were associated with alcohol and other drug use and/or periods of abstinence)
- The M.I.N.I. Tracking (a 17-page document that provides symptom descriptors that can be used to monitor a client's progress in treatment, monitor how a client's symptoms are affected by treatment interventions or medications or other factors, and help with documenting where, when, and why changes occur)

Brief Symptom Inventory-18

Another proprietary instrument that can be used to track clients from session to session or over longer periods of time is the Brief Symptom Inventory-18 (BSI-18). The BSI-18 questionnaire contains 18 items and asks clients to rate each question on a five-point scale. In addition to a Global Severity Index score, there are separate scores for anxiety, depression, and somatization subscales. The BSI-18 was derived from the 53-item Brief Symptom Inventory, which was derived from the Symptom Checklist-90-Revised (SCL-90-R) (Derogatis 1975), and the 15-item SDS (McCorkle and Young 1978) also was a derivative of the BSI that has been superceded by the relatively new BSI-18.

ASI

The ASI (McLellan et al. 1992) does not screen for mental disorders and provides only a low-power screen for generic mental health problems. Use of the ASI ranges widely, with some substance abuse treatment programs using a scaled-down approach to gather basic information about a client's alcohol use, drug use, legal status, employment, family/social, medical, and psychiatric status, to an in-depth assessment and treatment planning instrument to be administered by a trained interviewer who makes complex judgments about the client's presentation and ASI-taking attitudes. Counselors can be trained to make clinical judgments about how the client comes across, how genuine and legitimate the client's way of responding seems, whether there are any safety or self-harm concerns requiring further investigation, and where the client falls on a nine-point scale for each dimension. With about 200 items, the ASI is a low-power instrument but with a very broad range, covering the seven areas mentioned above and requiring about 1 hour for the interview. Development of and research into the ASI continues, including training programs, computerization, and critical analyses. It is a public domain document that has been used widely for 2 decades. It is reproduced in TIP 38 as appendix D (CSAT 2000*c*, pp. 193–204), and information about obtaining the manual for the ASI and up-to-date information is in appendix G. Over the past several years, NIDA's Clinical Trials Network (CTN) has been researching both the use of and the training for the ASI (http://www.tresearch.org/ASI.htm).

Screening for past and present substance use disorder

This section is intended primarily for counselors working in mental health service settings. It suggests ways to screen clients for substance abuse problems.

Screening begins with inquiry about past and present substance use and substance-related problems and disorders. If the client answers yes to having problems and/or a disorder, further assessment is warranted. It is important to remember that if the client acknowledges a past substance problem but states that it is now resolved, assessment is still required. Careful exploration of what current strategies the individual is using to prevent relapse is warranted. Such information can help ensure that those strategies continue while the individual is focusing on mental health treatment.

Screening for the presence of substance abuse symptoms and problems involves four components:

- Substance abuse symptom checklists
- Substance abuse severity checklists
- Formal screening tools that work around denial
- Screening of urine, saliva, or hair samples

Symptom checklists: These include checklists of common categories of substances, history of associated problems with use, and a history of meeting criteria for substance dependence for that substance. It is *not* helpful to develop checklists that are overly detailed, because they begin to lose value as simple screening tools. It *is* helpful to remember to include abuse of over-the-counter medication (e.g., cold pills), abuse of prescribed medication, and gambling behavior in the checklist. It also is reasonable to screen for compulsive sexual behavior, Internet addiction, and compulsive spending.

Severity checklists: It is useful to monitor the severity of substance use disorder (if present) and to determine the possible presence of dependence. This process can begin with simple questions about past or present diagnosis of substance dependence, and the client's experience of associated difficulties. Some programs may use formal substance use disorder diagnostic tools; others use the ASI (McLellan et al. 1992) or similar instrument, even in the mental health setting. The New Hampshire Dartmouth Psychiatric Research Center has developed clinician-rated alcohol- and drug-use scales for monitoring substance abuse severity in individuals with mental disorders: the Alcohol Use Scale (AUS) and Drug Use Scale (DUS) (Drake et al. 1996*b*) and others (www.dartmouth.edu/~psychrc/instru.html).

Screening tools: Most common substance abuse screening tools have been used with individuals with COD. These include the CAGE (Mayfield et al. 1974), the Michigan Alcoholism Screen Test (MAST) (Selzer 1971), the Drug Abuse Screening Test (DAST) (Skinner 1982), and the Alcohol Use Disorders Identification Test (AUDIT) (Babor et al. 1992). The Dartmouth Assessment of Lifestyle Inventory (DALI) is used routinely as a screening tool in some research settings working with individuals with serious mental disorders (Rosenberg et al. 1998).

The SSI-SA was developed by the consensus panel of TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (CSAT 1994*c*). The SSI-SA is reproduced in its entirety in appendix H. It is a 16-item scale, although only 14 items are scored so that scores can range from 0 to 14. These 14 items were selected by the TIP 11 consensus panelists from existing alcohol and drug abuse screening tools. A score of 4 or greater has become the established cut-off point for warranting a referral for a full assessment. Since its publication in 1994 the SSI-SA has been widely used and its reliability and validity investigated. For example, Peters and colleagues (2004) reported on a national survey of correctional treatment for COD. Reviewing 20 COD treatment programs in correctional settings from 13 States, the SSI-SA was identified as among the most common screening instruments used. For more information, see appendix H.

> Screening begins with inquiry about past and present substance use and substance-related problems and disorders.

Toxicology screening: Given the high prevalence of substance use disorders in patients with mental health problems, the routine use of urine or other screening is indicated for all new mental health clients. It especially is sug-

gested in settings in which the likelihood of clients regularly presenting unreliable information is particularly great; for example, in adolescent and/or criminal justice settings. Use of urine screening is highly recommended whenever the clinical presentation does not seem to fit the client's story, or where there appear to be unusual mental status symptoms or changes not explained adequately. Saliva testing may be less intrusive than hair or urine testing in patients who are shy or who are extremely paranoid.

Trauma screening

Research projects focusing on the needs of people with COD who are victims of trauma have led to the development of specific screening tools to identify trauma in treatment populations. To screen for posttraumatic stress disorder (PTSD), assuming the client has a trauma, the Modified PTSD Symptom Scale: Self-Report Version would be a good choice (this instrument can be found in TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* [CSAT 2000*d*, p. 170]). This scale also is useful for monitoring and tracking PTSD symptoms over time. The PTSD Checklist (Blanchard et al. 1996) is a validated instrument that substance abuse treatment agencies also may find useful in trauma screening.

It is important to emphasize that in screening for a history of trauma or in obtaining a preliminary diagnosis of PTSD, it can be damaging to ask the client to describe traumatic events in detail. To screen, it is important to limit questioning to very brief and general questions, such as "Have you ever experienced childhood physical abuse? Sexual abuse? A serious accident? Violence or the threat of it? Have there been experiences in your life that were so traumatic they left you unable to cope with day-to-day life?" See the discussion of screening and assessment for PTSD in appendix D for more complete information.

Assessment Step 4: Determine Quadrant and Locus of Responsibility

Determination of quadrant assignment is based on the severity of the mental and substance use disorders (see chapter 2 for a detailed discussion of the four-quadrant model). Most of the information needed for this determination will have been acquired during step 2, but there are a few added nuances. Quadrant determination may be specified formally by procedures in certain States. For example, New York has drafted (but not yet adopted) a set of objective criteria for determining at screening who should be considered as belonging in quadrant IV. Where no such formal procedures are present, the following sequence may be useful and is certainly within the capability of substance abuse treatment clinicians in any setting.

The Four Quadrants

III	IV
• Less severe mental disorder/more severe substance disorder	• More severe mental disorder/more severe substance disorder
I	**II**
• Less severe mental disorder/less severe substance disorder	• More severe mental disorder/less severe substance disorder

Assessment Step 4—Application to Case Examples

Cases 1 and 2. Both Maria M. and George T. are examples of clients with serious addiction who also have serious mental disorders, but do not appear to be seriously disabled. They would therefore meet criteria for quadrant III and should be placed in programs for people who have less serious mental disorders and more serious substance use disorders. Note that though the diagnosis of bipolar disorder is typically considered a serious mental illness, the quadrant system emphasizes the acute level of disability/severity of the mental and substance use disorders of the individual, rather than relying solely on diagnostic classification.

Case 3. Jane B., the homeless woman with paranoid schizophrenia, generally would meet criteria for serious and persistent mental illness in almost every State, based on the severity of the diagnosis and disability, combined with the persistence of the disorder. Jane B. also has serious addiction. In the quadrant model, if she already has been identified as a mental health priority client (e.g., has a mental health case manager), she would be considered quadrant IV, and referral for mental health case management services would be important.

Determination of serious mental illness (SMI) status

Every State mental health system has developed a set of specific criteria for determining who can be considered seriously mentally ill (and therefore eligible to be considered a mental health priority client). These criteria are based on combinations of specific diagnoses, severity of disability, and duration of disability (usually 6 months to 1 year). Some require that the condition be independent of a substance use disorder. These criteria are different for every State. It would be helpful for substance abuse treatment providers to obtain copies of the criteria for their own States, as well as copies of the specific procedures by which eligibility is established by their States' mental health systems. By determining that a client might be eligible for consideration as a mental health priority client, the substance abuse treatment counselor can assist the client in accessing a range of services and/or benefits that the client may not know is open to her or him.

Determining SMI status begins with finding out if the client already is receiving mental health priority services (e.g., Do you have a mental health case manager? Are you a Department of Mental Health client?).

- *If the client already is a mental health client, then he or she will be assigned to quadrant II or IV.* Contact needs to be made with the mental health case manager and a means of collaboration established to promote case management.
- If the client is not already a mental health client, but appears to be eligible and the client and family are willing, referral for eligibility determination should be arranged.
- Clients who present in addiction treatment settings who look as if they might be SMI, but have not been so determined, should be considered to belong to quadrant IV.

For assistance in determination of the *severity* of symptoms and disability, the substance abuse treatment clinician can use the Dimension 3 (Emotional/Behavioral) subscales in the ASAM PPC-2R or LOCUS, especially the levels of severity of comorbidity and impairment/functionality.

Determination of severity of substance use disorders

Presence of active or unstable substance dependence or serious substance abuse (e.g., recurrent substance-induced psychosis without meeting other criteria for dependence) would identify the individual as being in quadrant III or IV. Less serious substance use disorder (mild to moderate substance abuse; substance depen-

dence in full or partial remission) identifies the individual as being in quadrant I or II.

If the client is determined to have SMI with serious substance use disorder, he falls in quadrant IV; those with SMI and mild substance use disorder fall in quadrant II. A client with serious substance use disorder who has mental health symptoms that do not constitute SMI falls into quadrant III. A client with mild to moderate mental health symptoms and less serious substance use disorder falls into quadrant I.

Clients in quadrant III who present in substance abuse treatment settings are often best managed by receiving care in the addiction treatment setting, with collaborative or consultative support from mental health providers. Individuals in quadrant IV usually require intensive intervention to stabilize and determination of eligibility for mental health services and appropriate locus of continuing care. If they do not meet criteria for SMI, once their more serious mental symptoms have stabilized and substance use is controlled initially, they begin to look like individuals in quadrant III, and can respond to similar services.

Note, however, that this discussion of quadrant determination is not validated by clinical research. It is merely a practical approach to adapting an existing framework for clinical use, in advance of more formal processes being developed, tested, and disseminated.

In many systems, the process of assessment stops largely after assessment step 4 with the determination of placement. Some information from subsequent steps (especially step 7) may be included in this initial process, but usually more in-depth or detailed consideration of treatment needs may not occur until after "placement" in an actual treatment setting.

Assessment Step 5: Determine Level of Care

The use of the ASAM PPC-2R provides a mechanism for an organized assessment of individuals presenting for substance use disorder treatment to determine appropriate placement in "level of care." This process involves consideration of six dimensions of assessment:

- Dimension 1: Acute Intoxication and/or Withdrawal Potential

Assessment Step 5—Application to Case Examples

Case 3. The severity of Jane B.'s condition and her psychosis, homelessness, and lack of stability may lead the clinician initially to consider psychiatric hospitalization or referral for residential substance abuse treatment. In fact, application of assessment criteria in ASAM PPC-2R might have led easily to that conclusion. In ASAM PPC-2R, more flexible matching is possible. The first consideration is whether the client meets criteria for involuntary psychiatric commitment (usually, suicidal or homicidal impulses, or inability to feed oneself or obtain shelter). In this instance, she is psychotic and homeless but has been able to find food and shelter; she is unwilling to accept voluntary mental health services. Further, residential substance abuse treatment is inappropriate, both because she is completely unmotivated to get help and because she is likely to be too psychotic to participate in treatment effectively. ASAM PPC-2R would therefore recommend Level I.5 intensive mental disorder case management as described above.

If after extended participation in the engagement strategies described earlier, she began to take antipsychotic medication, after a period of time her psychosis might clear up, and she might begin to express interest in getting sober. In that case, if she had determined that she is unable to get sober on the street, residential substance abuse treatment would be indicated. Because of the longstanding severity of her mental illness, it is likely that she would continue to have some level of symptoms of her mental disorder and disability even when medicated. In this case, Jane B. probably would require a residential program able to supply an enhanced level of services.

- Dimension 2: Biomedical Conditions and Complications
- Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications
- Dimension 4: Readiness to Change
- Dimension 5: Relapse, Continued Use, or Continued Problem Potential
- Dimension 6: Recovery/Living Environment

The ASAM PPC-2R (ASAM 2001) evaluates level of care requirements for individuals with COD. Dimension 3 encompasses "Emotional, Behavioral or Cognitive Conditions and Complications." Five areas of risk must be considered related to this dimension (ASAM 2001, pp. 283–284):

- Suicide potential and level of lethality
- Interference with addiction recovery efforts ("The degree to which a patient is distracted from addiction recovery efforts by emotional, behavioral and/or cognitive problems and conversely, the degree to which a patient is able to focus on addiction recovery")
- Social functioning
- Ability for self-care
- Course of illness (a prediction of the patient's likely response to treatment)

Consideration of these dimensions permits the client to be placed in a particular level on a continuum of services ranging from intensive case management for individuals with serious mental disorders who are not motivated to change (Level I.5) to psychiatric inpatient care (Level IV). In addition, there is the capacity to distinguish, at each level of care, individuals with lower severity of mental symptoms or impairments that require standard or Dual Diagnosis Capable programming at that level of care from individuals with moderately severe symptoms or impairments that require Dual Diagnosis Enhanced programming at that level of care. (See below for assessment of the level of impairment.) The ASAM PPC have undergone limited validity testing in previous versions, are used to guide addiction treatment matching in more than half the States, and are influential in almost all of the rest.

Tools: The LOCI–2R (Hoffmann et al. 2001) (see www.evinceassessment.com/product_loci2r.html for more information) is a proprietary tool designed specifically to perform a structured assessment for level of care placement based on ASAM PPC-2R levels of care (ASAM 2001). The GAIN (Dennis 1998) is another broad set of tools and training developed within an addiction setting; however, GAIN products are also proprietary.

In some systems, the LOCUS Adult Version 2000 (AACP 2000*a*) is being introduced as a systemwide level of care assessment instrument for either mental health settings only, or for both mental health and substance abuse treatment settings. Like the ASAM, LOCUS uses multiple dimensions of assessment:

- Risk of Harm
- Functionality
- Comorbidity (Medical, Addictive, Psychiatric)
- Recovery Support and Stress
- Treatment Attitude and Engagement
- Treatment History

LOCUS is simpler to use than ASAM PPC-2R. It has a point system for each dimension that permits aggregate scoring to suggest level of service intensity. LOCUS also permits level of care assessment for individuals with mental disorders or substance use disorders only, as well as for those with COD. Some pilot studies of LOCUS have supported its validity and reliability. However, compared to ASAM PC-2R, LOCUS is much less sensitive to the needs of individuals with substance use disorders and has greater difficulty distinguishing the separate contributions of mental and substance-related symptoms to the clinical picture.

Assessment Step 6: Determine Diagnosis

Determining the diagnosis can be a formidable clinical challenge in the assessment of COD. Clinicians in both mental health services and substance abuse treatment settings recognize that it can be impossible to establish a firm diagnosis when confronted with the mixed presentation of mental symptoms and ongoing substance abuse. Of course, substance abuse contributes to the emergence or severity of mental symptoms and therefore confounds the diagnostic picture. Therefore, this step often includes dealing with confusing diagnostic presentations.

Addiction counselors who want to improve their competencies to address COD are urged to become conversant with the basic resource used to diagnose mental disorders, the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* (DSM-IV-TR) (American Psychiatric Association 2000).

The importance of client history

- *Principle #1:* Diagnosis is established more by history than by current symptom presentation. This applies to both mental and substance use disorders.

The first step in determining the diagnosis is to determine whether the client has an established diagnosis and/or is receiving ongoing treatment for an established disorder. This information can be obtained by the counselor as part of the routine intake process. If there is evidence of a disorder but the diagnosis and/or treatment recommendations are unclear, the counselor immediately should begin the process of obtaining this information from collaterals. If there is a valid history of a mental disorder diagnosis at admission to substance abuse treatment, that diagnosis should be considered presumptively valid for initial treatment planning, and any existing stabilizing treatment should be maintained. In addition to confirming an established diagnosis, the client's history can provide insight into patterns that may emerge and add depth to knowledge of the client.

For example, if a client comes into the clinician's office under the influence of alcohol, it is reasonable to suspect alcohol dependence, but the only diagnosis that can be made based on that datum is "alcohol intoxication." It is important to note that this warrants further investigation; on the one hand, false positives can occur, while on the other, detoxification may be needed. Conversely, if a client comes into the clinician's office and has not had a drink in 10 years, attends Alcoholics Anonymous (AA) meetings three times per week, and had four previous detoxification admissions, the clinician can make a diagnosis of alcohol dependence (in remission at present). Moreover, the clinician can predict that 20 years from now that client will still have the diagnosis of alcohol dependence since the history of alcohol dependence and treatment sustains a lifetime diagnosis of alcohol dependence.

Similarly, if a client comes into the clinician's office and says she hears voices (whether or

Assessment Step 6—Application to Case Examples

Case 2. George T. has cocaine dependence and bipolar disorder stabilized with lithium. He reports that when he uses cocaine he has mood swings, but that these go away when he stops using for a while, as long as he takes his medication. At the initial visit, George T. states he has not used for a week and has been taking his medication regularly. He displays no significant symptoms of mania or depression and appears reasonably calm. The counselor should not conclude that because George T. has no current symptoms the diagnosis of bipolar disorder is incorrect, or that all the mood swings are due to cocaine dependence. At initial contact, the presumption should be that the diagnosis of bipolar disorder is accurate, and lithium needs to be maintained.

Assessment Step 6—Application to Case Example

Case 1. Maria M., the 38-year-old Hispanic/Latina female with cocaine and opioid dependence, initially was receiving methadone maintenance treatment only. She also used antidepressants prescribed by her outside primary care physician. She presented to methadone maintenance program staff with complaints of depression. Maria M. reported that since treatment with methadone (1 year) she had not used illicit opioids. However, she stated that when she does not use cocaine, she often feels depressed "for no reason." Nevertheless, she has many stressors involving her children, who also have drug problems. She reports that depression is associated with impulses to use cocaine, and consequently she has recurrent cocaine binges. These last a few days and are followed by persistent depression.

What is the mental diagnosis? To answer this question it is important to obtain a mental disorder history that relates mental symptoms to particular time periods and patterns of substance use and abuse.

The client's history reveals that although she grew up with an abusive father with an alcohol problem, she herself was not abused physically or sexually. Although hampered by poor reading ability, she stayed in school with no substance abuse until she became pregnant at age 16 and dropped out of high school. Despite becoming a single mother at such a young age, she worked three jobs and functioned well, while her mother helped raise the baby. At age 23, she began a 9-year relationship with an abusive person with an alcohol and illicit drug problem, during which time she was exposed to a period of severe trauma and abuse. She is able to recall that during this relationship, she began to lose her self-esteem and experience persistent depression and anxiety.

She began using cocaine at age 27, initially to relieve those symptoms. Later, she lost control and became addicted. Four years ago, she was first diagnosed as having major depression, and was prescribed antidepressant medication, which she found helpful. Two years ago, she began using opioids, became addicted, and then entered methadone treatment. She receives no specific treatment for cocaine dependence. She has noticed that her depression persists during periods of cocaine and opioid abstinence lasting more than 30 days. On one occasion, during one of these periods, her medication ran out, and she noticed her depression became much worse. Even at her baseline, she remains troubled by lack of self-confidence and fearfulness, as well as depressed mood.

Her depression persists during periods of more than 30 days of abstinence and responds to some degree to antidepressants. The fact that her depression persists even when she is abstinent and responds to antidepressants suggests strongly a co-occurring affective disorder. There are also indications of the persistent effects of trauma, possibly posttraumatic stress disorder. Trauma issues have never been addressed. Her opioid dependence has been stabilized with methadone. She has resisted recommendations to obtain more specific treatment for cocaine dependence.

not the client is sober currently), no diagnosis should be made on that basis alone. There are many reasons people hear voices. They may be related to substance-related syndromes (e.g., substance-induced psychosis or *hallucinosis*, which is the experience of hearing voices that the client knows are not real, and that may say things that are distressing or attacking—particularly when there is a trauma history—but are not bizarre). With COD, most causes will be independent of substance use (e.g., schizophrenia, schizoaffective disorder, affective disorder with psychosis or dissociative hallucinosis related to PTSD). *Psychosis* usually involves loss of ability to tell that the voices are not real, and increased likelihood that they are bizarre in content. Methamphetamine psychosis is particularly confounding because it can mimic schizophrenia. Many individuals with psychotic disorders will still hear voices when on medication, but the medication makes the

voices less bizarre and helps the client know they are not real.

If the client states he has heard voices, though not as much as he used to, that he has been clean and sober for 4 years, that he remembers to take his medication most days though every now and then he forgets, and that he had multiple psychiatric hospitalizations for psychosis 10 years ago but none since, then the client clearly has a diagnosis of psychotic illness (probably schizophrenia or schizoaffective disorder). Given the client's continuing symptoms while clean and sober and on medication, it is quite possible that the diagnosis will persist.

Documenting prior diagnoses

- *Principle #2*: It is important to document prior diagnoses and gather information related to current diagnoses, even though substance abuse treatment counselors may not be licensed to make a mental disorder diagnosis.

Diagnoses established by history should not be changed at the point of initial assessment. If the clinician has a suspicion that a long-established diagnosis may be invalid, it is important that he or she takes time to gather additional information, consult with collaterals, get more careful and detailed history (see below), and develop a better relationship with the client before recommending diagnostic re-evaluation. It is important for the counselor to raise issues related to diagnosis with the clinical supervisor or at a team meeting.

In many instances, of course, no well-established mental disorder diagnosis exists, or multiple diagnoses give a confusing picture. Even when there is an established diagnosis, it is helpful to gather information to confirm that diagnosis. During the initial assessment process, substance abuse treatment counselors can gather data that can assist in the diagnostic process, either by supporting the findings of the existing mental health assessment, or providing useful background information in the event a new mental health assessment is conducted. The key to doing this is not merely to gather lists of past and present symptoms, but to connect those symptoms to key time periods in the client's life that are helpful in the diagnostic process—namely, before the onset of a substance use disorder and during periods of abstinence (or during periods of very limited use) or those that occur after the onset of the substance use disorder and persist for more than 30 days.

The clinician also must seek to determine whether mental symptoms occur only when the client is using substances actively. Therefore, it is important to determine the nature and severity of the symptoms of the mental disorder when the substance disorder is stabilized.

Linking mental symptoms to specific periods

- *Principle #3*: For diagnostic purposes, it is almost always necessary to tie mental symptoms to specific periods of time in the client's history, in particular those times when active substance use disorder was not present.

Unfortunately, most substance abuse assessment tools are not structured to require connection of mental symptoms to such periods of use or abstinence. For this reason, mental disorder symptom information obtained from such tools can be confusing and often contributes to counselors feeling the whole process is not worth the effort. In fact, it is striking that when clinicians seek information about mental symptoms during periods of abstinence, such information is almost never part of traditional assessment forms. The mental history and substance use history have in the past been collected separately and independently. As a result, the opportunity to evaluate interaction, *which is the most important diagnostic information beyond the history*, has been routinely lost. Newer and more detailed assessment tools overcome these historical, unnecessary divisions.

One instrument that may be helpful in this regard is the M.I.N.I. Plus (described above), which has a structure to connect any identified symptoms to periods of abstinence. Clinicians can use this information to distinguish substance-induced mental disorders from independent mental disorders. Drake and others in their work on mental disorder treatment teams in New Hampshire have adapted the Timeline Follow Back Method (www.dartmouth.edu/~psychrc/instru.html), developed by Sobell and Mueser (Mueser et al. 1995*b*; Sobell et al. 1979), that can be used with individuals who have serious mental disorders and substance use disorders. More detailed mental health research diagnostic tools (e.g., the SCID) encourage a similar process.

Consequently, the substance abuse treatment counselor can proceed in two ways:

1. Inquire whether any mental symptoms or treatments identified in the screening process were present during periods of 30 days of abstinence or longer, or were present before onset of substance use. ("Did this symptom or episode occur during a period when you were clean and sober for at least 30 days?")
2. Define with the client specific time periods where substance use disorder was in remission, and then get detailed information about mental symptoms, diagnoses, impairments, and treatments during those periods of time. ("Can you recall a specific period when you were not using? Did these symptoms [or whatever the client has reported] occur during that period?") This approach may yield more reliable information.

During this latter process, the counselor can use one of the medium-power symptom screening tools as a guide. Alternatively, the counselor can use the handy outlines of the DSM-IV criteria for common disorders and inquire whether those criteria symptoms were met, whether they were diagnosed and treated, and if so, with what methods and how successfully. This information can suggest or support the accuracy of diagnoses. Documentation also can facilitate later diagnostic assessment by a mental-health–trained clinician.

Assessment Step 7: Determine Disability and Functional Impairment

Determination of both current and baseline functional impairment contributes to identification of the need for case management and/or higher levels of support. This step also relates to the determination of level of care requirements. Assessment of current cognitive capacity, social skills, and other functional abilities also is necessary to determine if there are deficits that may require modification in the treatment protocols of relapse prevention efforts or recovery programs. For example, the counselor might inquire about past participation in special education or related testing.

Assessment Step 7—Application to Case Example

Case 1. Assessment of Maria M.'s functional capacity at baseline indicated that she could read only at a second grade level. Consequently, educational materials presented in written form needed to be presented in alternative formats. These included audiotapes and videos to teach her about addiction, depression, trauma, and recovery from these conditions. In addition, Maria M.'s history of trauma (previously discussed) led her to experience anxiety in large group situations, particularly where men were present. This led her counselor to recommend attending 12-Step meetings that were smaller and/or women only. The counselor also suggested that she attend in the company of female peers. Further, the clinician referred her to trauma-specific counseling.

Assessment Step 7—Application to Case Example

Case 3. Once Jane B. had begun to stabilize on medication and expressed interest in residential addiction treatment, it became necessary to assess her ability to participate in standard dual diagnosis capable (DDC) treatment versus her need for more dual diagnosis enhanced (DDE) treatment. Jane B. was still living in a shelter, but was able to maintain her personal hygiene and dress appropriately now that she was on medication. She looked somewhat suspicious and guarded, but could answer questions appropriately and denied having hallucinations.

To determine her ability to succeed in standard residential substance abuse treatment, her counselor asked her to attend an AA meeting. The clinician also asked her to complete an assignment to read some substance abuse literature and write down what she had learned. The client reported that she was nervous at the meeting but was able to stay the whole time. She said that she related well to what one of the speakers was saying. She also completed the written assignment quite well; it turned out she was very bright and had completed 1 year of college. Noting that she was complying with medication and her mental status was stable, the counselor felt comfortable referring her to the DDC program.

Had this client been unable to attend AA without individual support, or if she experienced obvious difficulty with the assignment, it would have been clearer that a program with an enhanced capacity to treat persons with COD would be indicated. If such a program were not available, she would have needed to continue to build skills slowly to address her substance use with the assistance of her outpatient case management program.

Assessing functional capability

Current level of impairment is determined by assessing functional capabilities and deficits in each of the areas listed below. Similarly, baseline level of impairment is determined by identifying periods of extended abstinence and mental health stability (greater than 30 days) according to the methods described in the previous assessment step. The clinician determines:

- Is the client capable of living independently (in terms of independent living skills, not in terms of maintaining abstinence)? If not, what types of support are needed?
- Is the client capable of supporting himself financially? If so, through what means? If not, is the client disabled, or dependent on others for financial support?
- Can the client engage in reasonable social relationships? Are there good social supports? If not, what interferes with this ability, and what supports would the client need?
- What is the client's level of intelligence? Is there a developmental or learning disability? Are there cognitive or memory impairments that impede learning? Is the client limited in ability to read, write, or understand? Are there difficulties with focusing, concentrating, and completing tasks?

The ASI (McLellan et al. 1992) and the GAIN (Dennis 1998) provide some information about level of functioning for individuals with substance use disorders. They are valuable when supplemented by interview information in the above areas. (Note that the ASI also exists in an expanded version specifically for women [ASI-F, CSAT 1997*c*].) The counselor also should inquire about any current or past difficulties the client has had in learning or using relapse prevention skills, participating in self-help recovery programs, or obtaining medication or following medication regimens. In the same vein, the clinician may inquire about use of transportation, budgeting, self-care, and other related skills, and their effect on life functioning and treatment participation.

For individuals with COD, the impairment may be related to intellectual/cognitive ability or the mental disability. These disorders may exist in addition to the substance use disor-

der. The clinician should try to establish both level of intellectual/cognitive functioning in childhood and whether any impairment persists, and if so, at what level, during the periods when substance use is in full or partial remission, just as in the above discussion of diagnosis.

Determining the need for "Capable" or "Enhanced" level services

A specific tool to assess the need for "Capable" or "Enhanced" level services for persons with COD currently is not available. The consensus panel recommends a process of "practical assessment" that seeks to match the client's assessment (mental health, substance abuse, level of impairment) to the type of services needed. The individual may even be given trial tasks or assignments to determine in concert with the counselor if her performance meets the requirements of the program being considered.

Assessment Step 8: Identify Strengths and Supports

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.

Questions might focus on

- Talents and interests
- Areas of educational interest and literacy; vocational skill, interest, and ability, such as vocational skills, social skills, or capacity for creative self-expression
- Areas connected with high levels of motivation to change, for either disorder or both
- Existing supportive relationships, treatment, peer, or family, particularly ongoing mental disorder treatment relationships
- Previous mental health services and addiction treatment successes, and exploration of what worked
- Identification of current successes: What has the client done right recently, for either disorder?
- Building treatment plans and interventions based on utilizing and reinforcing strengths, and extending or supporting what has worked previously

Assessment Step 8—Application to Case Examples

Case 2. George T. had significant strengths in three areas: He had a strong desire to maintain his family, significant pride in his job, and attachment to a mutual self-help group for individuals with bipolar disorder—Manic-Depressive and Depressive Association (MDDA). Therefore his treatment plan involved attending a recovery group managed by the Employee Assistance Program (EAP) at his company (which included regularly monitored urine screens), family counseling sessions, and utilization of his weekly MDDA group for peer support. Despite not feeling engaged fully, George T. continued to attend 12-Step meetings two times per week, as there was no Dual Recovery Anonymous or Double Trouble meeting available in his area.

Case 3. Jane B. expressed significant interest in work, once her paranoia subsided. She was attempting to address her substance use on an outpatient basis, as an appropriate residential treatment program was not available. Her case management team found that she had some interest and experience in caring for animals, and, using individualized placement and support, helped her obtain a part-time job at a local pet shop two afternoons per week. She felt very proud of being able to do this, and reported that this helped her to maintain her motivation to stay away from substances and to keep taking medication.

For individuals with mental disabilities and COD, the Individualized Placement and Support model of psychiatric rehabilitation has been demonstrated to promote better vocational outcomes and (consequently) better substance abuse outcomes compared both to other models of vocational rehabilitation for this population and to outcomes when rehabilitative interventions are not offered (Becker et al. 2001). In this model, clients with disabilities who want to work may be placed in sheltered work activities based on strengths and preferences, even when actively using substances and inconsistently complying with medication regimens. In nonsheltered work activities, it is critical to remember that many employers have alcohol- and drug-free workplace policies. Participating in ongoing jobs is valuable to self-esteem in itself and can generate the motivation to address mental disorders and substance issues as they appear to interfere specifically with work success. Taking advantage of educational and volunteer opportunities also may enhance self-esteem and are often first steps in securing employment.

Social Security Disability secondary to a mental disorder, such as schizophrenia, usually is referred to as Supplemental Security Income (if the person never worked regularly), or Social Security Disability Insurance (if the person worked regularly and contributed social security payments while working). To qualify as having a mental disability, a person must have not only a confirmed major mental disorder diagnosis, but also a pattern related to the impact of that mental disorder diagnosis on his social and functional behavior that prevents employment. Social security disability benefits for an addiction disorder alone were abandoned by the Federal government in 1997. For persons with COD, disability must be caused by the mental disorder alone and not the combination of both mental and addiction disorders. Social security disability evaluation forms ask carefully about these issues and also ask whether the person is actively participating in treatments for their COD and substance abuse problems.

Assessment Step 9: Identify Cultural and Linguistic Needs and Supports

As noted above, detailed cultural assessment of individuals with substance use disorders is beyond the scope of this chapter. Cultural assessment of individuals with COD is not substantially different from cultural assessment for individuals with substance abuse or mental disorders only, but there are some specific issues that are worth addressing. These include

- Not fitting into the treatment culture (do not fit into either substance abuse or mental health treatment culture) and conflict in treatment
- Cultural and linguistic service barriers
- Problems with literacy

Not fitting into the treatment culture

To a certain degree, individuals with COD and SMI tend not to fit into existing treatment cultures. Most of these clients are aware of a variety of different attitudes and suggestions toward their disorders that can affect relationships with others. Traditional culture carriers (parents, grandparents) may have different

Assessment Step 9—Application to Case Example

Case 1. Maria M. initially had difficulty identifying herself as being a victim of trauma both because she had normalized her perception of her early family experience with her abusive father and because she had received cultural reinforcement in the past that condoned the behavior of her abusive boyfriend as "normal *machismo*." Referral to a group that included other Hispanic women who also had suffered abuse was very helpful to her. With the help of the group, she began to recognize the reality of the impact that trauma had had in her life.

Assessment Step 9—Application to Case Example

Case 2. George T. originally was referred to Cocaine Anonymous (CA) by his counselor because the counselor knew of several local meetings with a large membership of African-American men. When George T. went, however, he reported back to the counselor that he did not feel comfortable there. First, he felt that as a family man with a responsible job he had pulled himself out of the "street culture" that was prevalent at the meeting. Second, unlike many people with COD who feel more ashamed of mental disorders than addiction, he felt more ashamed at the CA meeting than at his support group for persons with mental disorders. Therefore, for George, it was more "culturally appropriate" to refer him to 12-Step meetings attended by other middle class individuals (regardless of race) and to continue to encourage him to attend his MDDA support group for his mental disorder.

views of their problems and the most appropriate treatment compared to peers. Individual clients may have positive or negative allegiance to a variety of peer or treatment cultures (e.g., mental health consumer movement, having mild or moderate severity mental disorders versus severe and persistent mental illness [SPMI], 12-Step or dual recovery self-help, etc.) based on past experience or on fears and concerns related to the mental disorder. Specific considerations to explore with the client include

- How are your substance abuse and mental health problems defined by your parents? Peers? Other clients?
- What do they think you should be doing to remedy these problems?
- How do you decide which suggestions to follow?
- In what kinds of treatment settings do you feel most comfortable?
- What do you think I (the counselor) should be doing to help you improve your situation?

Cultural and linguistic service barriers

Access to COD treatment is compounded by cultural or linguistic barriers. The assessment process must address specifically whether these barriers prevent access to care (e.g., the client reads or speaks only Spanish, or does not read any language) and if so, determine some possibilities for providing more individualized intervention or for integrating intervention into naturalistic culturally and linguistically appropriate human service settings.

Assessment Step 10: Identify Problem Domains

Individuals with COD may have difficulties in multiple life domains (e.g., medical, legal, vocational, family, social). As noted earlier, research by McLellan and others has determined the value of providing assistance in each problem area in promoting better outcomes (McLellan et al. 1997). The ASI is a tool that is used widely to identify and quantify addiction-related problems in multiple

Assessment Step 10—Application to Case Example

Case 2. Evaluation of George T. revealed several interrelated problem domains. First, it was established that work represented a major problem area, and that he risked losing his job if he did not comply with treatment. Further inquiry into the details of this expectation led the counselor to discover that the client had been evaluated by the EAP and had a very specific requirement to maintain cocaine abstinence with mandatory urine screens, meet treatment program attendance requirements, and adhere to a lithium treatment regimen, with mandatory reports of lithium levels.

domains, thereby determining which domains require specific attention. The value of the ASI is that it permits *identification of problem domains*. It is used most effectively as a component of a comprehensive assessment.

A comprehensive evaluation for individuals with COD requires clarifying how each disorder interacts with the problems in each domain, as well as identifying contingencies that might promote treatment adherence for mental health and/or substance abuse treatment. Information about others who might assist in the implementation of such contingencies (e.g., probation officers, family, friends) needs to be gathered, including appropriate releases of information.

Assessment Step 11: Determine Stage of Change

A key evidence-based best practice for treatment matching of individuals with COD in both substance abuse treatment and mental health services settings is the following:

- For each disorder or problem, interventions have to be matched not only to specific diagnosis, but also to stage of change; the interventions also should be consistent with the stage of treatment for each disorder.

In substance abuse treatment settings, stage of change assessment usually involves determination of Prochaska and DiClemente Stages of Change: precontemplation, contemplation, preparation (or determination), action, maintenance, and relapse (Prochaska and DiClemente 1992). This can involve using questionnaires such as the URICA (McConnaughy et al. 1983) or the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) (Miller and Tonigan 1996). It also can be determined clinically by interviewing the client and evaluating the client's responses in terms of stages of change. For example, a simple approach to identification of stage of change can be the following.

For each problem, select the statement that most closely fits the client's view of that problem:

- No problem and/or no interest in change (Precontemplation)
- Might be a problem; might consider change (Contemplation)
- Definitely a problem; getting ready to change (Preparation)
- Actively working on changing, even if slowly (Action)
- Has achieved stability, and is trying to maintain (Maintenance)

Stage of change assessment ideally will be applied separately to each mental disorder and to each substance use disorder. For example, a client may be willing to take medication for a depressive disorder, but unwilling to discuss trauma issues (as in case 1, Maria M.); or motivated to stop cocaine, but unwilling to consider alcohol as a problem (as in case 2, George T.).

Assessment Step 11—Application to Case Example

A 50-year-old Liberian woman with a diagnosis of paranoid schizophrenia, Lila B. illustrates the existence of differential stages of change for mental and substance abuse problems. The client permitted the case manager nurse to come to her home to give her intramuscular antipsychotic injections for her "nerves," but would not agree to engage in any other treatment activity or acknowledge having a serious mental disorder. She also had significant alcohol dependence, with an alcohol level of 0.25 to 0.3 most of the time, with high tolerance. She denied adamantly that she had used alcohol in the last 18 months, stating that her liver was impaired and therefore unable to get rid of the alcohol. She was able to agree that she had a "mysterious alcohol level problem" that might warrant medical hospitalization for testing and perhaps treatment, as well as evaluation of her recent onset rectal bleeding.

Although literature supporting the importance of stage-specific treatment has been available in both mental health and addiction literature for over a decade, very few programs routinely evaluate stage of change for the purpose of treatment matching.

In mental health settings working with individuals with SMI, the Substance Abuse Treatment Scale (SATS) (McHugo et al. 1995) is recommended strongly (www.dartmouth.edu/~psychrc/instru.html). This is a case-manager rated scale with eight items identified by the degree of the client's engagement in treatment. The stages are

- Pre-Engagement
- Engagement
- Early Persuasion
- Late Persuasion
- Early Active Treatment
- Late Active Treatment
- Relapse Prevention
- Remission

For more in-depth discussion of the stages of change and motivational enhancement, the reader is referred to TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*b*).

Assessment Step 12: Plan Treatment

A major goal of the screening and assessment process is to ensure the client is matched with appropriate treatment. Acknowledging the overriding importance of this goal, this discussion of the process of clinical assessment for individuals with COD begins with a fundamental statement of principle:

- Since clients with COD are not all the same, program placements and treatment interventions should be matched individually to the needs of each client.

The ultimate purpose of the assessment process is to develop an appropriately individualized integrated treatment plan. In this model, following the work of McLellan on comprehensive services for populations with substance use disorders, Minkoff on COD, and others, the consensus panel recommends the following approach:

- Treatment planning for individuals with COD and associated problems should be designed according to the principle of mental disorder dual (or multiple) primary treatment, where each disorder or problem has a specific intervention that is matched to problem or diagnosis, as well as to stage of change and external contingencies. Figure 4-2 (p. 96) shows a sample treatment plan consisting of the problem, intervention, and goal.
- Integrated treatment planning involves helping the client to make the best possible treatment choices for each disorder and adhere to that treatment consistently. At the same time, the counselor needs to help the client adjust the recommended treatment strategies for each disorder as needed in order to take into account issues related to the other disorder.

These principles are best illustrated by using a case example to develop a sample treatment plan. For this purpose, case 2 (George T.) is used and incorporates the data gathered during the assessment process discussion above (see Figure 4-1). Note that the problem description presents a variety of information bearing on the problem, including stage of change and client strengths. Also note that no specific person is recommended to carry out the intervention proposed in the second column, since a range of professionals might carry out each intervention appropriately.

Considerations in Treatment Matching

Previous chapters introduced a variety of concepts for categorizing individuals with COD and the clinicians, programs, and systems responsible for serving those individuals. The consensus panel has identified critical factors that have been determined, either by research evidence or by consensus clinical practice, to be relevant to the process of matching individu-

Figure 4-2
Sample Treatment Plan for George T. (Case 2)

PROBLEM	INTERVENTION	GOAL
1. Cocaine Dependence • Work problem primary reason for referral • Family and work support • Resists 12-Step • Mental symptoms trigger use • Action phase	Outpatient treatment • EAP monitoring • Family meetings • Work support group • Teach skills to manage symptoms without using • 12-Step meetings	Abstinence • Clean urines • Daily recovery plans
2. Rule Out Alcohol Abuse • No clear problem • May trigger cocaine use • Precontemplation	• Outpatient motivational enhancement; thorough evaluation of role of alcohol in patient's life, including family education	• Move into contemplation phase of readiness to change • Willing to consider the risk of use and/or possible abuse
3. Bipolar Disorder • Long history • On lithium • Some mood symptoms • Maintenance phase	• Medication management • Help to take medication while in recovery programs • MDDA meetings • Advocate/collaborate with prescribing health professional • Identify mood symptoms that are triggers	• Maintain stable mood • Able to manage fluctuating mood symptoms that do occur without using cocaine or other substances to regulate his bipolar disorder

al clients to available treatment. These considerations are shown in Figure 4-3.

Assessment Process Summary

The assessment process described above is a systematic approach for substance abuse treatment clinicians (and mental health clinicians) to gather the information needed to develop appropriately matched treatment plans for individuals with COD. The most important question about this process, from the clinician's standpoint, is the following:

But—can this really be done?

To answer the question, this process is approached from the perspective of a real system. Many public sector substance abuse treatment systems already define assessment procedures that require use of a level of care assessment tool (often the ASAM, but sometimes a State-derived version of the ASAM) and a comprehensive addiction severity and outcome measure (such as the ASI [McLellan et al. 1992]). How can the assessment process described here be built on these existing assessment procedures in a reasonably efficient manner?

The first steps involve engaging the client, gathering information from family and other providers, and beginning to screen for the presence of mental symptoms and disorders. The ASAM PPC-2R (and other level of care tools, such as LOCUS) will provide a reason-

Figure 4-3
Considerations in Treatment Matching

Variable	Key Data
Acute Safety Needs Determines need for immediate acute stabilization to establish safety prior to routine assessment	• Immediate risk of harm to self or others • Immediate risk of physical harm or abuse from others (ASAM 2001) • Inability to provide for basic self-care • Medically dangerous intoxication or withdrawal • Potentially lethal medical condition • Acute severe mental symptoms (e.g., mania, psychosis) leading to inability to function or communicate effectively
Quadrant Assignment Guides the choice of the most appropriate setting for treatment	• SPMI versus non-SPMI • Severely acute and/or disabling mental symptoms versus mild to moderate severity symptoms • High severity substance use disorder (e.g., active substance dependence) versus lower severity substance use disorder (e.g., substance abuse) • Substance dependence in full versus partial remission (ASAM 2001; National Association of State Mental Health Program Directors/National Association of State Alcohol and Drug Abuse Directors 1999)
Level of Care Determines the client's program assignment	• Dimensions of assessment for each disorder using criteria from ASAM PPC-2R and/or the LOCUS (see chapter 2)
Diagnosis Determines the recommended treatment intervention	• Specific diagnosis of each mental and substance use disorder, including distinction between substance abuse and substance dependence and substance-induced symptoms • Information about past and present successful and unsuccessful treatment efforts for each diagnosis • Identification of trauma-related disorders and culture-bound syndromes, in addition to other mental disorders and substance-related problems

Figure 4-3 (continued) *Considerations in Treatment Matching*	
Disability Determines case management needs and whether a standard intervention is sufficient—one that is at the "capable" or intermediate level—or whether a more advanced "enhanced" level intervention is essential	• Cognitive deficits, functional deficits, and skill deficits that interfere with ability to function independently and/or follow treatment recommendations and which may require varying types and amounts of case management and/or support • Specific functional deficits that may interfere with ability to participate in substance abuse treatment in a particular program setting and may therefore require a DDE setting rather than DDC • Specific deficits in learning or using basic recovery skills that require modified or simplified learning strategies
Strengths and Skills Determines areas of prior success around which to organize future treatment interventions Determines areas of skills building needed for disease management of either disorder	• Areas of particular capacity or motivation in relation to general life functioning (e.g., capacity to socialize, work, or obtain housing) • Ability to manage treatment participation for any disorder (e.g., familiarity and comfort with 12-Step programs, commitment to medication adherence)
Availability and Continuity of Recovery Support Determines whether continuing relationships need to be established and availability of existing relationships to provide contingencies to promote learning	• Presence or absence of continuing treatment relationships, particularly mental disorder treatment relationships, beyond the single episode of care • Presence or absence of an existing and ongoing supportive family, peer support, or therapeutic community; quality and safety of recovery environment (ASAM 2001)
Cultural Context Determines most culturally appropriate treatment interventions and settings	• Areas of cultural identification and support in relation to each of the following • Ethnic or linguistic culture identification (e.g., attachment to traditional American-Indian cultural healing practices) • 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) • Gender • Sexual orientation • Rural versus urban

Figure 4-3 (continued) Considerations in Treatment Matching	
Problem Domains Determines problems to be solved specifically, and opportities for contingencies to promote treatment participation	Is there impairment, need, or (conversely) strength in any of the following areas • Financial • Legal • Employment • Housing • Social/family • Medical, parenting/child protective, abuse/victimization/victimizer Note: Each area of need may be associated with the presence of contingencies and/or supports that may affect treatment motivation and participation (McLellan et al. 1993, 1997)
Phase of Recovery/Stage of Change (for each problem) Determines appropriate phase-specific or stage-specific treatment intervention and outcomes	• Requirement for acute stabilization of symptoms, engagement, and/or motivational enhancement • Active treatment to achieve prolonged stabilization • Relapse prevention/maintenance • Rehabilitation, recovery, and growth • Within the motivational enhancement sequence, precontemplation, contemplation, preparation, action, maintenance, or relapse (Prochaska and DiClemente 1992) • Engagement, persuasion, active treatment, or relapse prevention (McHugo et al. 1995; Osher and Kofoed 1989)

able way of screening for acute safety issues and presence of persistent mental disorders and disability. The ASI also provides a low-power screen for mental health difficulties (McLellan et al. 1992). These tools alone can provide a beginning picture of whether there is a need for acute mental health services intervention, ongoing case management, and/or in-depth mental assessment. The consensus panel recommends use of a low- or medium-power symptom screening tools in addition to low-power tools (e.g., M.I.N.I. or Mental Health Screening Form [Carroll and McGinley 2001]), but in many settings, ASAM plus ASI will suffice.

Next, the information gathered from ASAM and ASI can give a sufficient picture of mental impairment and substance use disorder severity to promote quadrant identification, and the ASAM itself clearly is used to identify level of care. The ASI further screens for problem domains, including a beginning picture of mental health disability.

Finally, ASAM PPC-2R includes attention to stage of change for both mental health and

substance-related issues in dimension 4. Other level of care tools cover similar ground.

Through the assessment process, the counselor seeks to accomplish the following aims:

- To obtain a more detailed chronological history of past mental symptoms, diagnosis, treatment, and impairment, particularly before the onset of substance abuse, and during periods of extended abstinence.
- To obtain a more detailed description of current strengths, supports, limitations, skill deficits, and cultural barriers related to following the recommended treatment regime for any disorder or problem.
- To determine the *stage of change for each problem,* and identify external contingencies that might help to promote treatment adherence.

Most of these activities are already a natural component of substance abuse-only assessment; the key addition is to attend to treatment requirements and stage of change for mental disorders, and the possible interference of mental health symptoms and disabilities (including personality disorder symptoms) in addiction treatment participation.

5 Strategies for Working With Clients With Co-Occurring Disorders

In This Chapter…

Guidelines for a Successful Therapeutic Relationship With a Client Who Has COD

Techniques for Working With Clients With COD

Overview

Maintaining a therapeutic alliance with clients who have co-occurring disorders (COD) is important—and difficult. The first section of this chapter reviews guidelines for addressing these challenges. It stresses the importance of the counselor's ability to manage feelings and biases that could arise when working with clients with COD (sometimes called countertransference). Together, clinicians and clients should monitor the client's disorders by examining the status of each disorder and alerting each other to signs of relapse. The consensus panel recommends that counselors use primarily a supportive, empathic, and culturally appropriate approach when working with clients with COD. With some clients who have COD, it is important to distinguish behaviors and beliefs that are cultural in origin from those indicative of a mental disorder. Finally, counselors should increase structure and support to help their clients with COD make steady progress throughout recovery.

The second part of this chapter describes techniques effective in counseling clients with COD. One is the use of motivational enhancement consistent with the client's specific stage of recovery. This strategy is helpful even for clients whose mental disorder is severe. Other strategies include contingency management, relapse prevention, and cognitive–behavioral techniques. For clients with functional deficits in areas such as understanding instructions, repetition and skill-building strategies can aid progress. Finally, 12-Step and other dual recovery mutual self-help groups have value as a means of supporting individuals with COD in the abstinent life. Clinicians often play an important role in facilitating the participation of these clients in such groups. This chapter will provide a basic overview of how counselors can apply each of these strategies to their clients who have COD. The material in this chapter is consistent with national or State consensus practice guidelines for COD treatment, and consonant with many of their recommendations.

The purpose of this chapter is to describe for the addiction counselor and other practitioners how these guidelines and techniques, many of which are useful in the treatment of substance abuse or as general treatment principles, can be modified specifically and applied to people with COD. These guidelines and techniques are particularly relevant in working with clients in quadrants II and III. Additionally, this chapter contains Advice to the Counselor boxes to highlight the most immediate practical guidance (for a full listing of these boxes see the table of contents).

Guidelines for a Successful Therapeutic Relationship With a Client Who Has COD

The following section reviews seven guidelines that have been found to be particularly helpful in forming a therapeutic relationship with clients who have COD (see text box below).

Develop and Use a Therapeutic Alliance To Engage the Client in Treatment

General. Research suggests that a therapeutic alliance is "one of the most robust predictors of treatment outcome" in psychotherapy (Najavits et al. 2000, p. 2172). Some studies in the substance abuse treatment field also have found associations between the strength of the therapeutic alliance and counseling effectiveness. One research team found that both clinician and client ratings of the alliance were strong predictors of alcoholic outpatients' treatment participation in treatment, drinking behavior during treatment, and drinking behavior at a 12-month follow-up, even after controlling for a variety of other sources of variance (Connors et al. 1997). Similarly, Luborsky and colleagues (1985) found that the development of a "helping alliance" was correlated with positive outcomes.

A number of researchers have verified that clients are more responsive when the therapist acts consistently as a nurturing and nonjudgmental ally (Frank and Gunderson 1990; Luborsky et al. 1997; Siris and Docherty 1990; Ziedonis and D'Avanzo 1998). For example, in a study of clients with opioid dependence and psychopathology, Petry and Bickel (1999) found that among clients with moderate to severe psychiatric problems, fewer than 25 percent of those with weak therapeutic alliances completed treatment, while more than 75 percent of those with strong therapeutic alliances completed treatment. In this study, they did not find the strength of the therapeutic alliance to be

Guidelines for Developing Successful Therapeutic Relationships With Clients With COD

1. Develop and use a therapeutic alliance to engage the client in treatment
2. Maintain a recovery perspective
3. Manage countertransference
4. Monitor psychiatric symptoms
5. Use supportive and empathic counseling
6. Employ culturally appropriate methods
7. Increase structure and support

related to treatment completion among clients with few psychiatric symptoms.

Advice to the Counselor: Forming a Therapeutic Alliance

The consensus panel recommends the following approaches for forming a therapeutic alliance with clients with COD:

- Demonstrate an understanding and acceptance of the client.
- Help the client clarify the nature of his difficulty.
- Indicate that you and the client will be working together.
- Communicate to the client that you will be helping her to help herself.
- Express empathy and a willingness to listen to the client's formulation of the problem.
- Assist the client to solve some external problems directly and immediately.

Challenges for the clinician

General. The clinician's ease in working toward a therapeutic alliance also is affected by his or her comfort level in working with the client. Substance abuse counselors may find some clients with significant mental illnesses or severe substance use disorders to be threatening or unsettling. It is therefore important to recognize certain patterns that invite these feelings and not to let them interfere with the client's treatment. This discomfort may be due to a lack of experience, training, or mentoring. Likewise, some mental health clinicians may feel uncomfortable or intimidated by clients with substance use disorders. Clinicians who experience difficulty forming a therapeutic alliance with clients with COD are advised to consider whether this is related to the client's difficulties; to a limitation in the clinician's own experience and skills; to demographic differences between the clinician and the client in areas such as age, gender, education, race, or ethnicity; or to issues involving countertransference (see the discussion of countertransference below). A consultation with a supervisor or peer to discuss this issue is important. Often these reactions can be overcome with further experience, training, supervision, and mentoring.

Individuals with COD often experience demoralization and despair because of the complexity of having two problems and the difficulty of achieving treatment success. Inspiring hope often is a necessary precursor for the client to give up short-term relief in exchange for long-term work with some uncertainty as to timeframe and benefit.

Challenges in working with clients with serious mental and substance use disorders. Achieving a therapeutic alliance with clients with serious mental illness and substance use disorders can be challenging. According to Ziedonis and D'Avanzo (1998), many people who abuse substances also may have some antisocial traits. Such individuals are "less amenable to psychological and pharmacological interventions and avoid contact with the mental health treatment staff." Therefore, it is reasonable to conclude that "the dually diagnosed are less likely to develop a positive therapeutic alliance than non–substance-abusing patients with schizophrenia…" (p. 443).

Individuals with both schizophrenia and a substance use disorder may be particularly challenging to treat. These individuals "present and maintain a less involved and more distant stance in relation to the therapist than do non–substance-abusing individuals with schizophrenia" (Ziedonis and D'Avanzo 1998,

p. 443). The presence or level of these deficits may vary widely for people living with schizophrenia, and also may vary significantly for that individual within the course of his illness and the course of his lifetime. While "this configuration of interpersonal style suggests that developing a therapeutic alliance can be difficult," Ziedonis and D'Avanzo insist, "working with the dually diagnosed requires a primary focus on the therapeutic alliance" (Ziedonis and D'Avanzo 1998, p. 444).

For all clients with co-occurring disorders, the therapeutic relationship must build on the capacity that does exist. These clients often need the therapeutic alliance to foster not only their engagement in treatment but as the cornerstone of the entire recovery process. Once established, the therapeutic alliance is rewarding for both client and clinician and facilitates their participation in a full range of therapeutic activities; documentation of these types of interactions provides an advantage in risk management.

Maintain a Recovery Perspective

Varied meanings of "recovery"

The word "recovery" has different meanings in different contexts. Substance abuse treatment clinicians may think of a person who has changed his or her substance abuse behavior as being "in recovery" for the rest of his or her life (although not necessarily in formal treatment forever). Mental health clinicians, on the other hand, may think of recovery as a process in which the client moves toward specific behavioral goals through a series of stages. Recovery is assessed by whether or not these goals are achieved. For persons involved with 12-Step programs, recovery implies not only abstinence from drugs or alcohol but also a commitment to "work the steps," which includes changing the way they interact with others and taking responsibility for their actions. Consumers with mental disorders may see recovery as the process of reclaiming a meaningful life beyond mental disorder, with symptom control and positive life activity.

While "recovery" has many meanings, generally, it is recognized that recovery does not refer solely to a change in substance use, but also to a change in an unhealthy way of living. Markers such as improved health, better ability to care for oneself and others, a higher degree of independence, and enhanced self-worth are all indicators of progress in the recovery process.

Implications of the recovery perspective

The recovery perspective as developed in the substance abuse field has two main features: (1) It acknowledges that recovery is a long-term process of internal change, and (2) it recognizes that these internal changes proceed through various stages (see De Leon 1996 and Prochaska et al. 1992 for a detailed description).

The recovery perspective generates at least two main principles for practice:

- ***Develop a treatment plan that provides for continuity of care over time.*** In preparing this plan, the clinician should recognize that treatment may occur in different settings over time (e.g., residential, outpatient) and that much of the recovery process is client-driven and occurs typically outside of or following professional treatment (e.g., through participation in mutual self-help groups) and the counselor should reinforce long-term participation in these constantly available settings.
- ***Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the COD recovery process.*** The use of treatment interventions that are specific to the tasks and challenges faced at each stage of the COD recovery process enables the clinician (whether within the substance abuse or mental health treatment system) to use sen-

Advice to the Counselor: Maintaining a Recovery Perspective

The consensus panel recommends the following approaches for maintaining a recovery perspective with clients who have COD:

- Assess the client's stage of change (see section on Motivational Enhancement below).
- Ensure that the treatment stage (or treatment expectations) is (are) consistent with the client's stage of change.
- Use client empowerment as part of the motivation for change.
- Foster continuous support.
- Provide continuity of treatment.
- Recognize that recovery is a long-term process and that even small gains by the client should be supported and applauded.

sible stepwise approaches in developing and using treatment protocols. In addition, markers that are unique to individuals—such as those related to their cultural, social, or spiritual context—should be considered. It is therefore important to engage the client in defining markers of progress that are meaningful to him and to each stage of recovery.

Stages of change and stages of treatment

Working within the recovery perspective requires a thorough understanding of the interrelationship between stages of change (see De Leon 1996 and Prochaska et al. 1992) and stages of treatment (see section on motivational enhancement below for a description of the stages of change; see also TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [Center for Substance Abuse Treatment (CSAT) 1999*b*]). De Leon has developed a measure of motivation for change and readiness for treatment—The Circumstances, Motivation and Readiness Scales—and provided scores for samples of persons with COD (De Leon et al. 2000*a*). De Leon has demonstrated the relationship between these scales and retention in treatment for general substance abuse treatment populations and programs (De Leon 1996). It is important that the expectation for the client's progress through treatment stages (e.g., outreach, stabilization, early-middle-late primary treatment, continuing care, and long-term care/cycles into and out of treatment) be consistent with the client's stage of change.

Client empowerment and responsibility

The recovery perspective also emphasizes the empowerment and responsibility of the client and the client's network of family and significant others. As observed by the American Association of Community Psychiatrists (AACP), the strong client empowerment movement within the mental health field is a cornerstone for recovery:

> Pessimistic attitudes about people with COD represent major barriers to successful system change and to effective treatment interventions … recovery is defined as a process by which a person with persistent, possibly disabling disorders, recovers self-esteem, self-worth, pride, dignity, and meaning, through increasing his or her ability to maintain stabilization of the disorders and maximizing functioning within the constraints of the disorders. As a general principle, every person, regardless of the severity and disability associated with each disorder, is entitled to experience the promise and hope of dual recovery, and is considered to have the potential to achieve dual recovery (AACP 2000*b*).

Continuous support

Another implication of the recovery perspective is the need for continuing support for recovery. This means the provider encourages clients to build a support network that offers respect, acceptance, and appreciation. For example, an important element of long-term participation in

Alcoholics Anonymous (AA) is the offering of a place of belonging or a "home." AA accomplishes this supportive environment without producing overdependence because the client is expected to contribute, as well as receive, support.

Continuity of treatment

An emphasis on continuity of treatment also flows from a recovery perspective. Continuity of treatment implies that the services provided by the program are constant, and a client might remain a consumer of substance abuse or mental health services indefinitely. Treatment continuity for individuals with COD begins with proper and thorough identification, assessment, and diagnosis. It includes easy and early access to the appropriate service providers "…through multiple episodes of acute and subacute treatment … independent of any particular setting or locus of care" (AACP 2000*b*).

Manage Countertransference

Though somewhat dated and infrequently used in the COD literature, the concept of "countertransference" is useful for understanding how the clinician's past experience can influence current attitudes toward a particular client. "Transference" describes the process whereby clients project attitudes, feelings, reactions, and images from the past onto the clinician. For example, the client may regard the clinician as an "authoritative father," "know-it-all older brother," or "interfering mother."

Once considered a technical error, countertransference now is understood to be part of the treatment experience for the clinician. Particularly when working with multiple and complicated problems, clinicians are vulnerable to the same feelings of pessimism, despair, anger, and the desire to abandon treatment as the client. Inexperienced clinicians often are confused and ashamed when faced with feelings of anger and resentment that can result from situations where there is a relative absence of gratification from working with clients with these disorders (Cramer 2002). Less experienced practitioners may have more difficulty identifying countertransference, accessing feelings evoked by interactions with a client, naming them, and working to keep these feelings from interfering with the counseling relationship.

Both substance use disorders and mental disorders are illnesses that are stigmatized by the general public. These same attitudes can be present among clinicians. Mental health clinicians who usually do not treat persons with substance abuse issues may not have worked out their own response to the disorder, which can influence their interactions with the client. Similarly, substance abuse treatment clinicians may not be aware of their own reactions to persons with specific mental disorders and may have difficulty preventing these reactions from influencing treatment. The clinician's negative attitudes or beliefs may be communicated, directly or subtly, to the client. For example: "I was depressed too, but I never took medications for it—I just worked the steps

Advice to the Counselor: Managing Countertransference

The consensus panel recommends the following approach for managing countertransference with clients who have COD:

- The clinician should be aware of strong personal reactions and biases toward the client.
- The clinician should obtain further supervision where countertransference is suspected and may be interfering with counseling.
- Clinicians should have formal and periodic clinical supervision to discuss countertransference issues with their supervisors and the opportunity to discuss these issues at clinical team meetings.

and got over it. So why should this guy need medication?"

Such feelings often are related to burnout and are exacerbated by the long time required to see progress in many clients with COD. For example, one study found that therapists' attitudes toward their substance abuse clients tended to become more negative over time, though the increasing negativity was found to be less extreme for substance abuse counselors without graduate degrees who used the 12 steps to inform their counseling approach than for psychotherapists with graduate training who participated in the study (Najavits et al. 1995). (For a full discussion of countertransference in substance abuse treatment see Powell and Brodsky 1993.)

Cultural issues also may arouse strong and often unspoken feelings and, therefore, generate transference and countertransference. Although counselors working with clients in their area of expertise may be familiar with countertransference issues, working with an unfamiliar population will introduce different kinds and combinations of feelings.

The clinician is advised to understand and be familiar with some of the issues related to countertransference and strategies to manage it. Such countertransference issues are particularly important when working with persons with COD because many people with substance abuse and mental disorders may evoke strong feelings in the clinician that could become barriers to treatment if the provider allows them to interfere. The clinician may feel angry, used, overwhelmed, confused, anxious, uncertain how to proceed with a case, or just worn out.

Monitor Psychiatric Symptoms

In working with clients who have COD, especially those requiring medications or who also are receiving therapy from a mental health services provider, it is especially important for the substance abuse counselor to participate in the development of the treatment plan and to monitor psychiatric symptoms. At a minimum, the clinician should be knowledgeable about the overall treatment plan to permit reinforcement of the mental health part of the plan as well as the part specific to recovery from addiction.

It is equally important that the client participate in the development of the treatment plan. For example, for a client who has both bipolar disorder and alcoholism, and who is receiving treatment at both a substance abuse treatment agency and a local mental health center, the treatment plan might include individual substance abuse treatment counseling, medication management, and group therapy. In another example, the substance abuse treatment clinician may assist in medication monitoring of a person taking lithium. The clinician can ask such questions as, "How are your meds doing? Are you remembering to take them? Are you having any problems with them? Do you need to check in with the prescribing doctor?" It also is prudent to ask the client to bring in all medications and ask the client how he is taking them, when, how much, and if medication is helping and how. Clinicians should help educate clients about the effects of medication, teach clients to monitor themselves (if possible),

Advice to the Counselor: Monitoring Psychiatric Symptoms

The consensus panel recommends the following approaches for monitoring psychiatric symptoms with clients with COD:

- Obtain a mental status examination to evaluate the client's overall mental health and danger profile. Ask questions about the client's symptoms and use of medication and look for signs of the mental disorder regularly.
- Keep track of changes in symptoms.
- Ask the client directly and regularly about the extent of his or her depression and any associated suicidal thoughts.

and consult with clients' physicians whenever appropriate.

Status of symptoms

Substance abuse counselors need to have a method by which to monitor changes in severity and number of symptoms over time. For example, most clients present for substance abuse treatment with some degree of anxiety or depressive symptoms. As discussed in chapters 2 and 4, these symptoms are referred to as substance induced if caused by substances and resolved within 30 days of abstinence. Substance-induced symptoms tend to follow the "teeter totter" principle of "what goes up, must come down," and vice versa—so that after a run of amphetamine or cocaine the individual will appear fatigued and depressed, while after using depressants such as alcohol or opioids, the individual more likely will appear agitated and anxious. These "teeter totter" symptoms are substance withdrawal effects and usually are seen for days or weeks. They may be followed by a substance-related depression (which can be seen as a neurotransmitter depletion state), which should begin to improve within a few weeks. If depressive or other symptoms persist, then a co-occurring (additional) mental disorder is likely, and the differential diagnostic process ensues. These symptoms may be appropriate target symptoms for establishing a diagnosis or determining treatment choices (medication, therapy, etc.). Clients using methamphetamines may present with psychotic symptoms that require medications.

A number of different tools are available to substance abuse treatment providers to help monitor psychiatric symptoms. Some tools are simply questions and require no formal instrument. For example, to gauge the status of depression quickly, ask the client: "On a scale of 0 to 10, how depressed are you? (0 is your best day, 10 is your worst)." This simple scale, used from session to session, can provide much useful information. Adherence to prescribed medication also should be monitored by asking the client regularly for information about its use and effect.

To identify changes, it is important to track symptoms that the client mentions at the onset of treatment from week to week. The clinician should keep track of any suggestions made to the client to alleviate symptoms to determine whether the client followed through, and if so, with what result. For example: "Last week you mentioned low appetite, sleeplessness, and a sense of hopelessness. Are these symptoms better or worse now?"

Potential for harm to self or others

Blumenthal (1988) has written an important paper on suicide and the risk for suicide in clients with COD. The following is derived largely from her writing.

Suicidality is a major concern for many clients with COD. Persons with mental disorders are at 10 times greater risk for suicide than the general population, and the risk for suicidal behavior and suicide is increased with almost every major mental disorder. Of adults who commit suicide, 90 percent have a mental disorder, most frequently a major affective illness or posttraumatic stress disorder (PTSD). Alcohol and substance abuse often are associated with suicides and also represent major risk factors. Clients with COD—especially those with affective disorders—have two of the highest risk factors for suicide.

For clients who mention or appear to be experiencing depression or sadness, it is always important to explore the extent to which suicidal thinking is present. Similarly, a client who reports that he or she is thinking of doing harm to someone else should be monitored closely. The clinician always should ask explicitly about suicide or the intention to do harm to someone else when the client assessment indicates that either is an issue.

In addition to asking the client about suicidal thoughts and plans as a routine part of every session with a suicidal or depressed person, Blumenthal stresses that *the clinician should immediately follow up appointments missed*

by an acutely suicidal person. Management of the suicidal client requires securing an appropriate mental health professional for the client and having the client monitored closely by that mental health professional. The counselor also should have 24-hour coverage available, such as a hotline for the client to call for help during off hours. However, there are effective ways of managing individuals who have suicidal thoughts but no immediate plan, and are willing and able to contact the counselor in the event these thoughts become too strong, prior to action. See the more extensive discussion of suicidality in chapter 8 and in appendix D of this TIP. Screening for suicide risk is discussed in chapter 4.

Use Supportive and Empathic Counseling

Definition and importance

A supportive and empathic counseling style is one of the keys to establishing an effective therapeutic alliance. According to Ormont, empathy is the ability to "experience another person's feeling or attitude while still holding on to our own attitude and outlook"; it is the foundation adults use for relating to and interacting with other adults (Ormont 1999, p. 145). The clinician's empathy enables clients to begin to recognize and own their feelings, an essential step toward managing them and learning to empathize with the feelings of others.

However, this type of counseling must be used consistently over time to keep the alliance intact. This caveat often is critical for clients with COD, who usually have lower motivation to address either their mental or substance abuse problems, have greater difficulty understanding and relating to other people, and need even more understanding and support to make a major lifestyle change such as adopting abstinence. Support and empathy on the clinician's part can help maintain the therapeutic alliance, increase client motivation, assist with medication adherence, model behavior that can help the client build more productive relationships, and support the client as he or she makes a major life transition.

Confrontation and empathy

The overall utility of confrontational techniques is well accepted in the substance abuse literature. It is used widely in substance abuse treatment programs, including those surveyed in the Drug Abuse Treatment Outcomes Study in which the effectiveness of such programs was demonstrated. Confrontation is a form of interpersonal exchange in which individuals present

Using an Empathic Style

Empathy is a key skill for the counselor, without which little could be accomplished. The practice of empathy "requires sharp attention to each new client statement, and a continual generation of hypotheses as to the underlying meaning" (Miller and Rollnick 1991, p. 26). An empathic style

- Communicates respect for and acceptance of clients and their feelings
- Encourages a nonjudgmental, collaborative relationship
- Allows the clinician to be a supportive and knowledgeable consultant
- Compliments and reinforces the client whenever possible
- Listens rather than tells
- Gently persuades, with the understanding that the decision to change is the client's
- Provides support throughout the recovery process

(See also TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999*b*], p. 41.)

to each other their observations of, and reactions to, behaviors and attitudes that are matters of concern and should change (De Leon 2000*b*).

In substance abuse treatment counseling, some tension always is felt between being empathic and supportive, and having to handle minimization, evasion, dishonesty, and denial. However, a counselor can be empathic and firm at the same time. This is especially true when working with clients with COD. The heart of confrontation is not the aggressive breaking down of the client and his or her defenses, but feedback on behavior and the compelling appeal to the client for personal honesty, truthfulness in interacting with others, and responsible behavior. A straightforward and factual presentation of conflicting material or of problematic behavior in an inquisitive and caring manner can be both "confrontative" and caring. The ability to do this well and with balance often is critical in maintaining the therapeutic alliance with a client who has COD. Chapter 6 includes a more complete discussion of confrontation including a definition, description of its application, and suggested modifications for using this technique with clients who have COD.

Employ Culturally Appropriate Methods

Understanding the client's cultural background

It is well known that population shifts are resulting in increasing numbers of minority racial and ethnic groups in the United States. Each geographic area has its own cultural mix, and providers are advised to learn as much as possible about the cultures represented in their treatment populations. Of particular importance are the backgrounds of those served, conventions of interpersonal communication, understanding of healing, views of mental disorder, and perception of substance abuse.

To work effectively with persons of various cultural groups, the provider should learn as much as possible about characteristics of the cultural group such as communication style, interpersonal interactions, and expectations of family. For example, some cultures may tend to somaticize symptoms of mental disorders, and clients from such groups may expect the clinician to offer relief for physical complaints. The same client may be offended by too many probing, personal questions early in treatment and never return. Similarly, understanding the client's role in the family and its cultural significance always is important (e.g., expectations of the oldest son, a daughter's responsibilities to her parents, grandmother as matriarch).

At the same time, the clinician should not make assumptions about any client based on his or her perception of the client's culture. The level of acculturation and the specific experiences of an individual may result in that person identifying with the dominant culture, or even other cultures. For example, a person from India adopted by American parents at an early age may know little about the cultural practices in his birth country. For such clients, it is still important to recognize the birth country and discover what this association means to the client; however, it may exert little influence on his beliefs and practices. For more detailed information about cultural issues in substance abuse treatment, see the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT in development *a*).

Clients' perceptions of substance abuse, mental disorders, and healing

Clients may have culturally driven concepts of what it means to abuse substances or to have a mental disorder, what causes these disorders, and how they may be "cured." Clinicians are encouraged to explore these concepts with people who are familiar with the cultures represented in their client population. Counselors should be alert to differences in how their role and the healing process are perceived by persons who are of cultures other than their own.

Advice to the Counselor: Using Culturally Appropriate Methods

The consensus panel recommends the following approach for using culturally appropriate treatment methods with clients with COD:

- Take cultural context, background, and experiences into account in the evaluation, diagnosis, and treatment of clients from various groups, cultures, or countries.
- Recognize the importance of culture and language, acknowledging the cultural strengths of a people.
- Adapt services to meet the unique needs and value systems of persons in all groups.
- Expand and update [the provider's/system's] cultural knowledge.
- Work on stigma reduction with a culturally sensitive approach.

Source: Center for Mental Health Services 2001.

Wherever appropriate, familiar healing practices meaningful to these clients should be integrated into treatment. An example would be the use of acupuncture to calm a Chinese client or help control cravings, or the use of traditional herbal tobacco with some American Indians to establish rapport and aid emotional balance.

Cultural perceptions and diagnosis

It is important to be aware of cultural and ethnic bias in diagnosis. For example, in the past some African Americans were stereotyped as having paranoid personality disorders, while women have been diagnosed frequently as being histrionic. American Indians with spiritual visions have been misdiagnosed as delusional or as having borderline or schizotypal personality disorders. Some clinicians would be likely to over diagnose obsessive-compulsive disorder among Germans or histrionic disorder in Hispanic/Latino populations. The diagnostic criteria should be tempered by sensitivity to cultural differences in behavior and emotional expression and by an awareness of the clinician's own biases and stereotyping.

Cultural differences and treatment: Empirical evidence on effectiveness

Studies related to cultural differences and treatment issues among clients with COD are scarce. However, one study that compared nonwhite and white clients with COD who were treated in mental health settings suggests issues that deserve providers' attention. Researchers found that African-American, Asian-American, and Hispanic/Latino clients tended to self-report a lower level of functioning and to be "viewed by clinical staff as suffering from more severe and persistent symptomatology and as having lower psychosocial functioning." Researchers noted "this was due in part to the chronicity of their mental disorders and persistent substance abuse, but also was magnified by cross-cultural misperceptions; for example, system bias, countertransference, or inadequate support systems" (Jerrell and Wilson 1997, p. 138).

The study also found that nonwhite clients tended to have fewer community resources available to them than white clients, and that clinicians had more difficulty connecting them with needed services. For example, staff members experienced "extraordinary difficulties in identifying willing and suitable sponsors for the young ethnic clients" in 12-Step programs (Jerrell and Wilson 1997, p. 138). To address such issues, researchers stressed the importance of developing cultural competence in staff, giving extra attention to the needs of such clients, and engaging in "more active advocacy for needed, culturally relevant services" (Jerrell and Wilson 1997, p. 139).

Increase Structure and Support

To assist clients with COD, counselors should provide an optimal amount of structure for the individual. Free time is both a trigger for substance use cravings and a negative influence for many individuals with mental disorders; therefore it is a particular issue for clients with COD. Strategies for managing free time include structuring one's day to have meaningful activities and to avoid activities that will be risky. Clinicians often help clients to plan their time (especially weekends). Creating new pleasurable activities can both help depression and help derive "highs" from sources other than substance use. Other important activities to include are working on vocational and relationship issues.

In addition to structure, it is also important that the daily activities contain opportunities for receiving support and encouragement. Counselors should work with clients to create a healthy support system of friends, family, and activities. Increasing support, time organization, and structured activities are strategies in cognitive–behavioral therapies (see section below) for both mental disorders and substance abuse treatment.

Techniques for Working With Clients With COD

The following section reviews techniques, mainly from the substance abuse field, that have been found to be particularly helpful in the treatment of clients with substance abuse and that are being adapted for work with clients with COD (see text box below).

Provide Motivational Enhancement Consistent With the Client's Specific Stage of Change

Definition and description

Motivational Interviewing (MI) is a "client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller and Rollnick 2002, p. 25). MI has proven effective in helping clients clarify goals and make commitment to change (CSAT 1999*b*; Miller 1996; Miller and Rollnick 2002; Rollnick and Miller 1995). This approach shows so much promise that it is one of the first two psychosocial treatments being sponsored in multisite trials in the National Institute on Drug Abuse (NIDA) Clinical Trials Network program.

As Miller and Rollnick have pointed out, MI is "a way of being with a client, not just a set of techniques for doing counseling" (Miller and Rollnick 1991, p. 62). This approach involves *accepting* a client's level of motivation, whatever it is, as the only possible starting point for change. For example, if a client says she has no interest in changing her drinking amounts or frequency, but only is interested in complying with the interview to be eligible for something else (such as the right to return to work or a housing voucher), the clinician would avoid argumentation or

Key Techniques for Working With Clients Who Have COD

1. Provide motivational enhancement consistent with the client's specific stage of change.
2. Design contingency management techniques to address specific target behaviors.
3. Use cognitive–behavioral therapeutic techniques.
4. Use relapse prevention techniques.
5. Use repetition and skills-building to address deficits in functioning.
6. Facilitate client participation in mutual self-help groups.

confrontation in favor of establishing a positive rapport with the client—even remarking on the positive aspect of the client wishing to return to work or taking care of herself by obtaining housing. The clinician would seek to probe the areas in which the client does have motivation to change. The clinician is interested in eventually having an impact on the client's drinking or drug use, but the strategy is to get to that point by working with available openings.

A variety of adaptations of MI have emerged. Examples include brief negotiation, motivational consulting, and motivational enhancement therapy (MET). MET combines the clinical style associated with MI with systematic feedback of assessment results in the hope of producing rapid, internally motivated change. For more information, see the Project MATCH *Motivational Enhancement Therapy Manual* (National Institute on Alcohol Abuse and Alcoholism 1994). Rollnick and other practitioners of MI find that the many variants differ widely in their reliance on the key principles and elements of MI (Miller and Rollnick 2002).

Guiding principles of motivational interviewing

The four principles outlined below guide the practice of MI (see text box p. 114). In this section, each principle is summarized. For each principle, some of the related strategies that practitioners use when applying this principle to client interactions are highlighted.

1. Expressing empathy

Miller and Rollnick state that "an empathic counseling style is one fundamental and defining characteristic of motivational interviewing" (Miller and Rollnick 2002, p. 37). The counselor refrains from judging the client; instead, through respectful, reflective listening, the counselor projects an attitude of acceptance. This acceptance of the person's perspectives does not imply agreement. It "does not prohibit the counselor from differing with the client's views and expressing that divergence" (Miller and Rollnick 2002, p. 37). It simply accepts the individual's ambivalence to change as normal and expected behavior in the human family. Practitioners find that projecting acceptance rather than censure helps free the client to change (Miller and Rollnick 2002).

2. Developing discrepancies

While recognizing the client's ambivalence to change as normal, the counselor is not neutral or ambivalent about the need for change. The counselor advances the cause of change not by insisting on it, but by helping the client perceive the discrepancy between the current situation and the client's personal goals (such as a supportive family, successful employment, and good health). The task of the counselor is to call attention to this discrepancy between "the present state of affairs and how one wants it to be," making it even more significant and larger in the client's eyes. The client is therefore more likely to change, because he sees that the current behavior is impeding progress to his goals—not the counselor's (Miller and Rollnick 2002, p. 39).

3. Rolling with resistance

Practitioners believe that "the least desirable situation, from the standpoint of evoking change, is for the counselor to advocate for change while the client argues against it" (Miller and Rollnick 2002, p. 39). The desired situation is for clients themselves to make the argument for change. Therefore, when resistance is encountered, the counselor does not oppose it outright. Instead, the counselor offers new information and alternative perspectives, giving the client respectful permission to "take what you want and leave the rest" (Miller and Rollnick 2002, p. 40).

The counselor's response to resistance can defuse or inflame it. Miller and Rollnick describe a number of techniques the skillful clinician can use when resistance is encountered. For example, the counselor may use var-

Guiding Principles of Motivational Interviewing	
1. Express empathy	• Acceptance facilitates change. • Skillful reflective listening is fundamental. • Ambivalence is normal.
2. Develop discrepancy	• The client rather than the counselor should present the arguments for change. • Change is motivated by a perceived discrepancy between present behavior and important personal goals or values.
3. Roll with resistance	• Avoid arguing for change. • Resistance is not opposed directly. • New perspectives are invited but not imposed. • The client is a primary resource in finding answers and solutions. • Resistance is a signal to respond differently.
4. Support self-efficacy	• A person's belief in the possibility of change is an important motivator. • The client, not the counselor, is responsible for choosing and carrying out change. • The counselor's own belief in the person's ability to change becomes a self-fulfilling prophecy.
Source: Miller and Rollnick 2002, pp. 36–41.	

ious forms of reflection, shift the focus of discussion, reframe the client's observation, or emphasize the client's personal choice or control. While description of these and other specific techniques for "rolling with resistance" is beyond the scope of this TIP, the reader is referred to chapter 8 of Miller and Rollnick 2002, "Responding to Resistance" (pp. 98–110).

4. Supporting self-efficacy

The final principle of Motivational Interviewing recognizes that an individual must believe he or she actually can make a change before attempting to do so. Therefore, the counselor offers support for the change and communicates to the client a strong sense that change is possible. Self-efficacy also can be enhanced through the use of peer role models, as well as by pointing out past and present evidence of the client's capacity for change.

One way practitioners put this principle into action is by evoking "confidence talk" in which the client is invited to share "ideas, experiences, and perceptions that are consistent with ability to change" (Miller and Rollnick 2002, p. 113). This could involve reviewing past successes, discussing specific steps for making change happen, identifying personal strengths, and acknowledging sources of support.

"Change talk"

Clients' positive remarks about change, or "change talk," are the opposite of resistance. The counselor responds to any expression of desire to change with interest and encourages the client to elaborate on the statement. For example in a person with combined alcohol dependence and PTSD, the clinician might ask, "What are some other reasons why you might want to make a change?" (Miller and Rollnick 2002, p. 87). The counselor also can use reflec-

tive listening to clarify the client's meaning and explore what is being said. It is important, however, to do this in a way that does not appear to be taking a side in the argument. This sometimes results in resistance and the client may begin to argue with the counselor instead of continuing to think about change.

"Decisional balance"

Practitioners of MI have coined the term "decisional balance" to describe a way of looking at ambivalence. Picture a seesaw, with the costs of the status quo and the benefits of change on one side, and the costs of change and the benefits of the status quo on the other (Miller and Rollnick 2002). The counselor's role is to explore the costs and benefits of substance use with the aim of tipping the balance toward change. That change will be stronger and more likely to endure if it is owned by the client's perception that the benefits of change are greater than the costs.

Matching motivational strategies to the client's stage of change

The motivational strategies selected should be consistent with the client's stage of change (summarized in Figure 5-1, p. 116). Clients could be at one stage of recovery or change for the mental disorder and another for the substance use disorder; to complicate things further, a client may be at one stage of change for one substance and another stage of change for another substance. For example, a client with combined alcohol and cocaine dependence with co-occurring panic disorder may be in the *contemplation stage* (i.e., aware that a problem exists and considering overcoming it, but not committed to taking action) in regard to alcohol, *precontemplation* (i.e., unaware that a problem exists, with no intention of changing behavior) in regard to cocaine, and *action* (i.e., actively modifying behavior, experiences, or environment to overcome the problem) for the panic disorder.

In each case, the clinician examines the internal and external leverage available to move the client toward healthy change. For example, a client may want to talk about her marriage, but not about the substance abuse problem. The clinician can use this as an opening; the marriage doubtless will be affected by the substance abuse, and the motivation to improve the marriage may lead to a focus on substance abuse. Evaluating a client's motivational state necessarily is an ongoing process. It should be recognized that court mandates, rules for clients engaged in group therapy, the treatment agency's operating restrictions, or other factors may place some barriers on how this strategy is implemented in particular situations.

Figure 5-2 (pp. 117–118) illustrates approaches that a clinician might use at different stages of readiness to change to apply MI techniques when working with a substance abuse client showing evidence of COD. For a thorough discussion of MI and the stages of change, the reader is referred to Miller and Rollnick 2002 (pp. 201–216).

Although MI is a well-accepted and commonly used strategy in the substance abuse treatment field, the issue of when it is appropriate to avoid or postpone addressing the client's substance use is the subject of some debate. MI does make a distinction between agreeing with a client's denial system (which is counterproductive) and sidestepping it in order to make some progress. As shown above, these motivational strategies are employed to help both clinician and client work together toward the common goal of helping the client. With practice and experience, the clinician will come to recognize when to sidestep disagreements and pursue MI and when to move forward with traditional methods with clients who are motivated sufficiently and ready for change. The details of these strategies and

Figure 5-1 Stages of Change	
Stage	**Characteristics**
Precontemplation	No intention to change in the foreseeable future; may be unaware or under-aware of problems.
Contemplation	Aware that a problem exists and thinking seriously about overcoming it, but have no commitment to take action yet made; weighing pros and cons of the problem and its solution.
Preparation	Combines intention and behavior—action is planned within the next month, and action has been taken unsuccessfully in the past year; some reductions have been made in problem behaviors, but a criterion for effective action has not been reached.
Action	Behavior, experiences, or environment are modified to overcome the problem; successful alteration of the addictive behavior for anywhere between 1 day to 6 months (note that action does not equal change).
Maintenance	Working to prevent relapse and consolidate gains attained during the Action stage; remaining free from addictive behavior and engaging consistently in a new incompatible behavior for more than 6 months.
Source: Adapted from Prochaska et al. 1992.	

techniques are presented in TIP 35 (CSAT 1999*b*) and in Miller and Rollnick 2002.

Motivational interviewing and co-occurring disorders

Approaches based on MI have been adapted for people with COD with some initial evidence of efficacy for improved treatment engagement. In a sample of 100 inpatient clients with COD from a large university hospital, Daley and Zuckoff (1998, p. 472) found that with only one "motivational therapy" session prior to hospital discharge, "…the show rate for the initial outpatient appointment almost doubled, increasing from 35 percent to 67 percent." In this study MI approaches were modified to focus on contrasting the goals and methods of hospital and outpatient treatment. Also, the client was invited to consider the advantages and challenges of continuing in outpatient treatment. Daley and Zuckoff's results are relevant for people in most quadrants (see chapters 2 and 3), as the majority of their clientele are described as "public sector clients who have mood, anxiety, personality, or psychotic disorders combined with alcohol, cocaine, heroin, sedative hypnotic, cannabis, or polysubstance use disorders."

Swanson and colleagues (1999) modified MI techniques by increasing the amount of discussion of the client's perception of the problem and his understanding of his clinical condition. Of the 121 study participants who were selected from psychiatric inpatients at two inner-city hospitals, 93 had concomitant substance use disorders. Participants were assigned randomly to either standard treatment or standard treatment with the addition of a motivational interview. The MI focused on exploring the clients' commitment to treatment, plans for continuing care, and understanding of their role in their own recovery.

Essentially, the therapists were attempting to elicit a motivational statement that indicated the clients' commitment to treatment. The authors found that, whether considering the entire sample or only those with COD, study participants who received the MI were significantly more likely to attend an initial outpatient treatment session.

Motivational strategies have been shown to be helpful with persons who have serious mental disorders. Most programs designed for persons with such disorders recognize "that the majority of psychiatric clients have little readiness for abstinence-oriented substance use disorder (SUD) treatments;" therefore, they "incorporate motivational interventions designed to help clients who either do not rec-

Figure 5-2
Motivational Enhancement Approaches

Stage of Readiness	Motivational Enhancement Approaches
Precontemplation	• Express concern about the client's substance use, or the client's mood, anxiety, or other symptoms of mental disorder. • State nonjudgmentally that substance use (or mood, anxiety, self-destructiveness) is a problem. • Agree to disagree about the severity of either the substance use or the psychological issues. • Consider a trial of abstinence to clarify the issue, after which psychological evaluation can be reconsidered. • Suggest bringing a family member to an appointment. • Explore the client's perception of a substance use or psychiatric problem. • Emphasize the importance of seeing the client again and that you will try to help.
Contemplation	• Elicit positive and negative aspects of substance use or psychological symptoms. • Ask about positive and negative aspects of past periods of abstinence and substance use, as well as periods of depression, hypomania, etc. • Summarize the client's comments on substance use, abstinence, and psychological issues. • Make explicit discrepancies between values and actions. • Consider a trial of abstinence and/or psychological evaluation.
Preparation	• Acknowledge the significance of the decision to seek treatment for one or more disorders. • Support self-efficacy with regard to each of the COD. • Affirm the client's ability to seek treatment successfully for each of the COD. • Help the client decide on appropriate, achievable action for each of the COD. • Caution that the road ahead is tough but very important. • Explain that relapse should not disrupt the client–clinician relationship.

Figure 5-2 (continued) Motivational Enhancement Approaches	
Stage of Readiness	**Motivational Enhancement Approaches**
Action	• Be a source of encouragement and support; remember that the client may be in the action stage with respect to one disorder but only in contemplation with respect to another; adapt your interview approach accordingly. • Acknowledge the uncomfortable aspects of withdrawal and/or psychological symptoms. • Reinforce the importance of remaining in recovery from both problems.
Maintenance	• Anticipate and address difficulties as a means of relapse prevention. • Recognize the client's struggle with either or both problems, working with separate mental health and substance abuse treatment systems, and so on. • Support the client's resolve. • Reiterate that relapse or psychological symptoms should not disrupt the counseling relationship.
Relapse	• Explore what can be learned from the relapse, whether substance-related or related to the mental disorder. • Express concern and even disappointment about the relapse. • Emphasize the positive aspect of the effort to seek care. • Support the client's self-efficacy so that recovery seems achievable.
Source: Reproduced from Samet et al. 1996 (used with permission).	

ognize their SUD or do not desire substance abuse treatment to become ready for more definitive interventions aimed at abstinence" (Drake and Mueser 2000).

A four-session intervention has been developed specifically to enhance readiness for change and treatment engagement of persons with schizophrenia who also abuse alcohol and other substances (Carey et al. 2001). This intervention is summarized in Figure 5-3 (p. 119). In a pilot study of the intervention, 92 percent of the 22 participants completed the series of sessions, all of whom reported that intervention was both positive and helpful. A range of motivational variables showed post-intervention improvements in recognition of substance use problems and greater treatment engagement, confirmed by independent clinician ratings. Those who began the intervention with low problem recognition made gains in that area; those who began with greater problem recognition made gains in the frequency of use and/or involvement in treatment. Although these data are preliminary, the technique is well articulated. It shows promise and warrants further research, including efforts to determine its efficacy among clients with COD who have mental disorders other than schizophrenia.

It should be noted, however, that assessment of readiness to change could differ markedly between the client and the clinician. Addington et al. (1999) found little agreement between self-report of stage of readiness to

change and the assessment of stage of readiness determined by interviewers for their 39 outpatients with diagnoses of both schizophrenia and a substance use disorder. In view of these observations, clinicians should be careful to establish a mutual agreement on the issue of readiness to change with their clients.

Applying the motivational interviewing approach to clients with COD

To date, motivational interviewing strategies have been applied successfully to the treatment of clients with COD, especially in

- Assessing the client's perception of the problem
- Exploring the client's understanding of his or her clinical condition

Figure 5-3
A Four-Session Motivation-Based Intervention

Session 1—Introduction, Assessment, and Information Feedback		
Goals	**Therapeutic Activities**	**Purpose**
Establish therapeutic alliance and collaborative approach Begin to develop discrepancy (raise awareness of the extent of use and negative consequences)	Introduce intervention	• To elicit reasons and motivations for attending • To establish understanding of the nature and purpose of the intervention
	Assess and discuss readiness to change	• To establish mutual understanding of attitudes toward substance use and prospects for change • To convey respect for the client's attitudes • To evaluate using open-ended and structured techniques
	Feedback of current use, consequences, and risks	• To foster client's awareness of extent of use, comparison to norms, negative consequences, and risks of pattern of use
Session 2—Decisional Balance		
Goals	**Therapeutic Activities**	**Purpose**
Continue emphasis on therapeutic alliance and collaborative approach Place more emphasis on developing discrepancy	Review Session 1 and introduce Session 2	• To let the client know what to expect (alleviates anxiety) • To help the client remember insights/reactions to reinforce gains
	Decisional balance	• To help the client identify and verbalize salient cons of using and pros of quitting • To foster dissatisfaction with use, and interest in quitting, clarifying barriers to change

Figure 5-3 (continued)
A Four-Session Motivation-Based Intervention

Session 3—Strivings and Efficacy		
Goals	**Therapeutic Activities**	**Purpose**
Continue emphasis on developing discrepancy Place more emphasis on self-efficacy	Review Session 2 and introduce Session 3	• To reorient the client to the treatment process and reinforce past gains
	Assess and discuss expectancies with regard to behavior change	• To monitor changes in perceived importance and self-efficacy to change substance use • To shore up motivation for change or address reasons for low motivation
	Strivings list	• To develop discrepancy between a future with and without change in substance use by verbalizing personal aspirations, likely negative effects of use to achieving goals, and potential facilitative effects of abstinence
Session 4—Goals and Action Plan		
Goals	**Therapeutic Activities**	**Purpose**
Reinforce motivational gains (in perceived importance of change, self-efficacy) To leave the client with a clear plan of action	Review treatment	• To reinforce motivational changes • To extend the principle of providing periodic summaries of discussion throughout the course of each session • To use repetition to compensate for deficits in attention and memory
	Elicit goals and develop written plan of action	• To help identify and clarify specific, realistic goals around substance use reduction • To help develop a plan of action, including mobilizing external supports and internal resources • To help the client anticipate barriers and solve problems around him

Source: Carey et al. 2001.

- Examining the client's desire for continued treatment
- Ensuring client attendance at initial sessions
- Expanding the client's assumption of responsibility for change

Future directions include

- Further modification of MI protocols to make them more suitable for clients with COD, particularly those with serious mental disorders
- Tailoring and combining MI techniques with other treatments to solve the problems (e.g., engagement, retention, etc.) of all treatment modalities

See the text box below for a case study applying MET.

Design Contingency Management Techniques To Address Specific Target Behaviors

Description

Contingency Management (CM) maintains that the form or frequency of behavior can be altered through a planned and organized system of positive and negative consequences. CM

Case Study: Using MET With a Client Who Has COD

Gloria M. is a 34-year-old African-American female with a 10-year history of alcohol dependence and 12-year history of bipolar disorder. She has been hospitalized previously both for her mental disorder and for substance abuse treatment. She has been referred to the outpatient substance abuse treatment provider from inpatient substance abuse treatment services after a severe alcohol relapse.

Over the years, she sometimes has denied the seriousness of both her addiction and mental disorders. Currently, she is psychiatrically stable and is prescribed valproic acid to control the bipolar disorder. She has been sober for 1 month.

At her first meeting with Gloria M., the substance abuse treatment counselor senses that she is not sure where to focus her recovery efforts—on her mental disorders or her addiction. Both have led to hospitalization and to many life problems in the past. Using motivational strategies, the counselor first attempts to find out Gloria M.'s own evaluation of the severity of each disorder and its consequences to determine her stage of change in regard to each one.

Gloria M. reveals that while in complete acceptance and an active stage of change around alcohol dependence, she is starting to believe that if she just goes to enough recovery meetings she will not need her bipolar medication. Noting her ambivalence, the counselor gently explores whether medications have been stopped in the past and, if so, what the consequences have been. Gloria M. recalls that she stopped taking medications on at least half a dozen occasions over the last 10 years; usually, this led her to jail, the emergency room, or a period of psychiatric hospitalization. The counselor explores these times, asking: Were you feeling then as you were now—that you could get along? How did that work out? Gloria M. remembers believing that if she attended 12-Step meetings and prayed she would not be sick. In response to the counselor's questions, she observes, "I guess it hasn't ever really worked in the past."

The counselor then works with Gloria M. to identify the best strategies she has used for dual recovery in the past. "Has there been a time you really got stable with both disorders?" Gloria M. recalls a 3-year period between the ages of 25 and 28 when she was stable, even holding a job as a waitress for most of that period. During that time, she recalls, she saw a psychiatrist at a local mental health center, took medications regularly, and attended AA meetings frequently. She recalls her sponsor as being supportive and helpful. The counselor then affirms the importance of this period of success and helps Gloria M. plan ways to use the strategies that have already worked for her to maintain recovery in the present.

assumes that neurobiological and environmental factors influence substance use behaviors and that the consistent application of reinforcing environmental consequences can change these behaviors. CM principles for substance abuse treatment have been structured around four central principles (Higgins and Petry 1999):

- The clinician arranges for regular drug testing to ensure the client's use of the targeted substance is detected readily.
- The clinician provides positive reinforcement when abstinence is demonstrated. These positive reinforcers are agreed on mutually.
- The clinician withholds the designated incentives from the individual when the substance is detected.
- The clinician helps the client establish alternate and healthier activities.

CM techniques are best applied to specific targeted behaviors such as

- Drug abstinence
- Clinic attendance and group participation
- Medication adherence
- Following treatment plan
- Attaining particular goals

The clinician may use a variety of CM techniques or reinforcers. The most common are

- Cash
- Vouchers
- Prizes
- Retail items
- Privileges

Figure 5-4 contains a checklist for a clinician designing CM programs. See also p. 124 for a case study applying CM.

Empirical evidence on the effectiveness of contingency management

A substantial empirical base supports CM techniques, which have been applied effectively to a variety of behaviors. CM techniques have demonstrated effectiveness in enhancing retention and confronting drug use (e.g., Higgins 1999; Petry et al. 2000). The techniques have been shown to address use of a variety of specific substances, including opioids (e.g., Higgins et al. 1986; Magura et al. 1998), marijuana (Budney et al. 1991), alcohol (e.g., Petry et al. 2000), and a variety of other drugs including cocaine (Budney and Higgins 1998). However, CM techniques have not been implemented in community-based settings until recently. The use of vouchers and other reinforcers has considerable empirical support (e.g., Higgins 1999; Silverman et al. 2001), but little evidence is apparent for the relative efficacy of different reinforcers. The effectiveness of CM principles when applied in community-based treatment settings and specifically with clients who have COD remains to be demonstrated.

Some examples of the use of CM techniques have direct implications for people with COD:

- *Housing and employment contingent on abstinence.* CM, where housing and employment are contingent on abstinence, has been used and studied among populations of homeless persons, many with COD (Milby et al. 1996; Schumacher et al. 1995). Results show that participants in treatment with contingencies were more likely than those in conventional treatment to test clean for drugs, to move into stable housing, and to gain regular employment following treatment.
- *Managing benefits and establishing representative payeeships.* Procedures have been established to manage benefits for persons with serious mental illness and substance use disorders (Ries and Comtois 1997) and for establishing representative payeeships for clients with COD that involve managing money and other benefits (e.g., Conrad et al. 1999). In these approaches, once abstinence is achieved, clients are allowed greater latitude for management of their own finances.
- *A token economy for homeless clients with COD.* A token economy has been developed with clients with COD in a shelter to provide immediate and systematic reinforce-

Figure 5-4 Checklist for Designing CM Programs	
Step	**Description**
1. Choose a behavior	• One that is objectively quantifiable, occurs frequently, and is considered to be most important. • Set reasonable expectations.
2. Choose a reinforcer	• Determine available resources (in-house rewards or donations of cash or services from local businesses such as movie theaters and restaurants). • Identify intangible rewards, such as frequent positive reports to parole officers, flexibility in methadone dosing, and increased freedom (smoke breaks, passes, etc.).
3. Use behavioral principles	• Develop a monitoring and reinforcement schedule that is optimized through application of behavioral principles. • Keep the schedule simple so staff can apply principles consistently and clients can understand what is expected.
4. Prepare a behavioral contract	• Draw up a contract for the target behavior that considers the monitoring system and reinforcement schedule. • Be specific and consider alternate interpretations; have others review the contract and comment. • Include any time limitations.
5. Implement the contract	• Ensure consistent application of the contract; devise methods of seeing that staff understands and follows procedures. • Remind the client of behaviors and their consequences (their "account balance" and what is required to obtain a bonus) to increase the probability that the escalating reward system will have the desired effect.
Source: Petry 2000*a*.	

ment for an array of behaviors during the engagement phase. Points were awarded for the successful accomplishment of a standard list of behaviors essential to the development of commitment, such as medication adherence, abstinence, attendance at program activities, and followthrough on referrals. Points were tallied weekly and tangible rewards (phone cards, treats, toiletries, etc.) were distributed commensurate with the earned point totals (Sacks et al. 2002).

Awareness of the principles of CM can help the clinician to focus on quantifiable behaviors that occur with a good deal of frequency and to provide the reinforcers in an immediate and consistent fashion. CM principles and methods can be accommodated flexibly and applied to a range of new situations that can increase clinician effectiveness. It should be noted that many counselors and programs employ CM principles informally when they praise or reward particular behaviors and accomplishments and that even formal use of CM principles are found in

Case Study: Using CM With a Client With COD

Initial Assessment
Mary A. is a 45-year-old Caucasian woman diagnosed with heroin and cocaine dependence, depression, antisocial personality disorder, and cocaine-induced psychotic episodes. She has a long history of prostitution and sharing injection equipment. She contracted HIV 5 years ago.

Mary A. had been on a regimen of methadone maintenance for about 2 years. Despite dose increases up to 120 mg/day, she continued using heroin at the rate of 1 to 15 bags per day as well as up to 3 to 4 dime bags per day of cocaine. After cessation of a cocaine run, Mary A. experienced tactile and visual hallucinations characterized by "bugs crawling around in my skin." She mutilated herself during severe episodes and brought in some of the removed skin to show the "bugs" to her therapist.

Mary A. had been hospitalized four times for cocaine-induced psychotic episodes. Following an 11-day stay in an inpatient dual diagnosis program subsequent to another cocaine-induced psychotic episode, Mary A. was referred to an ongoing study of contingency management interventions for methadone-maintained, cocaine-dependent outpatients.

Behaviors To Target
Mary A.'s primary problem was her drug use, which was associated with cocaine-induced psychosis and an inability to adhere to a regimen of psychiatric medications and methadone. Because her opioid and cocaine use were linked intricately, it was thought that a CM intervention that targeted abstinence from both drugs would improve her functioning. As she was already maintained on a high methadone dose, methadone dose adjustments were not made.

CM Plan
Following discharge from the psychiatric unit, Mary A. was offered participation in a NIDA-funded study evaluating lower-cost contingency management treatment (e.g., Petry et al. 2000, pp. 250–257) for cocaine-abusing methadone clients. As part of participation in this study, Mary A. agreed to submit staff-observed urine samples on 2 to 3 randomly selected days each week for 12 weeks. She was told that she had a 50 percent chance of receiving standard methadone treatment plus frequent urine sample testing of standard treatment along with a contingency management intervention. She provided written informed consent, as approved by the University's Institutional Review Board.

Mary A. was assigned randomly to the CM condition. In this condition, she earned one draw from a bowl for every urine specimen that she submitted that was clean from cocaine or opioids and four draws for every specimen that was clean from both substances. The bowl contained 250 slips of paper. Half of them said "Good job" but did not result in a prize. Other slips stated "small prize" (N=109), "large prize" (N=15), or "jumbo prize" (N=1). Slips were replaced after each drawing so that probabilities remained constant. A lockable prize cabinet was kept onsite in which a variety of small prizes (e.g., socks, lipstick, nail polish, bus tokens, $1 gift certificates to local fast-food restaurants, and food items), large prizes (sweatshirts, portable CD players, watches, and gift certificates to book and record stores), and jumbo prizes (VCRs, televisions, and boom boxes) were kept. When a prize slip was drawn, Mary A. could choose from items available in that category. All prizes were purchased through funds from the research grant.

In addition to the draws from the bowl for clean urine specimens, for each week of consecutive abstinence from both cocaine and opioids Mary A. earned bonus draws. The first week of consecutive cocaine and opioid abstinence resulted in five bonus draws, the second week resulted in six bonus draws, the third week seven and so on. In total, Mary A. could earn about 200 draws if she maintained abstinence throughout the 12-week study.

Clinical Course
Mary A. earned 175 draws during treatment, receiving prizes purchased for a total of $309. She never missed a day of methadone treatment, attended group sessions regularly, and honored all her individual counseling sessions at the clinic. At 6-month follow-up, she had experienced only one drug use lapse, which she self-reported. Her depression cleared with her abstinence, and so did her antisocial behavior. She was pleased with the prizes and stated, "Having good stuff in my apartment and new clothes makes me feel better about myself. When I feel good about me, I don't want to use cocaine."

Source: Adapted from Petry et al. 2001*b*.

programs where attainment of certain levels and privileges are contingent on meeting certain behavioral criteria.

Use Cognitive–Behavioral Therapeutic Techniques

Description

Cognitive–behavioral therapy (CBT) is a therapeutic approach that seeks to modify negative or self-defeating thoughts and behavior. CBT is aimed at both thought and behavior change (i.e., coping by thinking differently and coping by acting differently). One cognitive technique is known as "cognitive restructuring." For example, a client may think initially, "The only time I feel comfortable is when I'm high," and learn through the counseling process to think instead, "It's hard to learn to be comfortable socially without doing drugs, but people do so all the time" (TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* [CSAT 1999*a*], pp. 64–65). CBT includes a focus on overt, observable behaviors—such as the act of taking a drug—and identifies steps to avoid situations that lead to drug taking. CBT also explores the interaction among beliefs, values, perceptions, expectations, and the client's explanations for why events occurred.

An underlying assumption of CBT is that the client systematically and negatively distorts her view of the self, the environment, and the future (O'Connell 1998). Therefore, a major tenet of CBT is that the person's thinking is the source of difficulty and that this distorted thinking creates behavioral problems. CBT approaches use cognitive and/or behavioral strategies to identify and replace irrational beliefs with rational beliefs. At the same time, the approach prescribes new behaviors the client practices. These approaches are educational in nature, active and problem-focused, and time-limited.

CBT for substance abuse

CBT for substance abuse combines elements of behavioral theory, cognitive social learning theory, cognitive theory, and therapy into a distinctive therapeutic approach that helps clients recognize situations where they are likely to use substances, find ways of avoiding those situations, and learn better ways to cope with feelings and situations that might have, in the past, led to substance use (Carroll 1998).

Advice to the Counselor: Using Contingency Management Techniques

The consensus panel recommends that substance abuse treatment clinicians and programs employ CM techniques with clients with COD in such activities as

- Providing refreshments for attendance at groups or social activities
- Monitoring urine specimens
- Checking medication adherence
- Rewarding clients for obtaining particular goals in their treatment plan
- Reinforcing appropriate verbal and social behavior

CBT for people with substance use disorders also addresses "coping behaviors." Coping "refers to what an individual does or thinks in a relapse crisis situation so as to handle the risk for renewed substance use" (Moser and Annis 1996, p. 1101). The approach assumes that "substance abusers are deficient in their ability to cope with interpersonal, social, emotional, and personal problems. In the absence of these skills, such problems are viewed as threatening, stressful, and potentially unsolvable. Based on the individual's observation of both family members' and peers' responses to similar situations and on their own initial experimental use of alcohol or drugs, the individual uses substances as a means of trying to address these problems and the emotional reactions they create" (CSAT 1999*a*, p. 71). The clinician seeks to help the client increase his coping skills so he will not use drugs in high-stress situations. (See TIP 34 [CSAT 1999*a*] for a more detailed explanation of the theoretical background of CBT and how it is applied in substance abuse treatment.)

CBT and COD

Distortions in thinking generally are more severe with people with COD than with other substance abuse treatment clients. For example, a person with depression and an alcohol use disorder who has had a bad reaction to a particular antidepressant may claim that all antidepressant medication is bad and must be avoided at all costs. Likewise, individuals may use magnification and minimization to exaggerate the qualities of others, consistently presenting themselves as "losers" who are incapable of accomplishing anything. Clients with COD are, by definition, in need of better coping skills. The Substance Abuse Management Model in the section on Relapse Prevention Therapy later in this chapter provides a pertinent example of how to increase behavioral coping skills.

Grounding

Some clients with COD, such as those who have experienced trauma or sexual abuse, can benefit from a particular coping skill known as "grounding" (Najavits 2002). Many such clients frequently experience overwhelming feelings linked to past trauma, which can be triggered by a seemingly small comment or event. Sometimes, this sets off a craving to use substances. Grounding refers to the use of strategies that soothe and distract the client who is experiencing tidal waves of pain or other strong emotions, helping the individual anchor in the present and in reality. These techniques work by directing the mental focus outward to the external world, rather than inward toward the self. Grounding also can be referred to as "centering," "looking outward," "distraction," or "healthy detachment" (Najavits 2002).

Grounding "can be done anytime, anywhere, by oneself, without anyone else noticing it. It can also be used by a supportive friend or partner who can guide the patient in it when the need arises" (Najavits 2002, p. 125). It is used commonly for PTSD, but can be applied to substance abuse cravings, or any other intense negative feeling, such as anxiety, panic attacks, and rage. Grounding is so basic and simple that it gives even the most impaired clients a useful strategy. However, it must be practiced frequently to be maximally helpful. For a lesson plan and other materials on grounding, see Najavits 2002. See also the section on PTSD in chapter 8 and appendix D of this TIP.

Roles of the client and clinician

CBT is an active approach that works most effectively with persons who are stabilized in the acute phase of their substance use and mental disorders. To be effective, the clinician and the client must develop rapport and a working alliance. The client's problem is assessed extensively and thorough historical data are collected. Then, collaboratively, dysfunctional automatic thoughts, schemas, and cognitive distortions are identified. Treatment consists of the practice of adaptive skills within the therapeutic environment and in homework sessions. Booster sessions are used following

Case Study: Using CBT With a Client With COD

Jack W. is referred to the substance abuse treatment agency for evaluation after a positive urine test that revealed the presence of cocaine. He is a 38-year-old African American. Initially, Jack W. engages in treatment in intensive outpatient therapy three times weekly, has clean urine tests, and seems to be doing well. However, after 2 months he starts to appear more depressed, has less to say in group therapy sessions, and appears withdrawn. In a private session with the substance abuse treatment counselor, he says that, "All this effort just isn't worth it. I feel worse than I did when I started. I might as well quit treatment and forget the job. What's the point?" The counselor explores what has changed, and Jack W. reveals that his wife has been having a hard time interacting with him as a sober person. Now that he is around the house more than he used to be (he was away frequently, dealing drugs to support his habit), they have more arguments. He feels defeated.

In the vocabulary of CBT, Jack W. demonstrates "all or nothing" thinking (I might as well lose everything because I'm having arguments), overgeneralization, and discounting the positive (he is ignoring the fact that he still has his job, has been clean for 2 months, looks healthier and, until recently, had an improved outlook). His emotionally clouded reasoning is blackening the whole recovery effort, as he personalizes the blame for what he sees as failure to improve his life.

Clearly, Jack W. has lost perspective and seems lost in an apparently overwhelming marital problem. The counselor, using a pad and pencil, draws a circle representing the client and divides it into parts, showing Jack that they represent physical health, his work life, his recovery, risk for legal problems, and family or marriage. He invites Jack to review each one, comparing where he is now and where he was when he first arrived at the clinic in order to evaluate the whole picture. Jack observes that everything is actually getting better with the exception of his marriage. The counselor helps Jack gain the skills needed to stand back from his situation and put a problem in perspective. He also negotiates to determine the kind of help that Jack would see as useful in his marriage. This might be counseling for the couple or an opportunity to practice and rehearse ways of engaging his wife without either of them becoming enraged.

If Jack's depression continues despite these interventions, the counselor may refer him to a mental health provider for evaluation and treatment of depression.

termination of treatment to assist people who have returned to old maladaptive patterns of thinking.

The client with COD is an active participant in treatment, while the role of the clinician is primarily that of educator. The clinician collaborates with the client or group in identifying goals and setting an agenda for each session. The counselor also guides the client by explaining how thinking affects mood and behavior. Clients with COD may need very specific coping skills to overcome the combined challenges of their substance abuse and their mental disorder. For example, Ziedonis and Wyatt (1998, p. 1020) address the need to target "the schizophrenic's cognitive difficulties (attention span, reading skills, and ability to abstract)." Their approach for these clients includes role-playing to help build communication and problemsolving skills.

Some specific CBT strategies for programs working with clients with COD are described below. See also the text box above for a case example.

Use Relapse Prevention Techniques

Description

Marlatt defines relapse as "a breakdown or setback in a person's attempt to change or modify any target behavior" (1985, p. 3). NIDA elaborates this definition by describing relapse as "any occasion of drug use by recovering

Adapting CBT for Clients With COD

- Use visual aids, including illustrations and concept mapping (a visual presentation of concepts that makes patterns evident).
- Practice role preparation and rehearse for unexpected circumstances.
- Provide specific in vivo feedback on applying principles and techniques.
- Use outlines for all sessions that list specific behaviorally anchored learning objectives.
- Test for knowledge acquisition.
- Make use of memory enhancement aids, including notes, tapes, and mnemonic devices.

Source: Adapted from Peters and Hills 1997.

addicts that violates their own prior commitment and that often they regret almost immediately" (NIDA 1993, p. 139), and adds Relapse Prevention Therapy (RPT) to its list of effective substance abuse treatment approaches. Relapse can be understood not only as the event of resuming substance use, but also as a process in which indicators of increasing relapse risk can be observed prior to an episode of substance use, or lapse (Daley 1987; Daley and Marlatt 1992).

A variety of relapse prevention models are described in the literature (e.g., Gorski 2000; Marlatt et al. 1999; Monti et al. 1993; NIDA 1993; Rawson et al. 1993). However, a central element of all clinical approaches to relapse prevention is anticipating problems that are likely to arise in maintaining change and labeling them as high-risk situations for resumed substance use, then helping clients to develop effective strategies to cope with those high-risk situations without having a lapse. A key factor in preventing relapse is to understand that relapses are preceded by triggers or cues that signal that trouble is brewing and that these triggers precede exposure to events or internal processes (high-risk situations) where or when resumed substance use is likely to occur. A lapse will occur in response to these high-risk situations unless effective coping strategies are available to the person and are implemented quickly and performed adequately. Clinicians using relapse prevention techniques recognize that lapses (single episodes or brief returns to drug use) are an expected part of overcoming a drug problem, rather than a signal of failure and an indication that all treatment progress has been lost. Therapy sessions aimed at relapse prevention can occur individually or in small groups, and may include practice or role-play on how to cope effectively with high-risk situations.

According to Daley and Marlatt (1992), approaches to relapse prevention have many common elements. Generally they focus on the need for clients to

1. Have a broad repertoire of cognitive and behavioral coping strategies to handle high-risk situations and relapse warning signs.
2. Make lifestyle changes that decrease the need for alcohol, drugs, or tobacco.
3. Increase healthy activities.
4. Prepare for interrupting lapses, so that they do not end in full-blown relapse.
5. Resume or continue to practice relapse prevention skills even when a full-blown relapse does occur by renewing their commitment to abstinence rather than giving up the goal of living a drug-free life.

RPT is an intervention designed to teach individuals who are trying to maintain health behavior changes how to anticipate and cope with the problem of relapse (Marlatt 1985). RPT strategies can be placed in five categories: Assessment Procedures, Insight/Awareness Raising Techniques, Coping Skills

Training, Cognitive Strategies, and Lifestyle Modification (Marlatt 1985). RPT *Assessment Procedures* are designed to help clients appreciate the nature of their problems in objective terms, to measure motivation for change, and to identify risk factors that increase the probability of relapse. *Insight/Awareness Raising Techniques* are designed to provide clients with alternative beliefs concerning the nature of the behavior change process (e.g., to view it as a learning process) and, through self-monitoring, to help clients identify patterns of emotion, thought, and behavior related to both substance use and co-occurring mental disorders. *Coping Skills Training* strategies include teaching clients behavioral and cognitive strategies. *Cognitive Strategies* are used to manage urges and craving, to identify early warning signals, and to reframe reactions to an initial lapse. Finally, *Lifestyle Modification Strategies* (e.g., meditation and exercise) are designed to strengthen clients' overall coping capacity.

In Marlatt's model of RPT, lapses are seen as a "fork in the road" or a "crisis." Each lapse contains the dual elements of "danger" (progression to full-blown relapse) and "opportunity" (reduced relapse risk in the future due to the lessons learned from debriefing the lapse). The goal of effective RPT is to teach clients to recognize increasing relapse risk and to intervene at earlier points in the relapse process in order to encourage clients to progress toward maintaining abstinence from drugs and living a life in which lapses occur less often and are less severe.

Specific aspects of RPT might include

- Exploring with the client both the positive and negative consequences of continued drug use ("decisional balance," as discussed in the motivational interviewing section of this chapter)
- Helping clients to recognize high-risk situations for returning to drug use
- Helping clients to develop the skills to avoid those situations or cope effectively with them when they do occur
- Developing a "relapse emergency plan" in order to exercise "damage control" to limit the duration and severity of lapses
- Learning specific skills to identify and cope effectively with drug urges and craving

Clients also are encouraged to begin the process of creating a more balanced lifestyle to manage their COD more effectively and to fulfill their needs without using drugs to cope with life's demands and opportunities. In the treatment of clients with COD, it often is critical to consider adherence to a medical regimen required to manage disruptive and disorganizing symptoms of mental disorder as a relapse issue. In terms of medication adherence, a "lapse" is defined as not taking the prescribed drugs one needs rather than the resumption of taking illicit drugs for self-medication or pleasure seeking.

Empirical evidence related to relapse prevention therapy

Carroll (1996) reviewed 24 randomized controlled trials of RPT among smokers and abusers of alcohol, marijuana, cocaine, opioids, and other drugs. While many of the studies were of smokers—in which Carroll noted the strongest support for RPT in terms of improved outcomes for relapse severity, durability of effects, and client-treatment matching, as compared to no-treatment controls—comparable results were found for alcohol and illicit drugs as well. Of particular importance was the observation that the positive effects of RPT treatment were greater among those with higher severities of both psychiatric symptoms and addiction impairment, which suggests the technique would be helpful in the treatment of clients with COD.

In a meta-analytic review of 26 published and unpublished studies using Marlatt's RPT model, Irvin et al. (1999) found that RPT generally was effective particularly for alcohol problems and was most effective when applied to alcohol or polysubstance use disorders, combined with medication. The efficacy of RPT has been demonstrated sufficiently to

Advice to the Counselor: Using Relapse Prevention Methods

The consensus panel recommends using the following relapse prevention methods with clients with COD:

- Provide relapse prevention education on both mental disorders and substance abuse and their interrelations.
- Teach skills to help the client handle pressure for discontinuing psychotropic medication and to increase medication adherence.
- Encourage attendance at dual recovery groups and teach social skills necessary for participation.
- Use daily inventory to monitor psychiatric symptoms and symptoms changes.
- If relapse occurs, use it as a learning experience to investigate triggers with the client. Reframe the relapse as an opportunity for self-knowledge and a step toward ultimate success.

be included by NIDA (1999*a*) as a recommended approach "to supplement or enhance—not replace—existing treatment programs" (p. 35).

Adaptations for clients with COD

Several groups have developed relapse prevention interventions aimed at clients with different mental disorders or substance use diagnoses (see Evans and Sullivan 2001). Weiss and colleagues (1998) developed a 20-session relapse prevention group therapy for the treatment of clients with co-occurring bipolar and substance use disorders. This group stressed concepts of importance to both disorders—for example, it contrasts "may as well" thinking, which allows for relapse and failure to take medication, with "it matters what you do." It also teaches useful skills relevant to both disorders, such as coping with high-risk situations and modifying lifestyle to improve self-care (p. 49). Ziedonis and Stern (2001) have developed a dual recovery therapy, which blends traditional mental health and addiction treatments (including both motivational enhancement therapy and relapse prevention) for clients with serious mental illness. Also, Nigam and colleagues (1992) developed a relapse prevention group for clients with COD.

Substance abuse management module

Roberts et al. (1999) developed *The Substance Abuse Management Module* (SAMM) based on the previously described RPT approach of Marlatt and his colleagues. SAMM originally was designed to be a component of a comprehensive approach to the treatment of co-occurring substance use dependence and schizophrenia. This detailed treatment manual illustrates many RPT techniques and focuses on the most common problems encountered by clients with severe COD. SAMM offers a detailed cognitive–behavioral strategy for each of several common problems that clients face. Each strategy includes both didactics and detailed skills training procedures including role-play practice. Emphasis is placed on rehearsing such key coping behaviors as refusing drugs, negotiating with treatment staff, acting appropriately at meetings for mutual self-help, and developing healthy habits. Both counselor and client manuals are available.

The text box beginning on p. 131 describes the SAMM protocol (Roberts et al. 1999) shows how a clinician might work with a substance abuse treatment client with COD to help the client avoid drugs.

Integrated treatment

RPT (Marlatt and Gordon 1985) and other cognitive–behavioral approaches to psychotherapy and substance abuse treatment allow clinicians to treat COD in a integrated way by

Overview of SAMM Concepts and Skills

How to Avoid Drugs (Made Simple)

The concepts and skills taught in this module are designed to help clients follow these four recommendations:

- If you slip, quit early.
- When someone offers drugs, say no.
- Don't get into situations where you can't say no.
- Do things that are fun and healthy.

Overview of Module Concepts and Skills

Clients learn how to follow these recommendations by learning key concepts and the skills. Here are four recommendations restated in terms of the module's key concepts:

Plain English	Module Concepts
If you slip, quit early.	Practice damage control.
When someone offers drugs, say no.	Escape high-risk situations.
Don't get into situations where you can't say no.	Avoid high-risk situations.
Do things that are fun and healthy.	Seek healthy pleasures.

Concepts and Skills Associated With Each Recommendation

Practice damage control

Main point: If you slip and use drugs or alcohol again, stop early and get right back into treatment. This will reduce damage to your health, relationships, and finances.

Concepts: Maintain recovery, slip versus full-blown relapse, risk reduction, abstinence violation effect, bouncing back into treatment.

Skills: Leaving a drug-using situation despite some use; reporting a slip to a support person

Escape high-risk situations

Main point: Some situations make it very hard to avoid using drugs. Be prepared to escape from these situations without using drugs. Realize that it would be much better to avoid these situations in the first place.

Concepts: High-risk situations.

Skills: Refusing drugs from a pushy dealer; refusing drugs offered by a friend.

Overview of SAMM Concepts and Skills (continued)

Avoid high-risk situations

Main point: Avoid high-risk situations by learning to recognize the warning signs that you might be headed toward drug use.

Concepts: Drug habit chain (trigger, craving, planning, getting, using), warning signs, U-turns, removing triggers, riding the wave, money management, representative payee.

Skills: Getting an appointment with a busy person; reporting symptoms and side effects; getting a support person.

Seek healthy pleasures

Main point: You can avoid drugs by focusing on the things that are most important and enjoyable to you. Do things that are fun and healthy.

Concepts: Healthy pleasures, healthy habits, activities schedule.

Skills: Getting someone to join you in a healthy pleasure; negotiating with a representative payee.

Additional Recommendations and Concepts

Understand how you learned to use drugs.

Main point: Drug abuse is learned and can be unlearned.

Concepts: Habits, reinforcement, craving, conditioning, extinction, riding the wave.

Know why you decided to quit.

Main point: Make sure you can always remember why you decided to quit using drugs.

Concepts: Advantages and disadvantages of using drugs and of not using drugs.

Carry an emergency card.

Main point: Make an emergency card that contains vital information and reminders about how and why to avoid drugs. Carry it with you at all times.

Concepts: Support person, coping skills, why quit.

Source: Adapted from Roberts et al. 1999 (used with permission).

1. Doing a detailed functional analysis of the relationships between substance use, Axis I or II symptoms, and any reported criminal conduct
2. Evaluating the unique and common high-risk factors for each problem and determining their interrelationships
3. Assessing both cognitive and behavioral coping skills deficits
4. Implementing both cognitive and behavioral coping skills training tailored to meet the specific needs of an individual client with respect to all three target behaviors (i.e., substance use, symptoms of mental disorder, and criminal conduct)

Summary of RP strategies for clients with COD

Daley and Lis (1995) summarize RP strategies that can be adapted for clients with COD, some of which are listed below:

- Regardless of the client's motivational level or recovery stage, relapse education should be provided and related to the individual's mental disorder. The latter is important, particularly because the pattern typically followed by clients with COD begins with an increase in substance use leading to lowered efficacy or discontinuation of psychiatric medication, or missed counseling sessions. As a consequence, symptoms of mental disorders reappear or worsen, the client's tendency to self-medicate through substance use is exacerbated, and the downward spiral is perpetuated.
- Clients with COD need effective strategies to cope with pressures to discontinue their prescribed psychiatric medication. One such strategy simply is to prepare clients for external pressure from other people to stop taking their medications. Rehearsing circumstances in which this type of pressure is applied, along with anticipating the possibility, enables clients with COD to react appropriately. Reinforcing the difference between substances of abuse—getting "high"—and taking psychiatric medication to treat an illness is another simple but effective strategy.
- An integral component of recovery is the use of mutual self-help and dual recovery groups to provide the support and understanding of shared experience. To maximize the effectiveness of their participation, clients with COD usually need help with social skills (listening, self-disclosure, expressing feelings/desires, and addressing conflict).

Clients can use daily self-ratings of persistent psychiatric symptoms to monitor their status. Use of the daily inventory and symptom review should be encouraged to help clients with COD to track changes and take action before deteriorating status becomes critical. See the text box on p. 134 for a case study applying RP strategies.

Use Repetition and Skills-Building To Address Deficits in Functioning

In applying the approaches described above, keep in mind that clients with COD often have cognitive limitations, including difficulty concentrating. Sometimes these limitations are transient and improve during the first several weeks of treatment; at other times, symptoms persist for long periods. In some cases, individuals with specific disorders (schizophrenia, attention deficit disorder) may manifest these symptoms as part of their disorder.

General treatment strategies to address cognitive limitations in clients include being more concrete and less abstract in communicating ideas, using simpler concepts, having briefer discussions, and repeating the core concepts many times. In addition, individuals often learn and remember better if information is presented in multiple formats (verbally; visually; or affectively through stories, music, and experiential activities). Role-playing real-life situations also is a useful technique when working with clients with cognitive limitations. For example, a client might be assigned to practice "asking for help" phone calls using a prepared script. This can be done individually with the counselor coaching, or in a group, to obtain feedback from the members.

When compared to individuals without additional disorders or disabilities, persons with COD and additional deficits often will require more substance abuse treatment in order to attain and maintain abstinence. A primary reason for this is that abstinence requires the development and utilization of a set of recovery skills, and persons with mental disorders often have a harder time learning new skills. They may require more support in smaller steps with more practice, rehearsal, and repetition. The challenge is not to provide more intensive or more complicated treatment for clients with COD, but rather to tailor the process of acquiring new skills to the needs and abilities of the client.

Case Study: Preventing Relapse in a Client With COD

Stan Z. is a 32-year-old with diagnoses of recurrent major depression, antisocial personality disorder, crack/cocaine dependence, and polysubstance abuse. He has a 15-year history of addiction, including a 2-year history of crack addiction. Stan Z. has been in a variety of psychiatric and substance abuse treatment programs during the past 10 years. His longest clean time has been 14 months. He has been attending a dual-diagnosis outpatient clinic for the past 9 months and going to Narcotics Anonymous (NA) meetings off and on for several years. Stan Z. has been clean from all substances for 7 months. Following is a list of high-risk relapse factors and coping strategies identified by Stan Z. and his counselor:

High-Risk Factor 1

Stan Z. is tired and bored "with just working, staying at home and watching TV, or going to NA meetings." Recently, he has been thinking about how much he "misses the action of the good old days" of hanging with old friends and does not think he has enough things to do that are interesting.

Possible coping strategies for Stan Z. include the following: (1) remind him of problems caused by hanging out with people who use drugs and using drugs by writing out a specific list of problems associated with addiction; (2) challenge the notion of the "good old days" by looking closely at the "bad" aspects of those days; (3) remind him of how far he has come in his recent recovery, especially being able to get and keep a job, maintain a relationship with one woman, and stay out of trouble with the law; (4) discuss current feelings and struggles with an NA sponsor and NA friends to find out how they handled similar feelings and thoughts; and (5) make a list of activities that will not threaten recovery and can provide a sense of fun and excitement and plan to start active involvement in one of these activities.

High-Risk Factor 2

Stan Z. is getting bored with his relationship with his girlfriend. He feels she is too much of a "home body" and wants more excitement in his relationship with her. He also is having increased thoughts of having sex with other women.

Possible coping strategies for Stan Z. include the following: (1) explore in therapy sessions why he is really feeling bored with his girlfriend, noting he has a long-standing pattern of dumping girlfriends after just a few months; (2) challenge his belief that the problem is mainly his girlfriend so that he sees how his attitudes and beliefs play a role in this problem; (3) talk directly with his girlfriend in a nonblaming fashion about his desire to work together to find ways to instill more excitement in the relationship; (4) remind him of potential dangers of casual sex with a woman he does not know very well and that he cannot reach his goal of maintaining a meaningful, mutual relationship if he gets involved sexually with another woman. His past history is concrete proof that such involvement always leads to sabotaging his primary relationship.

High-Risk Factor 3

Stan Z. wants to stop taking antidepressant medications. His mood has been good for several months and he does not see the need to continue medications.

Possible coping strategies include the following: (1) discuss his concern about medications with his counselor and psychiatrist before making a final decision; (2) review with his treatment team the reasons for being on antidepressant medications; (3) remind him that because he had several episodes of depression, even during times when he has been drug-free for a long period, medication can help "prevent" the likelihood of a future episode of depression.

Source: Daley and Lis 1995, pp. 255–256.

Case Study: Using Repetition and Skills Building With a Client With COD

In individual counseling sessions with Susan H., a 34-year-old Caucasian woman with bipolar disorder and alcohol dependence, the counselor observes that often she is forgetful about details of her recent past, including what has been said and agreed to in therapy. Conclusions the counselor thought were clear in one session seem to be fuzzy by the next. The counselor begins to start sessions with a brief review of the last session. He also allows time at the end of each session to review what has just happened. As Susan H. is having difficulty remembering appointment times and other responsibilities, he helps her devise a system of reminders in big letters on her refrigerator.

Facilitate Client Participation in Mutual Self-Help Groups

Just as the strategies discussed in this chapter have proven helpful both to clients who have only substance use disorders as well as to those with COD, so the use of mutual self-help groups is a key tool for the clinician in assisting both categories of clients. In addition to traditional 12-Step groups, dual recovery mutual self-help approaches are becoming increasingly common in most large communities. The clinician plays an important role in helping clients with COD access appropriate mutual self-help resources and benefit from them. (See chapter 7 for an extended presentation of Dual Recovery Mutual Self-Help approaches tailored to meet the needs of persons with COD.) Groups for those who do not speak English may not be available, and the clinician is advised to seek resources in other counties or, if the number of clients warrants it, to initiate organization of a group for those who speak the same non-English language.

The clinician can assist the client by:

- *Helping the client locate an appropriate group.* The clinician should strive to be aware not only of what local 12-Step and other dual recovery mutual self-help groups meet in the community, but also which 12-Step groups are known to be friendly to clients with COD, have other members with COD, or are designed specifically for people with COD. Clinicians do this by visiting groups to see how they are conducted, collaborating with colleagues to discuss groups in the area, updating their own lists of groups periodically, and gathering information from clients. The clinician should ensure that the group the client attends is a good fit for the client in terms of the age, gender, and cultural factors of the other members. In some communities, alternatives to 12-Step groups are available, such as Secular Organizations for Sobriety.
- *Helping the client find a sponsor, ideally one who also has COD and is at a later stage of recovery.* Knowing that he or she has a sponsor who truly understands the impact of two or more disorders will be encouraging for the client. Also, some clients may "put people off" in a group and have particular difficulty finding a sponsor without the clinician's support.
- *Helping the client prepare to participate appropriately in the group.* Some clients, particularly those with serious mental illness or anxiety about group participation, may need to have the group process explained ahead of time. Clients should be told the structure of a meeting, expectations of sharing, and how to participate in the closing exercises, which may include holding hands and repeating sayings or prayers. They may need to rehearse the kinds of things that are and are not appropriate to share at such meetings. Clients also should be taught how to "pass" and when this would be appropriate. The counselor should be familiar enough with group function and dynamics to actually "walk the

client" through the meeting before attending.

- *Helping overcome barriers to group participation.* The clinician should be aware of the genuine difficulties a client may have in connecting with a group. While clients with COD, like any others, may have some resistance to change, they also may have legitimate barriers they cannot remove alone. For example, a client with cognitive difficulties may need help working out how he or she can physically get to the meeting. The counselor may need to write down very detailed instructions for this person that another client would not need (e.g., "Catch the number 9 bus on the other side of the street from the treatment center, get off at Main Street, and walk three blocks to the left to the white church. Walk in at the basement entrance and go to Room 5.")
- *Debriefing with the client after he or she has attended a meeting to help process his or her reactions and prepare for future attendance.* The clinician's work does not end with referral to a mutual self-help group. The clinician must be prepared to help the client overcome any obstacles after attending the first group to ensure engagement in the group. Often this involves a discussion of the client's reaction to the group and a clarification of how he or she can participate in future groups.

Case Study: Helping a Client Find a Sponsor

Linda C. had attended her 12-Step group for about 3 months, and although she knew she should ask someone to sponsor her, she was shy and afraid of rejection. She had identified a few women who might be good sponsors, but each week in therapy she stated that she was afraid to reach out, and no one had approached her, although the group members seemed "friendly enough." The therapist suggested that Linda C. "share" at a meeting, simply stating that she'd like a sponsor but was feeling shy and didn't want to be rejected. The therapist and Linda C. role-played together in a session, and the therapist reminded Linda C. that it was okay to feel afraid and if she couldn't share at the next meeting, they would talk about what stopped her.

After the next meeting, Linda C. related that she almost "shared" but got scared at the last minute, and was feeling bad that she had missed an opportunity. They talked about getting it over with, and Linda C. resolved to reach out, starting her sharing statement with, "It's hard for me to talk in public, but I want to work this program, so I'm going to tell you all that I know it's time to get a sponsor." This therapy work helped Linda C. to put her need out to the group, and the response from group members was helpful to Linda C., with several women offering to meet with her to talk about sponsorship. This experience also helped Linda C. to become more attached to the group and to learn a new skill for seeking help. While Linda C. was helped by counseling strategies alone, others with "social phobia" also may need antidepressant medications in addition to counseling.

6 Traditional Settings and Models

In This Chapter…

Essential Programming for Clients With COD

Outpatient Substance Abuse Treatment Programs for Clients With COD

Residential Substance Abuse Treatment Programs for Clients With COD

Overview

What happens to clients with co-occurring disorders (COD) who enter traditional substance abuse settings? How can programs provide the best possible services to these people?

This chapter adopts a program perspective to examine both outpatient and residential settings, highlighting promising treatment models that have emerged both within the substance abuse field and elsewhere. It also discusses the various treatment approaches and models available to those working in substance abuse settings.

The chapter opens with a review of the seven essential programming elements in COD programming for substance abuse treatment agencies that treat clients with COD: (1) screening, assessment, and referral; (2) mental and physical health consultation; (3) the use of a prescribing onsite psychiatrist; (4) medication and medication monitoring; (5) psychoeducational classes; (6) onsite double trouble groups; and (7) offsite dual recovery mutual self-help groups. These elements are applicable in both residential and outpatient programs. This section of the chapter also discusses general considerations in treatment of clients with COD.

Essential background related to outpatient care for this population, including available data on its effectiveness, follows the discussion of essential programming. The chapter then turns to an overview of the critical factors in the successful design, implementation, evaluation, and maintenance of effective outpatient programs for clients with COD. Two examples of successful outpatient programs are highlighted: the Clackamas County Mental Health Center of Oregon City, Oregon, an outpatient substance abuse and mental health treatment center; and the Arapahoe House of Denver, Colorado, which is the State's largest provider of substance abuse treatment services. These are intended to "prime the pump" for readers considering the addition of new program elements to serve clients with COD. The section closes with an exploration of two specialized outpatient models for clients with co-occurring

substance use and serious mental disorders, Assertive Community Treatment and Intensive Case Management.

A discussion of residential substance abuse treatment programs for clients with COD completes the chapter. Like the discussion of outpatient care, this section describes the background and effectiveness of residential care for the COD population, the key issues that arise in program design and implementation, and the challenges of evaluating and sustaining residential programs. Modified therapeutic communities (MTCs)—forms of residential care particularly well suited to clients with COD—are described in detail. The chapter closes with a presentation of two other residential models: Gaudenzia, Inc., located in Norristown, Pennsylvania, which uses an MTC to provide care for its clients, the majority of whom have serious mental illness, and the Na'nizhoozi Center, Inc., located in the rural community of Gallup, New Mexico, a program that uses a range of culturally appropriate interventions to meet the needs of its predominantly American-Indian clients.

Essential Programming for Clients With COD

Individuals with COD are found in all addiction treatment settings, at every level of care. Although some of these individuals have serious mental illness and/or are unstable or disabled, many of them have relatively stable disorders of mild to moderate severity. As substance abuse treatment programs serve the increasing number of clients with COD, the essential program elements required to meet their needs must be defined clearly and set in place.

Program components described in this section should be developed by any substance abuse treatment program seeking to provide integrated substance abuse and mental health services to clients with COD (that is, to attain the level of capacity associated with the "COD capable" classification defined in chapter 2). These elements have been culled from a variety of strategies, approaches, and models described in the TIP and from consensus panel discussion of current clinical programming. The panel believes these elements constitute the best practices currently available for designing COD programs in substance abuse treatment agencies. A detailed discussion of these elements appears in chapter 1. What follows are program considerations for implementing these essential components.

Screening, Assessment, and Referral

All substance abuse treatment programs should have in place appropriate procedures for screening, assessing, and referring clients with COD. It is the responsibility of each provider to be able to identify clients with both mental and substance use disorders and ensure that they have access to the care needed for each disorder. For a detailed discussion, see chapter 4. If the screening and assessment process establishes a substance abuse or mental disorder beyond the capacity and resources of the agency, referral should be made to a suitable residential or mental health facility, or other community resource. Mechanisms for ongoing consultation and collaboration are needed to ensure that the referral is suitable to the treatment needs of persons with COD.

Physical and Mental Health Consultation

Any substance abuse treatment program that serves a significant number of clients with COD would do well to expand standard staffing to include mental health specialists and to incorporate consultation (for assessment, diagnosis, and medication) into treatment services. Adding a master's level clinical specialist with strong diagnostic skills and expertise in working with clients with COD can strengthen an agency's ability to provide services for these clients. These staff members could function as consultants to the rest of the team on matters related to mental disorders, in addition to

being the liaison for a mental health consultant and provision of direct services.

A psychiatrist provides services crucial to sustaining recovery and stable functioning for people with COD: assessment, diagnosis, periodic reassessment, medication, and rapid response to crises. (See the section below on the advantages of having a psychiatrist on staff as part of the treatment team.) If lack of funding prevents the substance abuse treatment agency from hiring a consultant psychiatrist, the agency could establish a collaborative relationship with a mental health agency to provide those services. A memorandum of agreement formalizes this arrangement and ensures the availability of a comprehensive service package for clients with COD. Such arrangements are used widely in the field, and examples of "best practices" are available (Ridgely et al. 1998; Treatment of Persons 2000).

Prescribing Onsite Psychiatrist

Adding an onsite psychiatrist in an addiction treatment setting to evaluate and prescribe medication for clients with COD has been shown to improve treatment retention and decrease substance use (Charney et al. 2001; Saxon and Calsyn 1995). The onsite psychiatrist brings diagnostic, medication, and psychiatric counseling services directly to the location clients are based for the major part of their treatment. This approach often is the most effective way to overcome barriers presented by offsite referral, including distance and travel limitations, the inconvenience of enrolling in another agency and of the separation of clinical services (more "red tape"), fears of being seen as "mentally ill" (if referred to a mental health agency), cost, and the difficulty of becoming comfortable with different staff.

The consensus panel is aware that the cost of an onsite psychiatrist is a concern for many programs. Many agencies that use the onsite psychiatrist model find that they can afford to hire a psychiatrist part-time, even 4 to 16 hours per week, and that a significant number of clients can be seen that way. A certain amount of that cost can be billed to Medicaid, Medicare, insurance agencies, or other funders. For larger agencies, the psychiatrist may be full time or share a full-time position with a nurse practitioner. The psychiatrist also can be employed concurrently by the local mental health program, an arrangement that helps to facilitate access to such other mental health services as intensive outpatient treatment, psychosocial programs, and even inpatient psychiatric care if needed. Studies describing this model more fully and including outcome data include Saxon and Calsyn (1995) and Charney and colleagues (2001). The approach also has been shown to be cost effective in a large health maintenance organization (Weisner et al. 2001).

An onsite psychiatrist fosters the development of substance abuse treatment staff, enhancing their comfort and skill in assisting clients with COD.

Some substance abuse programs may be reluctant to hire a psychiatrist or to provide psychiatric services. This issue can be resolved through agencywide discussions of the types of clients with COD seen by the agencies, how their services are coordinated, and the barriers clients experience to receiving all the elements of COD treatment. In many cases, the largest and most obviously missing elements of good, integrated, onsite COD treatment are mental disorder diagnosis and treatment. It also should be noted that an onsite psychiatrist fosters the development of substance abuse treatment staff, enhancing their comfort and skill in assisting clients with COD. The psychiatrist may be able upgrade counselors' skills through seminars on medication management and other

pertinent topics. Also, the psychiatrist usually attends the weekly meeting of the clinical team, helping to develop effective treatment plans for active cases of clients with COD. For many psychiatrists, this arrangement also affords a welcome opportunity for further exposure to substance abuse treatment.

Ideally, agencies should hire a psychiatrist with substance abuse treatment expertise to work onsite at the substance abuse treatment agency. Finding psychiatrists with this background may present a challenge. Psychiatrists certified by the American Society of Addiction Medicine (ASAM), the American Academy of Addiction Psychiatry, or the American Osteopathic Association (for osteopathic physicians) are good choices. They can provide leadership, advocacy, development, and consultation for substance abuse staff. Historically, however, substance abuse education in medical schools and residencies has received little attention, though promising efforts on multiple levels are working to ensure that all physicians receive at least a basic knowledge of substance use disorders. Thus, learning usually flows both ways, to the benefit of the client. When recruiting a psychiatrist, the substance abuse treatment program should discuss key issues around this bidirectional flow of clinical information and knowledge. In addition, a discussion of prescribing guidelines (such as those included in appendix F) is in order.

The prescribing onsite psychiatrist model is a useful and recommended step that substance abuse treatment agencies can take to provide integrated COD treatment services. A detailed manual is needed to help agencies install this model and to guide the participating psychiatrists to provide the best services within the model. Further research is needed to document cost offsets for implementing the model and gauge its clinical effectiveness in a variety of substance abuse treatment settings.

Medication and Medication Monitoring

Many clients with COD require medication to control their psychiatric symptoms and to stabilize their psychiatric status. The importance of stabilizing the client with COD on psychiatric medication when indicated is now well established in the substance abuse treatment field. (See appendix F for a comprehensive description of the role of medication and the available medications.) One important role of the psychiatrist working in a substance abuse treatment setting is to provide psychiatric medication based on the assessment and diagnosis of the client, with subsequent regular contact and review of medication. These activities include careful monitoring and review of medication adherence.

Psychoeducational Classes

Substance abuse treatment programs can help their clients with COD by offering psychoeducational classes such as those described below.

Mental and substance use disorders

Psychoeducational classes on mental and substance use disorders are important elements in basic COD programs. These classes typically focus on the signs and symptoms of mental disorders, medication, and the effects of mental disorders on substance abuse problems. Psychoeducational classes of this kind increase client awareness of their specific problems and do so in a safe and positive context. Most important, however, is that education about mental disorders be open and generally available within substance abuse treatment programs. Information should be presented in a factual manner, similar to the presentation of information on sexually transmitted diseases (STDs). Some mental health clinics have prepared synopses of mental illnesses for clients in terms that are factual but unlikely to cause distress. A range of literature written for the layperson also is available through government

agencies and advocacy groups (see appendix I). This material provides useful background information for the substance abuse treatment counselor as well as for the client.

Relapse prevention

Programs also can adopt strategies designed to help clients become aware of cues or "triggers" that make them more likely to abuse substances and help them develop alternative coping responses to those cues. Some providers suggest the use of "mood logs" that clients can use to increase their consciousness of the situational factors that underlie the urge to use or drink. These logs help answer the question, "When I have an urge to drink or use, what is happening?" Similarly, basic treatment agencies can offer clients training on recognizing cues for the return of psychiatric symptoms and for affect or emotion management, including how to identify, contain, and express feelings appropriately.

Double Trouble Groups (Onsite)

Onsite groups such as "Double Trouble" provide a forum for discussion of the interrelated problems of mental disorders and substance abuse, helping participants to identify triggers for relapse. Clients describe their psychiatric symptoms (e.g., hearing voices) and their urges to use drugs. They are encouraged to discuss, rather than to act on, these impulses. Double Trouble groups also can be used to monitor medication adherence, psychiatric symptoms, substance use, and adherence to scheduled activities. Double Trouble provides a constant framework for assessment, analysis, and planning. Through participation, the individual with COD develops perspective on the interrelated nature of mental disorders and substance abuse and becomes better able to view his or her behavior within this framework.

Dual Recovery Mutual Self-Help Groups (Offsite)

Fortunately, a variety of dual recovery mutual self-help groups exist in many communities. Substance abuse treatment programs can refer clients to dual recovery mutual self-help groups, which are tailored to the special needs of a variety of people with COD. These groups provide a safe forum for discussion about medication, mental health, and substance abuse issues in an understanding, supportive environment wherein coping skills can be shared. Chapter 7 contains a comprehensive description of this approach and a listing of organizations that provide such services. See also appendix J, which provides a list of such programs, their characteristics, and contacts.

General Considerations for Treatment

In addition to these seven essential elements of COD programming, all treatment providers would do well to develop specific approaches to working with COD clients in groups and find meaningful ways of including them in program design. Since families can have a powerful

Advice to Administrators: Recommendations for Providing Essential Services for People With COD

Develop a COD Program with the following components:

1. Screening, assessment, and referral for persons with COD
2. Physical and mental health consultation
3. Prescribing onsite psychiatrist
4. Medication and medication monitoring
5. Psychoeducational classes
6. Double trouble groups (onsite)
7. Dual recovery self-help groups (offsite)

influence on a client's recovery, it is especially important to reach out to the families of persons with COD and help them understand more about COD and how they can best support the client and help the person recover.

Working in groups

Group therapy in substance abuse treatment settings is regarded generally as a key feature of substance abuse treatment. However, group therapy should be augmented by individual counseling since individual contact is important in helping the client with COD make maximum use of group interventions.

> It is not uncommon for groups tailored to individuals with COD to consist of between two and four individuals in the early stages.

Group therapy should be modified for clients with COD. Generally, it is best to reduce the emotional intensity of interpersonal interaction in COD group sessions; issues that are nonprovocative to clients without COD may lead to reactions in clients with COD. Moreover, because many clients with COD often have difficulty staying focused, their treatment groups usually need stronger direction from staff than those for clients who do not have COD. Typically, some persons with COD have trouble sitting still, while others may have trouble getting moving at all (for instance, some people with depression); therefore, the duration of a group (and other activities) should be shortened to less than an hour, with the typical group or activity running for no more than 40 minutes. Because of the need for stability, the groups should run regularly and without cancellation.

Because many clients with COD have difficulty in social settings, group sizes may need to be smaller than is typical. There is benefit even to allowing a few individuals to be considered a group, so long as sessions are group-oriented and used as a means to introduce the client to a larger group setting. It is not uncommon for groups tailored to individuals with COD to consist of between two and four individuals in the early stages. Co-leaders are especially important in these groups, as one leader may need to leave the group with one member, while the group continues with the co-leader. With appropriate staff guidance, peers who have completed the program or advanced to its latter stages can sometimes be used as group cofacilitators.

Considerable tolerance is needed for varied (and variable) levels of participation depending on the client's level of functioning, stability of symptoms, response to medication, and mental status. Many clients with serious mental illness (e.g., those with a diagnosis of schizophrenia, schizoid and paranoid personality) may not fit well in groups and must be incorporated gradually at their own pace and to the degree they are able to participate. Even minimal or inappropriate participation can be viewed as positive in a given case or circumstance. Verbal communication from group leaders should be brief, simple, concrete, and repetitive. This is especially important to reach clients with cognitive and functional impairments. Affirmation of accomplishments should be emphasized over disapproval or sanctions. Negative behavior should be amended rapidly with a positive learning experience designed to teach the client a correct response to a situation. In general, group leaders will need to be sensitive and responsive to needs of the client with COD and the addition of special training can enhance his or her competency. TIP 41, *Substance Abuse Treatment: Group Therapy* (Center for Substance Abuse Treatment [CSAT] 2005) contains more information on the techniques and types of groups used in substance abuse treatment.

Involving clients in treatment and program design

Because clients can provide important guidance relative to their treatment and valuable feedback on program design and effectiveness, they should be involved in program discussions. Some guidelines for involving client/consumers include:

- Form a Consumer Advisory Group.
- Include both current clients from the program and past clients.
- Elect a client representative to discuss client concerns with staff.
- Provide a staff liaison to help coordinate client meetings and to provide a continuing link to staff.
- Hold regular meetings and phone conferences.
- Provide incentives to clients for participation.
- Solicit input on a variety of matters and in an ongoing way.
- Involve clients in meaningful projects.
- When client input is solicited and received, consider it respectfully, respond appropriately, and give the client feedback on your response.

Family education

It is important that family members and significant others who are close to the client receive information on mental disorders and substance abuse, as well as on how the disorders interact with one another. Particularly in cultures that value interdependence and are community- and/or family-oriented, a family and community education and support group can be helpful. In an effort to build or maintain support for the client and his treatment, family members and significant others need to understand the implications of having COD and the treatment options available to the client. Programs must provide this instruction in an interactive style that allows questions, not in a lecture mode. The essentials of this information include:

- The name of the disorder
- Its symptoms
- Its prevalence
- Its cause
- How it interacts with substance abuse—that is, the implications of having both disorders
- Treatment options and considerations in choosing the best treatment
- The likely course of the illness
- What to expect
- Programs, resources, and individuals who can be helpful

Outpatient Substance Abuse Treatment Programs for Clients With COD

Background and Effectiveness

Treatment for substance abuse occurs most frequently in outpatient settings—a term that subsumes a wide variety of disparate programs (Simpson et al. 1997*b*). Some offer several hours of treatment each week, which can include mental health and other support services as well as individual and group counseling for substance abuse; others provide minimal services, such as only one or two brief sessions to give clients information and refer them elsewhere (Etheridge et al. 1997). Some agencies offer outpatient programs that provide services several hours per day and several days per week, thus meeting ASAM's criteria for Intensive Outpatient Programs. Typically, treatment includes individual and group counseling, with referrals to appropriate community services. Until recently, there were few specialized approaches for people with COD in outpatient substance abuse treatment settings. One of many small exceptions was a methadone maintenance program that also made psychiatrists and mental health services available to its clients (Woody et al. 1983).

Deinstitutionalization and other factors are increasing the prevalence of persons with COD in outpatient programs. Many of these individuals have multiple health and social problems that complicate their treatment. Evidence from prior studies indicates that a mental disorder often makes effective treatment for substance use more difficult (Mueser et al. 2000; National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors 1999). Because outpatient treatment programs are available widely and serve the greatest number of clients (Committee on Opportunities in Drug Abuse Research 1996; Lamb et al. 1998), using current best practices from the substance abuse treatment and mental health services fields is vital. Doing so enables these programs to use the best available treatment models to reach the greatest possible number of persons with COD.

Prevalence

COD is clearly a defining characteristic commonly found in clients who enter substance abuse treatment. A Drug Abuse Treatment Outcome Study (DATOS) of 99 treatment programs in 11 U.S. metropolitan areas between 1991 and 1993 found the following distribution of co-occurring mental disorders: 39.3 percent met DSM-III-R (*Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition, revised [American Psychiatric Association 1987]) diagnostic criteria for antisocial personality disorder, 11.7 percent met criteria for a major depressive episode, and about 3.7 percent met criteria for a general anxiety disorder (Flynn et al. 1996) (see also Figure 1-2 in chapter 1). DATOS and other data indicate that substance abuse programs can expect a substantial proportion of the clientele to have COD.

Empirical evidence of effectiveness

Evidence suggests that outpatient treatment can lead to positive outcomes for certain clients with COD, even when treatment is not tailored specifically to their needs. Outpatient substance abuse treatment programs can be effective settings for treating substance abuse in clients with less serious mental disorders. This conclusion is supported by evidence from the most current and comprehensive database on substance abuse treatment, the DATOS dataset (Flynn et al. 1997).

Clients who were in outpatient treatment, including individual and group counseling and mutual self-help groups, showed reductions in drug use after treatment. Clients with 3 months or more of outpatient treatment reported even lower rates of drug use compared to their rate of use prior to treatment (Hubbard et al. 1997; Simpson et al. 1997*a*). These data show that substance abuse treatment outpatient programs can help clients, many with COD, who remain in treatment at least 3 months. However, modifications designed to address issues faced even by those with less serious mental disorders can enhance treatment effectiveness and in some instances are essential.

Designing Outpatient Programs for Clients With COD

The population of persons with COD is heterogeneous in terms of motivation for treatment, nature and severity of substance use disorder (e.g., drug of choice, abuse versus dependence, polysubstance abuse), and nature and severity of mental disorder. For the most part, however, clients with COD in outpatient treatment have less serious and more stabilized mental and substance abuse problems compared to those in residential treatment (Simpson et al. 1999).

Outpatient treatment can be the primary treatment or can provide continuing care for clients subsequent to residential treatment, which implies a degree of flexibility in the activities/interventions and the intensity of the treatment approaches. However, reports from clinical administrators indicate that an increasing number of clients with serious mental illness (SMI) and substance abuse problems are entering the outpatient substance abuse treatment system. Treatment failures occur with both people with SMI and those with less serious mental illness for several reasons, but among the most important are that programs lack the resources to provide the time for mental health services and medications that, in all likelihood, significantly would improve recovery rates and recovery time.

If lack of funding prevents the full integration of mental health assessment and medication services within a substance abuse treatment agency that provides outpatient services, establishing a collaborative relationship with a mental health agency (through the mechanism of a memorandum of agreement) would ensure that the services for the clients with COD are adequate and comprehensive. In addition, modifications are needed both to the design of treatment interventions and to the training of staff to ensure implementation of interventions appropriate to the needs of the client with COD.

To meet the needs of specific populations among persons with COD, the consensus panel encourages outpatient treatment programs to develop special services for populations that are represented in significant numbers in their programs. Examples include women, women with dependent children, homeless individuals and families, racial and ethnic minorities, and those with health problems such as HIV/AIDS. Several substance abuse treatment agencies have already developed programs for specialized subpopulations. Two such programs—the Clackamas County Mental Health Center (women, criminal justice, young adults) and Arapahoe House (women with children, homeless persons)—are described later in this chapter. Since the types of co-occurring disorder will vary according to the subpopulation targeted, each of these programs must deal with COD in a somewhat different manner, often by adding other treatment components for COD to existing program models.

Screening and assessment

As chapter 4 provides a full discussion of assessment, this section will address only those screening and assessment issues of concern in outpatient settings or that deserve reiteration in this specific context.

> A centralized intake team is a useful approach to screening and assessment, providing a common point of entry for many clients entering treatment.

Screening and assessment are used to make two essential decisions:

1. Is the individual stable enough to remain in an outpatient setting, or is more intense care indicated, warranting rapid referral to an appropriate alternative treatment?
2. What services will the client need?

To answer either question, staff must first determine the scope of the client's problems, including his physical and mental status, living situation, and the support he has available to face these problems. Whereas screening requires basic counseling skills, the consensus panel recommends that only specially trained or highly capable staff should perform assess-

ments—not, as is too often the case, less experienced personnel.

A thorough assessment should establish the client's mental and physical status. The process should determine any preexisting medical conditions or complications, substance use history, level of cognitive functioning, prescription drug needs, current mental status, and mental health history.

Centralized intake

A centralized intake team is a useful approach to screening and assessment, providing a common point of entry for many clients entering treatment. When applied in an agency with multiple programs, centralized intake reduces duplication of referral materials as well as assessment services. At Arapahoe House (a model described later in this chapter), the information and access team manages hundreds of telephone calls weekly, conducts screenings, and sets appointments for admission to any of the programs within the agency, with the exception of three detoxification programs. Where centralized intake serves a multi-modality treatment organization or a community with multiple settings (the latter being especially difficult), the intake process can be used to refer clients to the treatment modality most appropriate to their needs (e.g., residential or outpatient), so long as careful attention is paid to the accurate coordination of intake information.

Reassessment

Once admitted to treatment, clients need regular reassessment as reductions in acute symptoms of mental distress and substance abuse may precipitate other changes. Periodic assessment will provide measures of client change and enable the provider to adjust service plans as the client progresses through treatment.

Referral and placement

Careful assessment will help to identify those clients who require more secure inpatient treatment settings (e.g., clients who are actively suicidal or homicidal), as well as those who require 24-hour medical monitoring, those who need detoxification, and those with serious substance use disorders who may require a period of abstinence or reduced use before they can engage actively in all treatment components. TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998*e*), contains information on assessing physical and cognitive functioning that is relevant for all populations.

It is important to view the client's placement in outpatient care in the context of continuity of care and the network of available providers and programs. Outpatient treatment programs may serve a variety of functions, including outreach/engagement, primary treatment, and continuing care. Ideally, a full range of outpatient substance abuse treatment programs would include interventions for unmotivated, disaffiliated clients with COD, as well as for those seeking abstinence-based primary treatments and those requiring continuity of supports to sustain recovery.

Likewise, ideal outpatient programs will facilitate access to services through rapid response to all agency and self-referral contacts, imposing few exclusionary criteria, and using some client/treatment matching criteria to ensure that all referrals can be engaged in some level of treatment. In those instances where funding for treatment is controlled by managed care, additional levels of control over admission may be imposed on the treatment agency. The consensus panel has mentioned that treatment providers should be careful not to place clients in a higher level of care (i.e., more intense) than is necessary. A client who might remain engaged in a less intense treatment environment may drop out in response to the demands of a more intense treatment program.

Improving Adherence of Clients With COD in Outpatient Settings

- Use telephone or mail reminders.
- Provide reinforcement for attendance (e.g., snacks, lunch, or reimbursement for transportation).
- Increase the frequency and intensity of the outpatient services offered.
- Develop closer collaboration between referring staff and the outpatient program's staff.
- Reduce waiting times for outpatient appointments.
- Have outpatient programs designed particularly for clients with COD.
- Provide clients with case managers who engage in outreach and provide home visits.
- Coordinate treatment and monitoring with other systems of care providing services to the same client.

Source: Adapted from Daley and Zuckoff 1998.

Engagement

Clients with COD, especially those opposed to traditional treatment approaches and those who do not accept that they have COD, have particular difficulty committing to and maintaining treatment. By providing continuous outreach, engagement, direct assistance with immediate life problems (e.g., housing), advocacy, and close monitoring of individual needs, the Assertive Community Treatment (ACT) and Intensive Case Management (ICM) models (described below) provide techniques that enable clients to access services and foster the development of treatment relationships. In the absence of such supports, those individuals with COD who are not yet ready for abstinence-oriented treatment may not adhere to the treatment plan and may be at high risk for dropout (Drake and Mueser 2000).

Because clients with COD often have poor treatment engagement, it is particularly important that every effort be made to employ methods with the best prospects for increasing engagement. Daley and Zuckoff (1998) note a number of useful strategies for improving engagement and adherence with this population.

Discharge planning

Discharge planning is important to maintain gains achieved through outpatient care. Clients with COD leaving an outpatient substance abuse treatment program have a number of continuing care options. These options include mutual self-help groups, relapse prevention groups, continued individual counseling, mental health services (especially important for clients who will continue to require medication), as well as intensive case management monitoring and supports. A carefully developed discharge plan, produced in collaboration with the client, will identify and match client needs with community resources, providing the supports needed to sustain the progress achieved in outpatient treatment.

Clients with COD often need a range of services besides substance abuse treatment and mental health services. Generally, prominent needs include housing and case management services to establish access to community health and social services. In fact, these two services should not be considered "ancillary," but key ingredients for clients' successful recovery. Without a place to live and some degree of economic stability, clients with COD are likely to return to substance abuse or experience a return of symptoms of mental disorder. Every substance abuse treatment

provider should have, and many do have, the strongest possible linkages with community resources that can help address these and other client needs. Clients with COD often will require a wide variety of services that cannot be provided by a single program.

It is imperative that discharge planning for the client with COD ensures continuity of psychiatric assessment and medication management, without which client stability and recovery will be severely compromised. Relapse prevention interventions after outpatient treatment need to be modified so that the client can recognize symptoms of psychiatric or substance abuse relapse on her own and can call on a learned repertoire of symptom management techniques (e.g., self-monitoring, reporting to a "buddy," and group monitoring). This also includes the ability to access assessment services rapidly, since the return of psychiatric symptoms can often trigger substance abuse relapse.

The provider seeks to develop a support network for the client that involves family, community, recovery groups, friends, and significant others.

Developing positive peer networks is another important facet of discharge planning for continuing care. The provider seeks to develop a support network for the client that involves family, community, recovery groups, friends, and significant others. Where a client's family of origin is not healthy and supportive, other networks can be accessed or developed that will support him. Programs also should encourage client participation in mutual self-help groups, particularly those that focus on COD (e.g., dual recovery mutual self-help programs). These groups can provide a continuing supportive network for the client, who usually can continue to participate in such programs even if he moves to a different community. Therefore, these groups are an important method of providing continuity of care.

The consensus panel also recommends that programs working with clients with COD try to involve advocacy groups in program activities. These groups can help clients become advocates themselves, furthering the development and responsiveness of the treatment program while enhancing clients' sense of self-esteem and providing a source of affiliation.

Continuing care

Continuing care and relapse prevention are especially important with this population, since people with COD are experiencing two long-term conditions (i.e., mental disorder often is a cyclical, recurring illness; substance abuse is likewise a condition subject to relapse). Clients with COD often require long-term continuity of care that supports their progress, monitors their condition, and can respond to a return to substance use or a return of symptoms of mental disorder. Continuing care is both a process of post-treatment monitoring and a form of treatment itself. (In the present context, the term "continuing care" is used to describe the treatment options available to a client after leaving one program for another, less intense, program.)

The relative seriousness of a client's mental and substance use disorders may be very different at the time she leaves a primary treatment provider; thus, different levels of intervention will be appropriate. After leaving an outpatient program, some clients with COD

may need to continue intensive mental health care but can manage their substance abuse treatment by participation in mutual self-help groups. Others may need minimal mental health care but require some form of continued formal substance abuse treatment. For people with SMI, continued treatment often is warranted; a treatment program can provide these clients with structure and varied services not usually available from mutual self-help groups.

Upon leaving a program, clients with COD always should be encouraged to return if they need assistance with either disorder. Because the status of these individuals can be fragile, they need to be able to receive help or a referral quickly in times of crisis. Regular informal check-ins with clients also can help alleviate potential problems before they become serious enough to threaten recovery. A good continuing care plan will include steps for when and how to reconnect with services. The plan and provision of these services also makes readmission easier for clients with COD who need to come back. The client with COD should maintain contact postdischarge (even if only by telephone or informal gatherings). Increasingly, substance abuse programs are undertaking follow-up contact and periodic groups to monitor client progress and assess the need for further service.

Implementing Outpatient Programs

The challenge of implementing outpatient programs for COD is to incorporate specific interventions for a particular subgroup of outpatient clients into the structure of generic services available for a typically heterogeneous population. Often this is best accomplished by establishing a separate track for COD consisting of the services described in the section on essential programming above. Accomplishing this implies organizational change as substance abuse and mental health service agencies modify their mission to address the special needs of persons with COD. Note that the section on residential treatment contains some additional principles of implementation that are equally applicable to outpatient programs.

Staffing

To accommodate clients with COD, standard outpatient drug treatment staffing should include both mental health specialists and psychiatric consultation and access to onsite or offsite psychopharmacologic consultation. All treatment staff should have sufficient understanding of the substance use and mental disorders to implement the essential elements described above. Ideally, this staffing pattern would include mental health clinicians with master's level education, strong diagnostic skills, and substantial experience with clients with COD. These clinicians could provide a link to psychiatric services as well as to consultation on other clinical activities within the program. It is important that the staff function as an integrated team. Staff cooperation can often be fostered by cross-training, clinical team meetings and, most importantly, a treatment culture that stresses teamwork and collaboration.

Training

An integrated model of treatment for clients with COD requires that each member of the treatment team has substantial competency in both fields. Both mental health and substance abuse treatment staff require training, cross-training, and on-the-job training to meet adequately the needs of clients with COD. Within substance abuse treatment settings, this means training in these areas:

- Recognizing and understanding the symptoms of the various mental disorders
- Understanding the relationships between different mental symptoms, drugs of choice, and treatment history
- Individualizing and modifying approaches to meet the needs of specific clients and achieve treatment goals

- Accessing services from multiple systems and negotiating integrated treatment plans

The addition of mental health staff into a substance abuse treatment setting also raises the need for training. Training should address

- Differing perspectives regarding the characteristics of the person with COD
- The nature of addiction
- The nature of mental disability
- The conduct of treatment and staff roles in the treatment process
- The interactive effects of both conditions on the person and his or her outcomes
- Staff burnout

Staff trained exclusively either in mental health services or in substance abuse treatment models often have difficulty accepting the other's view of the person, the problem, and the approach to treatment. Cross-training and open discussion of differing viewpoints and challenging issues can help staff to reach a common perspective and approach for the treatment of clients with COD within each agency or program setting. Chapter 3 provides a more complete discussion of staff training, while appendix I identifies a number of training resources.

Evaluating Outpatient Programs

Five elements are needed to design an evaluation process for an outpatient program that can provide useful feedback to program staff and administrators on the effectiveness or outcome of treatment for persons with COD. These important data can be used to improve programs.

1. *Define the operational goals of the program in terms of the client behaviors for which change is sought.* Programs may define their goals for client change narrowly in terms of reductions in alcohol and drug use and crime only or more broadly, to include reductions in psychological symptoms, homelessness, unemployment, and so on.
2. *Decide who the study clients will be and devise a plan for selecting or sampling those clients.* Depending on the rate of client entry into a program and the number of clients sought for the outcome study (typically at least 35), a program may select every client presenting to treatment over the course of a designated time period or may sample systematically (e.g., taking every third client) or randomly (e.g., using a coin toss). It is important to use a system that avoids bias (i.e., avoids the selection of clients who, for one reason or another, are believed to be more likely to respond particularly well or particularly poorly to the treatment program).
3. *Locate and/or develop instruments that can be used to assess client functioning in the areas of concern for outcome.* Include areas about which the program staff feels information is needed (e.g., demographic characteristics and background variables such as source of referral, drug use and criminal justice histories, education or employment histories, prior drug treatment, social support, physical and mental health histories, etc.). For studies generally, and for in-treatment studies in particular, it is also important to gather information about client retention. Indeed, a number of studies now suggest that length of retention is a useful proxy measure for understanding posttreatment outcomes, and that retention to 3 months in outpatient programs is critical for clients to achieve meaningful behavior change.
4. *Develop a plan for data collection.* Information on client functioning can be gathered using selected instruments at the time of entry into treatment (baseline) and at intervals of 1 or more months from time of entry while the individual is in treatment. Data gathered may be restricted to self-report or may include biological markers such as urinalysis and/or data gathered from others knowledgeable about the client's functioning (e.g., family or school

personnel). Outcome studies frequently involve continuing assessment after the client leaves treatment, and again at designated intervals; typically, assessments at 6- to 12-month intervals.

5. *Develop a plan for data analysis and reporting.* Data analysis may be comparatively simple, describing client functioning at baseline in the areas of concern (e.g., drug use) and client functioning in those same areas at times of assessment or follow-up; alternatively, it may be complex, comparing client functioning in the areas of concern at multiple points in time and controlling for variables that might affect that functioning (e.g., prior treatment history). The findings obtained through data analysis are communicated through written and oral reporting to interested parties, particularly program staff who can use this information on program effectiveness to its greatest advantage (i.e., to improve the program's capacity to facilitate client change). Both the National Institute on Drug Abuse (NIDA) and CSAT have developed manuals for outcome studies designed to be conducted by treatment program staff. NIDA's document (1993) is titled *How Good Is Your Drug Abuse Treatment Program? A Guide to Evaluation.* CSAT's document (1997*b*) is titled *Demystifying Evaluation: A Manual for Evaluating Your Substance Abuse Treatment Program.*

Sustaining Outpatient Programs

Funding resources for substance abuse treatment remain significantly lower per client than those available for mental health services. Models demonstrating positive results originating in the mental health field often are too expensive to be implemented fully in more fiscally limited substance abuse treatment settings. The consensus panel recommends developing funding for the essential programming described in this chapter and, where possible, for adapting the successful models for the treatment of mental disorders in outpatient settings described below.

Financing integrated treatment

As noted earlier, systemic difficulties related to the organization and financing of integrated treatment models, including funding for enhanced mental health services, have delayed implementation of integrated treatment models in many outpatient substance abuse treatment settings. Resources for funding extended continuity of treatment, which are available generally in mental health settings, are not usually provided in substance abuse treatment systems. Since the majority of substance abuse treatment agencies treat clients with COD, an obvious solution to funding shortfalls is to access funding streams that support mental health services. Such funding may be based on demonstrating the nature, severity, and extent of co-occurring mental disorders among their clients, with documentation of the full range of diagnosed disabilities of clients with COD. This information also helps programs to modify their programs to address current client needs, and to educate and promote an appreciation for the documented efficacy of integrated treatment for those with COD (Drake et al.

Since the majority of substance abuse treatment agencies treat clients with COD, an obvious solution to funding shortfalls is to access funding streams that support mental health services.

1998*b*). Chapter 3 presents additional information on overcoming barriers and for accessing funding for COD in substance abuse treatment settings.

Planning for organizational change

Substance abuse treatment agencies should plan for any organizational changes needed to introduce new or altered approaches into program settings (e.g., adding and integrating mental health staff into the substance abuse setting). Agencies should be aware, however, that changing the processes and approaches in an organization is challenging. Strategies should be grounded in sound organizational change principles and may be effective in helping all parties understand, accept, and adjust to the changes. A recommended sourcebook administrators might find useful is *The Change Book: A Blueprint for Technology Transfer* (Addiction Technology Transfer Center National Office 2000).

Examples of Outpatient Programs

A CSAT initiative, titled *Grants for Evaluation of Outpatient Treatment Models for Persons With Co-Occurring Substance Abuse and Mental Health Disorders* (Substance Abuse and Mental Health Services Administration [SAMHSA] 2000) promotes the development and evaluation of new models for the treatment of COD in outpatient substance abuse treatment settings. A variety of models for treatment of clients with COD in outpatient substance abuse treatment settings are now emerging, some of which are outlined in appendix E.

Recognizing that providers must address these issues within the constraints of particular systems that differ significantly from each other, two providers have been chosen—the Clackamas County Mental Health Center, Oregon, and Arapahoe House, Colorado—to illustrate different approaches to providing outpatient care for clients with COD.

Assertive Community Treatment and Intensive Case Management: Specialized Outpatient Treatment Models for Clients With COD

This section focuses on two existing outpatient models, ACT and ICM (both from the mental health field) and the challenges of employing them in the substance abuse field. The rationale for selecting these specialized models is that the framework, model, and methods of each are articulated clearly, both have been disseminated widely and applied, and each has support from a body of empirical evidence (though the empirical support for ICM is relatively modest compared to ACT). Because service systems are layered and difficult to negotiate, and because people with COD need a wide range of services but often lack the knowledge and ability to access them, the utility of case management is recognized widely for this population. Although ACT and ICM can be thought of as similar in several features (e.g., both emphasize case management, skills training, and individual counseling), they function differently from each other with regard to goals, operational characteristics, and the nature and extent of the activities and interventions they provide. Therefore, each is described separately below.

Assertive Community Treatment

Developed in the 1970s by Stein and Test (Stein and Test 1980; Test 1992) in Madison, Wisconsin, for clients with SMI, the ACT model was designed as an intensive, long-term service for those who were reluctant to engage in traditional treatment approaches and who required significant outreach and engagement activities. ACT has evolved and been modified to address the needs of individuals with serious mental disorders and co-occurring substance use disorders (Drake et al. 1998*a*; Stein and Santos 1998).

The Clackamas County Mental Health Center, Oregon

Overview

Clackamas County is a geographically large county in northwest Oregon that is about the size of the State of Delaware and encompasses urban, suburban, and rural areas. Oregon City, the county seat, is home to 15,000 people. The County provides outpatient substance abuse and mental health treatment services at four major clinics throughout the county. Its substance abuse treatment program has made a concerted and sustained effort to develop working agreements with major sources of referral, reflecting client needs in the community (e.g., corrections, child protective services, adult and family services, and a local community college). In addition, the program continues to consult with other service providers to build further linkages.

All staff members who provide initial assessment and treatment have at least master's level training and substance abuse certification (or its equivalent), which has facilitated the awareness of potential co-occurring interactions beginning at intake. It is recognized that this level of staffing is unusual within substance abuse treatment programs.

Clients Served

The county provides treatment for clients with substance abuse and COD. The Clackamas County Mental Health Center has a number of programs that target specific populations, including a women's program; a program for clients involved in the criminal justice system who are on electronic surveillance or who were referred by juvenile and adult Drug Courts; clients with serious and persistent mental illness; and through the Passport Program, young adult men and women ages 17 to 23 who have co-occurring substance use disorders and significant mental disorders.

Services

Each clinic offers both Level 1 and 2 services (as defined by ASAM) (2001) and has working agreements with residential treatment programs for those who need that level of care. Outpatient services include treatment for individuals, families, and groups; case management; and consultation. More specialized treatment has been developed for some subpopulations within the program (e.g., clients with serious and persistent mental illness, clients on electronic surveillance, women).

Program model

ACT programs typically employ intensive outreach activities, active and continued engagement with clients, and a high intensity of services. ACT emphasizes shared decisionmaking with the client as essential to the client's engagement process (Mueser et al. 1998). Multidisciplinary teams including specialists in key areas of treatment provide a range of services to clients. Members typically include mental health and substance abuse treatment counselors, case managers, nursing staff, and psychiatric consultants. The ACT team provides the client with practical assistance in life management as well as direct treatment, often within the client's home environment, and remains responsible and available 24 hours a day (Test 1992). The team has the capacity to intensify services as needed and may make several visits each week (or even per day) to a client. Caseloads are kept smaller than other community-based treatment models to accommodate the intensity of service provision (a 1:12 staff-to-client ratio is typical).

ACT treatment activities and interventions

Examples of ACT interventions include

- *Outreach/engagement.* To involve and sustain clients in treatment, counselors and administrators must develop multiple means of attracting, engaging, and re-engaging clients. Often the expectations placed on

Arapahoe House, Colorado

Overview

Arapahoe House, a nonprofit corporation located near Denver, Colorado, is the State's largest provider of substance abuse treatment services. In addition, Arapahoe House is a licensed mental health clinic and strives to provide fully integrated services for clients with COD in all of its treatment programs. Because all Arapahoe House programs are designed to provide integrated treatment for clients with COD, the agency employs several psychiatrists on contract in both the residential and outpatient settings.

Clients Served

The Arapahoe House Adult Outpatient Programs admit clients with substance use disorders who do not require 24-hour medical monitoring or detoxification and do not have symptoms of mental illness that place them at high risk of harming themselves or others. Adult clients who do not meet these criteria are referred to Arapahoe House's detoxification services or its inpatient treatment program where they can receive comprehensive assessment and stabilization. Arapahoe House also has a number of programs for specific populations. There is a residential treatment program for women with dependent children and specialized services for homeless persons.

Services

Arapahoe House provides a full continuum of treatment services, including residential and outpatient treatment for adults and adolescents of multiple levels of intensity; case management services for specific target populations; nonmedical detoxification services; housing and vocational services; and, for adolescents, school-based counseling. The organization offers outpatient services at six locations in the metropolitan Denver area. These outpatient programs provide individual and group therapy, education, family counseling, sobriety monitoring, and mental health evaluation.

Arapahoe House also provides a wide array of services devoted to the needs of homeless persons, including intensive case management services and a housing program. Specific services for persons with COD include the 20-bed adult short-term intensive residential treatment program, the six adult outpatient clinics, and the New Directions for Families program, which is a comprehensive residential treatment program for women and their dependent children. New Directions has a capacity of sixteen families, with an expected length of stay of 4 months, followed by 4 months of outpatient continuing care.

Finally, with respect to adult services, The Wright Center, which is a 22-bed transitional residential program for men and women, has been modified to serve clients with COD. In addition to these programs for adults, Arapahoe House offers an array of programs designed to meet the needs of adolescents, and all of these programs target young persons with COD. This continuum of adolescent services includes counselors who work onsite in 16 high schools across the metropolitan Denver area; outpatient services at two sites, including day treatment; and two intensive residential treatment centers: one comprising 20 beds for male and female adolescents and the other a center for 15 adolescent females. These residential treatment centers offer comprehensive substance abuse and mental health treatment using an integrated model, and both sites contain an accredited school.

clients are minimal to nonexistent, especially in those programs serving very resistant or hard-to-reach clients.

- *Practical assistance in life management.* This feature incorporates case management activities that facilitate linkages with support services in the community. While the role of a counselor in the ACT approach includes standard counseling, in many instances substantial time also is spent on life management and behavioral management matters.

Making ACT Work

Team cohesion and smooth functioning are critical to success. The ACT multidisciplinary team has shared responsibility for the entire defined caseload of clients and meets frequently (ideally, teams meet daily) to ensure that all members are fully up-to-date on clinical issues. While team members may play different roles, all are familiar with every client on the caseload. Additionally, the ACT model includes the clients' family and friends within treatment services.

Source: Wingerson and Ries 1999.

- *Close monitoring.* For some clients, especially those with SMI, close monitoring is required.

  This can include (Drake et al. 1993):

  – Medication supervision and/or management

  – Protective (representative) payeeships

  – Urine drug screens
- *Counseling.* The nature of the counseling activity is matched to the client's motivation and readiness for treatment.
- *Crisis intervention.* This is provided during extended service hours (24 hours a day, ideally through a system of on-call rotation).

Key modifications for integrating COD

When working with a client who has COD, the goals of the ACT model are to engage the client in a helping relationship, to assist in meeting basic needs (e.g., housing), to stabilize the client in the community, and to provide direct and integrated substance abuse treatment and mental health services. The standard ACT model as developed by Test (1992) has been modified to include treatment for persons who have substance use disorders as well as mental disorders (Stein and Santos 1998). The key elements in this evolution have been

- The use of direct substance abuse treatment interventions for clients with COD (often through the inclusion of a substance abuse treatment counselor on the multidisciplinary team)
- A team focus on clients with COD (Drake et al. 1998*a*)
- COD treatment groups (Drake et al. 1998*a*)
- Modifications of traditional mental health interventions, including a strong focus on the relationships between mental health and substance use issues (e.g., providing skills training that focuses on social situations involving substance use [Drake and Mueser 2000])

Substance abuse treatment strategies are related to the client's motivation and readiness for treatment and include

- Enhancing motivation (for example, through use of motivational interviewing)
- Cognitive–behavioral skills for relapse prevention
- 12-Step programming, including use of the peer recovery community to strengthen supports for recovery
- Psychoeducational instruction about addictive disorders

For clients who are not motivated to achieve abstinence, motivational approaches are structured to help them recognize the impact of substance use on their lives and on the lives of those around them. Therapeutic interventions are modified to meet the client's current stage of change and receptivity.

Populations served

When modified as described above to serve clients with COD, the ACT model is capable of including clients with greater mental and functional disabilities who do not fit well into many traditional treatment approaches. The characteristics of those served by ACT programs for

Nine Essential Features of ACT

1. Services provided in the community, most frequently in the client's living environment
2. Assertive engagement with active outreach
3. High intensity of services
4. Small caseloads
5. Continuous 24-hour responsibility
6. Team approach (the full team takes responsibility for all clients on the caseload)
7. Multidisciplinary team, reflecting integration of services
8. Close work with support systems
9. Continuity of staffing

Source: Drake et al. 1998*a*.

COD include those with a substance use disorder and

- Significant mental disorders
- Serious and persistent mental illness
- Serious functional impairments
- Who avoided or did not respond well to traditional outpatient mental health services and substance abuse treatment
- Co-occurring homelessness
- Co-occurring criminal justice involvement (National Alliance for the Mentally Ill [NAMI] 1999)

In addition to, and perhaps as a consequence of, the characteristics cited above, clients targeted for ACT often are high utilizers of expensive service delivery systems (emergency rooms and hospitals) as immediate resources for mental health and substance abuse services.

Empirical evidence for ACT

The ACT model has been researched widely as a program for providing services to people who are chronically mentally ill. The general consensus of research to date is that the ACT model for mental disorders is effective in reducing hospital recidivism and, less consistently, in improving other client outcomes (Drake et al. 1998*a*; Wingerson and Ries 1999).

Randomized trials comparing clients with COD assigned to ACT programs with similar clients assigned to standard case management programs have demonstrated better outcomes for ACT. ACT resulted in reductions in hospital use, improvement on clinician ratings of alcohol and substance abuse, lower 3-year posttreatment relapse rates for substance use, and improvements on measures of quality of life (Drake et al. 1998*a*; Morse et al. 1997; Wingerson and Ries 1999). It is important to note that ACT has not been effective in reducing substance use when the substance use services were brokered to other providers and not provided directly by the ACT team (Morse et al. 1997). Researchers also considered the cost-effectiveness of these interventions, concluding that ACT has better client outcomes at no greater cost and is, therefore, more cost-effective than brokered case management (Wolff et al. 1997).

Other studies of ACT were less consistent in demonstrating improvement of ACT over other interventions (e.g., Lehman et al. 1998). In addition, the 1998 study cited previously (Drake et al. 1998*b*) did not show differential improvement on several measures important for establishing the effectiveness of

ACT with COD—that is, retention in treatment, self-report measures of substance abuse, and stable housing (although both groups improved). Drake notes that "drift" occurred in the comparison group; that is, elements of ACT were incorporated gradually into the standard case management model, which made it difficult to determine the differential effectiveness of ACT. Further analyses indicated that clients in high-fidelity ACT programs showed greater reductions in alcohol and drug use and attained higher rates of remissions in substance use disorders than clients in low-fidelity programs (McHugo et al. 1999). Nevertheless, ACT is a recommended treatment model for clients with COD, especially those with serious mental disorders, based on the weight of evidence.

Intensive case management

The earliest model of case management was primarily a brokerage model, in which linkages to services were forged based on the individual needs of each client, but the case manager did not provide formal clinical services. Over time, it became apparent that clinicians could provide more effective case management services; consequently, clinical case management largely supplanted the brokerage model. ICM emerged as a strategy in the late 1980s and early 1990s. It was designed as a thorough, long-term service to assist clients with SMI (particularly those with mental and functional disabilities and a history of not adhering to prescribed outpatient treatment) by establishing and maintaining linkages with community-based service providers.

ICM is not a precisely defined term, but rather is used in the literature to describe an alternative to both traditional case management and ACT. The goals of the ICM model are to engage individuals in a trusting relationship, assist in meeting their basic needs (e.g., housing), and help them access and use brokered services in the community. The fundamental element of ICM is a low caseload per case manager, which translates into more intensive and consistent services for each client. TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998*b*), contains more information on the history of case management, both how it has developed to meet the needs of clients in substance abuse treatment (including clients with COD) and specific guidelines about how to implement case management services.

Program model

ICM programs typically involve outreach and engagement activities, brokering of community-based services, direct provision of some support/counseling services, and a higher intensity of services than standard case management. The intensive case manager assists the client in selecting services, facilitates access to these ser-

Advice to Administrators: Treatment Principles From ACT

- Provide intensive outreach activities.
- Use active and continued engagement techniques with clients.
- Employ a multidisciplinary team with expertise in substance abuse treatment and mental health.
- Provide practical assistance in life management (e.g., housing), as well as direct treatment.
- Emphasize shared decisionmaking with the client.
- Provide close monitoring (e.g., medication management).
- Maintain the capacity to intensify services as needed (including 24-hour on-call, multiple visits per week).
- Foster team cohesion and communication; ensure that all members of the team are familiar with all clients on the caseload.
- Use treatment strategies that are related to the client's motivation and readiness for treatment, and provide motivational enhancements as needed.

vices, and monitors the client's progress through services provided by others (inside or outside the program structure and/or by a team). Client roles in this model include serving as a partner in selecting treatment components.

In some instances, the ICM model uses multidisciplinary teams similar to ACT. The composition of the ICM team is determined by the resources available in the agency implementing the programs. The team often includes a cluster-set of case managers rather than the specialists prescribed as standard components of the treatment model. The ICM team may offer services provided by ACT teams, including practical assistance in life management (e.g., housing) and some direct counseling or other forms of treatment. Caseloads are kept smaller than those in other community-based treatment models (typically, the client-to-counselor ratio ranges from 15:1 to 25:1), but larger than those in the ACT model. Because the case management responsibilities are so wide ranging and require a broad knowledge of local treatment services and systems, a typically trained counselor may require some retraining and/or close, instructive supervision in order to serve effectively as a case manager.

Treatment activities and interventions

Examples of ICM activities and interventions include

- **Engaging** the client in an alliance to facilitate the process and connecting the client with community-based treatment programs
- **Assessing** needs, identifying barriers to treatment, and facilitating access to treatment
- **Offering practical assistance** in life management and facilitating linkages with support services in the community
- **Making referrals** to treatment programs and services provided by others in the community (see TIP 27 [CSAT 1998*b*] for guidance on establishing linkages for service provision and interagency cooperation)
- **Advocating for the client** with treatment providers and service delivery systems
- **Monitoring progress**
- **Providing counseling and support** to help the client maintain stability in the community
- **Crisis intervention**
- **Assisting** in integrating treatment services by facilitating communication between service providers

Key modifications of ICM for co-occurring disorders

Key ICM modifications from basic case management for clients with COD include

- Using direct interventions for clients with COD, such as enhancing motivation for treatment and discussing the interactive effects of mental and substance use disorders
- Making referrals to providers of integrated substance abuse and mental health services or, if integrated services are not available or accessible, facilitating communication between separate brokered mental health and substance abuse service providers
- Coordinating with community-based services to support the client's involvement in mutual self-help groups and outpatient treatment activities

Empirical evidence

The empirical study of ICM for COD is not as extensive or as clarifying as the research on ACT; however, some studies do provide empirical support. ICM has been shown to be effective in engaging and retaining clients with COD in outpatient services and to reduce rates of hospitalization (Morse et al. 1992). Further, treatments combining substance abuse counseling with intensive case management services have been found to reduce substance use behaviors for this population in terms of days of drug use, remission from alcohol use, and reduced consequences of substance use (Bartels et al. 1995; Drake et al. 1993, 1997; Godley et al. 1994). The con-

tinued use and further development of ICM for COD is indicated based on its overall utility and modest empirical base.

Comparison of ACT and ICM

Similarities between ACT and ICM

Both ACT and ICM share the following key activities and interventions:

- Focus on increased treatment participation
- Client management
- Abstinence as a long-term goal, with short-term supports
- Stagewise motivational interventions
- Psychoeducational instruction
- Cognitive–behavioral relapse prevention
- Encouraging participation in 12-Step programs
- Supportive services
- Skills training
- Crisis intervention
- Individual counseling

Differences between ACT and ICM

ACT is more intensive than most ICM approaches. The ACT emphasis is on developing a therapeutic alliance with the client and delivery of service components in the client's home, on the street, or in program offices (based on the client's preference). ACT services, as described by NAMI (1999), are provided predominantly by the multidisciplinary staff of the ACT team (typically, 75 percent of services are team provided), and the program often is located in the community. Most ACT programs provide services 16 hours a day on weekdays, 8 hours a day on weekends, plus on-call crisis intervention, including visits to the client's home at any time, day or night, with the capacity to make multiple visits to a client on any given day. Caseloads usually are 12:1. ICM programs typically include fewer hours of direct treatment, though they may include 24-hour crisis intervention; the focus of ICM is on brokering community-based services for the client. ICM caseloads range up to 25:1.

The ACT multidisciplinary team has shared responsibility for the entire defined caseload of clients and meets frequently (ideally, teams meet daily) to ensure that all members are fully up-to-date on clinical issues. While team members may play different roles, all are familiar with every client on the caseload. The nature of ICM team functioning is not as defined, and cohesion is not necessarily a focus of team functioning; the ICM team can operate as a loose federation of independent case managers or as a cohesive unit in a manner similar to ACT. Also, the ACT model has been developed to include the clients' family and friends within treatment services (Wingerson and Ries 1999), which is not necessarily true for ICM models.

ICM most frequently involves the coordination of services across different systems and/or over extended periods of time, while ACT integrates and provides treatment for COD within the team. As a consequence, while advocacy with other providers is a major component of ICM, advocacy in ACT focuses on ancillary services. Additionally,

Advice to Administrators: Treatment Principles From ICM

- Select clients with greater mental and functional disabilities who are resistant to traditional outpatient treatment approaches.
- Employ low caseload per case manager to accommodate more intensive services.
- Assist in meeting basic needs (e.g., housing).
- Facilitate access to and utilization of brokered community-based services.
- Provide long-term support, such as counseling services.
- Monitor the client's progress through services provided by others.
- Use multidisciplinary teams.

the ACT multidisciplinary team approach to treatment places greater emphasis on providing integrated treatment for clients with COD directly, assuming that the team members include both mental health and substance abuse treatment counselors and are fully trained in both approaches.

Recommendations for extending ACT and ICM in substance abuse treatment settings

It is not self-evident that ACT and ICM models translate easily to substance abuse settings. The consensus panel offers the following six key recommendations for successful use of ACT and ICM in substance abuse settings with clients who have COD:

1. *Use ACT and ICM for clients who require considerable supervision and support.* ACT is a treatment alternative for those clients with COD who have a history of sporadic adherence with continuing care or outpatient services and who require extended monitoring and supervision (e.g., medication monitoring or dispensing) and intensive onsite treatment supports to sustain their tenure in the community (e.g., criminal justice clients). For this subset of the COD population, ACT provides accessible treatment supports without requiring return to a residential setting. The typical ICM program is capable of providing less intense levels of monitoring and supports, but can still provide these services in the client's home on a more limited basis.
2. *Develop ACT and/or ICM programs selectively to address the needs of clients with SMI who have difficulty adhering to treatment regimens most effectively.* ACT, which is a more complex and expensive treatment model to implement compared with ICM, has been used for clients with SMI who have difficulty adhering to a treatment regimen. Typically, these are among the highest users of expensive (e.g., emergency room, hospital) services. ICM programs can be used with treatment-resistant clients who are clinically and functionally capable of progressing with much less intensive onsite counseling and less extensive monitoring.
3. *Extend and modify ACT and ICM for other clients with COD in substance abuse treatment.* With their strong tradition in the mental health field, particularly for clients with SMI, ACT and ICM are attractive, accessible, and flexible treatment approaches that can be adapted for individuals with COD. Components of these programs can be integrated into substance abuse treatment programs.
4. *Add substance abuse treatment components to existing ACT and ICM programs.* Incorporating methods from the substance abuse treatment field, such as substance abuse education, peer mutual self-help, and greater personal responsibility, can continue to strengthen the ACT approach as applied to clients with COD. The degree of integration of substance abuse and mental health components within ACT and ICM is dependent upon the ability of the individual case manager/counselor or the team to provide both services directly or with coordination.
5. *Extend the empirical base of ACT and ICM to further establish their effectiveness for clients with COD in substance abuse treatment settings.* The empirical base for ACT derives largely from its application among people with SMI and needs to be extended to establish firm support for the use of ACT across the entire COD population. In particular, adding an evaluation component to new ACT programs in substance abuse settings can provide documentation currently lacking in the field concerning the effectiveness and cost benefit of ACT in treating the person who abuses substances with co-occurring men-

tal disorders in substance abuse treatment settings. The limitations of ICM have been listed above. The use of ACT or ICM should turn on the assessed needs of the client.

Residential Substance Abuse Treatment Programs for Clients With COD

Background and Effectiveness

Residential treatment for substance abuse comes in a variety of forms, including long-term (12 months or more) residential treatment facilities, criminal justice-based programs, halfway houses, and short-term residential programs. The long-term residential substance abuse treatment facility is the primary treatment site and the focus of this section of the TIP. Historically, residential substance abuse treatment facilities have provided treatment to clients with more serious and active substance use disorders but with less SMI. Most providers now agree that the prevalence of people with SMI entering residential substance abuse treatment facilities has risen.

Prevalence

As noted, mental disorders have been observed in an increasing proportion of clients in many substance abuse treatment settings (De Leon 1989; Rounsaville et al. 1982*a*). Compared to the rates found in clients in the outpatient programs of DATOS, slightly higher rates of antisocial personality disorder, and roughly similar rates of major depressive episode and generalized anxiety disorder, were found among adult clients admitted to the long-term residential programs that were part of DATOS (Flynn et al. 1996; see also Figure 1-2 in chapter 1 of this TIP). Of course, those admitted to long-term residential care tended to have more severe substance abuse problems. Additionally, in the year prior to admission to treatment, clients in long-term residential care reported the highest rate of past suicidal thoughts or attempts (23.6 percent) as compared to outpatient drug-free (19.3 percent) and outpatient methadone treatment (16.6 percent). Only the suicide thoughts and attempts rate for clients admitted to short-term inpatient treatment was higher (31.0 percent) (Hubbard et al. 1997, Table 2). This evidence points to the need for a programmatic response to the problems posed by those with COD who enter residential treatment settings.

Empirical evidence of effectiveness

Evidence from a number of large-scale, longitudinal, national, multisite treatment studies has established the effectiveness of residential substance abuse treatment (Fletcher et al. 1997; Hubbard et al. 1989). In general, these studies have shown that residential substance abuse treatment results in significant improvement in drug use, crime, and employment.

The most recent of these national efforts is NIDA's DATOS (Fletcher et al. 1997). The DATOS study involved a total of 10,010 adult clients, including many minorities, admitted between 1991 and 1993 to short-term inpatient substance abuse treatment programs, residential TCs, outpatient drug-free programs, or outpatient methadone maintenance programs across 11 cities (Chicago, Houston, Miami, Minneapolis,

> Historically, residential substance abuse treatment facilities have provided treatment to clients with more serious and active substance use disorders but with less SMI.

Newark, New Orleans, New York, Phoenix, Pittsburgh, Portland, and San Jose). Of the 4,229 clients eligible for follow-up and interviewed at intake, 2,966 were re-interviewed successfully after treatment (Hubbard et al. 1997).

Encouragingly, even with this high prevalence of clients with COD, DATOS study participants displayed positive outcomes for substance use and other maladaptive behaviors in the first year after treatment. Because studies of populations that abuse substances have shown that those who remain in treatment for at least 3 months have more favorable outcomes, a critical retention threshold of at least 90 days has been established for residential programs (Condelli and Hubbard 1994; Simpson et al. 1997*b*, 1999). Persons admitted to residential programs likely have the most severe problems, and those remaining beyond the 90-day threshold have the most favorable outcomes (Simpson et al. 1999).

Legal pressure and internal motivation among clients in residential programs have been associated with retention beyond the 90-day threshold (Knight et al. 2000). This relationship between legal pressure and retention supports practices that encourage court referrals to residential treatment for drug-involved persons (Hiller et al. 1998). Broome and colleagues (1999) found that hostility was related to a lower likelihood of staying in residential treatment beyond the 90-day threshold, but depression was associated with a greater likelihood of retention beyond the threshold.

Designing Residential Programs for Clients With COD

To design and develop services for clients with COD, a series of interrelated program activities must be undertaken, as discussed below. While the MTC described in detail later in this chapter is used frequently as a frame of reference throughout this discussion, these observations are applicable both to such TCs and to other residential programs that might be developed for COD.

Intake

Chapter 4 provides a full discussion of screening and assessment. This section will address intake procedures relevant to persons with COD in residential substance abuse treatment settings. The four interrelated steps of the relevant intake process include:

1. *Written referral.* Referral information from other programs or services can include the client's psychiatric diagnosis, history, current level of mental functioning, medical status (including results of screening for tuberculosis, HIV, STDs, and hepatitis), and assessment of functional level. Referrals also may include a psychosocial history and a physical examination.
2. *Intake interview.* An intake interview is conducted at the program site by a counselor or clinical team. At this time, the referral material is reviewed for accuracy and completeness, and each client is interviewed to determine if the referral is appropriate in terms of the history of mental and substance abuse problems. The client's residential and treatment history is reviewed to assess the adequacy of past treatment attempts. Finally, each client's motivation and readiness for change are assessed, and the client's willingness to accept the current placement as part of the recovery process is evaluated. Screening instruments, such as those described in chapter 4, can be used in conjunction with this intake interview.
3. *Program review.* Each client should receive a complete description of the program and a tour of the facility to ensure that both are acceptable. This review includes a description of the daily operation of the program in terms of groups, activities, and responsibilities; a tour of the physical site (including sleeping arrangements and communal areas); and

an introduction to some of the clients who are already enrolled in the program.

4. *Team meeting.* At the end of the intake interview and program review, the team meets with the client to arrive at a decision concerning whether the referred client should be admitted to the program. The client's receptivity to the program is considered and additional information (e.g., involvement with the justice system, suicide attempts) is obtained as needed. It should be noted that the decisionmaking process is inclusive; that is, a program accepts referrals as long as they meet the eligibility criteria, are not currently a danger to self or others, do not refuse medication, express a readiness and motivation for treatment, and accept the placement and the program as part of their recovery process.

Assessment

Once accepted into the program, the client goes through an assessment process that should include five areas:

1. *Substance abuse evaluation.* The substance abuse evaluation consists of assessing age at first use, primary drugs used, patterns of drug and alcohol use, and treatment episodes. This information can be augmented by some basic standard data collection method such as the Addiction Severity Index (ASI).
2. *Mental health evaluation.* Upon placement in a residential facility, it is desirable to have a psychiatrist, psychologist, or other qualified mental health professional evaluate each client's mental status, cognitive functioning, diagnosis, medication requirements, and the need for individual mental health services. If individual treatment is indicated, it is integrated with residential treatment via contact among the client, the case manager, and the therapist.
3. *Health and medical evaluation.* Referral information contains the results of recent medical examinations required for placement. All outstanding medical, dental, and other health issues, including infectious diseases, especially HIV and hepatitis, should be addressed early in the program through affiliation agreements with licensed medical facilities. Each client should receive a complete medical evaluation within 30 days of entry into the program.
4. *Entitlements.* The counselor should assess the status of each client's entitlements (e.g., Supplemental Security Income [SSI], Medicaid, etc.) and assist clients in completing all necessary paperwork to ensure maximum benefits. However, care must be taken not to jeopardize a client's eligibility for SSI by inadvertently mischaracterizing the client's disability as substance abuse primary.
5. *Client status.* Staff members assess clients' status as they enter treatment, including personal strengths, goals, family, and social supports. A key assessment weighs the client's readiness and motivation for change.

A successful engagement program helps clients to view the treatment facility as an important resource.

Engagement

The critical issue for clients with COD is engaging them in treatment so that they can make use of the available services. A successful engagement program helps clients to view the treatment facility as an important resource. To accomplish this, the program must meet essential needs and ensure psychiatric stabilization. Residential treatment programs can accomplish this by offering a wide

range of services that include both targeted services for mental disorders and substance abuse and a variety of other "wraparound" services including medical, social, and work-related activities. The extensiveness of residential services has been well documented (Etheridge et al. 1997; McLellan et al. 1993; Simpson et al. 1997*a*).

The interventions to promote engagement described in Figure 6-1 incorporate therapeutic community-oriented methods described in other studies (Items 1, 3, 5–7) (De Leon 1995), as well as strategies employed and found clinically useful in non-TC programs (Items 2 and 4). This approach holds promise for expanding treatment protocols for TC and many non-TC programs to permit wider treatment applicability.

Continuing care

Returning to life in the community after residential placement is a major undertaking for clients with COD, with relapse an ever-present danger. The long-term nature of mental disorders and substance abuse requires continuity of care for a considerable duration of time—at least 24 months (see, e.g., Drake et al. 1996*b*, 1998*b*). The goals of continuing care programming are sustaining abstinence, continuing recovery, mastering community living, developing vocational skills, obtaining gainful employment, deepening psychological understanding, increasing assumption of responsibility, resolving family difficulties, and consolidating changes in values and identity. The key services are life skills education, relapse prevention, 12-Step or double trouble groups, case management (especially for housing) and vocational training and employment. A recent study (Sacks et al. 2003*a*) provided preliminary evidence that a continuing care strategy using TC-oriented supported housing stabilizes gains in drug use and crime prevention, and is associated with incremental improvement in psychological functioning and employment.

Discharge planning

Discharge planning follows many of the same procedures discussed in the section on outpatient treatment. However, there are several other important points for residential programs:

- Discharge planning begins upon entry into the program.
- The latter phases of residential placement should be devoted to developing with the client a specific discharge plan and beginning to follow some of its features.
- Discharge planning often involves continuing in treatment as part of continuity of care.
- Obtaining housing, where needed, is an integral part of discharge planning.

Implementing Residential Programs

The literature contains many descriptions of programs that are employed in the various agencies but far fewer descriptions of how to design and implement these programs. Figure 6-2 (p. 166) identifies some principles found effective in designing and implementing residential programs.

Staffing

Developing a new treatment model places unique demands on staff. Staff for clients with COD should contain a substantial proportion of both mental health and substance abuse treatment providers, include both recovering and nonrecovering staff, and be culturally competent with regard to the population in treatment. A typical 25-bed residential program should consist of about 15 staff, as follows:

- Program director (preferably with an advanced degree in the human service field or with at least 5 years' experience in substance abuse treatment, including at least 3 years of supervisory experience), a secretary, a program supervisor (preferably with a

Figure 6-1
Engagement Interventions

Item	Element	Description
1	Client Assistance Counseling	• Emphasizes client responsibility, coaching and guiding the client, and using the client's senior peers to provide assistance
2	Medication	• Begins with mental health assessment and medication prescription, then monitors for medication adherence, side effects, and effectiveness
3	Active Outreach and Continuous Orientation	• Builds relationships and enhances program compliance and acceptance through multiple staff contacts
4	Token Economy	• Awards points (redeemable for tangible rewards such as phone cards, candy, toiletries) for positive behaviors including medication adherence, abstinence, attendance at program activities, follow-through on referrals, completing assignments, and various other activities essential to the development of commitment
5	Pioneers—Creating a Positive Peer Culture	• Facilitates program launch by forming a seedling group of selected residents (pioneers) to transmit the peer mutual self-help culture and to encourage newly admitted clients to make full use of the program
6	Client Action Plan	• Formulated by clients and staff to specify, monitor, and document client short-term goals under the premise that substantial accomplishments are achieved by attaining smaller objectives
7	Preparation for Housing	• Entitlements are obtained—a Section 8 application for housing is filed, available treatment and housing options are explored, work readiness skills are developed, and household management skills are taught

Source: Adapted from Sacks et al. 2002.

Figure 6-2 Principles of Implementation
How to organize • Identify the key person responsible for the successful implementation of the program. • Use a field demonstration framework in which there is cross-fertilization between program design and empirical data.
How to integrate with a system • Follow system policy, guidelines, and constraints. • Involve system stakeholders.
How to integrate in an agency • Select an agency that displays organizational readiness and encourages program change. • Form collaborative relationships at all levels of the organization, including both program and executive staff.
How to design, launch, and implement • Develop a planning group of key stakeholders that meets regularly. • Ensure client and staff orientation to all program elements. • Provide training and technical assistance in the context of implementation.
Source: Adapted from Sacks et al. 1997*b*.

bachelor's degree), and 10 line staff (with high school diplomas or associate's degrees)

- A clinical coordinator, a nurse practitioner (half-time), an entitlements counselor (half-time), and a vocational rehabilitation counselor (half-time)
- Consultive and/or collaborative arrangements for medical, psychiatric, and psychological input or care

The optimal staffing ratio for morning, afternoon, and night shifts is 3:1, 3:1, and 8:1, respectively. The critical position is the clinical coordinator who will direct program implementation.

Training

Initial training

To implement a new initiative such as the multicomponent MTC requires both initial training and continuing technical assistance. Learning should be both a didactic and experiential activity. The initial training for an MTC, conducted at the program site for 5 days before program launch, provides a model of structure and process that can be applied in other TC and non-TC settings. The training includes an overview of the philosophy, history, and background of the TC approach; a review of structure, including the daily regimen, role of staff, role of peers, peer work structure, privileges, and sanctions; and a review of treatment process, including a description of the stages and phases of treatment. This curriculum also includes special training in the assessment and treatment of clients with COD and in the key modifications of the TC for clients with COD (see Figure 6-3). Once established, the flagship program becomes the model for subsequent experiential training.

Figure 6-3

Sample Training and Technical Assistance Curriculum

What is a TC?	• Describes the theory, principles, and methods of the TC • Presents the TC perspective of four views: person, disorder, recovery, and "right living" • Describes the fundamentals of the TC approach with an emphasis on community-as-method; i.e., the community is the healing agent
What do we know about the treatment of people with COD?	• Reviews the literature on the increased prevalence of clients with COD in the mental health services, substance abuse treatment, and criminal justice systems • Presents a selected review and classification of treatment approaches and principles; provides a review of the research literature and its implications for practice • Describes research establishing the effectiveness of MTCs for clients with COD
What is an MTC?	• Describes the seven main modifications of the TC for clients with COD • Elaborates key changes in structure, process, and interventions of MTCs for clients with COD
How do we assess/diagnose the client with COD?	• Describes the main signs and symptoms of SMI for schizophrenia, major depression, and mania • Presents critical differences between Axis I and Axis II disorders (see the DSM-IV-TR) and their implications for program design • Describes the 10 main characteristics of populations of people with substance use disorders • Presents a classification of criminal behavior and criminal thinking • Presents three clinical instruments for assessing mental disorders, substance abuse, and danger profile • Presents empirical data on profiles of clients with COD
How do we start/implement the program?	• Presents six guidelines for successful program implementation • Provides practical advice on how to recruit, select, and initially evaluate • Emphasizes how to establish the TC culture • Describes six techniques for engaging the client in treatment • Presents empirical data from staff studies on the process of change • Develops a sequence for implementing the core TC elements

Figure 6-3 (continued) Sample Training and Technical Assistance Curriculum	
What are the main interventions and activities of the TC?	• Provides a complete list and brief discussion of all TC interventions in four areas: community enhancement (e.g., morning meeting), therapeutic/educative (e.g., conflict resolution groups, interpersonal skills training, medication/medication monitoring), community/clinical management (e.g., learning experiences), and work/other (e.g., peer work hierarchy) • Delineates the interventions for both the residential and continuing care components • Uses illustrations to teach three main interventions
How do clients change?	• Presents the stages and phases of TC programs • Describes the domains and dimensions of change • Describes an instrument for measuring change • Presents empirical data from staff studies on the process of change
What is the role of the staff?	• Describes the staffing patterns and job responsibilities of TC staff • Discusses the role of mental health, substance abuse, and criminal justice staff • Uses exercises to establish teamwork and "esprit de corps" • Provides the major cross-training experiences
What is it like to be in a TC?	• Discusses the "nuts and bolts" of TC operations • Provides a description of a typical day in the life of a TC resident • Demonstrates a typical schedule for a TC day/week • Addresses the concerns and issues of non-TC trained staff

Ongoing training and technical assistance

Training and technical assistance take place in the field; both are direct and immediate. Staff members learn exactly how to carry out program activities by participating in the activities. Technical assistance begins with a discussion of TC methods over a period of time (usually several weeks) before implementation, followed by active illustration during the initiation period (several weeks to several months). Supervisors hold briefing and debriefing sessions before and after each group activity, a process that continues for several months. As staff members begin to lead new activities, technical assistance staff members provide guidance for a period of several weeks. Monitoring continues until staff demonstrate competency (which takes several weeks, on average), as established by supervisory ratings. Thereafter, quarterly reviews ensure continued staff competency and fidelity of program elements to TC principles and methods. Training in the MTC model and its implementation has been conducted nationally by National Development and Research Institutes as a part of grant supported activities on NIDA- and SAMHSA-funded projects at no cost to the provider agencies. Other TC agencies (e.g., Gaudenzia, Odyssey House in New York) have also developed this model and either provide training or have the capacity to provide training. SAMHSA's Co-Occurring Center for Excellence affords a unique opportunity for training and the further dissemination of the MTC and other evidence- and consensus-based practices recommended by the consensus panel. See also appendix I for a list of training resources.

Evaluating Residential Programs

The model outlined in the section on outpatient services can be applied here. Program evaluation for use by administrators to improve their programs also can consist of assessing performance standards such as bed or occupancy rates, program retention, average duration of stay, existence of service plans, and referral rates to continuing care. These will be evaluated by comparing standards (to be established by each program) to actual data. Such measures are available in almost all programs and require very little in the way of additional resources. In addition, client satisfaction surveys and focus groups are useful in providing feedback from the perspective of the client and his or her family.

The efficacy of programs can be evaluated by determining change from pre- to post-treatment on basic measures of substance abuse and psychological functioning. Chapter 4 outlines a variety of measures that are available for this purpose including the ASI (McLellan et al. 1985), the Global Appraisal of Individual Needs (Dennis 2000), the Symptom Checklist-90 (Derogatis and Spencer 1982; Derogatis et al. 1973) and the Beck Depression Inventory (Beck and Steer 1987). These measures are relatively easy to use and can be employed even in substance abuse treatment programs with limited resources. The highest level of evaluation involves systematic research study; such efforts

Special Issue: The Use of Confrontation in Residential Substance Abuse Treatment

Confrontation is used commonly in residential substance abuse treatment. De Leon (2000*b*) presents a full description of confrontation that serves as the basis of this discussion. De Leon defines confrontation as a form of interpersonal exchange in which individuals present to each other their observations of, and reactions to, behaviors and attitudes that are matters of concern and that should change. In TC-oriented programs, confrontation is used informally in peer interactions, and formally in the encounter group process. The primary objective of confrontational communication simply is to raise the individual's awareness of how his or her behavior and attitudes affect others. Compassionate conversation, mutual sharing, and other supportive communications and interactions balance properly implemented confrontational exchanges.

Confrontation presents "reality" to individuals. Reality in this sense consists of peer reactions to each other's behavior and attitudes: teaching clients to say it as they see it and to say it honestly. Peer reactions include thoughts as well as the expression of honest feelings that enhance the credibility of the observations. These emotional expressions may be uncomfortable (e.g., hurt, anger, disappointment, fear, sadness) or comfortable (e.g., love, hope, happiness, encouragement, optimism). Appropriate intensity of emotions always is delivered with responsible concern. Thus, the observations and reactions of a confrontation may address negative "reality" and also affirm the "reality" of positive changes in behaviors and attitudes in individuals as they are perceived by others.

Confrontation skills and their application in encounter group are learned through staff training. There are tools and rules that enhance the therapeutic utility of confrontation in particular and the encounter group process in general. Thus, clients and staff must be trained in the proper use of confrontation.

The consensus panel notes that in working with individuals who have COD, the conflict resolution group replaces the encounter group, and the conflict resolution group is described below in the section on MTCs. In brief, the conflict resolution group has many of the same goals as the encounter group but modifies some of the features (especially the degree of emotional intensity) that characterize the confrontation employed in standard encounter groups as described by De Leon above.

usually require partnerships with research investigators.

Sustaining Residential Programs

One important vehicle for sustaining the residential program is through the development of a Continuous Quality Improvement (CQI) plan. The goal of CQI is to assess and ensure that the program meets established standards. It is a participatory process led by internal program staff with consultation from experts who use both quantitative and qualitative information to monitor and review program status and to develop action plans for program improvements and refinements. For quality control, the CQI staff uses observation, key informant interviews, resident focus groups, standardized instruments, and staff review. CQI is a management plan for sustaining program quality, for ensuring that programs are responsive to client needs, and for maintaining performance standards.

> The goals of the TC are to promote abstinence from alcohol and illicit drug use, to decrease antisocial behavior, and to effect a global change in lifestyle, including attitudes and values.

A sample CQI plan for an MTC in residential facilities, applicable with modified instruments to other residential programs, is as follows:

- *Fidelity of program implementation to program design and TC standards.* Program fidelity (i.e., assurance that the key elements/interventions of the TC are present) may be tested by administration of the TC Scale of Essential Elements Questionnaire (SEEQ) (Melnick and De Leon 1999). Any scores that fall below the level of "meets the standard" will trigger discussion and appropriate adjustments.
- *Delivery of actual program activities/elements.* Appropriate measures for success include (1) the delivery of an established number of program hours per day or week, as measured by a review of staff schedules and information systems report; (2) the delivery of an established level of specific groups and activities, as assessed by program schedules and program management information system activity reports; and (3) satisfactory concordance rate between program activities as designed and as delivered. This rate may be assessed using the Program Monitoring Form and the TC Scale of Essential Elements Questionnaire (Melnick and De Leon 1999).
- *Presence of a therapeutic environment.* The use of community as the healing agent, the existence of trust in interpersonal relationships, and the perception of the TC program as a place to facilitate recovery and change, together constitute a therapeutic environment. The extent to which these elements exist may be established by participant observation, interviews, and focus groups.

Therapeutic Communities

The goals of the TC are to promote abstinence from alcohol and illicit drug use, to decrease antisocial behavior, and to effect a global change in lifestyle, including attitudes and values. The TC views drug abuse as a disorder of the whole person, reflecting problems in conduct, attitudes, moods, values, and emotional management. Treatment focuses on drug abstinence, coupled with social and psychological change that requires a multidimensional effort, involving intensive mutual self-help typically in a residential set-

ting. At the time of this writing, the duration of residential TC treatment typically is about 12 months, although treatment duration has been decreasing under the influence of managed care and other factors. In a definitive book titled *The Therapeutic Community: Theory, Model, and Method*, De Leon (2000*b*) has provided a full description of the TC for substance abuse treatment to advance research and guide training, practice, and program development.

The effectiveness of TCs in reducing drug use and criminality has been well documented in a number of program-based and multisite evaluations. In general, positive outcomes are related directly to increased length of stay in treatment (De Leon 1984; Hubbard et al. 1984; Simpson and Sells 1982). Short- and long-term follow-up studies show significant decreases in alcohol and illicit drug use, reduced criminality, improved psychological functioning, and increased employment (Condelli and Hubbard 1994; De Leon 1984; Hubbard et al. 1997; Simpson and Sells 1982).

In terms of psychological functioning, clients demonstrate improvement in psychological well-being after treatment (Brook and Whitehead 1980; Carroll and McGinley 1998; De Leon 1984, 1989; De Leon and Jainchill 1982; Kennard and Wilson 1979). Research findings indicate that psychological status improves during treatment, with larger changes in self-esteem, ego strength, socialization, and depression, and smaller changes in long-standing characteristics such as personality disorders (De Leon and Jainchill 1982).

Modified therapeutic communities for clients with COD

The MTC approach adapts the principles and methods of the TC to the circumstances of the COD client. The illustrative work in this area has been done with people with COD, both men and women, providing treatment based on community-as-method—that is, the community is the healing agent. This section focuses on the MTC as the potent residential model developed within the substance abuse treatment field; most of this section applies to both TC and other residential substance abuse treatment programs. A complete description of the MTC for clients with COD, including treatment manuals and guides to implementation, can be found in other writings (e.g., De Leon 1993*a*; Sacks et al. 1997*a*, *b*, 1999).

Treatment activities/interventions

All program activities and interactions, singly and in combination, are designed to produce change. Interventions are grouped into four categories—community enhancement (to promote affiliation with the TC community), therapeutic/educative (to promote expression and instruction), community/clinical management (to maintain personal and physical safety), and vocational (to operate the facility and prepare clients for employment). Implementation of the groups and activities listed in Figure 6-4 (p. 172) establishes the TC community. Although each intervention has specific individual functions, all share community, therapeutic, and educational purposes.

Key modifications

The MTC alters the traditional TC approach in response to the client's psychiatric symptoms, cognitive impairments, reduced level of functioning, short attention span, and poor urge control. A noteworthy alteration is the change from encounter group to conflict resolution group. Conflict resolution groups have the following features:

- They are staff led and guided throughout.
- They have three highly structured and often formalized phases—(1) feedback on behavior from one participant to another, (2) opportunity for both participants to explain their position, and (3) resolution between participants with plans for behavior change.
- There is substantially reduced emotional intensity and an emphasis on instruction and the learning of new behaviors.

Figure 6-4 Residential Interventions	
Community Enhancement	
Morning Meeting	Increases motivation for the day's activities and creates a positive family atmosphere.
Concept Seminars	Review the concept of the day.
General Interest Seminars	Provide information in areas of general interest (e.g., current events).
Program-Related Seminars	Address issues of particular relevance (e.g., homelessness, HIV prevention, and psychotropic medication).
Orientation Seminars	Orient new members and introduce all new activities.
Evening Meetings	Review house business for the day, outline plans for the next day, and monitor the emotional tone of the house.
General Meetings	Provide public review of critical events.
Therapeutic/Educative	
Individual Counseling	Incorporates both traditional mental health and unique M TC goals and methods.
Psychoeducational Classes	Are predominant, using a format to facilitate learning among clients with COD; address topics such as entitlements/money management, positive relationship skills training, triple trouble group, and feelings management.
Conflict Resolution Groups	Modified encounter groups designed specifically for clients with COD.
Medication/Medication Monitoring	Begins with mental health assessment and medication prescription; continues with psychoeducation classes concerning the use and value of medication; and then monitors, using counselor observation, the peer community, and group reporting for medication adherence, side effects, and effectiveness. (See chapter 1, subsection titled "Pharmacological advances," and chapter 5, subsection titled "Monitor Psychiatric Symptoms" for more details on the role of the counselor and the peer-community in monitoring mental disorder symptoms and medication.)
Gender-Specific Groups	Combine features of "rap groups" and therapy groups focusing on gender-based issues.

Figure 6-4 (continued) Residential Interventions	
Community and Clinical Management Policies	A system of rules and regulations to maintain the physical and psychological safety of the environment, ensuring that resident life is orderly and productive, strengthening the community as a context for social learning.
Social Learning Consequence	A set of required behaviors prescribed as a response to unacceptable behavior, designed to enhance individual and community learning by transforming negative events into learning opportunities.
Vocational	
Peer Work Hierarchy	A rotating assignment of residents to jobs necessary to the day-to-day functioning of the facility, serving to diversify and develop clients' work skills and experience.
World of Work	A psychoeducational class providing instruction in applications and interviews, time and attendance, relationships with others at work, employers' expectations, discipline, promotion, etc.
Recovery and World of Work	A psychoeducational class that addresses issues of mental disorders, substance abuse, and so on, in a work context.
Peer Advocate Training	A program for suitable clients offering role model, group facilitator, and individual counseling training.
Work Performance Evaluation	Provides regular, systematic feedback on work performance.
Job Selection and Placement	Individual counseling after 6 months to establish direction and to determine future employment.
Source: Sacks et al. 1999.	

- There is a persuasive appeal for personal honesty, truthfulness in dealing with others, and responsible behavior to self and others.

In general, to create the MTC program for clients with COD, three fundamental alterations were applied within the TC structure:

- Increased flexibility
- Decreased intensity
- Greater individualization

Nevertheless, the central TC feature remains; the MTC, like all TC programs, seeks to develop a culture in which clients learn through mutual self-help and affiliation with the community to foster change in themselves and others. Respect for ethnic, racial, and gender differences is a basic tenet of all TC programs and is part of teaching the general lesson of respect for self and others.

Figure 6-5 (p. 174) summarizes the key modifications necessary to address the unique needs of clients with COD.

Role of the family

While many MTC clients come from highly impaired and disrupted family situations and find in the MTC program a new reference and support group, some clients do have available

Figure 6-5
TC Modifications for Persons With COD

Modifications to Structure	Modifications to Process	Modifications to Elements (Interventions)
There is increased flexibility in program activities.	Sanctions are fewer with greater opportunity for corrective learning experiences.	Orientation and instruction are emphasized in programming and planning.
Meetings and activities are shorter.		Individual counseling is provided more frequently to enable clients to absorb the TC experience.
There is greatly reduced intensity of interpersonal interaction.	Engagement and stabilization receive more time and effort.	Task assignments are individualized.
More explicit affirmation is given for achievements.		Breaks are offered frequently during work tasks.
Greater sensitivity is shown to individual differences.	Progression through the program is paced individually, according to the client's rate of learning.	Individual counseling and instruction are more immediately provided in work-related activities.
There is greater responsiveness to the special developmental needs of the individual.		Engagement is emphasized throughout treatment.
More staff guidance is given in the implementation of activities; many activities remain staff assisted for a considerable period of time.	Criteria for moving to the next phase are flexible to allow lower-functioning clients to move through the program phase system.	Activities are designed to overlap.
There is greater staff responsibility to act as role models and guides.		Activities proceed at a slower pace.
Smaller units of information are presented gradually and are fully discussed.	Live-out re-entry (continuing care) is an essential component of the treatment process.	Individual counseling is used to assist in the effective use of the community.
Greater emphasis is placed on assisting individuals.		The conflict resolution group replaces the encounter group.
Increased emphasis is placed on providing instruction, practice, and assistance.	Clients can return to earlier phases to solidify gains as necessary.	

Source: Sacks et al. 1999.

intact families or family members who can be highly supportive. In those cases, MTC programs offer a variety of family-centered activities that include special family weekend visiting, family education and counseling sessions, and, where children are involved, classes focused on prevention. All these activities are designed in the latter part of treatment to facilitate the client's reintegration into the family and to mainstream living.

Empirical evidence

A series of studies has established that

- Homeless persons with COD have multiple impairments requiring multifaceted treatment (Sacks et al. 1997*b*, 1998*a*), and the homeless population with COD contains distinctive subgroups (De Leon et al. 1999).
- Residential MTCs for people with COD, including women, produce significantly greater positive outcomes for substance use and employment than treatment as customarily provided (De Leon et al. 2000*c*). A parallel study (Rahav et al. 1995) also demonstrated significantly improved psychological functioning (e.g., lower depression) for an MTC group as compared to a "low demand" community residence program.
- Preliminary evidence shows that TC-oriented supported housing stabilizes the gains from the residential program (Sacks et al. 2003*a*).
- The cost of providing effective treatment through the MTC is no more than the cost of providing less effective treatment delivered through customarily available services (French et al. 1999; McGeary et al. 2000).
- MTC treatment produces $6 in benefit for every dollar spent (French et al. 2002).
- Initial evidence indicates that those with both a mental and substance use disorder in an MTC group show significantly lower reincarceration rates than a group receiving regular mental health services (Sacks et al. 2004).

Current applications

The MTC model has been adopted successfully in community residence programs for serious and persistent mental illness (Sacks et al. 1998*a*), general hospitals (Galanter et al. 1993), and substance abuse treatment programs, both nationally (Caroll 1990) and internationally. It has spread particularly within TC agencies such as Phoenix House, Walden House (Guydish et al. 1994), Odyssey House, Gaudenzia, and Second Genesis.

Manuals have been developed that describe the MTC programs (Sacks et al. 1998*b*, 2002) and principles of implementation (Sacks et al. 1999). In addition, there are procedures that ensure the quality control of new applications (see section on "Continuous Quality Improvement" above). This information is useful to providers planning to develop MTC programs. A representative example of such MTC programs from Gaudenzia is provided on pages 176–178.

Advice to Administrators: Recommended Treatment and Services From the MTC Model

In addition to all the guidelines for treatment cited in chapter 1, the following treatment recommendations are derived from MTC work and are applicable across all models.

- Treat the whole person.
- Provide a highly structured daily regimen.
- Use peers to help one another.
- Rely on a network or community for both support and healing.
- Regard all interactions as opportunities for change.
- Foster positive growth and development.
- Promote change in behavior, attitudes, values, and lifestyle.
- Teach, honor, and respect cultural values, beliefs, and differences.

Gaudenzia, Inc., Pennsylvania

Overview

Gaudenzia, Inc. is a substance abuse treatment organization that provides a range of services at a number of different facilities. It is the largest nonprofit provider of substance abuse treatment services in the State of Pennsylvania, and it has more than 30 different facilities located across the State. Most programs are based on TC or MTC principles and methods. The entire agency has about 550 staff consisting of administrative management, clinical management, front line clinical, administrative, operational support, and nursing personnel. Most of the funding for these programs comes from municipal and State Offices of Mental Health.

While Gaudenzia has facilities in a variety of different areas (urban, suburban, rural), all of the programs described below are in urban areas. Urban locations can support more specialized programs because they serve a larger population, with substantial concentrations of particular subgroups. Six of its facilities were developed as MTC programs to exclusively or primarily serve clients with COD, and a seventh has become a facility for people with HIV/AIDS and COD. They share a common perspective, principles, and methods, which are described below.

Gaudenzia House Broad Street

Gaudenzia House Broad Street is a 30-bed residential treatment program for adult men and women, 18 years or older, who have been diagnosed with both substance use disorders and co-occurring chronic and persistent mental disorders. This facility was opened as a response to the closure of Byberry, Philadelphia's State Hospital, to provide community-based treatment for people with COD. Broad Street is a drug and alcohol and mental health residential program dually licensed by the Commonwealth of Pennsylvania Bureau of Drug and Alcohol Programs as a residential treatment program and by the Office of Mental Health as a residential treatment facility. The program also is accredited by the Joint Commission on Accreditation of Healthcare Organizations. The program uses an MTC approach to treat substance abuse, provides onsite mental health services for co-occurring mental disorders, and integrates substance abuse treatment and mental health services. Program services include individual counseling, work therapy, life skills training, group therapy, educational seminars on substance abuse and mental health, 12-Step and Double Trouble meetings, family counseling, and mental health treatment.

Focus House

Focus House is a long-term (9 months to 2 years) residential substance abuse treatment and mental health services program for men ages 18 and over who have chronic COD. This 12-bed facility provides substance abuse counseling, community residential rehabilitation, and transitional living arrangements for clients with severe and persistent mental illness. Focus House teaches clients the essential life skills they will need to live independent and productive lives in the community, to cease the substance abuse that complicates their mental illness, and to promote self-motivated involvement in the mental health service system. This program is used as a step-down from a more intensive residential inpatient program. All of the clients attend day programs at the local mental health center. In-house program services include group therapy, relapse prevention, individual counseling, socialization skill training, and life skills training.

New Beginnings

Gaudenzia's New Beginnings is an 18-bed residential program that provides long-term residential care for homeless men and women who are chronically mentally ill and have co-occurring substance use disorders. The program initially is a "low-demand" environment that first addresses essential needs and then helps residents change the dysfunctional patterns that contribute to chronic homelessness and aggravate their mental disorders. It is called a "progressive demand facility," which recognizes the need to meet clients where they are, but expects individuals to reach their potential through layering services and expectations in a logical building block manner.

Joy of Living

Gaudenzia's Joy of Living is a 14-bed program that provides long-term (9 to 18 months) residential services for homeless men and women who have COD. The facility provides residents with shelter, support for recovery from substance abuse, and assistance in stabilizing the symptoms of chronic mental disorders. Clients at both the Joy of Living and New Beginnings programs (see above) arrive typically from a hospital or through interventions by city outreach workers or as a next step residence for those who have completed longer-term treatment but are not able to sustain themselves. They generally are not motivated for treatment and have many pressing needs that must be met before they are capable of engaging in a treatment program. Mental health treatment services are not provided onsite because the majority of the clients are in partial-hospital day programs off-site. Case management services are provided to help coordinate services based on clients' abilities to engage in these services.

The facility is considered a specialized progressive demand residence that engages people into formal treatment services by intervention and referral to outside services as needed, such as mental health care, medical services, and vocational/educational programs. Onsite substance abuse treatment includes individual and group counseling, treatment planning, life skills training, medication management, and 12-Step programs.

Progress House

Gaudenzia's Progress House is a 14-bed moderate care community residential rehabilitation program for clients with COD. The facility has six apartments; one is an office and the other five are residences shared by the clients. The program provides semi-independent living for clients who have completed treatment at one of Gaudenzia's other programs. Staff is onsite 16 hours a day, and residents are provided with counseling for mental health and substance abuse issues. All clients go to mental health service programs, vocational programs, or sheltered workshops during the day. Program services include life skills training, vocational guidance, 12-Step meetings, and transitional living services.

New View

Gaudenzia's New View was established to provide community residential rehabilitation services to adult residents (both men and women) of Dauphin County who have SMI and a history of drug and alcohol problems. The program can last up to 2 years depending on a client's clinical progress. The eight-bed program has the features of an MTC, with a strong emphasis on community reintegration. The goal for the majority of the clients is to obtain employment in the community during the later stages of treatment. There also is a strong family component and a weekly continuing care group for clients who have completed inpatient care and are making the transition to independent living.

People With Hope

This program is an MTC 23-bed facility for adult men and women who have AIDS (and are symptomatic) with a variable length of treatment (3 to 9 months); the majority of these clients have co-occurring substance abuse and mental disorders. The goal is to provide substance abuse treatment, shelter, medical care, seminars on HIV disease, and educational services that are designed to enhance the quality of life for the individual. The services during the intensive phase of treatment include individual and group therapy, work therapy, GED/literacy classes, and daily seminars that focus on life skills, AIDS-related issues, parenting, sexual orientation, nutrition, relapse prevention, budgeting, and socialization. The re-entry and continuing care phases of the program include a transitional living component and a strong emphasis on 12-Step participation. For those clients who have a co-occurring disorder, ongoing mental health services such as medication evaluation and monitoring are arranged through the nearby community mental health center. People With Hope has a nursing staff onsite providing medication management and health care case management.

Together House

Together House consists of three distinct programs in the same building licensed by the Commonwealth of Pennsylvania under one umbrella to provide residential treatment for three distinct populations. Among the three tracks, a total of 57 clients are served. The three programs are (1) Men's Forensic Intensive Recovery pro-

gram (MFIR), (2) Women's Forensic Intensive Recovery program (WFIR), and (3) Short-Term Program (STP). MFIR and WFIR each provide residential treatment for 24 adults with COD who have been referred through the City of Philadelphia Forensic network. The majority of these clients come directly to Together House from the city prison system where they have been incarcerated for drug- or alcohol-related offenses.

This program represents a major effort by the city of Philadelphia to provide treatment instead of incarceration to individuals with substance use disorders, recognizing the special needs of the person with COD. The STP serves nine men and women who have HIV, are homeless, and have COD. They must have issues of addiction and also have a co-existing mental disorder. The purpose of STP is engagement, stabilization, thorough assessment, and referral for longer-term treatment. Maximum length of stay is 4 to 6 weeks. In each track, all services are provided onsite, including a full nursing staff, medical management, mental health services, individual and group counseling, life skills education, health and mental health education, vocational planning, onsite 12-Step meetings, and recreational programming.

FIRst Program

The Department of Corrections FIRst (Forensic Intensive Recovery state) is located in the Together House complex and provides a community corrections transitional living program for men coming from incarceration in the State penal system with SMI and substance abuse issues. Started in the summer of 1999, this program was a response to a gaping lack of support for men who were returning to their communities after serving lengthy sentences for what was often a drug- or alcohol-related offense. Their SMI presented a particular problem for early release, hence the FIRst program was indeed a first effort to aid in transition from incarceration to community living.

There are 24 men in residence for 9 to 12 months, with a thorough initial evaluation and stabilization period, followed by increasing reliance on services in the community, decreasing dependence on the program, and gradual re-introduction to the world of work, if possible. Onsite counseling (group and individual), nursing support, mental health services, vocational assessment and referral, recreation, and resocialization classes are all provided. However, after initial engagement, community services are utilized to aid in practicing accessing outside supports in planning a return to outside life. 12-Step meetings are provided onsite and through outside groups.

Recommendations

A considerable research base exists for the MTC approach, and the consensus panel recommends the MTC as an effective model for treating persons with COD, including those with SMI. Recently, the MTC has been rated as one of a few promising practices for COD by the National Registry of Effective Programs and Practices (NREPP), as part of NREPP's ongoing evaluation of COD strategies and models. However, although improved psychological functioning has been reported, differential improvement in mental health functioning using the MTC approach in comparison to more standard treatment has yet to be demonstrated. The TC and MTC approach, although demonstrably effective with various populations of people who use drugs, including those with COD, encounters difficulty in achieving more widespread acceptance. To accomplish greater receptivity to TC and application of its methods, several developments are necessary:

- The principles, methods, and empirical data on MTC approaches need better articulation and broader dissemination to the mental health and other treatment fields. The development of MTCs in mainstream mental health programs is one useful approach (Galanter et al. 1993).
- The application of MTC methods for COD in non-TC medical and mental health settings needs to be established more firmly. It is especially important to ascertain whether, and to what extent, these methods can be separated from their TC framework and made "portable" as services to be used by other systems and approaches.
- As MTC programs continue to adapt for specific populations (e.g., adolescents, prison

inmates, people with COD, women and children), their longer term effectiveness after treatment needs to be evaluated.

- Quality assurance of MTC programs is essential. The theory-based work of De Leon and his colleagues for standard TCs provides the necessary tools for this effort. Specifically, the development of an instrument for measuring the essential elements of TC programs (Melnick and De Leon 1999) and the development of standards for TC prison programs (with Therapeutic Communities of America 1999) enable the service and research communities to assess to what extent TC programs contain the essential elements and meet applicable standards. Further work is needed in adapting these instruments for MTC programs.

Additional Residential Models

A variety of other residential models have been adapted for COD. Two representative models are the Na'nizhoozi model in the Southwest, designed for American Indians with alcohol problems, with the recent incorporation of services for COD (p. 180); and the Foundations Associates model that integrates short-term residential treatment with outpatient services (pp. 181–182).

The Na'nizhoozi Center, Inc. (NCI)

Overview

The NCI has facilities in the town of Gallup, New Mexico (population 20,000), and serves clients throughout a largely rural region of some 450,000 square miles, spanning two States and multiple counties within those States. (In fact, because of the unique nature of the services it offers, the program has accepted clients from across the United States.) The population in the area served by the program predominantly is American Indian.

In 1992, the Navajo Nation, the City of Gallup, the Zuni Pueblo, and McKinley County created NCI to address a significant public intoxication problem in Gallup and in McKinley County, New Mexico. In the 1980s, Gallup alone had more than 34,000 people placed into protective custody for public drunkenness; in 1999, this number had decreased to 14,600.

Clients

The client population is 95 percent American Indian with the great majority (approximately 93 percent) being members of the Navajo Nation. The program has a 150-bed residential facility built to provide service primarily to clients in protective custody (a form of criminal justice sanction that does not involve felony or misdemeanor or other criminal charge in a minimum-security setting, meaning that all doors are locked and the units are segregated).

The primary substance abused by clients entering NCI is alcohol, and the majority of clients (70 percent) is male. Clients exhibit an array of psychological problems and mental disorders. The incidence of COD with the protective custody population is 20 percent. Posttraumatic stress disorder, major affective disorders, and personality disorders are seen most commonly at NCI.

NCI also has a 3-week short-term residential program that is based on American-Indian philosophy. The NCI averages 12 clients per day, of whom 25 percent are admitted from the protective custody residential unit.

Services

NCI's 28-day residential program consists of 150 beds and provides services that are based largely on practices from both Dine' (Navajo) and intertribal traditions. Treatment literature emphasizes culturally appropriate interventions and NCI has made a major effort toward accomplishing this with the American-Indian population it serves. Sweat lodge ceremonies, Talking Circles, language, appropriate individual and group counseling, and culture-based treatment curricula are a few of the initiatives used. Sweat lodge ceremonies are nondenominational group activities with a strong spiritual component. Participants discuss problems or successes in life and receive feedback from other participants. Talking Circles often have a greater number of participants than the sweat lodge ceremonies with less interaction between the speaker and others in the circle. An important factor associated with both activities is that they often are conducted in the native language with Navajo values emphasized in the dialog. Because more than one tribe is served at NCI, the services are designed to meet the needs of different tribal cultures in the southwestern region.

The program has been increasing its services for clients with COD, which include referral to psychiatric assessment, medication, and case management. NCI provides residential and shelter services to support psychiatric interventions by monitoring medication use and providing crisis intervention services within the context of the facility.

Foundations Associates

Foundations Associates in Nashville, Tennessee offers a residential program and a fully integrated continuum of care for clients with COD. Foundations' residential model employs a TC-like structure modified to incorporate best practice concepts for COD. Foundations' program has been recognized as a national leader in serving clients with co-occurring substance abuse and SMI, such as schizophrenia.

Clients

Foundations typically serves clients diagnosed with substance dependence and SMI. Approximately 70 percent of Foundations' residents are diagnosed with schizophrenia, schizo-affective, or mood disorders with psychotic features. Typical substance abuse problems include crack/cocaine, alcohol, and cannabis. Fifty percent of Foundations' consumers are women, and 80 percent are referred from primary substance abuse or mental health treatment programs, typically after referring staff recognize the presence of a second (co-occurring) disorder.

Assessment

Substance abuse, mental health, physical health, vocational/educational, financial, housing/life skills, spiritual, and recreational/social needs are assessed prior to program enrollment. Individualized therapy and case management plans are developed and service matching is determined through the assessment (using ASAM Patient Placement Criteria, Second Edition, Revised). Based on the assessment, clients are assigned to appropriate services.

Services

Core residential services include Dual Diagnosis Enhanced Therapeutic Community, Halfway House, and Independent Living levels of care. Clients progress through the residential program in a series of five stages, based on clinical progress and earned privilege. All clinical activities, including treatment team staffing, are fully integrated to blend treatment for substance use and mental disorders. Program services are comprehensive to meet the complex needs of clients, and frequently include case management, vocational rehabilitation, individual/family/group therapy, and skills training.

Evaluation

Initial findings from a 3-year CSAT-funded evaluation of Foundations' residential program indicated abstinence in 70 to 80 percent of Foundations' clients up to 1 year following treatment. Severity of psychiatric symptoms was reduced by 60 percent, with corresponding improvements in quality of life. Perhaps most notably, high-cost service utilization dropped substantially following integrated treatment, with 80 to 90 percent reductions in inpatient and emergency room (ER) visits related to substance use or mental health problems. Likewise, inpatient and ER visits for general health care declined by 50 to 60 percent. Service profiles showed an increase in appropriate, cost-effective utilization of community supports and services. These results suggest that the program model of integrated and continuous treatment breaks the repetitive cycle of traditional substance abuse and mental health treatment for consumers with COD.

Best Practices

Best practice integrated treatment concepts serve as the basis for all program activities, including

- Continuous cross-training of professional and nonprofessional staff
- Empowerment of clients to engage fully in their own treatment
- Reliance upon motivational enhancement concepts
- Culturally appropriate services
- A long-term, stagewise perspective addressing all phases of recovery and relapse
- Strong therapeutic alliance to facilitate initial engagement and retention

Foundations Associates (continued)

- Group-based interventions as a forum for peer support, psychoeducation, and mutual self-help activities
- A side-by-side approach to life skills training, education, and support
- Community-based services to attend to clinical, housing, social, or other needs
- Fundamental optimism regarding "hope in recovery" by all staff

These principles reflect best practice concepts for COD, but the challenge lies in day-to-day program implementation. To facilitate broader adoption of integrated practices, Foundations Associates will make available upon request implementation guides, program manuals, and clinical curricula for programs interested in adapting this model to their community.

Contact information, detailed program materials, and research findings may be obtained via Foundations' Web site at www.dualdiagnosis.org.

7 Special Settings and Specific Populations

In This Chapter…

Acute Care and Other Medical Settings

Dual Recovery Mutual Self-Help Programs

Specific Populations

Overview

Building on the programmatic perspective of chapter 6, this chapter describes substance abuse treatment for co-occurring disorders (COD) within special settings and with specific populations. The chapter begins with a discussion of treatment in acute care and other medical settings. While not devoted to drug treatment, important substance abuse treatment does occur there, hence their inclusion in the TIP. Two examples of medical settings in which care is provided for clients with COD are presented: the Harborview Medical Center of Seattle, Washington, a teaching and research county hospital that serves a number of clients with serious mental illness (SMI) and severe substance abuse; and the HIV Integration Project (HIP), run out of The CORE Center, an ambulatory infectious disease clinic in Chicago, Illinois. HIP provides integrated care to persons living with HIV/AIDS who also are diagnosed with co-occurring mental and substance use disorders.

This chapter then turns to a description of the emerging dual recovery mutual self-help programs, and the work of various advocacy groups is highlighted. Finally, specific populations of clients with COD are discussed, including the homeless, women, and those in criminal justice settings. This section highlights the treatment strategies that have proven effective in responding to the needs of these populations. Several examples of programs designed to serve such populations are cited, including a variety of models for trauma. Two such programs for specific populations are illustrated: the Clackamas County programs (Oregon City, Oregon) for persons with COD who are under electronic surveillance or in jail and the Triad Women's Project, located in a semi-rural area of Florida that spans three counties. The latter program was designed to provide integrated services for women with histories of trauma and abuse who have COD.

Additionally, this chapter contains Advice to the Counselor boxes, to provide readers who have basic backgrounds with the most immediate practical guidance. (For a full listing of these boxes see the table of contents.)

Acute Care and Other Medical Settings

Background

Although not substance abuse treatment settings per se, acute care and other medical settings are included here because important substance abuse and mental health treatment do occur in medical units. Acute care refers to short-term care provided in intensive care units, brief hospital stays, and emergency rooms (ERs). Providers in acute care settings usually are not concerned with treating substance use disorders beyond detoxification, stabilization, and/or referral. In other medical settings, such as primary care offices, providers generally lack the resources to provide any kind of extensive substance abuse treatment, but may be able to provide brief interventions (for more information see TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* [Center for Substance Abuse Treatment (CSAT) 1997*a*]). Exceptions are programs for chronic physical illnesses such as HIV/AIDS, which may have the staff and resources to provide some types of ongoing treatment for mental illness and/or substance abuse. TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT 2000*e*), provides comprehensive information on substance abuse treatment for this population, including integrated treatment for people who have substance use disorders and HIV/AIDS as well as co-occurring mental disorders.

The integration of substance abuse treatment with primary medical care can be effective in reducing both medical problems and levels of substance abuse. More clients can be engaged and retained in substance abuse treatment if that treatment is integrated with medical care than if clients are referred to a separate substance abuse treatment program (Willenbring and Olson 1999). While extensive treatment for substance abuse and co-occurring mental disorders may not be available in acute care settings given the constraints on time and resources, brief assessments, referrals, and interventions can be effective in moving a client to the next level of treatment.

More information on particular issues relating to substance abuse screening and treatment in acute and medical care settings can be found in TIP 16, *Alcohol and Other Drug Screening of Hospitalized Trauma Patients* (CSAT 1995*a*); TIP 19, *Detoxification From Alcohol and Other Drugs* (CSAT 1995*c*); and TIP 24 (CSAT 1997*a*). More information on the use and value of brief interventions can be found in TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* (CSAT 1999*a*).

Examples of Programs

Because acute care and primary care clinics are seeing chronic physical diseases in combination with substance abuse and psychological illness (Wells et al. 1989*b*), treatment models appropriate to medical settings are emerging. Two programs, the Harborview Medical Center's Crisis Triage Unit (CTU) in Seattle and The CORE Center (an ambulatory facility for the prevention, care, and research of infectious disease) in Chicago, are examples of two different medical settings in which COD treatment has been effectively integrated. (For a full description of these programs, see the text boxes on pages 185 and 186.) The consensus panel notes that the programs selected have advantages over more typical situations—the Harborview Medical Setting is a teaching and research hospital run by the county and The CORE Center has the support of a research grant. Nonetheless, program features are suggestive of the range of services that can be offered.

The programs featured above typify the "no wrong door" to treatment approach (CSAT 2000*a*). These providers have the capacity to meet and respond to the client at the location where care is requested, ensuring that each disorder is addressed in the treatment plan.

Harborview Medical Center's Crisis Triage Unit, Seattle, Washington

Overview

The Harborview Medical Center is a teaching and research county hospital owned by King County and managed by the University of Washington. As the major trauma center facility in the Seattle area, it receives clients from throughout the Pacific Northwest. The Center has by far the busiest ER in the region, part of which is dedicated to the Crisis Triage Unit for clients with substance abuse and/or mental illness–related emergencies. Across the street from the program is a walk-in crisis center for persons with less severe psychological or substance-related disorders and drug-related emergencies.

Clients Served

The type of clients seen differs at each of the Center's locations. Although clients representative of each of the four quadrants are served, those seen in the ER fall generally into quadrant IV of the four-quadrant model, that is, those with SMI and severe substance abuse problems (see chapters 2, 3, and 4 for more information about the four-quadrant system).

Services

The focus of services at the CTU is on acute care. Primary goals are to ensure safety, assessment, stabilization, and, as needed, triage to another level of care (either within the facility or outside). The CTU's treatment can involve intensive medical interventions (which may mean that the client is sent back to the medical/surgical ER), psychiatric interventions (which may include engagement, assessment, acute medications, and even use of restraints), substance abuse–related interventions (emergency detoxification, treatment for withdrawal, and HIV screening and counseling), and holding and referral activities. Clients' needs vary greatly; while some may only receive a brief crisis intervention, others will require medical care and medication, and still others need social services such as referral to housing.

The Crisis Triage Unit has a 23-hour holding area in the ER where clients can be held long enough to be evaluated (the average length of stay is 4.5 hours). About 1,000 clients come through the CTU each month and close to half of these have co-occurring substance use and mental disorders. Based on the client's needs, disposition can range from brief evaluation and referral to involuntary acute inpatient hospitalization.

Over the years, staff providing integrated treatment for people with COD have been placed (1) in the CTU, (2) on all three inpatient acute psychiatric units, (3) in the mental health center outpatient program, (4) at the off-site substance abuse treatment detoxification unit, and (5) at the regional substance abuse treatment residential center. Most of the larger mental health centers in the area have developed treatment tracks for persons with COD, and several of the larger substance abuse treatment agencies have hired onsite, part-time psychiatrists.

Providing Treatment to Clients With COD in Acute Care and Other Medical Settings

Programs that rely on identification (i.e., screening and assessment) and referral have a particular service niche within the treatment system; to be successful, they must have a clear view of their treatment goals and limitations. Effective linkages with various community-based substance abuse treatment facilities are essential to ensure an appropriate response to client needs and to facilitate access to additional services when clients are ready. This section highlights the essential features of providing treatment to clients with COD in acute care and other medical settings.

The HIV Integration Project of The CORE Center, Chicago, Illinois

Overview

The HIV Integration Project (HIP) is run out of The CORE Center, an ambulatory infectious disease clinic in Chicago, Illinois. It is part of a cooperative agreement funded by six Federal agencies. The goal of this project is to evaluate the impact of the integration of primary care, mental health, and substance abuse treatment services on the healthcare costs, treatment adherence, and health outcomes of persons living with HIV/AIDS who also are diagnosed with co-occurring mental health and substance use disorders.

Clients Served

The center serves more than 3,000 HIV-infected clients annually. Clients predominantly are economically disadvantaged minorities, and include 33 percent women, 73 percent African Americans, 14 percent Hispanics/Latinos, and 12 percent Caucasians. Approximately one-third of the clients present with co-occurring mental health and substance use disorders.

Services

Many settings, despite close proximity, may deliver "co-located" care but not fully integrated care. The HIP model focuses on developing a behavioral science triad that consists of a mental health counselor, a substance abuse treatment counselor, and a case manager. Both medical and social service providers are present during outpatient HIV clinic sessions and clients are screened for eligibility onsite. The triad works together to assess, engage, and facilitate clinically appropriate services for clients with HIV and COD. If clients need immediate services—such as housing, psychiatric hospitalization, or detoxification—the appropriate triad member will facilitate linkage and coordination of care. Outpatient mental health care and substance abuse treatment are offered at the same center where clients receive their primary care.

The triads meet jointly with their clients. They develop joint assessments and treatment plans, communicating regularly with medical providers. Emphasis is placed on facilitating six processes among mental health, chemical dependency, case management, and medical providers: (1) interdisciplinary team identity building, (2) coordination and communication, (3) cross-disciplinary learning, (4) outreach for clients who do not engage initially or sustain mental health or substance abuse care, (5) mental health services, and (6) specialized training in the care of triply diagnosed clients.

Screening and assessment (in acute and other medical settings)

Clients entering acute care or other medical facilities generally are not seeking substance abuse treatment. Often, treatment providers (primary care and mental health) are not familiar with substance use disorders. Their lack of expertise can lead to unrealistic expectations or frustrations, which may be directed inappropriately toward the client.

The CORE Center serves as a good example of effective screening and assessment. To facilitate early identification of substance abuse and mental disorders within the HIV client population, The CORE Center attempts routine screening of all new clients accessing primary care. Treatment begins at the screening or assessment phase; the triad assesses not only psychological functioning and substance abuse severity, but also readiness for change. The provider will offer only those services that the client is willing to accept. Examples include literature to educate the client on his disorders, case management to address housing or other needs, or referral for detoxification. Next, the triad tries to engage the client, creating a positive experience that encourages

return visits. Since continuity of care is important, the triad attempts to follow clients while hospitalized and to work with inpatient medical staff in the same manner as with outpatient staff.

A majority of clients do return to The CORE Center for their primary care treatment. Primary care providers keep the triad informed of client visits so that counselors can build a trusting working relationship with clients that facilitates engagement in mental health or substance abuse care. After meeting with clients, the triad briefs the medical providers on the clinical disposition and treatment strategy. Often, these briefing sessions serve as an opportunity for cross-disciplinary learning. The CORE Center frames its treatment philosophy as holistic, and in one setting treats both the physical and emotional problems the client is experiencing.

At Harborview, clients are given a multidisciplinary evaluation that has medical, mental health, substance abuse, and social work components. Harborview does not employ any dedicated staff for performing evaluation, but rather trains a variety of staff to perform each part of the evaluation. Because of the nature of the setting (the fast-paced world of an emergency room), the basic assessments usually can be performed in 30 minutes, but may take longer in more complicated cases (e.g., if a client cannot communicate because of a speech disorder and information can be gathered only from records or family). Chapter 4 contains a full description of screening and assessment procedures and instruments applicable to COD.

Accessing services

The CORE Clinic offers clinical interventions focused on crisis counseling, single session treatment, motivational enhancement, short-term mental health services and substance abuse treatment counseling, and psychoeducation as appropriate while the client is in The CORE Center. Primary care providers sometimes are asked to help reinforce treatment recommendations and to join in being "one unified voice" that the client hears.

Given the diversity among people with COD, treatment referrals from The CORE Center are varied, ranging from residential substance abuse treatment to acute psychiatric hospitalization; solid working relationships with treatment communities are needed across settings. When the client is ready for more intensive treatment, the triad provides a critical triage function to the larger substance abuse treatment and mental health services communities.

When Harborview set up its CTU program, part of its contract required that the county mental health and substance abuse treatment systems provide "back door" staff with the authority to ensure client access to other required services. At least one of these staff is onsite 16 hours each day to make referrals for clients being discharged from the CTU. This service has proven extremely important for ensuring both that continuing care for COD is provided to clients leaving the unit and that disposition of CTU clients is efficient.

Implementation

Administrators who may be considering integrating substance abuse treatment and/or mental health services within existing medical settings should realize that they are introducing a new model of care. The systems and operating culture in place may view changes as unnecessary. Similar to the way in which providers assess a client's readiness for change (i.e., readiness for treatment), administrators should assess organizational readiness for change prior to implementing a plan of integrated care. This assessment should consider space for additional staff, establish a clear organizational reporting structure, and allow time for providers to work in partnership with other disciplines.

The assessment will inform the planning process. In developing a plan, administrators should:

- Seek input from all stakeholders, especially the clients, a necessary prerequisite to developing or offering services. This information can be gathered through archival data, focus groups, and provider interviews.
- Clarify the role of each of the primary care, substance abuse treatment, and mental health treatment providers.
- Clearly specify the desired outcome(s) for mental health and substance abuse treatment services.
- Outline and pilot both formal and informal communication mechanisms prior to full implementation of services.

When developing and implanting the program, administrators should not minimize or ignore the fact that the medical and social service cultures are very different; opportunities must be provided for relationship and team building (ideally in informal settings). Finally, continued monitoring and flexibility in the development of the model are critical.

Staffing, supervision, and training

Cross-training/cross-disciplinary learning

Cross-training of staff in acute care settings may be more difficult than in other settings because of the greater variety of staff present, but these activities are no less essential. For example, in the Harborview program, staff members include numerous doctors, nurses, physician assistants, psychiatric residents in training, medical students, social workers, social work students, substance abuse treatment counselors, and security officers. Such settings have a greater number of stakeholders than dedicated substance abuse treatment programs—all of whom will need to be involved, at some level, in the development and implementation of a program for clients with COD. Moreover, staff assigned to integrated settings will have varying degrees of commitment to integrated care. Staff also will come into these settings with different definitions of integrated care. They may have varying treatment approaches or may use discipline-specific language that inadvertently can become a barrier to integration. Time and other resource limitations can also pose an obstacle. The CORE Center's medical care providers cite time constraints as a major impediment to close working relationships with social service staff.

The CORE Center's staff training program serves to illustrate the potential of cross-training. Staff who work in The CORE Center have begun to look at cross-training more as cross-disciplinary learning. They are discovering what each discipline does, its language and beliefs, and the role of that discipline in the client's treatment. For example, even though a substance abuse treatment counselor may never serve as a primary care provider, the counselor can appreciate how this provider contributes to the client's well-being. Likewise, primary care providers can learn from case managers about the challenges of finding housing for clients with COD. Social service staff wear lab coats that identify their discipline and team affiliation during clinic sessions; this simple but noticeable change helps social service staff feel a sense of belonging and supports team-building efforts. Mutual respect for the disciplines and a deeper understanding of the interrelatedness of the various staff functions develop over time.

Team building

Staff training and consultation can help bring all staff on board and unify treatment approaches. To foster team building, The CORE Center has incorporated key components of competent care teams as discussed in the geriatric and oncology literature (Wadsworth and Fall Creek 1999). This effort includes formal and informal team building, training on working in an integrated healthcare team, and clear communication mechanisms.

Effective integrated care teams take time to develop, and a number of institutional and disciplinary barriers make it difficult for staff from different areas of expertise to work together. For instance, differences in philosophies of treatment and traditions of care, as well as differences in how language is used to describe and discuss disorders, can lead to major communication problems. Thus, staff need opportunities to become familiar with the vocabulary of substance abuse treatment, mental health services, and medical treatment.

Types of training

Specific training needs will vary depending on the type of program, but some mechanism for cross-training activities in acute care settings needs to be in place. The CORE Center has found it useful to have formal training activities where an instructor is invited into the facility (which, in their experience, works better than sending staff out of the facility for training). This strategy may be used in combination with informal training mechanisms, such as providing feedback to medical staff concerning The CORE Center program so they can better understand how medical decisions affect clients' success in substance abuse treatment and mental health services.

Continuing care and transition issues

Since medical care is continuous for clients with chronic medical conditions, continuing care (also called aftercare) or transition issues can become blurred for both clients and providers. The CORE Center attempts to facilitate linkage to more intensive services, but realizes that chronically ill clients do not make status transitions in the traditional sense, but rather enter periods of stability when little intervention is required. Because episodic use of services by these clients is the norm, staff need to be flexible and to realize that these clients are likely to return to The CORE Center when in crisis. This reality underscores the requirement for strong linkages to other services for clients who need a more intensive level of care than is available in acute or outpatient care.

Program evaluation

In developing programs such as the HIV Integration Project or Harborview, it is critical to incorporate program evaluation activities that examine both process and outcome. The evaluation of these programs can prove challenging. Logic models that describe the interrelationship between the conceptual framework, client demographics, treatment services, and expected outcomes are useful to guide evaluation efforts and to identify immediate, short-, and long-term outcomes. Evaluators should add measures such as increased treatment and medication adherence, quality of life, and physical health to the more standard outcome measures such as abstinence or remission of psychiatric symptoms. Since many of the gains involve improvement in quality of life and physical well-being, evaluations that incorporate quantitative and qualitative methods have the best success in capturing the impact of these integrated services. Given the high cost of medical care,

> Administrators who may be considering integrating substance abuse treatment and/or mental health services within existing medical settings should realize that they are introducing a new model of care.

economic analyses of the cost and benefits associated with treatment are essential.

Sustaining Programs for Clients With COD in Acute Care Settings

Acute care and other medical care settings generally will rely on very different funding streams than are available to outpatient or residential substance abuse treatment programs. These funding sources will vary depending on the type of program. At Harborview, for example, most funds come from the medical and mental health systems; very little substance abuse treatment money is involved. The program at Harborview has been highly visible and has a number of key county stakeholders (e.g., Department of Mental Health, Department of Alcohol and Drugs, County Hospital), which helps avoid budget cuts. Harborview also has clearly positioned itself as the program of last resort in the region and has developed its programs accordingly. Further, it has created a state-of-the-art integrated information system (each assessment generates a database entry); this enables staff to prepare detailed quality and clinical reports, which are of value to the entire system.

Initial funding for The CORE Center came from the Substance Abuse and Mental Health Services Administration (SAMHSA) through the AIDS demonstration program of SAMHSA's Center for Mental Health Services (CMHS). Additional funding was provided through other grants through CSAT. Funding from the Health Resources and Services Administration through the Ryan White Care Act supports opportunities to offer more intensive integrated services. Other funding mechanisms, such as private foundation grants, serve as vehicles to secure financial support for these unique integrated services. At present, it is difficult to secure sustained funding from sources such as Medicare or Medicaid. Continuing funding comes from the Ryan White Care Act with some additional funds from the county.

Dual Recovery Mutual Self-Help Programs

The dual recovery mutual self-help movement is emerging from two cultures: the 12-Step fellowship recovery movement and, more recently, the culture of the mental health consumer movement. This section describes both, as well as other, consumer-driven psychoeducational efforts.

Background

During the past decade, mutual self-help approaches have emerged for individuals affected by COD. Mutual self-help programs apply a broad spectrum of personal responsibility and peer support principles, usually including 12-Step methods that prescribe a planned regimen of change. These programs are gaining recognition as more meetings are being held in both agency and community settings throughout the United States, Canada, and abroad.

In recent years, dual recovery mutual self-help organizations have emerged as a source of support for people in recovery from COD (DuPont 1994; Ryglewicz and Pepper 1996). Such groups sometimes have been described as special needs groups for people in recovery from substance use disorders (Hendrickson et al. 1996; White 1996). Mental health advocacy organizations—including the National Alliance for the Mentally Ill and the National Mental Health Association—have published articles that have identified dual recovery mutual self-help organizations (Goldfinger 2000; Hamilton 2000). At the Federal level, SAMHSA also has produced documents identifying dual recovery mutual self-help organizations (CMHS 1998; CSAT 1994*a*).

The new dual recovery mutual self-help organizations are important signs of progress in several respects: First, they encourage men and women who are affected by COD to take responsibility for their personal recovery. Second, they reflect a growing trend toward consumer empowerment (Hendrickson et al.

1994). Finally, they reflect recognition of the importance of peer support in sustained recovery.

Several issues serve as the rationale for establishing dual recovery programs as additions to previously existing 12-Step community groups. To paraphrase Hamilton's review (Hamilton 2001):

- *Stigma and Prejudice:* Stigma related to both substance abuse and mental illness continues to be problematic, despite the efforts of many advocacy organizations. Unfortunately, these negative attitudes may surface within a meeting. When this occurs, people in dual recovery may find it difficult to maintain a level of trust and safety in the group setting.
- *Inappropriate Advice (Confused Bias):* Many members of substance abuse recovery groups recognize the real problem of cross-addiction and are aware that people do use certain prescription medications as intoxicating drugs. Confusion about the appropriate role of psychiatric medication exists, and as a result, some members may offer well-intended, but inappropriate, advice by cautioning newcomers against using medications. Clearly, confused bias against medications may create either of two problems. First, newcomers may follow inappropriate advice and stop taking their medications, causing a recurrence of symptoms. Second, newcomers quickly may recognize confused bias against medications within a meeting, feel uncomfortable, and keep a significant aspect of their recovery a secret.
- *Direction for Recovery:* A strength of traditional 12-Step fellowships is their ability to offer direction for recovery that is based on years of collective experience. The new dual recovery programs offer an opportunity to begin drawing on the experiences that members have encountered during both the progression of their COD and the process of their dual recovery. In turn, that body of experience can be shared with fellow members and newcomers to provide direction into the pathways to dual recovery.
- *Acceptance:* Twelve-Step fellowships provide meetings that offer settings for recovery. Dual recovery meetings may offer members and newcomers a setting of emotional acceptance, support, and empowerment. This condition provides opportunities to develop a level of group trust in which people can feel safe and able to share their ideas and feelings honestly while focusing on recovery from both illnesses.

> Dual recovery meetings may offer members and newcomers a setting of emotional acceptance, support, and empowerment.

Dual Recovery Mutual Self-Help Approaches

Dual recovery 12-Step fellowship groups recognize the unique value of people in recovery sharing their personal experiences, strengths, and hope to help other people in recovery. This section provides an overview of emerging self-help fellowships and describes a model self-help psychoeducational group.

Self-Help Groups

Four dual recovery mutual self-help organizations have gained recognition in the field, as represented in the literature cited in this section. Each of these fellowships is an independent and autonomous membership organization that is guided by the principles of its own steps and traditions (for more information on specific steps, see appendix J for each organization's contact information). Dual recovery fellowship members are free to interpret, use, or follow the 12 steps in a way that meets

their own needs. Members use the steps to learn how to manage their addiction and mental disorders together. The following section provides additional information on each of these specific organizations and the supported mutual self-help model.

1. *Double Trouble in Recovery (DTR).* This organization provides 12 steps that are based on a traditional adaptation of the original 12 steps. For example, the identified problem in step one is changed to COD, and the population to be assisted is changed in step 12 accordingly. The organization provides a format for meetings that are chaired by members of the fellowship.
2. *Dual Disorders Anonymous.* This organization follows a similar format to DTR. Like other dual recovery fellowships, the organization provides a meeting format that is used by group members who chair the meetings.
3. *Dual Recovery Anonymous.* This organization provides 12 steps that are an adapted and expanded version of the traditional 12 steps, similar to those used by DTR and Dual Disorders Anonymous. The terms "assets" and "liabilities" are used instead of the traditional term "character defects." In addition, it incorporates affirmations into three of the 12 steps. Similar to other dual recovery fellowships, this organization provides a suggested meeting format that is used by group members who chair the meetings.
4. *Dual Diagnosis Anonymous.* This organization provides a hybrid approach that uses 5 additional steps in conjunction with the traditional 12 steps. The five steps differ from those of other dual recovery groups in underscoring the potential need for medical management, clinical interventions, and therapies. Similar to other dual recovery fellowships, this organization provides a meeting format that is used by group members who chair the meetings.

The dual recovery fellowships are membership organizations rather than consumer service delivery programs. The fellowships function as autonomous networks, providing a system of support parallel to traditional clinical or psychosocial services. Meetings are facilitated by members, who are empowered, responsible, and take turns "chairing" or "leading" the meetings for fellow members and newcomers. Meetings are not led by professional counselors (unless a member happens to be a professional counselor and takes a turn at leading a meeting), nor are members paid to lead meetings. However, the fellowships may develop informal working relationships or linkages with professional providers and consumer organizations.

In keeping with traditional 12-Step principles and traditions, dual recovery 12-Step fellowships do not provide specific clinical or counseling interventions, classes on psychiatric symptoms, or any services similar to case management. Dual recovery fellowships maintain a primary purpose of members helping one another achieve and maintain dual recovery, prevent relapse, and carry the message of recovery to others who experience dual disorders. Dual recovery 12-Step members who take turns chairing their meetings are members of their fellowship as a whole. Anonymity of meeting attendees is preserved because group facilitators do not record the names of their fellow members or newcomers. Fellowship members carry out the primary purpose through the service work of their groups and meetings, some of which are described below.

Groups provide various types of meetings, such as *step study meetings*, in which the discussion revolves around ways to use the fellowship's steps for personal recovery. Another type of meeting is a *topic discussion meeting*, in which members present topics related to dual recovery and discuss how they cope with situations by applying the recovery principles and steps of their fellowship. *Hospital and institutional meetings* may be provided by fellowship members to individuals currently in hospitals, treatment programs, or correctional facilities.

Fellowship members who are experienced in recovery may act as sponsors to newer members. Newcomers may ask a member they view as experienced to help them learn to use the fellowship's recovery principles and steps.

Outreach by fellowship members may provide information about their organization to agencies and institutions through in-service programs, workshops, or other types of presentations.

Access and linkage

The fellowships are independent organizations based on 12-Step principles and traditions that generally develop cooperative and informal relationships with service providers and other organizations. The fellowships can be seen as providing a source of support that is parallel to formal services, that is, participation while receiving treatment and aftercare services.

Referral to dual recovery fellowships is informal:

- An agency may provide a "host setting" for one of the fellowships to hold its meetings. The agency may arrange for its clients to attend the scheduled meeting.
- An agency may provide transportation for its clients to attend a community meeting provided by one of the fellowships.
- An agency may offer a schedule of community meetings provided by one of the fellowships as a support to referral for clients.

Common features of dual recovery mutual self-help fellowships

Dual recovery fellowships tend to have the following in common:

- A perspective describing co-occurring disorders and dual recovery.
- A series of steps that provides a plan to achieve and maintain dual recovery, prevent relapse, and organize resources.
- Literature describing the program for members and the public.
- A format to structure and conduct meetings in a way that provides a setting of acceptance and support.
- Plans for establishing an organizational structure to guide the growth of the membership, that is, a central office, fellowship network of area intergroups, groups, and meetings. An "intergroup" is an assembly of people made up of delegates from several groups in an area. It functions as a communications link upward to the central office or offices and outward to all the area groups it serves.

Dual recovery 12-Step fellowship groups recognize the unique value of people in recovery sharing their personal experiences, strengths, and hope to help other people in recovery.

Empirical evidence

Empirical evidence suggests that participation in DTR contributes substantially to members' progress in dual recovery and should be encouraged. Specifically, studies found the following positive outcomes:

- A process analysis indicated that DTR involvement at baseline predicted greater levels of subsequent mutual self-help processes (e.g., helper-therapy and reciprocal learning experiences), which were associated with better drug/alcohol abstinence outcomes (Magura et al. 2003).

- An examination of the associations between DTR attendance, psychiatric medication adherence, and mental health outcomes indicated that consistent DTR attendance was associated with better adherence to medication, controlling for other relevant variables. Better adherence to medication was, in turn, associated with lower symptom severity at followup and no psychiatric hospitalization during the follow-up period (Magura et al. 2002).

Supported mutual self-help for dual recovery

Support Together for Emotional/Mental Serenity and Sobriety (STEMSS) is a supported self-help model for people with co-occurring disorders. It is a psychoeducational group intervention rather than a fellowship or membership organization; therefore it has no "parent organization." STEMSS uses trained facilitators to initiate, implement, and maintain support groups for clients. Facilitators may include professional counselors or trained clinicians, therapists, nurses, or paraprofessionals who are employed at various institutions, treatment programs, hospitals, or community agencies. In some instances, groups may be started and facilitated by other individuals trained in the STEMSS model.

> Empirical evidence suggests that participation in DTR contributes substantially to members' progress in dual recovery and should be encouraged.

The six steps of the program and the support groups are intended to complement participation in traditional 12-Step programs. Facilitators generally are providers who have received training in the theoretical concepts, the six steps for recovery, psychoeducational content, and group approaches. They are encouraged to work with the model in a flexible way, encouraging clients to develop leadership skills to help groups make the transition from psychoeducational groups to sources of mutual self-help. Facilitators may modify the approach, incorporate additional content, develop their own exercises, or incorporate the model into the treatment system. Roles commonly filled by the facilitator include

- *Psychoeducation:* The facilitator provides information related to recovery topics, psychiatric symptoms, medications, symptom management, coping skills, and other topics.
- *Exercises:* The facilitator may develop group exercises to stimulate discussions and group interaction, as well as to help maintain the recovery focus.
- *Step discussion:* Facilitators initiate discussions regarding the STEMSS six-step approach to recovery.

The STEMSS model may be incorporated into the milieu of an agency's services or may be an autonomous group established in a community setting; thus, STEMSS groups are supported mutual self-help approaches rather than fellowships or consumer service delivery organizations. Due to the anonymous nature of the groups and the way in which an agency uses the model, linkages to STEMSS groups would be established on a group-by-group basis. For more detail about the STEMSS model see TAP 17, *Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas* (CSAT 1995*e*).

Advocating for Dual Recovery

At this writing, advocacy organizations are at various stages of developing information materials, engaging in advocacy efforts to increase public awareness, coalition building to develop

consensus for services, and providing support for dual recovery mutual self-help organizations. For contact information on each organization, see appendix J.

Dual Diagnosis Recovery Network (DDRN)

The DDRN is a program of Foundations Associates that derives part of its funding from the Tennessee Department of Mental Health and Developmental Disabilities and part from the Tennessee Department of Health, Bureau of Alcohol and Drug Abuse Services. DDRN provides

- Dual recovery mutual self-help information for all areas of the services that are offered
- Education and training through community programs, inservice training, and workshops, and through State, regional, and national conferences
- Advocacy and coalition building through networking and coordinating a statewide task force that engages chemical dependency and mental health professionals, clients, and family members
- Information dissemination through the *Dual Network* quarterly journal and through the resource and information clearinghouse

Dual Recovery Empowerment Foundation (DREF)

The DREF provides training programs and materials to assist treatment providers, consumer-run programs, and consumer advocacy organizations in developing education programs for clients, consumers, and family members. One DREF program is Dual Recovery Self-Help, which encompasses information on dual recovery 12-Step fellowships, 12-Step principles for personal recovery, coping and life skills, and forming dual recovery 12-Step groups and meetings. DREF also offers Recovery Cultural Cross Training, which provides a cultural competency approach to reframe "philosophical barriers" and explore the histories, common goals, diversity, and accomplishments of both the substance abuse recovery culture and the mental health consumer recovery culture.

National Mental Health Association

The National Mental Health Association (NMHA) has expanded its mission to include COD. In 1999 the NMHA board of directors adopted a position statement that affirmed NMHA's commitment to advocacy, public education, and service delivery for consumers with co-occurring substance use and mental disorders. NMHA focuses its efforts in four major areas—prevention, treatment, research, and policy—and is committed to providing leadership in the substance abuse and mental health fields in the area of COD. The organization has a designated area on its Web site—Alcohol and Drug Abuse, Addiction and Co-Occurring Disorders—that contains information, facts, resources, and links to help mental health consumer advocates increase their knowledge about the key issues in COD (http://www.mentalhealthamerica.net/go/co-occurring-disorders).

National Council on Alcoholism and Drug Dependence

The National Council on Alcoholism and Drug Dependence, Inc. (NCADD) was founded in 1944 and works at the national level on policy issues related to barriers in education, prevention, and treatment for people with substance use disorders and their families. NCADD has a nationwide network of nearly 100 affiliates. These affiliates provide information and referrals to local services, including counseling and treatment. NCADD also offers a variety of publications and resources. For more information, visit www.ncadd.org.

Mental health consumer advocacy organizations

The consumer advocacy movement has a history separate from the substance abuse recovery and 12-Step recovery movements. The historical roots of the mental health recovery movement, to a great extent, are related directly to issues in the delivery of mental health services. The modern movement formed in response to concerns about the quality of care, availability of services, and lack of coordination during and following deinstitutionalization. The term "mental health consumer," though controversial to many people in the movement, clearly reflects both a personal and collective relationship to issues related to mental health care services and support. On the other hand, individuals in substance abuse recovery and those in 12-Step programs do not identify themselves in language that is related to treatment services.

The consumer advocacy movement has a history separate from the substance abuse recovery and 12-Step recovery movements.

The mental health recovery movement and the substance abuse recovery movement can develop ways to collaborate in an effort to support people affected by COD. In order to collaborate, the movements must engage in a coalition building process that involves

- Shared goals and visions of the movement
- Histories: identifying and valuing diversity
- Experience, strengths, and skills
- Accomplishments and progress
- Shared goals and visions for dual recovery

Consumer Organization and Networking Technical Assistance Center (CONTAC)

The West Virginia Mental Health Consumer's Association's CONTAC, which receives funding through SAMHSA's CMHS, serves as a resource center for consumers/survivors/ex-patients and consumer-run organizations across the United States, promoting self-help, recovery, and empowerment. The services that CONTAC provides include informational materials, onsite training and skills-building curricula, and networking and customized activities promoting self-help, recovery, leadership, business management, and empowerment. CONTAC also offers the Leadership Academy, a training program that is designed to help clients learn how to engage in and develop consumer services.

National Empowerment Center

The National Empowerment Center has prepared an information packet that includes a series of journal articles, newspaper articles, and a listing of organizations and Federal agencies that provide information, resources, and technical assistance related to substance abuse and dependence, COD, services, and mutual self-help support.

Specific Populations

In recent years, awareness of COD in subpopulations (such as the homeless, criminal justice clients, women with children, adolescents, and those with HIV/AIDS) and concern about its implications has been growing. This section focuses on three of these subgroups: the homeless, those in criminal justice settings, and women. A complete description of these clients and related programs is beyond the scope of this TIP. However, relevant information can be found in a number of other TIPs, including TIP 17, *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System* (CSAT 1995*d*); TIP 21, *Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System* (CSAT 1995*b*); TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT 1998*c*); and the forthcoming TIPs *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT in development *e*) and *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT in development *b*). This section provides background information on the problem of COD in these specific populations, describes some model programs and Federal initiatives, and offers recommendations for programs and services. The purpose of this section is to highlight the emergence of specific-population COD groups and the potential impact of these specialized populations on COD treatment.

Homeless Persons With COD

Homelessness

Homelessness continues to be one of the United States' most intractable and complex social problems. The Urban Institute estimates that 2.3 to 3.5 million people are homeless annually and 842,000 were homeless in February 1996 (Burt and Aron 2000). In New York City alone, more than 33,800 New Yorkers use the city shelter system each night (Bernstein 2002). Despite these statistics, an understanding of the diversity of this population and its service needs is incomplete, and treatment options are still meager.

Homeless people have a variety of medical problems (Institute of Medicine 1988), including HIV (CSAT 2000*e*). They are frequent victims of and participants in crime (Rahav and Link 1995). They also are disproportionately likely to use substances (Fischer and Breakey 1987) and to have some form of mental illness (Rossi 1990).

Homelessness and COD

Homeless persons with COD are a particularly problematic subgroup, one that places unique demands on the mental health and substance abuse treatment systems. The number of homeless persons with COD has been estimated to range from 82,215 to 168,000 in any given week (Rahav et al. 1995).

For most, if not all, homeless clients with COD, the impact of substance abuse and mental illness bears a direct relationship to their homeless status. The ability to maintain housing is affected profoundly by substance abuse (Hurlburt et al. 1996). Approximately 70 percent of participants in recent National Institute on Alcohol Abuse and Alcoholism demonstration projects identified substance abuse problems as the primary reason for their homelessness in both the first and most recent episodes (Leaf et al. 1993; Stevens et al. 1993). Among those in shelters, 86 percent are estimated to have alcohol problems and more than 60 percent have problems with illicit drugs (Fischer and Breakey 1991).

The importance of housing

Results from the homelessness prevention cooperative agreement funded by SAMHSA's CMHS and CSAT suggest the importance of providing interventions that address housing. Those that ensured housing by "control of housing stock" (i.e., programs that make housing available or ensure housing) are of

particular interest. This study explored the interactions among housing, treatment, and outcomes for persons with COD who are homeless. Researchers noted that after 6 months, the intervention group for whom housing was made available had 12 more days of stable housing (during the 6-month period) than the comparison group. After 1 year, the intervention group had 17 more such days (Williams et al. 2001). Among participants who had guaranteed access to housing, improvements were even greater: At 6 months and at 1 year, participants who had guaranteed access to housing showed significant short-term and longer-term improvements (on all residential measures) compared to a control group who did not have access to housing. The change in the stable housing measure represents a 40-day increase from baseline at 6 months and a 41-day increase at 1 year. In contrast, the comparison group showed decreases in housing stability. At 6 months they had 14 fewer days of homelessness, and at 1 year, 7 days. These results are significant, underlining the contribution of stable housing to recovery of individuals with COD (Williams et al. 2001).

Another study examined the cost of providing supportive housing versus allowing homeless people to continue in the homeless assistance system, including the cost to the mental health, substance abuse treatment, shelter, hospital, criminal justice, and other public systems. The study reported that psychiatric hospital stays were reduced by 28.2 days (49 percent) for each placement in supportive housing. The study found that supportive housing dramatically reduced use of other public systems by people who were homeless and had SMI, including many who also had substance abuse problems (Culhane et al. 2001).

Service models for homeless persons with COD

The treatment community has responded positively to the needs of this population. It has developed several models for homeless clients with COD.

Supportive housing

Supportive housing typically is housing combined with access to services and supports to address the needs of homeless individuals so that they may live independently in the community. Generally, it is considered an option for individuals and families who have either lived on the streets for longer periods of time and/or who have needs that can be best met by services accessed through their housing. Although the evidence base consists of a small number of studies that vary in methodological rigor and population focus, the results indicate that housing with supports in any form is a powerful intervention that improves the housing stability of individuals with substance abuse and mental disorders, including those who have been homeless (Hurlburt et al. 1996; Rog and Gutman 1997; Shinn et al. 1991). However, many of the same studies also indicate that substance abuse is a major cause of housing loss and that individuals with COD fare less well in housing than those with other disabilities (Shern et al. 1997).

The Pathways to Housing program developed by Tsemberis (Tsemberis et al. 2003; Tsemberis and Eisenberg 2000) is a form of supportive housing designed to serve a highly visible and vulnerable segment of New York's homeless population (persons with COD who live in the streets, parks, subway tunnels, and similar places). The Pathways program adopts a client perspective and offers clients the option of moving from the streets directly into a furnished apartment of their own (Tsemberis and Eisenberg 2000). However, clients must agree to receive case management and accept a representative payee to ensure that rent/utilities are paid and for resource management. Pathways also uses Assertive Community Treatment teams to offer clients their choice of a wide array of support services in twice-monthly sessions. Vocational, health, psychiatric, substance abuse, and other services are among the options.

A 2-year longitudinal, random assignment, clinical trial study evaluating the effectiveness of the Pathways program as compared to continuum of care programs (i.e., programs where clients move from one level of housing to the next least restrictive level) was conducted with 225 individuals who were homeless and had mental disabilities; 90 percent also had co-occurring substance use disorders. Housing outcomes were significantly better for the Pathways group at the 6-, 12-, 18-, and 24-month followup points. For example, between 18 and 24 months the Pathways group members spent 4 percent of their time literally homeless, compared to 23 percent for the continuum group; they also spent 74 percent of their time in stable housing, compared to 34 percent for the continuum group. In addition, Pathways participants were not more symptomatic at any point, and they did not differ from the continuum group on use of alcohol or other substances. However, the greater effectiveness of the Pathways program in comparison with other programs for the substance abuse, mental health, and other problems of these homeless clients with COD remains to be established.

Housing contingent on treatment

Milby and colleagues (1996) found promise in an intervention that added contingent work therapy and housing to a regular day treatment regimen. They compared a standard treatment that featured twice-weekly treatment sessions and referrals for housing and vocational services with an enhanced treatment program that included weekday day treatment (for 5.5 hours per day) and a work therapy component that provided clients with a salary great enough to afford subsidized housing (contingent upon drug-free urine samples). Clients in day treatment with the housing and vocational component had 36 percent fewer cocaine-positive urine toxicologies at 2 months after treatment and 18 percent fewer at 6 months compared to clients in the standard outpatient program. However, the study did not focus solely on clients with COD; in fact, it excluded clients with active psychosis (Milby et al. 1996).

In a later study, Milby and colleagues (2000) compared two different day treatment programs, one that added abstinent contingent employment and housing and one that did not. Although the study excluded clients with psychotic disorders, three fourths met Axis I diagnostic criteria for other mental disorders. Those who received the extra vocational and housing services achieved longer periods of abstinence than those who did not (the former having a median of approximately 9 consecutive weeks of abstinence out of 24 weeks, and the latter only 3–4 consecutive weeks during the same period). The clients who received these added services also showed greater gains in measures of homelessness and employment (Milby et al. 2000).

> For most, if not all, homeless clients with COD, the impact of substance abuse and mental illness bears a direct relationship to their homeless status.

Housing and treatment integrated

In New York City two specialized shelters are addressing the needs of people who are homeless and who have COD: the Greenhouse Program and the Salvation Army shelter. The

Greenhouse Program is a 28-bed modified therapeutic community (TC) shelter for hard-to-reach homeless persons with COD. Staff at the program are trained to address both mental and substance use disorder issues. Developed in 1991 by Bellevue Hospital, this was one of the first specialized shelter programs in the City to treat this population (Galanter et al. 1993; Silberstein et al. 1997). The second is the Salvation Army shelter. Developed in 1998 by the Salvation Army in association with National Development and Research Institutes, Inc., "Kingsboro New Beginnings" is a modified TC for engagement and retention in an 80-bed shelter. Designed for hard-to-reach people who are homeless and have co-occurring mental and substance use disorders—those who are seeking shelter, but not necessarily treatment—this program brought people with COD who were homeless into a specialized shelter setting, using strategies to engage them in mental health services and substance abuse treatment and prepare them for housing (Sacks et al. 2002).

In a series of papers, Sacks and colleagues report on a system of care for people who are homeless that uses a modified therapeutic community (MTC) approach (see chapter 6 for additional information on the MTC model). Clients move from a residential facility to co-located supportive housing as they progress though stages of treatment. Engagement, primary treatment, and planning for re-entry take place in the residential facility; re-entry takes place in the supportive housing program. The research indicated that these clients made significant improvement (compared to treatment-as-usual) on measures of substance use and employment during residential treatment (De Leon et al. 1999, 2000*c*). These gains appeared to stabilize during the supportive housing phase (Sacks et al. 2003*a*). The authors concluded:

> These pilot findings suggest that the positive behavioral change associated with completion of 12 months of residential treatment can be sustained and, in some cases, strengthened by the use of TC-oriented supported housing as an aftercare strategy. The particular gains in employment and symptom relief are noteworthy in that they speak to core problems of the homeless MICA [mentally ill chemical abusing] population. Combined with the capacity to maintain low levels of crime and substance use, supported housing can be seen as an important and effective way of achieving continuing progress for this population (Sacks et al. 2003*a*).

Advice to the Counselor: Working With Homeless Clients With COD

The consensus panel recommends the following in working with homeless clients with COD:

- Address the housing needs of clients.
- Help clients obtain housing.
- Teach clients skills for maintaining housing.
- Work closely with shelter workers and other providers of services to the homeless.
- Address real-life issues in addition to housing, such as substance abuse treatment, legal and pending criminal justice issues, Supplemental Security Insurance/entitlement applications, issues related to children, healthcare needs, and so on.

Criminal Justice Populations

Prevalence of COD

Estimates of the rates of severe mental and substance use disorders in jail and prison populations have varied between 3 and 16 percent (Peters and Hills 1993; Regier et al. 1990; Steadman et al. 1987). A U.S. Department of Justice special report (Ditton 1999) estimated that 16 percent of State prison inmates, 7 percent of Federal inmates, 16 percent of those in local jails, and about 16 percent of probationers reported either a mental disorder or an overnight stay in a mental hospital during their lifetime (Ditton

1999). Substance abuse is also common in the criminal justice population. Offenders in the U.S. Department of Justice Survey report a high incidence of drug and alcohol abuse. One third were alcohol dependent, while 6 in 10 were under the influence of alcohol or drugs at the time of offense (Ditton 1999).

Rationale for treatment

The rationale for providing substance abuse treatment in prisons is based on the well-established relationship between substance abuse and criminal behavior. According to Ditton (1999), offenders with mental illness were likely to be using substances when they committed their convicting offense and likely to be incarcerated for a violent crime. On the other hand, the majority of probationers with mental disorders (approximately three quarters) have not been involved in violent crime. The overall goal of substance abuse treatment for criminal offenders, especially for those who are violent, is to reduce criminality.

Treatment features and approaches

Several features distinguish the programs currently in place to treat inmates with COD from other substance abuse treatment programs:

- Staff are trained and experienced in treating both mental illness and substance abuse.
- Both disorders are treated as "primary."
- Treatment services are integrated whenever possible.
- Comprehensive treatment is flexible and individualized.
- The focus of the treatment is long-term.

Treatment approaches used with other populations (e.g., TCs, interventions using cognitive–behavioral approaches, relapse prevention strategies, and support groups) can be adapted to suit the particular needs of offenders with COD. Common modifications described in the literature (Edens et al. 1997; Peters and Hills 1997; Peters and Steinberg 2000; Sacks and Peters 2002) include

- Smaller caseloads
- Shorter and simplified meetings
- Special attention to criminal thinking
- Education about medication and COD
- An effort to minimize confrontation

The importance of post-release treatment and followup

In the last decade, a number of studies have established the importance of linking institutional services to community services (of various kinds). The initial rationale for providing aftercare subsequent to prison-based treatment was to ease the abrupt transition of the offender from prison to community, thus promoting reintegration while monitoring the offender's behavior in a semi-controlled environment (Clear and Braga 1995; McCarthy and McCarthy 1997). Significant reductions in recidivism were obtained; reductions were larger and sustained for longer periods of time when institutional care was integrated with aftercare programs. Examples are TC work-release (Butzin et al. 2002; Inciardi et al. 2001; Martin et al. 1999) or other community-based treatment such as post-prison TC (Griffith et al. 1999; Hiller et al. 1999; Knight et al. 1997; Wexler et al. 1999) or cognitive–behavioral programs (Johnson and Hunter 1995; Peters et al. 1993; Ross et al. 1988). Longer-term followup studies of TC in-prison plus aftercare programs have reported findings indicating that treatment effects producing lower rates of return to custody may persist for up to 5 years (Prendergast et al. 2004).

Recently, the National Institute on Drug Abuse has established the Criminal Justice Drug Abuse Treatment System. This initiative funds regional research centers that are intended to forge partnerships between substance abuse service providers and the crimi-

nal justice system to design and test approaches to the better integration of in-prison treatment and post-prison services.

Examples of programs in prisons

The Clackamas County program (Oregon City, Oregon)

Clackamas County offers two related programs for persons in jails. While incarcerated, inmates are offered pretreatment services in which psychoeducational and preliminary treatment issues are discussed. Discussion sessions are staffed by both a substance abuse treatment counselor, employed by the Mental Health Center, and a corrections counselor who is certified to provide substance abuse treatment services. Inmates are housed in a separate unit, creating some milieu intervention factors.

Many of these inmates are transferred to the Center's Corrections Substance Abuse Program, when space is available. The Corrections Substance Abuse Program is a residential treatment program within a work release setting. During the first phase clients stay in-house exclusively. With successful progress, they are allowed to seek work in the community. On completion of the program, clients are transitioned to outpatient care in the community with continued monitoring by probation or parole.

Clackamas County also offers intensive outpatient programs focused on different client needs. Through close consultation with the local criminal justice system, offenders under electronic surveillance receive intensive outpatient care. Programming is gender based, with parallel programming for men and women. Sufficient progress transitions the client to less intensive outpatient care.

The Clackamas County program for offenders under electronic surveillance was developed in close consultation with the criminal justice system, with staff members from that system serving as co-facilitators for treatment groups in the program. The highest incidence of personality disorders of any clients in Clackamas County's substance abuse treatment programs have been found in this particular population of offenders. Consequently, skills building to address such mental health issues as identifying thinking errors, anger management, and conflict resolution are emphasized and form an integral part of this intervention. A subprogram ("Bridges") works specifically with clients who have COD, providing case management and treatment services. Most Bridges clients have severe and persistent mental illness with histories of school and work failures; consequently, the intervention is intensive, stepwise, and structured, with the opportunity for support in developing social and work skills.

Another effort coordinated with criminal justice has been the intensive outpatient subprogram, drug court. To participate, clients must be of nonfelony status and can have their

Advice to the Counselor: Providing Community Supervision for Offenders With COD

The panel recommends the following strategies for community supervision of offenders with COD:

- Recognize special service needs.
- Give positive reinforcement for small successes and progress.
- Clarify expectations regarding response to supervision.
- Use flexible responses to infractions.
- Give concrete (i.e., not abstract) directions.
- Design highly structured activities.
- Provide ongoing monitoring of symptoms.

Source: Adapted from Peters and Hills 1997.

misdemeanor charges expunged by completion of the year-long program. This program, too, is conceived as a stepwise intervention.

The Colorado Prison program

In response to the increasing number of inmates with SMI, the Colorado Department of Corrections contracted with a private not-for-profit agency during the mid-1990s to develop Personal Reflections, a modified TC program. A separate 32-bed unit with a planned stay of 15 months, Personal Reflections is located in Pueblo at the San Carlos Correctional Facility, which houses only inmates with mental illness.

The goal of the program is to foster personal change and to reduce the incidence of return to a criminal lifestyle. Personal Reflections uses TC principles and methods as the foundation for recovery and to provide the structure for a cognitive–behavioral curriculum focused on the triple issues of substance abuse, mental illness, and criminal thinking and activity. At the same time, as is central to TC programming, a positive peer culture is employed to facilitate behavior change.

The Personal Reflections modified TC uses psychoeducational classes to increase an inmate's understanding of mental illness, addiction, the nature of COD, drugs of use and abuse, and the connection between thoughts and behavior. These classes also teach emotional and behavioral coping skills. Therapeutic interventions in the modified TC include (1) core groups to process personal issues, (2) modified encounter groups that address maladaptive behaviors and personal responsibility, and (3) peer groups to provide feedback and support.

Empirical evidence

The Personal Reflections program is being evaluated by a study design that randomly assigned and compared two groups, modified TC and services-as-usual (i.e., a mental health services approach). The results obtained from an intent-to-treat analysis of all study entries showed that inmates randomized into the MTC group had significantly lower rates of reincarceration compared to those in the mental health services only group (Sacks et al. 2004).

Because of the stigma associated with the combination of substance abuse, co-occurring mental illness, and a criminal record, this group of offenders will face barriers to being accepted into an aftercare program. They also will have difficulty locating effective programs for their complex problems that require specialized treatment (Broner et al. 2002).

Women

Women with co-occurring disorders can be served in the same types of mixed-gender co-occurring programs and with the strategies mentioned elsewhere in this TIP. However, specialized programs for women with COD have been developed primarily to address pregnancy and childcare issues as well as certain kinds of trauma, violence, and victimization that may best be dealt with in women-only programs.

Responsibility for care of dependent children is one of the most important barriers to entering treatment according to a major survey of public alcohol dependence authorities, treatment programs, and gatekeepers in 39 communities (CSAT 2001). Women who enter treatment sometimes risk losing public assistance support and custody of their children, making the decision to begin treatment a difficult one (Blume 1997). Women accompanied by their children into treatment can be successful in treatment. A CSAT study of 50 grantees in the Residential Women and Children and Pregnant and Postpartum Women programs reported that the 6- to 12-month treatment program had positive results according to a number of outcome measures (CSAT 2001).

Few women-centered or women-only outpatient co-occurring programs have been described, and most outpatient groups are mixed gender. However, Comtois and Ries (1995) concluded that gender-specific special-

ized programming may make very significant differences. They found that before specialized programming, women only accounted for 20 percent of group attendance, yet made up 40 percent of census in a large integrated COD treatment program for those with SMI. After women-only specialized programming was developed, the 40 percent census then accounted for 50 percent of group visits. Women attendees commented that they did not feel comfortable in mixed groups, especially in the early phases of treatment, but felt very differently when they had their own groups.

It is the responsibility of the program to address the specific needs of women, and mixed-gender programs need to be made more responsive to women's needs. Women in mixed-gender outpatient programs require very careful and appropriate counselor matching and the availability of specialized women-only groups to address sensitive issues such as trauma, parenting, stigma, and self-esteem. Strong administrative policies pertaining to sexual harassment, safety, and language must be clearly stated and upheld. These same issues occur in residential programs designed for women who have multiple and complex needs and require a safe environment for stabilization, intensive treatment, and an intensive recovery support structure. Residential treatment for pregnant women with co-occurring disorders should provide integrated co-occurring treatment and primary medical care, as well as attention to other related problems and disorders. The needs of women in residential care depend in part on the severity and complexity of their co-occurring mental disorders. Other issues meriting attention include past or present history of domestic violence or sexual abuse, physical health, and pregnancy or parental status.

Substance abuse and mental health problems in women

While alcohol, marijuana, and cocaine continue to be problems, heroin, methamphetamine, and new drugs like OxyContin® have gained popularity among women. In general, drugs of abuse today are more available and less expensive than in the past. The previously lower rate of addictions in women compared to men appears to be vanishing, as the rate of substance abuse among young females has become almost equivalent to that of young males. For example, according to SAMHSA's 2002 National Survey on Drug Use and Health, past-month use of methamphetamine reported by women was 0.2 percent, versus 0.3 percent reported by men (Office of Applied Studies 2003*b*).

Women and men have differing coping mechanisms and symptom profiles. As compared to their male counterparts, women with substance use disorders have more mental disorders (depression, anxiety, eating disorders, and posttraumatic stress disorder [PTSD]) and lower self-esteem. While women with substance use disorders have more difficulty with emotional problems, their male counterparts have more trouble with functioning (e.g., work, money, legal problems). See the TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT in development *b*) for more on the psychological impact of substance abuse on women.

Treatment for substance abuse in women should emphasize the importance of relationships, the link between relationships and substance abuse (many women continue to use with a partner), and the importance of relationships with children as a motivator in treatment. The stigma attached to females who abuse substances functions as a barrier to treatment, as does the lack of provision for children.

Pregnancy and co-occurring disorders

Pregnancy can aggravate or diminish the symptoms of co-occurring mental illness. Worsening symptoms of mental illness can result from hormonal changes that occur during pregnancy; lactation; medications given during pregnancy or delivery; the stresses of pregnancy, labor, and delivery; and adjusting to and bonding with a newborn (Grella 1997). Women with co-occurring disorders sometimes avoid early prenatal care, have difficulty complying with healthcare providers' instructions, and are unable to plan for their babies or care for them when they arrive. According to the literature, women with anxiety disorders or personality disorders are at increased risk for postpartum depression (Grella 1997).

Many pregnant women with co-occurring disorders are distrustful of substance abuse treatment and mental health service providers, yet they are in need of multiple services (Grella 1997). One concern is whether the mother can care adequately for her newborn. For her to do so requires family-centered, coordinated efforts from such caregivers as social workers, child welfare professionals, and the foster care system.

Issues to address with co-occurring mental illness

It is particularly important to make careful treatment plans during pregnancy for women with mental disorders that include planning for childbirth and infant care. Women often are concerned about the effect of their medication on their fetuses. Treatment programs should work to maintain medical and mental stability during the client's pregnancy and collaborate with other healthcare providers to ensure that treatment is coordinated.

When women are parenting, it can often retrigger their own childhood traumas. Therefore, providers need to balance growth and healing with coping and safety. Focusing on the woman's interest in and desire to be a good mother, the sensitive counselor will be alert to the inevitable guilt, shame, denial, and resistance to dealing with these issues, as the recovering woman increases her awareness of effective parenting skills. Providers also need to allow for evaluation over time for women with COD. Reassessments should occur as mothers progress through treatment.

Pharmacologic considerations

From a clinical standpoint, before giving any medications to pregnant women it is of vital importance that they understand the risks and benefits of taking these medications and that they sign informed consent forms verifying that they have received and understand the information provided to them. Certain psychoactive medications may be associated with birth defects, especially in the first trimester of pregnancy, and weighing potential risk/benefit is important. In most cases, a sensible direction can be found; however, this needs expert advice and consideration by a physician and pharmacist familiar with working with pregnant women with mental disorders. Since pregnant women often present to treatment in mid to late second trimester and polydrug use is the norm rather than the exception (Jones et al. 1999), it is important first to screen these women for dependence on the classes of substances that can produce a life-threatening withdrawal for the mother: alcohol, benzodiazepines, and barbiturates. These substances, as well as opioids, can cause a withdrawal syndrome in the baby, who may need treatment. Pregnant women should be made aware of any and all wrap-around services to assist them in managing newborn issues, including food, shelter, medical clinics for innoculations, etc., as well as programs that can help with developmental or physical issues the infant may experience as a result of alcohol/drug exposure. For more on pharmacologic considerations for pregnant women, see appendix F.

Postpartum depression

The term "postpartum depression" encompasses:

- Postpartum or maternity "blues," which affects up to 85 percent of new mothers
- Postpartum depression, which affects between 10 and 15 percent of new mothers
- Postpartum psychosis, which develops following about one per 500–1,000 births, according to some studies (Steiner 1998)

Postpartum "blues" is transient depression occurring most commonly within 3–10 days after delivery. There is evidence that the "blues" are precipitated by progesterone withdrawal (Harris et al. 1994). Prominent in its causes are a woman's emotional letdown following the excitement and fears of pregnancy and delivery, the discomforts of the period immediately after giving birth, fatigue from loss of sleep during labor and while hospitalized, energy expenditure at labor, anxieties about her ability to care for her child at home, and fears that she may be unattractive to her partner. Symptoms include weepiness, insomnia, depression, anxiety, poor concentration, moodiness, and irritability. These symptoms tend to be mild and transient, and women usually recover completely with rest and reassurance. Anticipation and preventive reassurance throughout pregnancy can prevent postpartum blues from becoming a problem. Women with sleep deprivation should be assisted in getting proper rest. Followup care should ensure that the woman is making sufficient progress and not heading toward a relapse to substance use.

Figure 7-1 lists the criteria for major depressive episode, of which postpartum onset is one specifier. Not all instances of postpartum depression meet the criteria for major depressive episode; they may have fewer than five symptoms.

According to the DSM-IV-TR (APA 2000), for a depressive episode to be characterized "with postpartum onset," it must begin within 4 weeks postpartum. Risk factors for postpartum depression include prior history of non-postpartum depression or psychological distress during pregnancy, other prepregnancy mental diagnosis, or family history of mental disorder (American Psychiatric Association [APA] 2001; Nielsen Forman et al. 2000; Steiner 2002; Webster et al. 2000). Prospects for recovery from postpartum depression are good with supportive psychological counseling

Figure 7-1

Criteria for Major Depressive Episode

At least five of the following symptoms present during the same 2-week period, representing a change from previous functioning; one of the symptoms is either depressed mood or loss of interest or pleasure:

- Depressed mood most of the day, nearly every day
- Diminished interest or pleasure in activities
- Significant weight loss
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of death, recurrent suicidal ideation, or a suicide attempt

Source: APA 2000.

accompanied as needed by pharmacological therapy (Chabrol et al. 2002; Cohen et al. 2001; O'Hara et al. 2000). Antidepressants, anxiolytic medications, and even electroconvulsive therapy have all been successful in treating postpartum depression (Griffiths et al. 1989; Oates 1989; Varan et al. 1985). Because some medications pass into breast milk and can cause infant sedation, it is best to consult an experienced psychiatrist or pharmacist for details. Patients with postpartum depression need to be monitored for thoughts of suicide, infanticide, and progression of psychosis in addition to their response to treatment.

Postpartum psychosis is a serious mental disorder. Women with this disorder may lose touch with reality and experience delusions, hallucinations, and/or disorganized speech or behavior. Women most likely to be diagnosed with postpartum psychosis are those with previous diagnoses of bipolar disorder, schizophrenia, or schizoaffective disorder or women who had a major depression in the year preceding the birth (Kumar et al. 1993). Other studies reviewed by Marks and colleagues (1991) indicate that other risk factors for postpartum psychosis include previous depressive illness or postpartum psychosis, first pregnancy, and family history of mental illness. Recurrence of postpartum psychosis in the next pregnancy occurs in 30–50 percent of women (APA 2000). Peak onset is 10–14 days after delivery but can occur any time within 6 months. The severity of the symptoms mandates pharmacological treatment in most cases, and sometimes, hospitalization. The risk of self-harm and/or harm to the baby needs to be assessed, and monitoring of mother–infant pairs by trained personnel can limit these risks.

Women, trauma, and violence

It is estimated that between 55 and 99 percent of women in substance abuse treatment have had traumatic experiences, typically childhood physical or sexual abuse, domestic violence, or rape. Of these, between 33 and 59 percent have been found to be experiencing current PTSD; yet, historically, few substance abuse treatment programs assess for, treat, or educate clients about trauma (Najavits 2000). This deficiency is a serious one, given the multiplying consequences of failure to address this problem. Greater violence leads to more serious substance abuse and other addictions (e.g., eating disorders, sexual addiction, and compulsive exercise), along with higher rates of depression, self-mutilation, and suicidal impulses. Addiction places women at higher risk of future trauma, through their associations with dangerous people and lowered self-protection when using substances (e.g., going home with a stranger after drinking).

Models for women's trauma recovery

Clearly, effective ways of addressing the trauma-specific needs of women with COD are essential. Fortunately, a number of models are emerging, many with data demonstrating their efficacy. Harris and Fallot have described the core elements of a trauma-informed addictions program as follows (2001, p. 63):

- "The program must have a commitment to teaching explanations that integrate trauma and substance use." The authors stress the need to help clients understand the interaction between trauma and substance use. They encourage the use of "self-soothing mechanisms" to help trauma survivors deal with symptoms such as flashbacks without resorting to substance use. (See "Grounding" in the discussion of PTSD, appendix D.)
- "The milieu must promote consumer empowerment and relationship building as well as healing." The authors stress the importance of building strengths, providing an opportunity for caring connections through group work and informal sharing, and establishing a milieu that is "warm, friendly, and nurturing."

- "Each woman must be encouraged to develop certain crossover skills that are equally important in recovery from trauma and chemical dependency." Examples of such skills include enhancing self regulation, limit setting, and building self-trust.
- "A series of ancillary services help a woman to continue her recovery once she leaves a structured program." Examples of areas to be addressed include legal services (e.g., child custody issues, childcare issues), safe housing (e.g., housing that accepts children), and health care (e.g., prenatal care, gynecology, pediatrics).
- "The program avoids the use of recovery tactics that are contraindicated for women recovering from physical and sexual violence." For many women, these include shaming, moral inventories, confrontation, emphasis on a higher power, and intrusive monitoring. Many practitioners find that alternatives to the 12-Step model are helpful for some women (Kasl 1992; Women for Sobriety 1993). On the other hand, many women have benefited from 12-Step programs. Gender-specific 12-Step meetings may compensate for the shortcoming of mixed gender or predominantly male programs.

While a detailed description of trauma recovery model programs is beyond the scope of this TIP, readers should be aware that there are a number of emerging models available for use. Many are supported by published materials, such as workbooks with session guides that aid in implementation. Examples include the following:

- *The Trauma Recovery and Empowerment Model (TREM)* is a group approach to healing from the effects of trauma. TREM combines the elements of social skills training, psychoeducational and psychodynamic techniques, and emphasizes peer support, which have proven to be highly effective approaches with survivors. A 33-session guide book for clinicians is available (Harris and Community Connections Trauma Work Group 1998).
- *Seeking Safety* offers a manual-based, cognitive–behavioral therapy model consisting of 25 sessions which has been used in a number of studies with women who have substance dependence and co-occurring PTSD (Najavits 2000, 2002).
- *Helping Women Recover: A Program for Treating Addiction* is an integrated program with a separate version for women in the criminal justice system. This model integrates theoretical perspectives of substance abuse and dependence, women's psychological development, and trauma (Covington 1999).
- *The Addiction and Trauma Recovery Integration Model* is designed to assess and intervene at the body, mind, and spiritual levels to address key issues linked to trauma and substance abuse experiences (Miller and Guidry 2001).
- *Trauma Adaptive Recovery Group Education and Therapy (TARGET)* aims to help clients replace their stress responses with a positive approach to personal and relational empowerment. TARGET has been adapted for deaf clients and for those whose primary language is Spanish or Dutch (Ford et al. 2000).

For more detailed information, including individual and other models of trauma healing, see the forthcoming TIPs *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT in development *b*) and *Substance Abuse Treatment and Trauma* (CSAT in development *d*).

The women, co-occurring disorders, and violence study

Three SAMHSA Centers—CSAT, CMHS, and the Center for Substance Abuse Prevention—collaborated on a nine-site study to develop systems of care for women with co-occurring disorders who also were survivors of violence (www.wcdvs.com) (the study ended in 2003). Each site was charged with implementing an intervention that models integrated care and

conducting a qualitative evaluation of the methods used. The work clearly underlined the need for integrated services, the need to address trauma and violence, and the need to include children with their mothers in treatment. Two of the the participating sites are featured below.

The sites also have identified many issues for children whose mothers had co-occurring disorders. In four of the nine sites in this study, an additional subset study focused on the children of women who participated in the study. The "Cooperative Agreement to Study Children of Women with Alcohol, Drug Abuse and Mental Health (ADM) Disorders who Have Histories of Violence" sought to generate and apply empirical knowledge about the effectiveness of trauma-informed, culturally relevant, age-specific intervention models for children 5 to 10 years of age (www.wcdvs.com/children). The intervention was driven by concern for children who experienced stress as a result of witnessing violence and were at risk for a multitude of problems as they grew older, including COD.

Community Connections

Community Connections is a comprehensive nonprofit human services agency serving an urban population in Washington, D.C. Community Connections was the lead agency in the District of Columbia Trauma Collaboration Study (DCTCS), one of nine sites in the SAMHSA research effort to examine the effectiveness of services for female trauma survivors with COD. The DCTCS served more than 150 women in the experimental condition at two agencies in Washington, D.C. All had histories of sexual and/or physical abuse and had co-occurring substance use and mental disorders.

For the past decade, Community Connections has focused both clinical and research efforts on the needs of trauma survivors. The agency has developed trauma-specific services, examined the prevalence and impact of trauma in the lives of individuals diagnosed with serious mental disorders, and developed training and consultation models addressing trauma. In the first 2 years of the SAMHSA project, Community Connections developed a comprehensive, integrated, trauma-focused network of services. A quasi-experimental research project that occurred from 2000 to 2003 assessed the impact of the key intervention components:

1. *TREM groups.* The TREM group treatment intervention was developed by clinicians at Community Connections with considerable input from consumers. TREM is a 33-session intervention that uses a psychoeducational focus and skill-building approach, emphasizes survivor empowerment and peer support, and teaches techniques for self-soothing, boundary maintenance, and current problemsolving. A more abbreviated version (24 sessions) was developed for agencies to use in a 3- to 6-month time frame. TREM has been published as a fully manualized leader's guide (Harris and Community Connections Trauma Work Group 1998), and in a self-help workbook format titled *Healing the Trauma of Abuse* (Copeland and Harris 2000).
2. *Integrated Trauma Services Teams (ITSTs).* ITSTs provide an integrated, comprehensive package of services, include consumer/survivor/recovering persons (C/S/Rs) in central roles, and are responsive to issues of gender and culture. Embedded in an integrated network of programs offering a full range of necessary support services, ITSTs are composed of primary clinicians cross-trained in trauma, mental health, and substance abuse domains. The teams provide services addressing these domains and the complex interactions among them simultaneously and in a closely coordinated way.
3. *Collateral Groups.* Several additional trauma-informed groups have been developed for women in the study. These modules are explicitly integrative, addressing the relationships among trauma, mental health, and substance abuse concerns.

Group modules are: Trauma Informed Addictions Treatment, Parenting Issues, Spirituality and Trauma Recovery, Domestic Violence, Trauma Issues Associated with HIV Infection, and Introduction to Trauma Issues for Women on Inpatient or Short-Stay Units.

4. *Women's Support and Empowerment Center (peer support).* Project C/S/Rs developed and offer a variety of peer-run services, including a Peer Representative program providing support, companionship, and advocacy within a women's peer center, open 5 days a week to women in the program.

Data from the DCTCS suggested that this TREM-based integrative approach was effective in facilitating recovery from substance use disorders and other mental illness. Pilot data from four different clinical sites indicate TREM's potential benefits in several domains: mental health symptom reduction, decreased utilization of intensive services such as inpatient hospitalization and emergency room visits, decreases in high-risk behavior, and enhanced overall functioning.

Advice to the Counselor: Treatment Principles and Services for Women With COD

The panel recommends the following treatment principles and services for women.

A report from the National Women's Resource Center (Finkelstein et al. 1997) reviews the literature on women's programs and finds that these models have many basic tenets in common. The overarching principle is that the provision of comprehensive services and treatment needs to be in accord with the context and needs of women's daily lives. Recommendations based on the Center's review include:

- Identify and build on each woman's strengths.
- Avoid confrontational approaches (or, as has been stated previously, supportive interventions are preferred to confrontational interventions for persons with COD, especially in the early stages of treatment).
- Teach coping strategies, based on a woman's experiences, with a willingness to explore the woman's individual appraisals of stressful situations.
- Arrange to meet the daily needs of women, such as childcare and transportation.
- Have a strong female presence on staff.
- Promote bonding among women.

In addition, the consensus panel adds the following advice:

- Offer program components that help women reduce the stress associated with parenting, and teach parenting skills.
- Develop programs for both women and children.
- Provide interventions that focus on trauma and abuse.
- Foster family reintegration and build positive ties with the extended/kinship family.
- Build healthy support networks with shared family goals.
- Make prevention and emotional support programs available for children.

Source: Adapted from Finkelstein et al. 1997.

The Triad Women's Project: A Cooperative Agreement Network

Overview

The Triad Women's Project was developed in 1998 with funds from a SAMHSA collaborative grant on Women, Co-Occurring Disorders, and Violence. The project was designed to provide integrated services for women with histories of trauma and abuse who have COD. Clients were frequent users of mental health and substance abuse treatment services in a semirural area of Florida that spans three counties. Services in the area previously had been delivered by different agencies in a nonintegrated system.

Clients

The program served up to 175 women, many of whom were mandated to treatment by the court.

Services

The three main service components were

- *Triad Specialists.* The Triad Specialists who provided case management services were located in and funded by their respective mental health or substance abuse treatment programs. They were cross-trained in mental health, substance abuse, and trauma/violence/abuse issues. (A cross-training package was developed on a video that features 16 hours of instruction.) The Triad Specialists met regularly to share information and resources. Caseloads were restricted to 25 clients, all of whom had histories of abuse and were diagnosed with COD. The Triad Specialist became a woman's case manager at the client's entrance into the "gateway" agency. The specialist continued to work with her even if she used other services.
- *Triad Women's Group.* This component was developed to assist triply diagnosed women with their substance abuse, mental health, and trauma issues. This integrated intervention was designed as a 16-week therapy group, employing a manualized skill development curriculum that could be used in outpatient or residential settings.
- *Peer Support Group.* The peer support group, called Women of Wisdom, was run by consumers/survivors and served both as a support group for women in treatment and as a continuing support group for those who had left. The groups were based on a 12-Step model for trauma survivors, but addressed substance abuse and mental health recovery issues. They met in community settings and were open to all women in the community.

Preliminary Empirical Evidence

A formal evaluation of the project began in October 2000. Data have shown reductions in mental disorder symptoms, reductions in symptoms related to child sexual abuse, and improvements in "approach or active" coping responses related to substance abuse recovery (as measured by the Coping Responses Inventory [Moos 1993]) as a result of the group intervention.

The Triad Women's Project

This project, featured in the text box above, has found, consistent with the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, that the prevalence of depression and anxiety disorders, especially PTSD, is higher among women than men, and that the incidence of borderline personality disorder also is higher (APA 2000).

Need for increased empirical information

Knowledge about, and understanding of, women with COD needs to be expanded, particularly for those women who experience SMI. The knowledge base should include accurate information on the rates of incidence of COD among women who have SMI, their profiles, and their use of services. In addi-

tion, COD outcome studies need to focus on gender differences to further improve treatment protocols for women. Research efforts should address the following questions:

- *Medication*—Do the problems that women in general have with prescribed psychoactive medication (e.g., concerns about weight gain affecting adherence) hold for women with COD, especially those who have SMI?
- *HIV/AIDS risk*—Is the current popularity of heroin or methamphetamine translating to increased HIV/AIDS in this subpopulation of women? Are there increasing rates of transmission of HIV/AIDS among females who abuse substances?
- *Populations*—What differences exist among different populations (e.g. women, teens, lesbian/gay/bisexual, rural, older adults)?
- *Drug use*—Is the current decline in crack cocaine use reflected in the drug habits of these women?
- *Networks*—Do social networks of women with COD support recovery, or do they trigger relapse?
- *Trauma*—Does the severity of mental illness affect the experience of trauma, violence, and victimization? What are the effects of trauma, violence, and abuse on the course of treatment for women with COD?
- *Systems*—Do existing models meet the complicated service needs of women with COD? Do these models achieve effective linkages with supports based in the community? Do these structures support women with SMI?
- *Community connections*—How are linkages established and maintained?
- *Treatment*—What treatment components are effective for women with COD, particularly those who have severe mental disorders?
- *Outcomes*—Are various treatments differentially effective for women? How do existing strategies and models for the treatment of COD need to be modified to produce the best outcomes for women? (Adapted from Alexander 1996)

8 A Brief Overview of Specific Mental Disorders and Cross-Cutting Issues

In This Chapter…

Cross-Cutting Issues

Personality Disorders

Mood Disorders and Anxiety Disorders

Schizophrenia and Other Psychotic Disorders

Attention-Deficit/ Hyperactivity Disorder (AD/HD)

Posttraumatic Stress Disorder (PTSD)

Eating Disorders

Pathological Gambling

Conclusion

Overview

This chapter provides a brief overview for working with substance abuse treatment clients who also have specific mental disorders. It is presented in concise form so that the counselor can refer to this one chapter to obtain basic information. Appendix D contains more in-depth information on suicidality, nicotine dependence, and each of the disorders addressed in this chapter. The material included is not a complete review of all disorders in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), but updates the material from TIP 9 (Center for Substance Abuse Treatment 1994*a*) (i.e., personality disorders, mood disorders, anxiety disorders, and psychotic disorders), adding other mental disorders with special relevance to co-occurring disorders (COD) not covered in TIP 9 (i.e., attention deficit/hyperactivity disorder, posttraumatic stress disorder, eating disorders, and pathological gambling). The consensus panel acknowledges that people with COD may have multiple combinations of the various mental disorders presented in this chapter (e.g., a person with a substance use disorder, schizophrenia, and a pathological gambling problem). However, for purposes of clarity and brevity the panel chose to focus the discussion on the main disorders and not explore the multitude of possible combinations.

The chapter begins with a brief description of cross-cutting issues—suicidality and nicotine dependency. While suicidality is not a DSM-IV diagnosed mental disorder per se, it is a high-risk behavior associated with COD. Nicotine dependency is recognized as a disorder in DSM-IV, and as such a client with nicotine dependency and a mental disorder could be considered to have a co-occurring disorder. Though this is the case, an important difference between tobacco addiction and

other addictions is that tobacco's chief effects are medical rather than behavioral, and, as such, it is not conceptualized and presented as a typical co-occurring addiction disorder. However, because of the high proportion of the COD population addicted to nicotine, as well as the devastating health consequences of tobacco use, nicotine dependency is treated as an important cross-cutting issue for people with substance use disorders and mental illness.

The discussions of suicidality and nicotine dependency highlight key information counselors should know about that disorder in combination with substance abuse. This section offers factual information (e.g., prevalence data), commonly agreed-upon clinical practices, and other general information that may be best characterized as "working formulations."

A brief description of selected disorders and their diagnostic criteria follows. This material has been extracted from DSM-IV-TR (Text Revision, American Psychiatric Association [APA] 2000) and highlights the descriptive features, diagnostic features, and symptom clusters of each mental disorder. The consensus panel elected to take this material directly from DSM-IV-TR to provide easy access to the material that is not typically available in the substance abuse treatment field. Use of a specialized dictionary that includes terminology related to mental disorders may be needed to understand terms in the quoted material from DSM-IV-TR, though the main features of each disorder should still be clear.

Because of the greater availability of case histories from the mental health literature, the illustrative material in the next section has a greater emphasis on the mental disorder. Wherever possible case histories were selected to illustrate the interaction of the mental and substance use disorders. Finally, each section contains an *Advice to the Counselor* box.

The consensus panel recognizes that no one chapter can replace the comprehensive training necessary for diagnosing and treating clients with specific mental disorders co-occurring with substance use disorders and that the Advice to the Counselor understates the complexity involved in treating clients with these disorders. The Advice to the Counselor boxes are designed to distill for the counselor the main actions and approaches that they can take in working with substance abuse treatment clients who have the specific mental disorder being discussed (see the table of contents for a full listing of these boxes throughout the TIP).

The consensus panel also recognizes the chapter cannot possibly cover each mental disorder exhaustively and that addiction counselors are not expected to diagnose mental disorders. The limited goals of the panel in providing this material are to increase substance abuse treatment counselors' familiarity with mental disorders terminology and criteria, as well as to provide advice on how to proceed with clients who demonstrate these disorders. It is also the purpose of this chapter and appendix D to stimulate further work in this area and to make this research accessible to the addiction field.

Cross-Cutting Issues

Suicidality

Suicidality is not a mental disorder in and of itself, but rather a high-risk behavior associated with COD, especially (though not limited to) serious mood disorders. Research shows that most people who kill themselves have a diagnosable mental or substance use disorder or both, and that the majority of them have depressive illness. Studies indicate that the most promising way to prevent suicide and suicidal behavior is through the early recognition and treatment of substance abuse and mental illnesses. This is especially true of clients who have serious depression (U.S. Public Health Service 1999). Substance-induced or exacerbated suicidal ideations, intentions, and behaviors are an ever-present

possible complication of substance use disorders, especially for clients with co-occurring mental disorders.

The topic of suicidality is critical for substance abuse treatment counselors working with clients with COD. Substance use disorders alone increase suicidality, while the added presence of some mental disorders doubles an already heightened risk. Counselors should be aware that the risk of suicide is greatest when relapse occurs after a substantial period of abstinence—especially if there is concurrent financial or psychosocial loss. Every agency that offers counseling for substance abuse also must have a clear protocol in place that addresses the recognition and treatment (or referral) of persons who may be suicidal.

Advice to the Counselor: Counseling a Client Who Is Suicidal

- Screen for suicidal thoughts or plans with anyone who makes suicidal references, appears seriously depressed, or who has a history of suicide attempts. Treat all suicide threats with seriousness.
- Assess the client's risk of self-harm by asking about what is wrong, why now, whether specific plans have been made to commit suicide, past attempts, current feelings, and protective factors. (See the discussion of suicidality in appendix D for a model risk assessment protocol.)
- Develop a safety and risk management process with the client that involves a commitment on the client's part to follow advice, remove the means to commit suicide (e.g., a gun), and agree to seek help and treatment. Avoid sole reliance on "no suicide contracts."
- Assess the client's risk of harm to others.
- Provide availability of contact 24 hours per day until psychiatric referral can be realized. Refer those clients with a serious plan, previous attempt, or serious mental illness for psychiatric intervention or obtain the assistance of a psychiatric consultant for the management of these clients.
- Monitor and develop strategies to ensure medication adherence.
- Develop long-term recovery plans to treat substance abuse.
- Review all such situations with the supervisor and/or treatment team members.
- Document thoroughly all client reports and counselor suggestions.

What counselors should know about suicide and substance abuse

Counselors should be aware of the following facts about the association between suicide and substance abuse:

- Abuse of alcohol or drugs is a major risk factor in suicide, both for people with COD and for the general population.
- Alcohol abuse is associated with 25 to 50 percent of suicides. Between 5 and 27 percent of all deaths of people who abuse alcohol are caused by suicide, with the lifetime risk for suicide among people who abuse alcohol estimated to be 15 percent.
- There is a particularly strong relationship between substance abuse and suicide among young people.
- Comorbidity of alcoholism and depression increases suicide risk.
- The association between alcohol use and suicide also may relate to the capacity of alcohol to remove inhibitions, leading to poor judgment, mood instability, and impulsiveness.
- Substance intoxication is associated with increased violence, both toward others and self.

Case study: counseling a substance abuse treatment client who is suicidal

Beth M., an American-Indian woman, comes to the substance abuse treatment center complaining that drinking too much causes problems for her. She has tried to stop drinking before but always relapses. The counselor finds that she is not sleeping, has been eating poorly, and has been calling in sick to work. She spends much of the day crying and thinking of how alcohol, which has cost her her latest significant relationship, has ruined her life. She also has been taking painkillers for a recurring back problem, which has added to her problems. The counselor tells her about a group therapy opportunity at the center that seems right for her, tells her how to register, and makes arrangements for some individual counseling to set her on the right path. The counselor tells her she has done the right thing by coming in for help and gives her encouragement about her ability to stop drinking.

> Counselors always should ask if the client has been thinking of suicide, whether or not the client mentions depression.

Beth M. does not arrive for her next appointment, and when the counselor calls home, he learns from her roommate that Beth made an attempt on her life after leaving the substance abuse treatment center. She took an overdose of opioids (painkillers) and is recovering in the hospital. The emergency room staff found that Beth M. was under the influence of alcohol when she took the opioids.

Discussion: Although Beth M. provided information that showed she was depressed, the counselor did not explore the possibility of suicidal thinking. Counselors always should ask if the client has been thinking of suicide, whether or not the client mentions depression. An American-Indian client, in particular, may not answer a very direct question, or may hint at something darker without mentioning it directly. Interpreting the client's response requires sensitivity on the part of the counselor. It is important to realize that such questions do not increase the likelihood of suicide. Clients who, in fact, are contemplating suicide are more likely to feel relieved that the subject has now been brought into the light and can be addressed with help from someone who cares.

It is important to note that the client reports taking alcohol and pain medications. Alcohol impairs judgment and, like pain medications, depresses brain and body functions. The combination of substances increases the risk of suicide or accidental overdose. Readers are encouraged to think through this case and apply the assessment strategy included in the discussion of suicidality in appendix D, imagining what kind of answers the counselor might have received. Then, readers could consider interventions and referrals that would have been possible in their treatment settings.

Nicotine Dependence

In 2003 an estimated 29.8 percent of the general population aged 12 or older report current (past month) use of a tobacco product (National Survey on Drug Use and Health 2003*c*). The latest report of the Surgeon General on the Health Consequences of Smoking (U.S. Public Health Service Office of the Surgeon General 2004) provides a startling picture of the damage caused by tobacco. Tobacco smoking injures almost every organ in the body, causes many dis-

eases, reduces health in general, and leads to reduced life span and death. Tobacco dependence also has serious consequences to nonsmokers through environmental tobacco smoke (secondhand smoke) and the negative effects on unborn children. Fortunately quitting smoking has immediate as well as long-term benefits (U.S. Public Health Service Office of the Surgeon General 2004).

Evidence suggests that people with mental disorders and/or dependency on other drugs are more likely to have a tobacco addiction. In fact, most people with a mental illness or another addiction are tobacco dependent—about 50 to 95 percent, depending on the subgroup (Anthony and Echeagaray-Wagner 2000; Centers for Disease Control and Prevention 2001; National Institute on Drug Abuse 1999*a*; Richter 2001; Stark and Campbell 1993*b*). Smokers with mental disorders consume nearly half of all the cigarettes sold in the United States (Lasser et al. 2000). A study of individuals doing well in recovery from alcohol dependence found that those who smoked lived 12 fewer years because of their tobacco dependence and the quality of their lives was affected by other tobacco-caused medical illnesses (Hurt et al. 1996).

There is increasing recognition of the importance of integrating tobacco dependence treatment and management into mental health services and addiction treatment settings. Although tobacco dependence treatment works for smokers with mental illness and other addictions, only recently have clinicians been given training to address this serious public health and addiction treatment concern. It is increasingly recognized that all clients deserve access to effective treatments for tobacco addiction, and that smokers and their families should be educated about the considerable risks of smoking as well as the benefits of tobacco dependence treatment. All current tobacco dependence clinical practice guidelines strongly recommend addressing tobacco during any clinical contact with smokers and suggest the use of one or more of the six Food and Drug Administration (FDA)-approved medications as first-line treatments (e.g., bupropion SR/zyban and the nicotine patch, gum, nasal spray, inhaler, and lozenge).

Tobacco use and dependence should be assessed and documented in all clinical baseline assessments, treatment plans, and treatment efforts. A motivation-based treatment model allows for a wider range of treatment goals and interventions that match the patient's motivation to change. Like other addictions, tobacco dependence is a chronic disease that may require multiple treatment attempts for many individuals and there is a range of effective clinical interventions, including medications, patient/family education, and stage-based psychosocial treatments. Recent evidence-based treatment guidelines have been published for the management of tobacco dependence and this information can be a primary guide for addressing tobacco. Few recognize how ignoring tobacco perpetuates the stigma associated with mental illness and addiction when some ask, "Why should tobacco be addressed in mental health or addiction settings?" or "Other than increased morbidity and mortality, why should we encourage and help this group to quit?" or "What else are they going to do if they cannot smoke?"

What counselors should know about nicotine dependence

- Tobacco dependence is common in clients with other substance use disorders and mental illnesses.
- Like patients in primary care settings, clients in mental health services and addiction treatment settings should be screened for tobacco use and encouraged to quit.
- The U.S. Public Health Service Guidelines encourage the use of the "5 A's" (Ask, Advise, Assess, Assist, Arrange Followup) as an easy road map to guide clinicians to help their patients who smoke:

- Ask about tobacco use and document in chart.
- Advise to quit in a clear, strong, and personal message.
- Assess willingness to make a quit attempt and consider motivational interventions for the lower motivated and assist those ready to quit.
- Assist in a quit attempt by providing practical counseling, setting a quit date, helping them to anticipate the challenges they will face, recommending the use of tobacco dependence treatment medications, and discussing options for psychosocial treatment, including individual, group, telephone, and Internet counseling options.
- Arrange followup to enhance motivation, support success, manage relapses, and assess medication use and the need for more intensive treatment if necessary.

- Assessment of tobacco use includes assessing the amount and type of tobacco products used (cigarettes, cigars, chew, snuff, etc.), current motivation to quit, prior quit attempts (what treatment, how long abstinent, and why relapsed), withdrawal symptoms, common triggers, social supports and barriers, and preference for treatment.
- Behavioral health professionals already have many of the skills necessary to provide tobacco dependence psychosocial interventions.
- Smokers with mental illness and/or another addiction can quit with basic tobacco dependence treatment, but may also require motivational interventions and treatment approaches that integrate medications and psychosocial treatments.
- Tobacco treatment is cost-effective, feasible, and draws on principles of addictions and co-occurring disorders treatment.
- The current U.S. Clinical Practice Guidelines indicate that all patients trying to quit smoking should use first-line pharmacotherapy, except in cases where there may be contraindications (Fiore 2000).
- Currently there are six FDA-approved treatments for tobacco dependence treatment: bupropion SR and five Nicotine Replacement Treatments (NRTs): nicotine polacrilex (gum), nicotine transdermal patch, nicotine inhaler, nicotine nasal spray, and nicotine lozenge.
- Tobacco treatment medications are effective even in the absence of psychosocial treatments, but adding psychosocial treatments to medications enhances outcomes by at least 50 percent.
- Specific coping skills should be addressed to help smokers with mental or substance use disorders to cope with cravings associated with smoking cues in treatment settings where smoking is likely to be ubiquitous.
- When clients with serious mental illnesses attempt to quit smoking, watch for changes in mental status, medication side effects, and the need to lower some psychiatric medication dosages due to tobacco smoke interaction.

Program-level changes

As with other COD, the most effective strategies to address tobacco include both enhancing clinician skills and making program and system changes. Effective steps for addressing tobacco at the treatment program level are listed in an outline in the text box on page 219. These steps have been developed at the University of Medicine and Dentistry of New Jersey Tobacco Program and used effectively to address tobacco in hundreds of mental health and addiction treatment settings (Ziedonis and Williams 2003*a*). The necessary steps include developing comprehensive tobacco dependence assessments; providing

Steps for Addressing Tobacco Within Treatment Programs

1. Acknowledge the challenge.
2. Establish a leadership group and commit to change.
3. Create a change plan and implementation timeline.
4. Start with easy system changes.
5. Assess and document in charts nicotine use, dependence, and prior treatments.
6. Incorporate tobacco issues into client education curriculum.
7. Provide medications for nicotine dependence treatment and required abstinence.
8. Conduct staff training.
9. Provide treatment and recovery assistance for interested nicotine-dependent staff.
10. Integrate motivation-based treatments throughout the system.
11. Develop addressing tobacco policies that are site specific.
12. Establish ongoing communication with 12-Step recovery groups, professional colleagues, and referral sources about system changes.

Source: Ziedonis et al. 2003.

treatment, patient education, and continuing care planning; making self-help groups such as Nicotine Anonymous available to clients and their families; providing nicotine dependence treatment to interested staff; and making policy changes related to tobacco. Such changes should include documentation forms in clinical charts that contain more tobacco related questions, labeling smoker's charts, not referring to breaks in the program's schedule as "smoking breaks," forbidding staff and patients to smoke together, providing patient education brochures, and providing NRT for all clients in smoke-free residential treatment settings (Ziedonis and Williams 2003*a*).

Case study: addressing tobacco in an individual with panic disorder and alcohol dependence

Tammy T. is a 47-year-old widow who has been treated in a substance abuse outpatient program for co-occurring alcohol dependence and panic disorder. She is about 9 months abstinent from alcohol and states that she is now ready to address her tobacco addiction. When she first entered treatment she was not ready to quit tobacco. Her substance abuse counselor recognized her ambivalence and implemented some motivational interventions and followup on this topic over the course of the 9 months of her initial recovery. This persistence was perceived as expressing empathy and concern, and Tammy T. eventually recognized the need to quit smoking as part of a long-term recovery plan. She was now ready to set a quit date.

Tammy T. started smoking at age 17. Her only period of abstinence was during her pregnancy. She quickly resumed smoking after giving birth. She cut back from 30 cigarettes per day (1.5 packs) to 20 cigarettes per day (1 pack) in the last year but has been unable to quit completely. She lives with her brother, who also smokes. Her panic disorder is well controlled by sertraline (Zoloft), and she sees a counselor monthly and a psychiatrist four times a year for medication management. She works full time in a medical office as an office manager and must leave the building to smoke during work hours. Tammy T. drank alcohol heavily for many years, consuming up to 10 beers 3 to 5 times per week

until about 1 year ago. At the advice of her physician, who initiated treatment for panic attacks, she was able to quit using alcohol completely. She was encouraged by her success in stopping drinking, but has been discouraged about continuing to smoke.

In creating a quit plan for Tammy T., it was important for the counselor to determine what supports she has available to help her to quit. Encouraging her brother to quit at the same time was seen as a useful strategy, as it would help to remove smoking from the home environment. Tammy T. was willing to attend a 10-week group treatment intervention to get additional support, education, and assistance with quitting. Some clients may desire individual treatment that is integrated into their ongoing mental health or addiction treatment, or the use of a telephone counseling service might be explored since it is convenient and is becoming more widely available. In discussing medication options, Tammy T. indicated that she was willing to use the nicotine inhaler. Medication education enhanced compliance with the product and increased its effectiveness. She was encouraged to set a quit date and to use nicotine replacement starting at the quit date and in an adequate dose.

Tammy T. was taking sertraline for her panic disorder (a selective serotonin reuptake inhibitor [SSRI]) and therefore another medication option might be to add bupropion SR (not an SSRI) to her current medications for a period of 12 weeks, specifically to address smoking if another quit attempt is needed in the future. If she had not been successful in this attempt, it would have been important to motivate her for future quit attempts and consider increasing the dose and/or duration of the medication or psychosocial treatment. In this case the group treatment, 6 months of NRT inhaler, and eliciting her brother's agreement to refrain from smoking in the house resulted in a successful quit attempt, as well as continued success in her recovery from co-occurring panic disorder and alcohol dependence.

Personality Disorders

These are the disorders seen most commonly by addiction counselors and in quadrant II substance abuse treatment settings.

Personality disorders (PDs) are rigid, inflexible, and maladaptive behavior patterns of sufficient severity to cause internal distress or significant impairment in functioning. PDs are enduring and persistent styles of behavior and thought, rather than rare or unusual events in someone's life. Furthermore, rather than showing these thoughts and behaviors in response to a particular set of circumstances or particular stressors, people with PDs carry with them these destructive patterns of thinking, feeling, and behaving as their way of being and interacting with the world and others.

Those who have PDs tend to have difficulty forming a genuinely positive therapeutic alliance. They tend to frame reality in terms of their own needs and perceptions and not to understand the perspectives of others. Also, most clients with PDs tend to be limited in terms of their ability to receive, accept, or benefit from corrective feedback.

A further difficulty is the strong countertransference clinicians can have in working with these clients, who are adept at "pulling others' chains" in a variety of ways. Specific concerns will, however, vary according to the specific PD and other individual circumstances.

Borderline Personality Disorder

What counselors should know about substance abuse and borderline personality disorders

The essential feature of borderline personality disorder (BPD) is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, along with marked impulsivity,

Diagnostic Features of Personality Disorders

The essential feature of a personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture and is manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control (Criterion A). This enduring pattern is inflexible and pervasive across a broad range of personal and social situations (Criterion B) and leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion C). The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood (Criterion D). The pattern is not better accounted for as a manifestation or consequence of another mental disorder (Criterion E) and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, exposure to a toxin) or a general medical condition (e.g., head trauma) (Criterion F).

General diagnostic criteria for a personality disorder

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
   (1) Cognition (i.e., ways of perceiving and interpreting self, other people, and events)
   (2) Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)
   (3) Interpersonal functioning
   (4) Impulse control

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

that begins by early adulthood and is present in a variety of contexts. Counselors should be aware that

- People with BPD may use drugs in a variety of ways and settings.
- At the beginning of a crisis episode, a client with this disorder might take a drink or a different drug in an attempt to quell the growing sense of tension or loss of control.
- People with BPD may well use the same drugs of choice, route of administration, and frequency as the individuals with whom they are interacting.
- People with BPD often use substances in idiosyncratic and unpredictable patterns.
- Polydrug use is common, which may involve alcohol and other sedative-hypnotics taken for self-medication.
- Individuals with BPD often are skilled in seeking multiple sources of medication that they favor, such as benzodiazepines. Once they are prescribed this medication in a mental health system, they may demand to be continued on the medication to avoid dangerous withdrawal.

Case Study: Counseling a Substance Abuse Treatment Client With Borderline Personality Disorder

Ming L., an Asian female, was 32 years old when she was taken by ambulance to the local hospital's emergency room. Ming L. had taken 80 Tylenol capsules and an unknown amount of Ativan in a suicide attempt. Once medically stable, Ming L. was evaluated by the hospital's social worker to determine her clinical needs.

The social worker asked Ming L. about her family of origin. Ming L. gave a cold stare and said, "I don't talk about that." Asked if she had ever been sexually abused, Ming L. replied, "I don't remember." Ming L. acknowledged previous suicide attempts as well as a history of cutting her arm with a razor blade during stressful episodes. She reported that the cutting "helps the pain."

Ming L. denied having "a problem" with substances but admitted taking "medication" and "drinking socially." A review of Ming L.'s medications revealed the use of Ativan "when I need it." It soon became clear that Ming L. was using a variety of benzodiazepines (anti-anxiety medications) prescribed by several doctors and probably was taking a daily dose indicative of serious dependence. She reported using alcohol "on weekends with friends" but was vague about the amount. Ming L. did acknowledge that before her suicide attempts, she drank alone in her apartment. This last suicide attempt was a response to a breakup with her boyfriend. Ming L.'s insurance company is pushing for immediate discharge and has referred her to the substance abuse treatment counselor to "address the addictions problem."

The counselor reads through notes from an evaluating psychiatrist and reviews the social worker's report of his interview with Ming. She notes that the psychiatrist describes the client as having a severe borderline personality disorder, major recurrent depression, and dependence on both benzodiazepines and alcohol. The counselor advises the insurance company that unless the client's co-occurring disorders also are addressed, there is little that substance abuse treatment counseling will be able to accomplish.

Discussion: While it is important not to refuse treatment for clients with co-occurring disorders, it is also important to know the limits of what a substance abuse treatment counselor or agency can and cannot do realistically. A client with problems this serious is *unlikely* to do well in standard substance abuse treatment unless she also is enrolled in a program qualified to provide treatment to clients with borderline personality disorders, and preferably in a program that offers treatment designed specially for this disorder such as Dialectical Behavior Therapy (Linehan et al. 1999)

Advice to the Counselor: Counseling a Client With Borderline Personality Disorder

- Anticipate that client progress will be slow and uneven.
- Assess the risk of self-harm by asking about what is wrong, why now, whether the client has specific plans for suicide, past attempts, current feelings, and protective factors. (See the discussion of suicidality in appendix D for a risk assessment protocol.)
- Maintain a positive but neutral professional relationship, avoid overinvolvement in the client's perceptions, and monitor the counseling process frequently with supervisors and colleagues.
- Set clear boundaries and expectations regarding limits and requirements in roles and behavior.
- Assist the client in developing skills (e.g., deep breathing, meditation, cognitive restructuring) to manage negative memories and emotions.

Diagnostic Features of Borderline Personality Disorder

The essential feature of borderline personality disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, along with marked impulsivity that begins by early adulthood and is present in a variety of contexts. Individuals with borderline personality disorder make frantic efforts to avoid real or imagined abandonment (Criterion 1). Individuals with borderline personality disorder have a pattern of unstable and intense relationships (Criterion 2). There may be an identity disturbance characterized by markedly and persistently unstable self-image or sense of self (Criterion 3). Individuals with this disorder display impulsivity in at least two areas that are potentially self-damaging (Criterion 4). Individuals with borderline personality disorder display recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior (Criterion 5). Individuals with borderline personality disorder may display affective instability that is due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days) (Criterion 6). Individuals with borderline personality disorder may be troubled by chronic feelings of emptiness (Criterion 7). Individuals with borderline personality disorder frequently express inappropriate, intense anger or have difficulty controlling their anger (Criterion 8). During periods of extreme stress, transient paranoid ideation or dissociative symptoms (e.g., depersonalization) may occur (Criterion 9), but these are generally of insufficient severity or duration to warrant an additional
diagnosis.

Diagnostic criteria for borderline personality disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

(2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

(3) Identity disturbance: markedly and persistently unstable self-image or sense of self.

(4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

(5) Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.

(6) Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

(7) Chronic feelings of emptiness.

(8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).

(9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 706–708, 710).

(although substance abuse treatment programs are increasingly developing their capacities to address specialized mental disorders). She is likely to need complicated detoxification either on an inpatient basis or in a long-term outpatient program that knows how to enclose the kinds of behavioral chaos that borderline clients often experience.

Antisocial Personality Disorder

The two essential features of antisocial personality disorder (APD) are: (1) a pervasive disregard for and violation of the rights of others, and (2) an inability to form meaningful interpersonal relationships.

What counselors should know about substance abuse and APD

The prevalence of antisocial personality disorder and substance abuse is high:

- Much of substance abuse treatment is particularly targeted to those with APD, and substance abuse treatment alone has been particularly effective for these disorders.
- The majority of people with substance use disorders are not sociopathic except as a result of their addiction.
- Most people diagnosed as having APD are not true psychopaths—that is, predators who use manipulation, intimidation, and violence to control others and to satisfy their own needs.
- Many people with APD use substances in a polydrug pattern involving alcohol, marijuana, heroin, cocaine, and methamphetamine.
- People with APD may be excited by the illegal drug culture and may have considerable pride in their ability to thrive in the face of the dangers of that culture. They often are in trouble with the law. Those who are more effective may limit themselves to exploitative or manipulative behaviors that do not make them as vulnerable to criminal sanctions.

Case study: counseling a substance abuse treatment client with antisocial personality disorder

Mark R., a Hispanic/Latino male, was 27 years old when he was arrested for driving while intoxicated. Mark R. presented himself to the court counselor for evaluation of the possible need for substance abuse treatment. Mark R. was on time for the appointment and was slightly irritated at having to wait 20 minutes due to the counselor's schedule. Mark R. was wearing a suit (which had seen better days) and was trying to present himself in a positive light.

Mark R. denied any "problems with alcohol" and reported having "smoked some pot as a kid." He denied any history of suicidal thinking or behavior except for a short period following his arrest. He acknowledged that he did have a "bit of a temper" and that he took pride in the ability to "kick ass and take names" when the situation required. Mark R. denied any childhood trauma and described his mother as a "saint." He described his father as "a real jerk" and refused to give any other information.

In describing the situation that preceded his arrest, Mark R. tended to see himself as the victim, using statements such as "The bartender should not have let me drink so much," "I wasn't driving that bad," and "The cop had it in for me." Mark R. tended to minimize his own responsibility throughout the interview. Mark R. had been married once but only briefly. His only comment about the marriage was, "She talked me into it but I got even with her." Mark R. has no children and lives alone in a studio apartment. Mark R. has attended two meetings of Alcoholics Anonymous (AA) "a couple of years ago before I learned how to control my drinking."

The counselor coordinates closely with the parole officer and arranges several three-way meetings. He carefully reviews details of the court contract and conditions of parole and

Diagnostic Features of Antisocial Personality Disorder

The essential feature of antisocial personality disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. This pattern also has been referred to as psychopathy, sociopathy, or dyssocial personality disorder. Because deceit and manipulation are central features of antisocial personality disorder, it may be especially helpful to integrate information acquired from systematic clinical assessment with information collected from collateral sources. For this diagnosis to be given, the individual must be at least age 18 (Criterion B) and must have had a history of some symptoms of conduct disorder before age 15 (Criterion C).

Diagnostic criteria for antisocial personality disorder

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15, as indicated by three (or more) of the following:

(1) Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest

(2) Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure

(3) Impulsivity or failure to plan ahead

(4) Irritability and aggressiveness, as indicated by repeated physical fights or assaults

(5) Reckless disregard for safety of self or others

(6) Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations

(7) Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least age 18.

C. There is evidence of Conduct Disorder (see APA 2000, p. 98) with onset before age 15.

D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 701, 702, 706).

keeps court records up to date. His work with Mark R. centers on clarifying expectations.

Discussion. It is likely that Mark R. has antisocial personality disorder. Clients with this disorder usually are very hard to engage in individual treatment and are best managed through strict limits with clear consequences. With such an individual, it is important to maximize the interaction with the court, parole officers, or other legal limit setters. This enforces the limits of treatment, and prevents the client from criticizing and blaming one agency representative to the other. People with this disorder are best managed in group treatment that addresses both their substance abuse and antisocial personality disorder. In such groups the approach is to hold the clients responsible for their behavior and its consequences and to confront dishonest and antisocial behavior directly and firmly and stress immediate learning experiences that teach corrective responses.

It is important to differentiate true antisocial personality from substance-related antisocial behavior. This can best be done by looking at how the person relates to others throughout

the course of his or her life. Persons with this disorder will have evidence of antisocial behavior preceding substance use and even during periods of enforced abstinence. It also is important to recognize that people with substance-related antisocial behavior may be more likely to have major depression than other typical personality disorders. However, the type and character of depressions that may be experienced by those with true APD have been less well characterized, and their treatment is unclear.

Mood Disorders and Anxiety Disorders

Because of the striking similarities in understanding and serving clients with mood and anxiety disorders, the sections have been combined to address both disorders. (It should be noted, however, that two disorder types are separated in DSM-IV-TR [APA 2000].)

What Counselors Should Know About Mood and Anxiety Disorders and Substance Abuse

Counselors should be aware of the following:

- Approximately one quarter of United States residents are likely to have some anxiety disorder during their lifetime, and the prevalence is higher among women than men.
- About one half of individuals with a substance use disorder have an affective or anxiety disorder at some time in their lives.
- Among women with a substance use disorder, mood disorders may be prevalent. Women are more likely than men to be clinically depressed and/or to have posttraumatic stress disorder.
- Certain populations are at risk for anxiety and mood disorders (e.g., clients with HIV, clients maintained on methadone, and older adults).
- Older adults may be the group at highest risk for combined mood disorder and substance problems. Episodes of mood disturbance generally increase in frequency with age. Older adults with concurrent mood and substance use disorders tend to have more mood episodes as they get older, even when their substance use is controlled.
- Both substance use and discontinuance may be associated with depressive symptoms.
- Acute manic symptoms may be induced or mimicked by intoxication with stimulants, steroids, hallucinogens, or polydrug combinations.
- Withdrawal from depressants, opioids, and stimulants invariably includes potent anxiety symptoms. During the first months of sobriety, many people with substance use disorders may exhibit symptoms of depression that fade over time and that are related to acute withdrawal.
- Medical problems and medications can produce symptoms of anxiety and mood disorders. About a quarter of individuals who have chronic or serious general medical conditions, such as diabetes or stroke, develop major depressive disorder.
- People with co-occurring mood or anxiety disorders and a substance use disorder typically use a variety of drugs.
- Though there may be some preference for those with depression to favor stimulation and those with anxieties to favor sedation, there appears to be considerable overlap. The use of alcohol, perhaps because of its availability and legality, is ubiquitous.
- It is now believed that substance use is more often a cause of anxiety symptoms rather than an effort to cure these symptoms.
- Since mood and anxiety symptoms may result from substance use disorders, not an underlying mental disorder, careful and continuous assessment is essential.

Diagnostic Features of Mood Disorders

The mood disorders are divided into the depressive disorders ("unipolar depression"), the bipolar disorders, and two disorders based on etiology—mood disorder due to a general medical condition and substance-induced mood disorder. The depressive disorders (i.e., major depressive disorder, dysthymic disorder, and depressive disorder not otherwise specified) are distinguished from the bipolar disorders by the fact that there is no history of ever having had a manic, mixed, or hypomanic episode. The bipolar disorders (i.e., bipolar I disorder, bipolar II disorder, cyclothymic disorder, and bipolar disorder not otherwise specified) involve the presence (or history) of manic episodes, mixed episodes, or hypomanic episodes, usually accompanied by the presence (or history) of major depressive episodes.

The section below describes mood episodes (major depressive episode, manic episode) which are not diagnosed as separate entities, but serve as the building block for the mood disorder diagnoses.

Major Depressive Episode

Episode features

The essential feature of a Major Depressive Episode is a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities. In children and adolescents, the mood may be irritable rather than sad. The individual also must experience at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. To count toward a Major Depressive Episode, a symptom must either be newly present or must have clearly worsened compared with the person's pre-episode status. The symptoms must persist for most of the day, nearly every day, for at least 2 consecutive weeks. The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning. For some individuals with milder episodes, functioning may appear to be normal but requires markedly increased effort.

Criteria for major depressive episode

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

(3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

(4) Insomnia or hypersomnia nearly every day.

(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

(6) Fatigue or loss of energy nearly every day.

(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode (see APA 2000, p. 365).

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one; the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Manic Episode

Episode features

A Manic Episode is defined by a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood. This period of abnormal mood must last at least 1 week (or less if hospitalization is required) (Criterion A). The mood disturbance must be accompanied by at least three additional symptoms from a list that includes inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activities or psychomotor agitation, and excessive involvement in pleasurable activities with a high potential for painful consequences. If the mood is irritable (rather than elevated or expansive), at least four of the above symptoms must be present (Criterion B). The symptoms do not meet criteria for a Mixed Episode, which is characterized by the symptoms of both a Manic Episode and a Major Depressive Episode occurring nearly every day for at least a 1-week period (Criterion C). The disturbance must be sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalization, or it is characterized by the presence of psychotic features (Criterion D). The episode must not be due to the direct physiological effects of a drug of abuse, a medication, other somatic treatments for depression (e.g., electroconvulsive therapy or light therapy), or toxin exposure. The episode also must not be due to the direct physiological effects of a general medical condition (e.g., multiple sclerosis, brain tumor) (Criterion E).

Criteria for manic episodes

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) Inflated self-esteem or grandiosity

(2) Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)

(3) More talkative than usual or pressure to keep talking

(4) Flight of ideas or subjective experience that thoughts are racing

(5) Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

(6) Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

(7) Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The symptoms do not meet criteria for a Mixed Episode (see APA 2000, p. 365).

D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 349, 356, 357, 362).

Case Study: Counseling a Substance Abuse Treatment Client With Bipolar Disorder

John W. is a 30-year-old African-American man with diagnoses of bipolar disorder and alcohol dependence. He has a history of hospitalizations, both psychiatric and substance-related; after the most recent extended psychiatric hospitalization, he was referred for substance abuse treatment. He told the counselor he used alcohol to facilitate social contact, as well as deal with boredom, since he had not been able to work for some time. The counselor learned that during his early twenties, John W. achieved full-time employment and established an intimate relationship with a non-drinking woman; however, his drinking led to the loss of both.

Advice to the Counselor: Counseling a Client With a Mood or Anxiety Disorder

- Differentiate among the following: mood and anxiety disorders; commonplace expressions of anxiety and depression; and anxiety and depression associated with more serious mental illness, medical conditions and medication side effects, and substance-induced changes.
- Although true for most counseling situations, it is especially important to maintain a calm demeanor and a reassuring presence with these clients.
- Start low, go slow (that is, start "low" with general and nonprovocative topics and proceed gradually as clients become more comfortable talking about issues).
- Monitor symptoms and respond immediately to any intensification of symptoms.
- Understand the special sensitivities of phobic clients to social situations.
- Gradually introduce and teach skills for participation in mutual self-help groups.
- Combine addiction counseling with medication and mental health treatment.

Diagnostic Features of Generalized Anxiety Disorder

The essential feature of generalized anxiety disorder is excessive anxiety and worry (apprehensive expectation), occurring more days than not for a period of at least 6 months, about a number of events or activities (Criterion A). The individual finds it difficult to control the worry (Criterion B). The anxiety and worry are accompanied by at least three additional symptoms from a list that includes restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension, and disturbed sleep (only one additional symptom is required in children) (Criterion C). The focus of the anxiety and worry is not confined to features of another Axis I disorder such as having a panic attack (as in panic disorder), being embarrassed in public (as in social phobia), being contaminated (as in obsessive-compulsive disorder), being away from home or close relatives (as in separation anxiety disorder), losing weight (as in anorexia nervosa), having multiple physical complaints (as in somatization disorder), or having a serious illness (as in hypochondriasis), and the anxiety and worry do not occur exclusively during posttraumatic stress disorder (Criterion D). Although individuals with generalized anxiety disorder may not always identify the worries as "excessive," they report subjective distress due to constant worry, have difficulty controlling the worry, or experience related impairment in social, occupational, or other important areas of functioning (Criterion E). The disturbance is not due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or toxin exposure) or a general medical condition and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder (Criterion F).

Diagnostic criteria for generalized anxiety disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The person finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note: Only one item is required in children.

   (1) Restlessness or feeling keyed up or on edge

   (2) Being easily fatigued

   (3) Difficulty concentrating or mind going blank

   (4) Irritability

   (5) Muscle tension

   (6) Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), losing weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 472, 473, 476).

During one of his alcohol treatments, he developed florid manic symptoms, believing himself to be a prophet with the power to heal others. He was transferred to a closed psychiatric unit, where he eventually stabilized on a combination of antipsychotic medications (risperdal) and lithium. Since that time he has had two episodes of worsening psychiatric symptoms leading to hospitalization; each of these began with drinking, which then led to stopping his medications, then florid mania and psychiatric commitment. However, when he is taking his medications and is sober, John W. has a normal mental status and relates normally to others. Recently, following a series of stressors, John W. left his girlfriend, quit his job, and began using alcohol heavily again. He rapidly relapsed to active mania, did not adhere to a medication regimen, and was rehospitalized.

At the point John W. is introduced to the substance abuse treatment counselor, his mental status is fairly normal; however, he warns the counselor that after manic episodes he tends to get somewhat depressed, even when he is taking medications. In taking an addiction history, the counselor finds that though John W. has had several periods of a year or two during which he was abstinent from both alcohol and drugs of abuse, he has never become involved with either ongoing alcohol treatment or AA meetings. John W. replies to his questions about this with, "Well, if I just take my meds and don't drink, I'm fine. So why do I need those meetings?"

Using a motivational approach, the counselor helps John W. analyze what has worked best for him in dealing with both addiction and mental problems, as well as what has not worked well for him. John W. is tired of the merry-go-round of his life; he certainly acknowledges that he has a major mental disorder, but thinks his drinking is only secondary to the mania. When the counselor gently points out that each of the episodes in which his mental disorder led to hospitalization began with an alcohol relapse, John W. begins to listen. In a group for clients with co-occurring disorders at the substance abuse treatment agency, John W. is introduced to another recovering manic patient with alcohol problems who tells his personal story and how he discovered that both of his problems need primary attention. This client agrees to be John W.'s temporary sponsor. The counselor calls John W.'s case manager, who works at the mental health center where John W. gets his medication, and describes the treatment plan. She then makes arrangements for a monthly meeting involving the counselor, case manager, and John W.

Discussion: The substance abuse treatment counselor has taken the wise step of taking a detailed history and attempting to establish the linkage between co-occurring disorders. The counselor tries to appreciate the client's own understanding of the relationship between the two. She uses motivational approaches to analyze what John W. did in his previous partially successful attempts to deal with the problem and helps develop connections with other recovering clients to increase motivation. Lastly, she is working closely with the case manager to ensure a coordinated approach to management of each disorder.

Schizophrenia and Other Psychotic Disorders

What Counselors Should Know About Substance Abuse and Psychotic Disorders

There are different types of psychotic disorders or disorders that have psychotic features. Schizophrenia, a relatively common type of psychotic disorder, is featured in this section.

Counselors should be aware of the following:

- There is evidence of increasing use of alcohol and drugs by persons with schizophrenia (from 14 to 22 percent in the 1960s and 1970s

Descriptive Features

The term "psychotic" historically has received a number of different definitions, none of which has achieved universal acceptance. The narrowest definition of psychotic is restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature. A slightly less restrictive definition also would include prominent hallucinations that the individual realizes are hallucinatory experiences. Broader still is a definition that also includes other positive symptoms of schizophrenia (i.e., disorganized speech, or grossly disorganized or catatonic behavior). Unlike these definitions based on symptoms, the definition used in earlier classifications (e.g., DSM-II and ICD-9) probably was far too inclusive and focused on the severity of functional impairment. In that context, a mental disorder was termed "psychotic" if it resulted in "impairment that grossly interferes with the capacity to meet ordinary demands of life." The term also has previously been defined as a "loss of ego boundaries" or a "gross impairment in reality testing."

Schizophrenia is a disorder that lasts for at least 6 months and includes at least 1 month of active-phase symptoms (i.e., two or more) of the following: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms. Definitions for the schizophrenia subtypes (paranoid, disorganized, catatonic, undifferentiated, and residual) are also included in this section.

Diagnostic criteria for schizophrenia

A. *Characteristic symptoms:* Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

(1) Delusions

(2) Hallucinations

(3) Disorganized speech (e.g., frequent derailment or incoherence)

(4) Grossly disorganized or catatonic behavior

(5) Negative symptoms, i.e., affective flattening, alogia, or avolition

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. *Social/occupational dysfunction:* For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. *Duration:* Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. *Schizoaffective and Mood Disorder exclusion:* Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. *Substance/general medical condition exclusion:* The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. *Relationship to a Pervasive Developmental Disorder:* If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations also are present for at least a month (or less if successfully treated).

Classification of longitudinal course (can be applied only after at least 1 year has elapsed since the initial onset of active-phase symptoms):

- Episodic With Interepisode Residual Symptoms (episodes are defined by the reemergence of prominent psychotic symptoms); *also specify if:* With Prominent Negative Symptoms
- Episodic With No Interepisode Residual Symptoms
- Continuous (prominent psychotic symptoms are present throughout the period of observation); *also specify if:* With Prominent Negative Symptoms
- Single Episode In Partial Remission; *also specify if:* With Prominent Negative Symptoms
- Single Episode In Full Remission
- Other or Unspecified Pattern

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 298–302, 312–313).

to 25 to 50 percent in the 1990s) (Fowler et al. 1998).

- There is no clear pattern of drug choice among clients with schizophrenia. Instead, it is likely that whatever substances happen to be available or in vogue will be the substances used most typically.
- What looks like resistance or denial may in reality be a manifestation of negative symptoms of schizophrenia.
- An accurate understanding of the role of substance use disorders in the client's psychosis requires a multiple-contact, longitudinal assessment.
- Clients with a co-occurring mental disorder involving psychosis have a higher risk for self-destructive and violent behaviors.
- Clients with a co-occurring mental disorder involving psychosis are particularly vulnerable to homelessness, housing instability, victimization, poor nutrition, and inadequate financial resources.
- Both psychotic and substance use disorders tend to be chronic disorders with multiple relapses and remissions, supporting the need for long-term treatment. For clients with co-occurring disorders involving psychosis, a long-term approach is imperative.

It is important that the program philosophy be based on a multidisciplinary team approach. Ideally, team members should be cross-trained, and there should be representatives from the medical, mental health, and addiction systems. The overall goals of long-term management should include (1) providing comprehensive and integrated services for both the mental and substance use disorders, and (2) doing so with a long-term focus that addresses biopsychosocial issues in accord with a treatment plan with goals specific to a client's situation.

Case Study: Counseling a Substance Abuse Treatment Client With Schizophrenia

Adolfo M. is a 40-year-old Hispanic male who began using marijuana and alcohol when he was 15. He was diagnosed as having schizophrenia when he was 18 and began using cocaine at 19. Sometimes he lives with his sister or with temporary girlfriends; sometimes he lives on the street. He has never had a sustained relationship, and he has never held a steady job. He has few close friends. He wears long hair, tattoos, torn jeans, and t-shirts with skulls or similar images. Although he has had periods of abstinence and freedom

Advice to the Counselor: Counseling a Client With a Psychotic Disorder

- Obtain a working knowledge of the signs and symptoms of the disorder.
- Work closely with a psychiatrist or mental health professional.
- Expect crises associated with the mental disorder and have available resources (i.e., crisis intervention, psychiatric consultation) to facilitate stabilization.
- Assist the client to obtain entitlements and other social services.
- Make available psychoeducation on the psychiatric condition and use of medication.
- Monitor medication and promote medication adherence.
- Provide frequent breaks and shorter sessions or meetings.
- Employ structure and support.
- Present material in simple, concrete terms with examples and use multimedia methods.
- Encourage participation in social clubs with recreational activities.
- Teach the client skills for detecting early signs of relapse for both mental illness and substance abuse.
- Involve family in psychoeducational groups that specifically focus on education about substance use disorders and psychosis; establish support groups of families and significant others.
- Monitor clients for signs of substance abuse relapse and a return of psychotic symptoms.

from hallucinations and major delusions, he generally has unusual views of the world that emerge quickly in conversation.

Adolfo M. has been referred to the substance abuse treatment counselor, who was hired by the mental health center to do most of the group and individual drug/alcohol work with clients. The first step the counselor takes is to meet with Adolfo M. and his case manager together. This provides a clinical linkage as well as a method to get the best history. The clinical history reveals that Adolfo M. does best when he is sober and on medications, but there are times when he will be sober and not adhere to a medical regimen, or when he is both taking medications and drinking (though these periods are becoming shorter in duration and less frequent). His case manager often is able to redirect him toward renewed sobriety and adherence to medications, but Adolfo M. and the case manager agree that the cycle of relapse and the work of pulling things back together is wearing them both out. After the meeting, the case manager, counselor, and Adolfo M. agree to meet weekly for a while to see what they can do together to increase the stable periods and decrease the relapse periods. After a month of these planning meetings, the following plan emerges. Adolfo M. will attend substance abuse treatment groups for persons with COD (run by the counselor three times a week at the clinic), see the team psychiatrist, and attend local dual disorder AA meetings. The substance abuse treatment group he will be joining is one that addresses not only addiction issues, but also issues with treatment follow through, life problems, ways of dealing with stress, and the need for social support for clients trying to get sober. When and if relapse happens, Adolfo M. will be accepted back without prejudice and supported in recovery and treatment of both his substance abuse and mental disorders; however, part of the plan is to analyze relapses with the group. His goal is to have as many sober days as possible with as many days adhering to a medical regimen as possible. Another aspect of the group is that monthly, 90-day, 6-month, and yearly sobriety birthdays are celebrated with both AA coins and refreshments. Part of the employment program at the center is that clients need to have

a minimum of 3 months of sobriety before they will be placed in a supported work situation, so this becomes an incentive for sobriety as well.

Discussion: Substance abuse treatment counselors working within mental health centers should be aware of the need not only to work with the client, but also to form solid working relationships with case managers, the psychiatrist, and other personnel. Seeing clients with case managers and other team members is a good way to establish important linkages and a united view of the treatment plan. In Adolfo M.'s case, the counselor used his ties with the case manager to good effect and also is using relapse prevention and contingency management strategies appropriately (see chapter 5 for a discussion of these techniques).

Attention Deficit/ Hyperactivity Disorder (AD/HD)

What Counselors Should Know About Substance Abuse and AD/HD

The essential feature of AD/HD is a persistent pattern of inattention and/or hyperactivity-impulsivity that is displayed more frequently and more serious than is observed typically in individuals at a comparable level of development (APA 2000). Counselors should be aware of the following:

- Studies of the adult substance abuse treatment population have found AD/HD in 5 to 25 percent of persons (Clure et al. 1999; King et al. 1999; Levin et al. 1998; Schubiner et al. 2000; Weiss et al. 1998).
- Approximately one third of adults with AD/HD have histories of alcohol abuse or dependence, and approximately one in five has other drug abuse or dependence histories.
- Adults with AD/HD have been found primarily to use alcohol, with marijuana being the second most common drug of abuse.
- The history of a typical AD/HD substance abuse treatment client may show early school problems before substance abuse began.
- The client may use self-medication for AD/HD as an excuse for drug use.
- The most common attention problems in substance abuse treatment populations are secondary to short-term toxic effects of substances, and these should be substantially better with each month of sobriety.
- The presence of AD/HD complicates the treatment of substance abuse, since clients with these COD may have more difficulty engaging in treatment and learning abstinence skills, be at greater risk for relapse, and have poorer substance use outcomes.

Case Study: Counseling a Substance Abuse Treatment Client With AD/HD

John R., a 29-year-old African-American man, is seeking treatment. He has been in several treatment programs but always dropped out after the first 4 weeks. He tells the counselor he dropped out because he would get cravings and that he just could not concentrate in the treatment sessions. He mentions the difficulty of staying focused during 3-hour intensive group sessions. A contributing factor in his quitting treatment was that group leaders always seemed to scold him for talking to others. The clinician evaluating him asks how John R. did in school and finds that he had difficulty in his classwork years before he started using alcohol and drugs; he was restless and easily distracted. He had been evaluated for a learning disability and AD/HD and took Ritalin for about 2 years (in the 5th and 6th grades), then stopped. He was not sure why, but he did terribly in school, eventually dropping out about the time he started using drugs regularly in the 8th grade.

Diagnostic Features of AD/HD

The essential feature of attention-deficit/hyperactivity disorder is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development (see Criterion A below). Some hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before age 7, although many individuals are diagnosed after the symptoms have been present for a number of years, especially in the case of individuals with the predominantly inattentive type (Criterion B). Some impairment from the symptoms must be present in at least two settings (e.g., at home and at school or work) (Criterion C). There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning (Criterion D). The disturbance does not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder and is not better accounted for by another mental disorder (e.g., a mood disorder, anxiety disorder, dissociative disorder, or personality disorder) (Criterion E).

Diagnostic criteria for AD/HD

A. Either (1) or (2):

(1) Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention

(a) Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
(b) Often has difficulty sustaining attention in tasks or play activities
(c) Often does not seem to listen when spoken to directly
(d) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
(e) Often has difficulty organizing tasks and activities
(f) Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
(g) Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
(h) Is often easily distracted by extraneous stimuli
(i) Is often forgetful in daily activities

(2) Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

(a) Often fidgets with hands or feet or squirms in seat
(b) Often leaves seat in classroom or in other situations in which remaining seated is expected
(c) Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
(d) Often has difficulty playing or engaging in leisure activities quietly; is often "on the go" or often acts as if "driven by a motor"
(e) Often talks excessively

Impulsivity

(a) Often blurts out answers before questions have been completed
(b) Often has difficulty awaiting turn
(c) Often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school or work and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Code based on type:

- Attention-Deficit/Hyperactivity Disorder, Combined Type: if both Criteria A1 and A2 are met for the past 6 months
- Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type: if Criterion A2 is met but Criterion A1 is not met for the past 6 months

Coding note: For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, "In Partial Remission" should be specified.

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 85–87, 92–93).

Discussion: The substance abuse treatment clinician reviewed John R.'s learning history and asked about anxiety or depressive disorders. The clinician referred him to the team's psychiatrist, who uncovered more history about the AD/HD and also contacted John R.'s mother. When the clinician reviewed a list of features commonly associated with AD/HD, she agreed that John R. had many of these features and that she had noticed them in childhood. John R. was started on bupropion medication and moved to a less intensive level of care (1 hour of group therapy, 30 minutes of individual counseling, and AA meetings three times weekly). Over the next 2 months, John R.'s ability to tolerate a more intensive treatment improved. Although he was still somewhat intrusive to others, he was able to benefit from more intensive group treatment.

Advice to the Counselor: Counseling a Client Who Has AD/HD

- Clarify for the client repeatedly what elements of a question he or she has responded to and what remains to be addressed.
- Eliminate distracting stimuli from the environment.
- Use visual aids to convey information.
- Reduce the time of meetings and length of verbal exchanges.
- Encourage the client to use tools (e.g., activity journals, written schedules, and "to do" lists) to organize important events and information.
- Refer the client for evaluation of the need for medication.
- Focus on enhancing the client's knowledge about AD/HD and substance abuse. Examine with the client any false beliefs about the history of both AD/HD and substance abuse difficulties.

Posttraumatic Stress Disorder (PTSD)

What Counselors Should Know About Substance Abuse and PTSD

PTSD is classified in DSM-IV-TR as one type of anxiety disorder. It is treated separately in this TIP because of its special relationship to substance abuse and the growing literature on PTSD and its treatment.

The essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (APA 2000, p. 463). Counselors should be aware that

- The lifetime prevalence of PTSD among adults in the United States is about 8 percent.
- Among high-risk individuals (those who have survived rape, military combat, and captivity or ethnically or politically motivated internment and genocide), the proportion of those with PTSD ranges from one-third to one-half.
- Among clients in substance abuse treatment, PTSD is two to three times more common in women than in men.
- The rate of PTSD among people with substance use disorders is 12 to 34 percent; for women with substance use disorders, it is 30 to 59 percent (Brown and Wolfe 1994).
- Women with substance abuse problems report a lifetime history of physical and/or sexual abuse ranging from 55 to 99 percent (Najavits et al. 1997).
- Most women with this co-occurring disorder experienced childhood physical and/or sexual abuse; men with both disorders typically experienced crime victimization or war trauma.
- Clinicians are advised not to overlook the possibility of PTSD in men.
- People with PTSD and substance abuse are more likely to experience further trauma than people with substance abuse alone.
- Because repeated trauma is common in domestic violence, child abuse, and some substance-using lifestyles (e.g., the drug trade), helping the client protect against future trauma may be an important part of work in treatment.
- People with PTSD tend to abuse the most serious substances (cocaine and opioids); however, abuse of prescription medications, marijuana, and alcohol also are common.
- From the client's perspective, PTSD symptoms are a common trigger for substance use.
- While under the influence of substances, a person may be more vulnerable to trauma—for example, a woman drinking at a bar may go home with a stranger and be assaulted.
- As a counselor, it is important to recognize, and help clients understand, that becoming abstinent from substances does not resolve PTSD; both disorders must be addressed in treatment.

Case Study: Counseling a Substance Abuse Treatment Client Who Binge Drinks and Has PTSD

Caitlin P. is a 17-year-old American-Indian female who was admitted to an inpatient substance abuse treatment program after she tried to kill herself during a drunken episode. She has been binge drinking since age 12 and also has tried a wide variety of pills without caring what she is taking. She has a history of depression and burning her arms with cigarettes. She

Diagnostic Features of PTSD

The essential feature of posttraumatic stress disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (Criterion A2). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent reexperiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D). The full symptom picture must be present for more than 1 month (Criterion E), and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F).

Diagnostic criteria for PTSD

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) The person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

(3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.

(4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) Efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) Inability to recall an important aspect of the trauma

(4) Markedly diminished interest or participation in significant activities

(5) Feeling of detachment or estrangement from others

(6) Restricted range of affect (e.g., unable to have loving feelings)

(7) Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) Difficulty falling or staying asleep

(2) Irritability or outbursts of anger

(3) Difficulty concentrating

(4) Hypervigilance

(5) Exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: duration of symptoms is less than 3 months
Chronic: duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: onset of symptoms is at least 6 months after the stressor

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 463, 467, 468).

was date-raped at age 15 and did not tell anyone except a close friend. She was afraid to tell her family for fear that they would think less of her for not preventing or fighting off the attack.

In treatment, she worked with staff to try to gain control over her repeated self-destructive behavior. Together they worked on developing compassion for herself, created a safety plan to encourage her to reach out for help when in distress, and began a log to help her identify her PTSD symptoms so that she could recognize them more clearly. When she had the urge to drink, drug, or burn herself, she was guided to try to "bring down" the feelings through grounding, rethink the situation, and reassure herself that she could get through it. She began to see that her substance use had been a way to numb the pain.

Discussion: Counselors can be very important in helping clients gain control over PTSD symptoms and self-destructive behavior associated with trauma. Providing specific coping strategies and a lot of encouragement typically are well received by PTSD/substance abuse treatment clients, who may want to learn how to be able to overcome the emotional roller coaster of the disorders. Notice that in such early-phase treatment, detailed exploration of the past is not generally advised.

Eating Disorders

What Counselors Should Know About Substance Abuse and Eating Disorders

The essential features of anorexia nervosa are that the individual refuses to maintain a minimal normal body weight, is intensely afraid of gaining weight, and exhibits a significant disturbance in the perception of the shape or size of his or her body. The essential features of bulimia nervosa are binge eating and inappropriate compensatory methods to prevent weight gain. In dealing with persons who have either disorder, counselors should be aware of the following:

- The prevalence of bulimia nervosa is elevated in women presenting for substance abuse treatment.

- Studies of individuals in inpatient substance abuse treatment centers (as assessed via questionnaire) suggest that approximately 15 percent of women and 1 percent of men had a DSM-III-R eating disorder (primarily bulimia nervosa) in their lifetime (Hudson et al. 1992).
- Substance abuse is more common in bulimia nervosa than in anorexia nervosa.
- Individuals with eating disorders are significantly more likely to use stimulants and significantly less likely to use opioids than other individuals undergoing substance abuse treatment who do not have a co-occurring eating disorder.
- Many individuals alternate between substance abuse and eating disorders.
- Alcohol and drugs such as marijuana can disinhibit appetite (i.e., remove normal restraints on eating) and increase the risk of binge eating as well as relapse in individuals with bulimia nervosa.
- Individuals with eating disorders experience craving, tolerance, and withdrawal from drugs associated with purging, such as laxatives and diuretics.
- Women with eating disorders often abuse pharmacological agents ingested for the purpose of weight loss, appetite suppression, and purging. Among these drugs are prescription and over-the-counter diet pills, laxatives, diuretics, and emetics. Nicotine and caffeine also must be considered when assessing substance abuse in women with eating disorders.
- Several studies have suggested that the presence of co-occurring substance-related disorders does not affect treatment outcome adversely for bulimia nervosa.
- Further studies are required to assess how the presence of an eating disorder affects substance abuse treatment and how best to integrate treatment for those with both conditions. This condition is quite serious and can be fatal. Treat it accordingly.
- Individuals with eating disorders experience urges (or cravings) for binge foods similar to urges for drugs.

Advice to the Counselor: Counseling a Client With PTSD

- Anticipate proceeding slowly with a client who is diagnosed with or has symptoms of PTSD. Consider the effect of a trauma history on the client's current emotional state, such as an increased level of fear or irritability.
- Develop a plan for increased safety where warranted.
- Establish both perceived and real trust.
- Respond more to the client's behavior than her words.
- Limit questioning about details of trauma.
- Recognize that trauma injures an individual's capacity for attachment. The establishment of a trusting treatment relationship will be a goal of treatment, not a starting point.
- Recognize the importance of one's own trauma history and countertransference.
- Help the client learn to de-escalate intense emotions.
- Help the client to link PTSD and substance abuse.
- Provide psychoeducation about PTSD and substance abuse.
- Teach coping skills to control PTSD symptoms.
- Recognize that PTSD/substance abuse treatment clients may have a more difficult time in treatment and that treatment for PTSD may be long term, especially for those who have a history of serious trauma.
- Help the client access long-term PTSD treatment and refer to trauma experts for trauma exploratory work.

Case Study: The History of a Substance Abuse Treatment Client With an Eating Disorder

Mandy H. was 28 years old, Caucasian, 5'10" and 106 pounds when she first presented to the eating disorders service. She reported 4 years of untreated bingeing and self-induced vomiting. In the months prior to presentation she had quit her job and was spending days locked in her mother's house doing nothing but bingeing and vomiting, up to 20 times per day. She had large ulcers and infected scrapes in her mouth as a result of inserting objects down her throat to induce vomiting. She denied the use of alcohol, drugs, or other substances to induce purging. Her mother and boyfriend had substantial difficulties with alcohol abuse. She was admitted to the hospital and had great difficulties complying with unit rules. Vomitus was found hidden in her room and other clients' rooms; she was caught smoking numerous times in the non-smoking ward. She stole objects from staff and other clients to insert down her throat to induce vomiting.

Although she was able to gain 10 pounds during her hospital stay, very little progress was made with the cognitive features of her bulimia nervosa. During subsequent outpatient followup, she managed to normalize her eating and reach a high weight of 125; however, she soon dropped out of treatment. One year later she presented again to the emergency room, this time weighing 103 pounds and intoxicated. Although she had managed to stop bingeing and purging, she had been restricting her food intake severely to about 250 calories per day from food (not including the amount of calories she took in the form of alcohol). She had been drinking excessively and smoking marijuana with her boyfriend. Her therapist searched for a treatment program for uninsured individuals that specialized in substance abuse and that could address the added complexity of co-occurring disordered eating.

Mandy H.'s therapist found a residential substance abuse treatment program that considered itself to have a balanced substance abuse and mental health approach, with a specialized dual disorders program for women who met American Society of Addiction Medicine Dual Diagnosis Enhanced criteria. The program offered group and individual counseling using the Dialectical Behavior Therapy (DBT) method. The therapist's use of DBT included psychosocial groups for skills training, individual psychotherapy to strengthen individual skills and increase motivation, and telephone contact with the therapist when needed to foster generalization of skills to everyday life outside the treatment context (Linehan et al. 1999). The woman in charge of the DBT component of the treatment services was delighted to form a collaborative relationship with Mandy H.'s eating disorder therapist. Once during Mandy H.'s treatment (with Mandy H.'s permission, and the permission of the DBT group), Mandy H.'s eating disorders therapist sat in on the substance abuse treatment agency's team treatment meeting and observed the DBT group counseling session that day. Mandy H.'s eating disorders therapist also was able to help Mandy H. get Medicaid coverage for her residential substance abuse treatment under the State's program for clients with severe and persistent mental illness by demonstrating the persistence of Mandy H.'s COD based on her hospital stay the prior year and her current severe, complex, co-occurring conditions.

Mandy H. did very well during her residential stay, and she responded positively to AA. From the extensive intake information and collateral reports from relatives, Mandy H.'s substance abuse treatment counselor learned that Mandy H.'s family tree was filled with people who had developed alcoholism, including a grandmother who might well have developed an addiction to sleeping pills and/or tranquilizers in the 1960s. Since the substance abuse treatment counselor also had a family tree with many people with chemical dependencies, the counselor could understand how Mandy H. could identify closely

Anorexia Nervosa

Diagnostic features

The essential features of anorexia nervosa are that the individual refuses to maintain a minimally normal body weight, is intensely afraid of gaining weight, and exhibits a significant disturbance in the perception of the shape or size of his or her body (see below Criterion A). In addition, postmenarcheal females with this disorder are amenorrheic. (The term anorexia is a misnomer because loss of appetite is rare.) Individuals with this disorder intensely fear gaining weight or becoming fat (Criterion B). This intense fear of becoming fat is usually not alleviated by the weight loss. In fact, concern about weight gain often increases even as actual weight continues to decrease. The experience and significance of body weight and shape are distorted in these individuals (Criterion C). In postmenarcheal females, amenorrhea (due to abnormally low levels of estrogen secretion that are due in turn to diminished pituitary secretion of follicle-stimulating hormone and luteinizing hormone) is an indicator of physiological dysfunction in Anorexia Nervosa (Criterion D).

Diagnostic criteria for anorexia nervosa

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85 percent of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85 percent of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Specify type:

Restricting Type: During the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Binge-Eating/Purging Type: During the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Bulimia Nervosa

Diagnostic features

The essential features of bulimia nervosa are binge eating and inappropriate compensatory methods to prevent weight gain. In addition, the self-evaluation of individuals with bulimia nervosa is excessively influenced by body shape and weight. To qualify for the diagnosis, the binge eating and the inappropriate compensatory behaviors must occur, on average, at least twice a week for 3 months (Criterion C). An episode of binge eating is also accompanied by a sense of lack of control (Criterion A2). Another essential feature of bulimia nervosa is the recurrent use of inappropriate compensatory behaviors to prevent weight gain (Criterion B).

Individuals with bulimia nervosa place an excessive emphasis on body shape and weight in their self-evaluation, and these factors are typically the most important ones in determining self-esteem (Criterion D). However, a diagnosis of bulimia nervosa should not be given when the disturbance occurs only during episodes of anorexia nervosa (Criterion E).

Diagnostic criteria for bulimia nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

(1) Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances

(2) A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specify type:

Purging Type: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Nonpurging Type: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 583, 584, 589-591, 594)

with what people had to say at AA meetings, even without a lengthy history of heavy alcohol use. Mandy H. found that the strong attachment to alcohol expressed by others was what she was already experiencing, including her finding that until she knew where her drinking would be able to occur during the day, not much else could keep her attention. Mandy H. felt she had a similar addictive response to marijuana.

The substance abuse treatment program directed Mandy H. to AA meetings that other people with co-occurring disorders attended. Mandy H. was able to find a sponsor who herself had a co-occurring depressive disorder, one that had been handled successfully with maintenance antidepressant medication.

Mandy H. did well throughout treatment, and by the time she was in her sixth month of outpatient continuing care, she had gained 12 pounds. At that point Mandy H. began to struggle with urges to binge and thoughts of inducing vomiting. Her eating disorders therapist contacted her continuing care substance abuse treatment counselor (the same woman who handled the DBT parts of the residential program). After discussing Mandy H.'s situation and improvement, the substance abuse treatment counselor agreed with the eating disorders counselor's recommendation that Mandy H. see the substance abuse treatment program's psychiatric consultant for possible use of an antidepressant to help with the emerging bingeing and purging concerns. The psychiatrist consultant saw Mandy H. and then called another psychiatrist who Mandy

H.'s eating disorder therapist used regularly. After a brief discussion with the other psychiatrist, the psychiatrist treating Mandy H. prescribed 20 mg of fluoxetine and discussed with Mandy H. what to expect.

It was helpful to Mandy H. to see the medication as part of how she could be empowered to take care of herself and to take care of her recovery. Mandy H. fully embraced the idea of being powerless over her use of alcohol, marijuana, or euphoria-producing drugs, as she saw that as a great help to her both in terms of averting thoughts about her weight and in terms of thoughts about whether just to smoke marijuana or have just a little wine, Mandy H.'s sponsor was able to share with Mandy H. her "research" with "just a little wine."

Mandy H.'s COD were a diagnostic challenge for the treatment team. Her DBT counselor thought she had an additional borderline personality disorder, but the treatment team thought she should be re-evaluated after 3 to 6 months of both sobriety and healthy eating, especially as Mandy H. had had regular but slow progress the prior year until she dropped out of treatment and began to drink and smoke marijuana.

Indeed, with a year of sobriety and strong feelings of a new lease on life through 12-Step living, Mandy H. was eligible for State vocational rehabilitation assistance and entered college. Mandy H. still went to AA once a month, or more if she or her sponsor thought it wise, and she stayed in touch about once a week with her sponsor. Mandy H. attended monthly continuing care groups, and she saw her eating disorders therapist every other month. Mandy H. also continued to see the psychiatrist for medication management, and she had unproblematic increases in her medication to a full therapeutic dose appropriate for her. On rare occasions Mandy H. had thoughts about foregoing her medication, but with her counselor's help she realized that such thoughts were akin to "stinking thinking" and often connected to some other reactions or concerns going on in other areas of her life.

Discussion: How would Mandy H. have fared without comprehensive and integrated treatment? Mandy H.'s case history highlights the importance of assisting clients in therapeutic and extra-therapeutic ways, such as assisting with Medicaid and vocational rehabilitation eligibilities. Also, the importance of Mandy H.'s particular background and the reactions it engendered to AA is taken into consideration, while nonacute concerns about diagnostic concerns were put in abeyance.

Advice to the Counselor: Counseling a Client With an Eating Disorder

- Where possible, work closely with a professional who specializes in eating disorders.
- Document through a comprehensive assessment the individual's full repertoire of weight loss behaviors since people with eating disorders will often go to dangerous extremes to lose weight.
- Conduct a behavioral analysis of the foods and substances of choice; high-risk times and situations for engaging in disordered eating and substance abuse behaviors; and the nature, pattern, and interrelationship of disordered eating and substance use.
- Develop a treatment plan for both the eating and substance use disorder.
- Employ psychoeducation and cognitive–behavioral techniques for bulimia nervosa.
- Use adjunctive strategies such as nutritional consultation, the setting of a weight range goal, and observations at and between meal times for disordered eating behaviors.
- Incorporate relapse prevention strategies to plan for a long course of treatment and several treatment episodes.

Last, the united front between the substance abuse counselor and persons involved in treatment of her mental disorder regarding medications and other aspects of treatment was helpful to Mandy H. maintaining her dual recovery.

Pathological Gambling

What Counselors Should Know About Substance Abuse and Pathological Gambling

The essential feature of pathological gambling is persistent and recurrent maladaptive gambling behavior that disrupts personal, family, or vocational pursuits. Counselors should be aware that

- Prevalence data for gambling regularly makes distinctions among "pathological" gamblers (the most severe category) and levels of "problem" gambling (less severe to moderate levels of difficulty). Recent general estimates (Gerstein et al. 1999; Shaffer et al. 1997) indicate about 1 percent of the U.S. general population could be classified as having pathological gambling, according to the diagnostic criteria below. Cogent considerations regarding prevalence are given in the DSM-IV-TR regarding variations due to the availability of gambling and seemingly greater rates in certain locations (e.g., Puerto Rico, Australia), which have been reported to be as high as 7 percent. Higher prevalence rates also have been reported in adolescents and college students, ranging from 2.8 to 8 percent (APA 2000). The general past-year estimate for pathological and problem gambling combined is roughly 3 percent. This can be compared to past year estimates of alcohol abuse/dependence of 9.7 percent and drug abuse/dependence of 3.6 percent.
- The rate of co-occurrence of pathological gambling among people with substance use disorders has been reported as ranging from 9 to 30 percent and the rate of substance abuse among individuals with pathological gambling has been estimated at 25 to 63 percent.
- Among pathological gamblers, alcohol has been found to be the most common substance of abuse. At minimum, the rate of problem gambling among people with substance use disorders is four to five times that found in the general population.
- It is important to recognize that even though pathological gambling often is viewed as an addictive disorder, clinicians cannot assume that their knowledge or experience in substance abuse treatment qualifies them automatically to treat people with a pathological gambling problem.
- With clients with substance use disorders who are pathological gamblers, it often is essential to identify specific triggers for each addiction. It is also helpful to identify ways in which use of addictive substances or addictive activities such as gambling act as mutual triggers.

In individuals with COD, it is particularly important to evaluate patterns of substance use and gambling. The following bullets provide several examples:

- Cocaine use and gambling may coexist as part of a broader antisocial lifestyle.
- Someone who is addicted to cocaine may see gambling as a way of getting money to support drug use.
- A pathological gambler may use cocaine to maintain energy levels and focus during gambling and sell drugs to obtain gambling money.
- Cocaine may artificially inflate a gambler's sense of certainty of winning and gambling skill, contributing to taking greater gambling risks.
- The gambler may use drugs or alcohol as a way of celebrating a win or relieving depression.
- One of the more common patterns that has been seen clinically is that of a sequential addiction. A frequent pattern is that someone who has had a history of alcohol depen-

Diagnostic Features of Pathological Gambling

The essential feature of pathological gambling is persistent and recurrent maladaptive gambling behavior (Criterion A) that disrupts personal, family, or vocational pursuits. The diagnosis is not made if the gambling behavior is better accounted for by a manic episode (Criterion B).

Diagnostic criteria

A. Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:

(1) Is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)

(2) Needs to gamble with increasing amounts of money in order to achieve the desired excitement

(3) Has repeated unsuccessful efforts to control, cut back, or stop gambling

(4) Is restless or irritable when attempting to cut down or stop gambling

(5) Gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)

(6) After losing money gambling, often returns another day to get even ("chasing" one's losses)

(7) Lies to family members, therapist, or others to conceal the extent of involvement with gambling

(8) Has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling

(9) Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling

(10) Relies on others to provide money to relieve a desperate financial situation caused by gambling

B. The gambling behavior is not better accounted for by a Manic Episode.

Source: Reprinted with permission from DSM-IV-TR (APA 2000, pp. 671, 674).

dence—often with many years of recovery and AA attendance—develops a gambling problem.

Case Study: Counseling a Substance Abuse Treatment Client With a Pathological Gambling Disorder

Louis Q. is a 56-year-old, divorced Caucasian male who presented through the emergency room, where he had gone complaining of chest pain. After cardiovascular problems were ruled out, he was asked about stressors that may have contributed to chest pain. Louis Q. reported frequent gambling and significant debt. However, he has never sought any help for gambling problems.

The medical staff found that Louis Q. had a 30-year history of alcohol abuse, with a significant period of meeting criteria for alcohol dependence. He began gambling at age 13. Currently, he meets criteria for both alcohol dependence and pathological gambling. He has attended AA a few times in the past for very limited periods.

He was referred to a local substance abuse treatment agency. Assessment indicated that drinking was a trigger for gambling, as well as a futile attempt at self-medication to manage depression related to gambling losses. The precipitating event for seeking help was anxiety related to embezzling money from his job and fear that his embezzlement was going to be found by an upcoming audit.

Advice to the Counselor: Counseling a Client With Pathological Gambling Disorder

- Carefully assess use and frequency of sports events, scratch tickets, games of chance, and bets.
- Ask if the client is at any physical risk regarding owing money to people who collect on such debts.
- Treat the disorders as separate but interacting problems.
- Become fluent in the languages of substance abuse and of gambling.
- Understand the similarities and differences of substance use disorders and pathological gambling.
- Utilize all available 12-Step and other mutual support groups.
- Recognize that a client's motivation level may be at different points for dealing with each disorder.
- Use treatments that combine 12-Step, psychoeducation, group therapy and cognitive–behavioral approaches.
- Use separate support groups for gambling and for alcohol and/or drug dependence. While the groups can supplement each other, they cannot substitute for each other.

During the evaluation, it became clear that treatment would have to address both his gambling as well as his alcohol dependence, since these were so intertwined. Education was provided on both disorders, using standard information at the substance abuse treatment agency as well as materials from Gamblers Anonymous (GA). Group and individual therapy repeatedly pointed out the interaction between the disorders and the triggers for each, emphasizing the development of coping skills and relapse prevention strategies for both disorders. Louis Q. also was referred to a local GA meeting and was fortunate to have another member of his addictions group to guide him there. The family was involved in treatment planning and money management, including efforts to organize, structure, and monitor debt repayment. Legal assistance was obtained to advise him on potential legal charges due to embezzlement at work. He began attending both AA and GA meetings, obtaining sponsors in both programs.

Discussion: The counselor takes time to establish the relationship of the two disorders. He takes the gambling problem seriously as a disorder in itself, rather than assuming it would go away when the addiction was treated. Even though his agency did not specialize in gambling addiction treatment, he was able to use available community resources (e.g., GA) as a source of educational material and a referral. He recognized the importance of regular group involvement for Louis Q. and also knew it was critical to support the family in working through existing problems and trying to avoid new ones.

Conclusion

The information contained in this chapter can serve as a quick reference for the substance abuse counselor when working with clients who have the mental disorders described or who may be suicidal. As noted above, appendix D provides more extensive information. The limited aims of the panel in providing this material are to increase substance abuse treatment counselors' familiarity with mental disorders terminology and criteria, as well as to provide advice on how to proceed with clients who demonstrate these disorders. The panel encourages counselors to continue to increase their understanding of mental disorders by using the resource material referenced in each section, attending courses and conferences in these areas, and engaging in dialog with mental health professionals who are involved in treatment. At the same time, the panel urges continued work to develop improved treatment approaches that address substance use in combination with specific mental disorders, as well as better translation of that work to make it more accessible to the substance abuse field.

9 Substance-Induced Disorders

In This Chapter…

Description
Alcohol
Caffeine
Cocaine and Amphetamines
Hallucinogens
Nicotine
Opioids
Sedatives

Diagnostic Considerations

Case Studies: Identifying Disorders

Overview

The toxic effects of substances can mimic mental illness in ways that can be difficult to distinguish from mental illness. This chapter focuses on symptoms of mental illness that are the result of substance abuse—a condition referred to as "substance-induced mental disorders."

Description

As defined in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, Text Revision (American Psychiatric Association [APA] 2000) (DSM-IV-TR), substance-induced disorders include:

- Substance-induced delirium
- Substance-induced persisting dementia
- Substance-induced persisting amnestic disorder
- Substance-induced psychotic disorder
- Substance-induced mood disorder
- Substance-induced anxiety disorder
- Hallucinogen persisting perceptual disorder
- Substance-induced sexual dysfunction
- Substance-induced sleep disorder

Substance-induced disorders are distinct from independent co-occurring mental disorders in that all or most of the psychiatric symptoms are the direct result of substance use. This is not to state that substance-induced disorders preclude co-occurring mental disorders, only that the specific symptom cluster at a specific point in time is more likely the result of substance use, abuse, intoxication, or withdrawal than of underlying mental illness. A client might even have both independent and substance-induced mental disorders. For example, a client may present with well-established independent and con-

trolled bipolar disorder and alcohol dependence in remission, but the same client could be experiencing amphetamine-induced auditory hallucinations and paranoia from an amphetamine abuse relapse over the last 3 weeks.

Symptoms of substance-induced disorders run the gamut from mild anxiety and depression (these are the most common across all substances) to full-blown manic and other psychotic reactions (much less common). The "teeter-totter principle"—i.e., what goes up must come down—is useful to predict what kind of syndrome or symptoms might be caused by what substances. For example, acute withdrawal symptoms from physiological depressants such as alcohol and benzodiazepines are hyperactivity, elevated blood pressure, agitation, and anxiety (i.e., the shakes). On the other hand, those who "crash" from stimulants are tired, withdrawn, and depressed. Virtually any substance taken in very large quantities over a long enough period can lead to a psychotic state.

Because clients vary greatly in how they respond to both intoxication and withdrawal given the same exposure to the same substance, and also because different substances may be taken at the same time, prediction of any particular substance-related syndrome has its limits. What is most important is to continue to evaluate psychiatric symptoms and their relationship to abstinence or ongoing substance abuse over time. Most substance-induced symptoms begin to improve within hours or days after substance use has stopped. Notable exceptions to this are psychotic symptoms caused by heavy and long-term amphetamine abuse and the dementia (problems with memory, concentration, and problemsolving) caused by using substances directly toxic to the brain, which most commonly include alcohol, inhalants like gasoline, and again amphetamines. Following is an overview of the most common classes of substances of abuse and the accompanying psychiatric symptoms seen in intoxication, withdrawal, or chronic use.

Alcohol

In most people, moderate to heavy consumption is associated with euphoria, mood lability, decreased impulse control, and increased social confidence (i.e., getting high). Such symptoms might even appear "hypomanic." However these often are followed with next-day mild fatigue, nausea, and dysphoria (i.e., a hangover). In a person who has many life stresses, losses, and struggles, which is often the case as addiction to alcohol proceeds, the mood lability and lowered impulse control can lead to increased rates of violence toward others and self. Prolonged drinking increases the incidence of dysphoria, anxiety, and such violence potential. Symptoms of alcohol withdrawal include agitation, anxiety, tremor, malaise, hyperreflexia (exaggeration of reflexes), mild tachycardia (rapid heart beat), increasing blood pressure, sweating, insomnia, nausea or vomiting, and perceptual distortions.

Following acute withdrawal (a few days), some people will experience continued mood instability, fatigue, insomnia, reduced sexual interest, and hostility for weeks, so called "protracted withdrawal." Differentiating protracted withdrawal from a major depression or anxiety disorder is often difficult. More severe withdrawal is characterized by severe instability in vital signs, agitation, hallucinations, delusions, and often seizures. The best predictor of whether this type of withdrawal may happen again is if it happened before. Alcohol-induced deliriums after high-dose drinking are characterized by fluctuating mental status, confusion, and disorientation and are reversible once both alcohol and its withdrawal symptoms are gone, while by definition, alcohol dementias are associated with brain damage and are not entirely reversible even with sobriety.

Caffeine

When consumed in large quantities, caffeine can cause mild to moderate anxiety, though the amount of caffeine that leads to anxiety varies. Caffeine is also associated with an increase in the number of panic attacks in individuals who are predisposed to them.

Cocaine and Amphetamines

Mild to moderate intoxication from cocaine, methamphetamine, or other stimulants is associated with euphoria, and a sense of internal well-being, and perceived increased powers of thought, strength, and accomplishment. In fact, low to moderate doses of amphetamines may actually increase certain test-taking skills temporarily in those with attention deficit disorders (see this in appendix D) and even in people who do not have attention deficit disorders. However, as more substance is used and intoxication increases, attention, ability to concentrate, and function decrease.

With street cocaine and methamphetamines, dosing is almost always beyond the functional window. As dosage increases, the chances of impulsive dangerous behaviors, which may involve violence, promiscuous sexual activity, and others, also increases. Many who become chronic heavy users go on to experience temporary paranoid delusional states. As mentioned above, with methamphetamines, these psychotic states may last for weeks, months, and even years. Unlike schizophrenic psychotic states, the client experiencing a paranoid state induced by cocaine more likely has intact abstract reasoning and linear thinking and the delusions are more likely paranoid and less bizarre (Mendoza and Miller 1992). After intoxication comes a crash in which the person is desperately fatigued, depressed, and often craves more stimulant to relieve these withdrawal symptoms. This dynamic is why it is thought that people who abuse stimulants often go on week- or month-long binges and have a hard time stopping. At some point the ability of stimulants to push the person back into a high is lost (probably through washing out of neurotransmitters), and then a serious crash ensues.

Even with several weeks of abstinence, many people who are addicted to stimulants report a dysphoric state that is marked by anhedonia (absence of pleasure) and/or anxiety, but which may not meet the symptom severity criteria to qualify as DSM-IV Major Depression (Rounsaville et al. 1991). These anhedonic states can persist for weeks. As mentioned above, heavy, long-term amphetamine use appears to cause long-term changes in the functional structure of the brain, and this is accompanied by long-term problems with concentration, memory, and, at times, psychotic symptoms. Month-long methamphetamine binges followed by week- or month-long alcohol binges, a not uncommon pattern, might appear to be "bipolar" disorder if the drug use is not discovered. For more information, see the National Institute on Drug Abuse Web site (www.nida.nih.gov).

Hallucinogens

Hallucinogens produce visual distortions and frank hallucinations. Some people who use hallucinogens experience a marked distortion of their sense of time and feelings of depersonalization. Hallucinogens may also be associated with drug-induced panic, paranoia, and even delusional states in addition to the hallucinations. Hallucinogen hallucinations usually are more visual (e.g., enhanced colors and shapes) as compared to schizophrenic-type hallucinations, which tend to be more auditory (e.g., voices). The existence of a marijuana-induced psychotic state has been debated (Gruber and Pope 1994), although a review of the research suggests that there is no such entity. A few people who use hallucinogens experience chronic reactions, involving prolonged psychotic reactions, depression, exacerbations of preexisting mental disorders, and flashbacks. The latter are symptoms that occur after one or more psychedelic "trips" and consist of flashes of light and after-image prolongation in the periphery.

The DSM-IV defines flashbacks as a "hallucinogen persisting perception disorder." A diagnosis requires that they be distressing or impairing to the client (APA 1994, p. 234).

Nicotine

Clients who are dependent on nicotine are more likely to experience depression than people who are not addicted to it; however, it is unclear how much this is cause or effect. In some cases, the client may use nicotine to regulate mood. Whether there is a causal relationship between nicotine use and the symptoms of depression remains to be seen. At present, it can be said that many persons who quit smoking do experience both craving and depressive symptoms to varying degrees, which are relieved by resumption of nicotine use (see chapter 8 for more information on nicotine dependence).

Opioids

Opioid intoxication is characterized by intense euphoria and well-being. Withdrawal results in agitation, severe body aches, gastrointestinal symptoms, dysphoria, and craving to use more opioids. Symptoms during withdrawal vary—some will become acutely anxious and agitated, while others will experience depression and anhedonia. Even with abstinence, anxiety, depression, and sleep disturbance can persist for weeks as a protracted withdrawal syndrome. Again, differentiating this from major depression or anxiety is difficult and many clinicians may just treat the ongoing symptom cluster. For many people who become opioid dependent, and then try abstinence, these ongoing withdrawal symptoms are so powerful that relapse occurs even with the best of treatments and client motivation. For these clients, opioid replacement therapy (methadone, suboxone, etc.) becomes necessary and many times life saving. There are reports of an atypical opioid withdrawal syndrome characterized by delirium after abrupt cessation of methadone (Levinson et al. 1995). Such clients do not appear to have the autonomic symptoms typically seen in opioid withdrawal. Long-term use of opioids is commonly associated with moderate to severe depression.

Phencyclidine (PCP) causes dissociative and delusional symptoms, and may lead to violent behavior and amnesia of the intoxication. Zukin and Zukin (1992) report that people who use PCP and who exhibit an acute psychotic state with PCP are more likely to experience another with repeated use.

Sedatives

Acute intoxication with sedatives like diazepam is similar to what is experienced with alcohol. Withdrawal symptoms are also similar to alcohol and include mood instability with anxiety and/or depression, sleep disturbance, autonomic hyperactivity, tremor, nausea or vomiting, and, in more severe cases, transient hallucinations or illusions and grand mal seizures. There are reports of a protracted withdrawal syndrome characterized by anxiety, depression, paresthesias, perceptual distortions, muscle pain and twitching, tinnitus, dizziness, headache, derealization and depersonalization, and impaired concentration. Most symptoms resolve within weeks, though some symptoms, such as anxiety, depression, tinnitus (ringing in the ears), and paresthesias (sensations such as prickling, burning, etc.), have been reported to last a year or more after withdrawal in rare cases. No chronic dementia-type syndromes have been characterized with chronic use; however, many people who use sedatives chronically seem to experience difficulty with anxiety symptoms, which respond poorly to other anxiety treatments.

Diagnostic Considerations

Diagnoses of substance-induced mental disorders will typically be provisional and will require reevaluation—sometimes repeatedly. Many apparent acute mental disorders may

Criteria for Diagnosis of Substance-Induced Mood Disorders

1. A prominent and persistent disturbance in mood predominates, characterized by (a) a depressed mood or markedly diminished interest or pleasure in activities, or (b) an elevated, expansive, or irritable mood.
2. There is evidence from the history, physical examination, or laboratory findings that the symptoms developed during or within a month after substance intoxication or withdrawal, or medication use, is etiologically related to the mood disturbance.
3. The disturbance is not better explained by a mood disorder.
4. The disturbance did not occur exclusively during a delirium.
5. The symptoms cause clinically significant distress or impairment.

Source: APA 1994.

really be substance-induced disorders, such as in those clients who use substances and who are acutely suicidal (see chapter 8 and appendix D for more on suicidality and drug use).

Some people who have what appear to be substance-induced disorders may turn out to have both a substance-induced disorder and an independent mental disorder. For most people who are addicted to substances, drugs eventually become more important than jobs, friends, family, and even children. These changes in priorities often look, sound, and feel like a personality disorder, but diagnostic clarity regarding personality disorders in general is difficult, and in clients with substance-related disorders the true diagnostic picture might not emerge or reveal itself for weeks or months. Moreover, it is not unusual for the symptoms of a personality disorder to clear with abstinence—sometimes even fairly early in recovery. Preexisting mood state, personal expectations, drug dosage, and environmental surroundings all warrant consideration in developing an understanding of how a particular client might experience a substance-induced disorder. Treatment of the substance use disorder and an abstinent period of weeks or months may be required for a definitive diagnosis of an independent, co-occurring mental disorder. As described in chapter 4 on assessment, substance abuse treatment programs and clinical staff can concentrate on screening for mental disorders and determining the severity and acuity of symptoms, along with an understanding of the client's support network and overall life situation. The text box above provides an example of the diagnostic criteria for one substance-induced disorder—substance-induced mood disorders.

Case Studies: Identifying Disorders

George M. is a 37-year-old divorced male who was brought into the emergency room intoxicated. His blood alcohol level was .152, and the toxicology screen was positive for cocaine. He was also suicidal ("I'm going to do it right this time!"). He has a history of three psychiatric hospitalizations and two inpatient substance abuse treatments. Each psychiatric admission was preceded by substance use. George M. has never followed through with mental health care. He has intermittently attended Alcoholics Anonymous, but not recently.

Teresa G. is a 37-year-old divorced female who was brought into a detoxification unit 4 days ago with a blood alcohol level of .150. She is observed to be depressed, withdrawn, with little energy, fleeting suicidal thoughts, and poor concentration, but states she is just fine, not depressed, and life was good last week before her relapse. She has never used drugs (other than alcohol), and began drink-

ing alcohol only 3 years ago. However, she has had several alcohol-related problems since then. She has a history of three psychiatric hospitalizations for depression, at ages 19, 23, and 32. She reports a positive response to antidepressants. She is currently not receiving mental health services or substance abuse treatment. She is diagnosed with alcohol dependence (relapse) and substance-induced mood disorder, with a likely history of, but not active, major depression.

Discussion

Many factors must be examined when making initial diagnostic and treatment decisions. For example, if George M.'s psychiatric admissions were 2 or 3 days long, usually with discharges related to leaving against medical advice, decisions about diagnosis and treatment would be different (i.e., it is likely this is a substance-induced suicidal state and referral at discharge should be to a substance abuse treatment agency rather than a mental health center) than if two of his psychiatric admissions were 2 or 3 weeks long with clearly defined manic and psychotic symptoms continuing throughout the course, despite aggressive use of mental health care and medication (this is more likely a person with both bipolar disorder and alcohol dependence who requires integrated treatment for both his severe alcoholism and bipolar disorder).

Similarly, if Teresa G. had become increasingly depressed and withdrawn over the past 3 months, and had for a month experienced disordered sleep, poor concentration, and suicidal thoughts, she would be best diagnosed with major depression with an acute alcohol relapse rather than substance-induced mood disorder secondary to her alcohol relapse.

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Appendix B: Acronyms

AA	Alcoholics Anonymous
AAAP	American Academy of Addiction Psychiatry
AACP	American Association of Community Psychiatrists
ACA	Adult Children of Alcoholics
ACT	Assertive Community Treatment
AD/HD	attention deficit/hyperactivity disorder
ADM	Alcohol, Drug Abuse or Mental Disorders
AHRQ	Agency for Healthcare Research and Quality (formerly AHCPR)
AIDS	acquired immunodeficiency syndrome
AOD	alcohol and other drugs
AOS	addiction only services
APA	American Psychological Association; American Psychiatric Association
APD	antisocial personality disorder
APPI	American Psychiatric Publishing, Inc.
ASAM	American Society of Addiction Medicine
ASI	Addiction Severity Index
ATTC	Addiction Technology Transfer Center
AUDIT	Alcohol Use Disorders Identification Test
AUS	Alcohol Use Scale

BAI	Beck Anxiety Inventory
BDI	Beck Depression Inventory
BED	binge-eating disorder
BPD	borderline personality disorder
BSI-18	Brief Symptom Inventory-18
CA	Cocaine Anonymous
CAMI	chemically abusing mentally ill, or chemically addicted and mentally ill
CBT	cognitive–behavioral therapy
CCISC	Comprehensive Continuous Integrated System of Care
CINA	Clinical Institute Narcotic Assessment
CIWA-Ar	Clinical Institute Withdrawal Assessment
CM	Contingency Management
CMHS	Center for Mental Health Services (SAMHSA)
COD	co-occurring disorders (in this TIP, specifically co-occurring substance abuse and one or more mental health disorders)
CONTAC	Consumer Organization and Networking Technical Assistance Center
CQI	Continuous Quality Improvement
CSAP	Center for Substance Abuse Prevention (SAMHSA); Corrections Substance Abuse Program
CSAT	Center for Substance Abuse Treatment (SAMHSA)
CTU	Crisis Triage Unit
DALI	Dartmouth Assessment of Lifestyle Inventory
DAST	Drug Abuse Screening Test
DATOS	Drug Abuse Treatment Outcome Studies
DBT	Dialectical Behavior Therapy
DDC	dual diagnosis capable
DDE	dual diagnosis enhanced
DDRN	Dual Diagnosis Recovery Network
DID	dissociative identity disorder, formerly known as multiple personality disorder
DIS	Diagnostic Interview Schedule
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
DTR	Double Trouble in Recovery
DUI	driving under the influence
DUS	Drug Use Scale
EAP	employee assistance program
ECA	Epidemiological Catchment Area
ER	emergency room
FY	fiscal year
GA	Gamblers Anonymous
GAD	general anxiety disorder
GAIN	Global Appraisal of Individual Needs
HIP	HIV Integration Project
HIPAA	Health Insurance Portability and Accountability Act
HIV	human immunodeficiency virus
ICM	Intensive Case Management
ICOPSD	individuals with co-occurring psychiatric and substance disorders

IOM	Institute of Medicine
LOCUS	Level of Care Utilization System
MAST	Michigan Alcoholism Screen Test
MATCH	Matching Alcoholism Treatment to Client Heterogeneity
MDDA	Manic Depressive and Depressive Association
MET	Motivational Enhancement Techniques
MFIR	Men's Forensic Intensive Recovery
MHSF-III	Mental Health Screening Form-III
MI	Motivational Interviewing
MICA	mentally ill chemically addicted or affected, mentally ill chemical abusing, or mentally ill chemical abuser
MICD	mentally ill chemically dependent
MIDAS	Mental Illness Drug and Alcohol Screening
MINI	Mini-International Neuropsychiatric Interview
MISA	mentally ill substance abuser
MISU	mentally ill substance using
MMPI	Minnesota Multiphasic Personality Inventory
MTC	Modified Therapeutic Community
NA	Narcotics Anonymous
NAADAC	National Association of Alcoholism and Drug Abuse Counselors
NAC	National Advisory Council
NAMI	National Alliance for the Mentally Ill
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NASMHPD	National Association of State Mental Health Program Directors
NCADI	National Clearinghouse for Alcohol and Drug Information
NCI	Na'nizhoozi Center, Inc.
NCS	National Comorbidity Study
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NLAES	National Longitudinal Alcohol Epidemiologic Study
NMHA	National Mental Health Association
NRC	National Research Council
NTIES	National Treatment Improvement Evaluation Study
OCD	obsessive-compulsive disorder
ONDCP	Office of National Drug Control Policy
PCP	phencyclidine
PD	personality disorder
PG	pathological gambling
PIC	Practice Improvement Collaboratives
PPC	patient placement criteria
PRISM	Psychiatric Research Interview for Substance and Mental Disorders
PTSD	posttraumatic stress disorder

RPT	Relapse Prevention Therapy
SADAP	State Alcohol and Drug Abuse Profiles
SAMHSA	Substance Abuse and Mental Health Services Administration
SAMI	substance abusing mentally ill
SAMM	Substance Abuse Management Module
SCID	Structured Clinical Interview for Diagnosis
SDS	Symptom Distress Scale
SMI	severely mentally ill
SOGS	South Oaks Gambling Screen
SPMI	serious and persistent mental illness
SSI-SA	Simple Screening Instrument for Substance Abuse
SSRI	selective serotonin reuptake inhibitor (a type of antidepressant)
STD	sexually transmitted disease
STEMSS	Support Together for Emotional/Mental Serenity and Sobriety
STP	Short-Term Program
TC	therapeutic community
TIP	Treatment Improvement Protocol
TREM	Trauma Recovery and Empowerment Model
UFDS	Uniform Facility Data Set
URICA	University of Rhode Island Change Assessment Scale
WFIR	Women's Forensic Intensive Recovery

Appendix C: Glossary of Terms

Note to the reader: The definitions of many of these terms have been taken verbatim from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision (DSM-IV-TR) (American Psychiatric Association 2000). Such definitions have been presented and properly attributed in the text of this TIP. See appendix B, Acronyms, for acronym definitions.

Abstinent

Not using substances of abuse at any time.

Acculturated

Mentally and physically in harmony with and connected to the culture in which one lives.

ACT

See Assertive Community Treatment

Acute care

Short-term care provided in intensive care units, brief hospital stays, and emergency rooms for those who are severely intoxicated or dangerously ill.

Addiction

Physical dependence on a substance of abuse. Inability to cease use of a substance without experiencing withdrawal symptoms. Sometimes used interchangeably with the term **substance dependence**.

AD/HD

See attention deficit/hyperactivity disorder

Addiction-only services

Programs that by law or regulation, by choice, or for lack of resources cannot accommodate patients who have psychiatric illnesses that require ongoing treatment, however stable the illness and however well-functioning the patient.

Advanced program

A treatment program that has the capacity to provide integrated substance abuse and mental health treatment for clients with COD. These programs address COD using an integrated perspective and provide services for both disorders.

Agitation

A restless inability to keep still. Agitation is most often psychomotor agitation, that is, having emotional and physical components. Agitation can be caused by anxiety, overstimulation, or withdrawal from depressants and stimulants.

Anorexia nervosa

A disorder in which the individual refuses to maintain a minimal normal body weight, is intensely afraid of gaining weight, and exhibits a significant disturbance in the perception of the shape or size of his or her body.

Antiretroviral combination therapy

Treatment for HIV/AIDS infection that employs several medications in combination to suppress the HIV virus or delay both the development of resistant viruses and the appearance of AIDS symptoms.

Antisocial personality disorder

An illness whose two essential features are: (1) a pervasive disregard for and violation of the rights of others and (2) an inability to form meaningful interpersonal relationships. Deceit and manipulation are important manifestations of antisocial personality disorder.

Anxiety disorder

An illness whose essential feature is excessive anxiety and worry. The individual with anxiety disorder finds it difficult to control the worry, and the anxiety and worry are accompanied by additional symptoms from a list that includes restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension, and disturbed sleep, among other signs and symptoms.

Assertive Community Treatment (ACT)

A form of treatment that typically employs intensive outreach activities, continuous 24-hour responsibility for client's welfare, active and continued engagement with clients, a high intensity of services, as well as the provision of services by multidisciplinary teams. ACT emphasizes shared decisionmaking with the client as essential to the client's engagement process.

Assessment

A basic assessment consists of gathering key information and engaging in a process with the client that enables the counselor to understand the client's readiness for change, problem areas, COD diagnosis, disabilities, and strengths. An assessment typically involves a clinical examination of the functioning and well-being of the client and includes a number of tests and written and oral exercises. The COD diagnosis is established by referral to a psychiatrist or clinical psychologist. Assessment of the client with COD is an ongoing process that should be repeated over time to capture the changing nature of the client's status.

Attention deficit/hyperactivity disorder (AD/HD)

A persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more serious than is typically observed in individuals at a comparable level of development.

Basic program

A treatment program with the capacity to provide treatment for one disorder, but thatalso screens for other disorders and is able to access necessary consultations.

Blackout

A blackout consists of a period of amnesia or memory loss, typically caused by chronic, high-dose substance abuse. The person later cannot remember the blackout period. Blackouts are most often caused by sedative-hypnotics such as alcohol and the benzodiazepines.

Borderline personality disorder
An illness whose essential feature is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, along with marked impulsivity that begins by early adulthood and is present in a variety of contexts.

Bulimia nervosa
An illness whose essential feature is binge eating and inappropriate compensatory methods to prevent weight gain. In addition, the self-evaluation of individuals with bulimia nervosa is excessively influenced by body shape and weight.

CAGE questionnaire
A brief alcoholism screening tool asking subjects about attempts to Cut down on drinking, Annoyance over others' criticism of the subject's drinking, Guilt related to drinking, and use of an alcoholic drink as an Eye opener.

CBT
See cognitive–behavioral therapy

CCISC
See Comprehensive Continuous Integrated System of Care

CM
See contingency management

COD
See co-occurring disorders

Coerced
Legally forced or compelled.

Cognitive
Pertaining to the mind's capacity to understand concepts and ideas.

Cognitive–behavioral therapy (CBT)
A therapeutic approach that seeks to modify negative or self-defeating thoughts and behavior. CBT is aimed at both thought and behavior change—that is, coping by thinking differently and coping by acting differently.

Coke bugs
Slang term for tactile hallucinations (also called formications) that feel like bugs crawling on or under the skin. Chronic and high-dose stimulant abuse can cause these hallucinations.

Collaboration
In the context of treatment programs, collaboration is distinguished from **consultation** by the formal quality of the collaborative agreement, such as a memorandum of understanding or a service contract, which documents the roles and responsibilities each party will assume in a continuing relationship.

Combined psychopharmacological intervention
Treatment episodes in which a client receives medications both to reduce cravings for substances and to medicate a mental disorder.

Comorbid disorders
See co-occurring disorders

Competency
An ability, capacity, skill, or set of skills.

Comprehensive Continuous Integrated System of Care (CCISC)
A theoretical method for bringing the mental health and substance abuse treatment systems (and other systems, potentially) into an integrated planning process to develop a comprehensive, integrated system of care. The CCISC is based on an awareness that co-occurring disorders are to be expected in clients throughout the service system.

Concomitant treatment
Treatment of two or more mental or physical disorders at the same time.

Confrontation
A form of interpersonal exchange in which individuals present to each other their observations of, and reactions to, behaviors and attitudes that are matters of concern and should be changed. Confrontation

presents "reality" to individuals. The goal of confrontation is feedback on behavior and the compelling appeal to the client for personal honesty, truthfulness in dealing with others, and responsible behavior.

Constricted pupils (pinpoint pupils)

Pupils that are temporarily narrowed or closed. This is usually a sign of opioid abuse.

Consultation

In the context of treatment programs, consultation is a traditional type of informal relationship among treatment providers, such as a referral or a request for exchanging information.

Contingency management (CM)

An approach to treatment that maintains that the form or frequency of behavior can be altered through a planned and organized system of positive and negative consequences. CM assumes that neurobiological and environmental factors influence substance use behaviors and that the consistent application of reinforcing environmental consequences can change these behaviors.

Continuing care

Care that supports a client's progress, monitors his or her condition, and can respond to a return to substance use or a return of symptoms of mental disorder. It is both a process of post-treatment monitoring and a form of treatment itself. Sometimes referred to as aftercare.

Convulsion

A symptom of a seizure, characterized by twitching and jerking of the limbs. A seizure is a sudden episode of uncontrolled electrical activity in the brain. If the abnormal electrical activity spreads throughout the brain, the result may be loss of consciousness and a grand mal seizure. Seizures may occur as the result of head injury, infection, cerebrovascular accidents, withdrawal from sedative-hypnotic drugs, or high doses of stimulants.

Co-occurring disorders (COD)

Refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have COD have one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs. See dually disordered.

Countertransference

The feelings, reactions, biases, and images from the past that the clinician may project onto the client with COD.

Crack

Cocaine (cocaine hydrochloride) that has been chemically modified so that it will become a gas vapor when heated at relatively low temperatures. Also called "rock" cocaine.

Cross-training

The simultaneous provision of material and training to persons from more than one discipline (for example, to substance abuse and social work counselors or to substance abuse counselors and corrections officers).

Cultural competence

The capacity of a service provider or an organization to understand and work effectively in accordance with the cultural beliefs and practices of persons from a given ethnic/racial group. Also includes an ability to examine and understand nuances and exercise full cultural empathy.

Cultural destructiveness

Practices or actions through which an individual shows that he or she regards other cultures as inferior to the dominant culture, through cultural incapacity and blindness to more positive attitudes and greater levels of skill.

Cultural proficiency

The highest level of cultural capacity, which implies an ability to perceive the nuances of a culture in depth and a willingness to work to advance in proficiency through leadership, research, and outreach.

Cultural sensitivity
The capacity and willingness of a clinician or other service provider to be open to working with issues of culture and diversity.

Culturally competent treatment
Biopsychosocial or other treatment that is adapted to suit the special cultural beliefs, practices, and needs of a client.

DDC
See dual diagnosis capable

DDE
See dual diagnosis enhanced

Deficit
In the context of substance abuse treatment, disability, or inability to function fully.

Detoxification
A clearing of toxins from the body. The medical and biopsychosocial procedure that assists a person who is dependent on one or more substances to withdraw from dependence on all substances of abuse.

Dilated pupils
Pupils that have become temporarily enlarged.

Disorder
An illness or a disruption of some mental or physical process.

Domestic violence
The use of emotional, psychological, sexual, or physical force by one family member or intimate partner to control another. Violent acts include verbal, emotional, and physical intimidation; destruction of the victim's possessions; maiming or killing pets; threats; forced sex; and slapping, punching, kicking, choking, burning, stabbing, shooting, and killing victims. Spouses, parents, stepparents, children, siblings, elderly relatives, and intimate partners may all be targets of domestic violence.

Downers
Slang term for drugs that exert a depressant effect on the central nervous system. In general, downers are sedative-hypnotic drugs, such as benzodiazepines and barbiturates.

Dual diagnosis capable (DDC)
Of or pertaining to programs that address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content, and discharge planning.

Dual diagnosis enhanced (DDE)
Of or pertaining to programs that have a higher than average level of integration of substance abuse and mental health treatment services. These programs are able to provide primary substance abuse treatment to clients who are, compared with those treatable in DDC programs, more symptomatic and/or functionally impaired as a result of their co-occurring mental disorder.

Dually disordered
Having been diagnosed with two disorders, for example a substance use disorder and a mental health disorder.

Dual recovery groups
Therapy groups in which recovery skills for co-occurring disorders are discussed.

DTs
Delirium tremens, a state of confusion accompanied by trembling and vivid hallucinations. Symptoms may include restlessness, agitation, trembling, sleeplessness, rapid heartbeat, and possibly convulsions. Delirium tremens often occurs in people with alcohol use disorders after withdrawal or abstinence from alcohol.

Ecstasy
Slang term for methylenedioxymethamphetamine (MDMA), a member of the amphetamine family (for example, speed). At lower doses, MDMA causes distortions of emotional perceptions. At higher doses, it causes potent stimulation typical of the amphetamines.

Empirical
Relying on observation or experience rather than theoretical principles or theory.

Engagement
A client's commitment to and maintenance of treatment in all of its forms. A successful engagement program helps clients view the treatment facility as an important resource.

Formal collaboration
Formal collaboration occurs when the nature of the client's disabilities requires more specific information and more complex and targeted intervention. This level of working relationship ensures that providers give attention to both mental health and substance abuse disorders in the treatment regimen. An example of such collaboration is an interagency staffing conference where representatives of both mental health and substance abuse agencies take part in the development and implementation of a specific treatment program for clients with co-occurring disorders. Focus is placed on the creation of an individualized treatment plan that is implemented under the auspices of one system or the other. (See also collaboration and service integration.)

Fully integrated program
A treatment program that actively combines substance abuse and mental health interventions to treat disorders, related problems, and the whole person more effectively.

Functional
Pertaining to a person's ability to carry out tasks. Also, working, able to work.

Grounding
The use of strategies that soothe and distract the client who is experiencing intense pain or other strong emotions, helping the client anchor in the present and in reality. Grounding techniques direct the mental focus outward to the external world, rather than inward toward the self. Also can be referred to as "centering," "looking outward," "distraction," or "healthy detachment."

Habilitation
Initial learning and the acquisition of skills necessary for everyday life.

Hallucinogens
A broad group of drugs that cause distortions of sensory perception. The prototype hallucinogen is lysergic acid diethylamide (LSD). LSD can cause potent sensory perceptions, such as visual, auditory, and tactile hallucinations. Related hallucinogens include peyote and mescaline.

Hepatitis
An inflammation of the liver, with accompanying liver cell damage and risk of death. Hepatitis may be of limited duration or a chronic condition. It may be caused by viral infection, or by chronic exposure to poisons, chemicals, or drugs of abuse, such as alcohol.

Ice
Slang term for smokeable methamphetamine. Just as cocaine can be modified into a smokeable state (crack cocaine), methamphetamine can be prepared so that it produces a gas vapor when heated at relatively low temperatures. When smoked, ice methamphetamine produces an extremely potent and long-lasting euphoria, an extended period of high energy and possible agitation, followed by an extended period of deep depression.

ICM
See Intensive Case Management

Impaired
Hampered or held back from being able to do some mental or physical task.

Infectious
Able to spread by an agent such as a virus or bacterium.

Informal collaboration
Informal collaboration ensures that both

mental illness and substance abuse problems are sufficiently understood by all participating providers to allow effective identification, engagement, prevention, and early intervention. An example of this type of collaboration is a telephone request for information or general advice regarding the origins and clinical course of depression in a person abusing alcohol or drugs. Discussion of a particular client usually does not occur, or occurs at a relatively general level. (See also collaboration, service integration.)

Integrated competencies

The possession of specific attitudes, values, knowledge, and skills required to provide appropriate services to individuals with COD in the context of their actual job and program setting.

Integrated interventions

Specific treatment strategies or therapeutic techniques in which interventions for two or more disorders are combined in a single session or interaction, or in a series of interactions or multiple sessions.

Integrated treatment

Any mechanism by which treatment interventions for **co-occurring disorders** are combined within the context of a primary treatment relationship or service setting. It recognizes the need for a unified treatment approach to meet the **substance abuse**, mental health, and related needs of a client, and is the preferred model of treatment.

Integration

As defined by **NASMHPD** and **NASADAD** in the context of treatment programs, denotes relationships among mental health and **substance abuse** providers in which the contributions of professionals in both fields are moved into a single treatment setting and treatment regimen.

Intensive Case Management (ICM)

A thorough, long-term service to assist clients with serious mental illness (particularly those with psychiatric and functional disabilities and a history of not adhering to prescribed outpatient treatment) by establishing and maintaining linkages with community-based service providers. ICM typically provides referrals to treatment programs, maintains advocacy for clients, provides counseling and crisis intervention, and assists in a wide variety of other basic services.

Intermediate program

A treatment program that focuses primarily on one disorder without substantial modification to its usual treatment, but also with the capacity to explicitly address specific needs of another disorder.

Intersystem linkages

Connections between substance abuse treatment and mental health systems that allow collaboration. Necessary because these are the primary care systems for persons with COD.

Intervention

Encompasses the specific treatment strategies, therapies, or techniques that are used to treat one or more disorders.

Legal problems

People who abuse substances are at a higher risk for engaging in behaviors that are high risk and illegal. These behaviors may result in arrest and other problems with the criminal justice system. Examples of such behaviors include driving while intoxicated, writing bad checks to obtain money for drugs, failure to pay bills and credit card debts, possession or sale of drugs, evictions, and drug-related violence.

Locus

A place or a setting for some activity.

Marijuana

The Indian hemp plant *cannabis sativa*; also called "pot" and "weed." The dried leaves and flowering tops can be smoked or prepared in a tea or food. Marijuana has two significant effects. In the person with

no tolerance for it, marijuana can produce distortions of sensory perception, sometimes including hallucinations. Marijuana also has depressant effects and is partially cross-tolerant with sedative-hypnotic drugs such as alcohol. Hashish (or "hash") is a combination of the dried resins and compressed flowers of the female plant.

Mental health program

An organized array of services and interventions with a primary focus on treating mental health disorders, whether providing acute stabilization or ongoing treatment.

Mental health treatment system

A broad array of services and programs intended to treat a wide range of mental health disorders.

MI

See motivational interviewing

Modified Therapeutic Community (MTC)

A therapeutic community whose approach to treatment adapts the principles and methods of the therapeutic community to the circumstances of the COD client. The MTC employs interventions that have special functions, all of which share community, therapeutic, and educational purposes. All interventions are grouped into four categories: community enhancement, therapeutic/ educative, community/clinical management, and vocational.

Mood disorders

Include the depressive disorders ("unipolar depression"), the bipolar disorders, and two disorders based on etiology—mood disorder due to a general medical condition and substance-induced mood disorder.

Motivational interviewing (MI)

A client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.

MTC

See Modified Therapeutic Community

Mutual self-help

An approach to recovery from substance use disorders that emphasizes personal responsibility, self-management, and clients' helping one another. Such programs apply a broad spectrum of personal responsibility and peer support principles, usually including 12-Step methods that prescribe a planned regimen of change.

Nodding out

Slang term for the early stages of depressant-induced sleep. Opioids and sedative-hypnotics induce depression of the central nervous system, causing mental and behavioral activity to become sluggish. As the nervous system becomes profoundly depressed, symptoms may range from sleepiness to coma and death. Typically, "nodding out" refers to fading in and out of a sleepy state.

National Mental Health Association (NMHA)

A policymaking and educational association that holds workshops and has an annual conference for clinicians working with persons with mental health problems, including persons with COD. The organization continues to develop resources, documents, publications, and a COD-designated section on its Web site.

Neuroleptic medication

A drug used to treat psychosis, especially schizophrenia.

NMHA

See National Mental Health Association

Opioid

A type of depressant drug that diminishes pain and central nervous system activity. Prescription opioids include morphine, meperidine (Demerol), methadone, codeine, and various opioid drugs for coughing and pain. Illicit opioids include heroin, also called "smack," "horse," and "boy."

Organization

An entity that provides mental health ser-

vices in two or three service settings (inpatient, residential, or outpatient) and is not classified as a psychiatric or general hospital or as a residential treatment center.

Outreach strategies

Approaches that actively seek out persons in a community who may have substance use disorders and engage them in substance abuse treatment.

Paranoia

A type of delusion, or false idea, that is unchanged by reasoned argument or proof to the contrary. Clinical paranoia involves the delusion that people or events are in some way specially related to oneself. People who are paranoid may believe that others are talking about them, plotting devious plans about them, or planning to hurt them. Paranoia often occurs during episodes of high-dose chronic stimulant use and may occur during withdrawal from sedative-hypnotics such as alcohol.

Paraphernalia

A broad term that describes objects used during the chemical preparation or use of drugs. These include syringes, syringe needles, roach clips, and marijuana or crack pipes.

Pathological gambling

An illness whose essential feature is persistent and recurrent maladaptive gambling behavior that disrupts personal, family, or vocational pursuits.

Personality disorders

Rigid, inflexible, and maladaptive behavior patterns of sufficient severity to cause internal distress or significant impairment in functioning. Personality disorders are enduring and persistent styles of behavior and thought, rather than rare or unusual events in someone's life.

Posttraumatic stress disorder (PTSD)

An illness whose essential feature is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close friend or relative.

Practice Improvement Collaboratives

Community-based initiatives that link treatment providers, researchers, and policymakers in order to build a strong foundation to effect action.

Prescribing Onsite Psychiatrist Model

A model for a substance abuse treatment agency that includes on its staff a psychiatrist who works onsite from 4 to 16 hours a week. The onsite psychiatrist brings diagnostic, behavioral, and medication services directly to where the clients are based for the major part of their treatment.

Prognosis

A clinician's judgment or estimate of how well a disorder will respond to treatment.

Program

Currently, substance abuse treatment programs use the Service Delivery Unit (SDU) as their program definition for the National Survey of Substance Abuse Treatment Services. Mental health treatment programs use facility or organization in reporting for the Survey of Mental Health Organizations, General Hospital Mental Health Services, and Managed Behavioral Health Care Organization (SMHD).

Protease inhibitor

Protease is an enzyme used by the HIV to process new copies of the virus after it has reproduced. Protease inhibitors are medications used to treat HIV; they interfere

with the action of this enzyme, thus interfering with viral reproduction.

Psychopharmacological
Pertaining to medications used to treat mental illnesses.

Psychosis
A mental disorder that is characterized by distinct distortions of a person's mental capacity, ability to recognize reality, and relationships to others to such a degree that it interferes with that person's ability to function in everyday life.

Psychosocial
Involving a person's psychological well-being, as well as housing, employment, family, and other social aspects of life circumstances.

PTSD
See posttraumatic stress disorder

Psychotropic medication
A drug that has an effect on the mind and sometimes affects behavior as well.

Quadrants of care
A conceptual framework that classifies settings within which clients with COD are treated. The four quadrants are based on relative symptom severity, rather than by diagnosis.

Referral
A process for facilitating client/consumer access to specialized treatments and services through linkage with, or directing clients/consumers to, agencies that can meet their needs. For COD, referrals are frequently made for detoxification, assessment, special treatment, and medications.

Relapse
A breakdown or setback in a person's attempt to change or modify any particular behavior. An unfolding process in which the resumption of substance abuse is the last event in a series of maladaptive responses to internal or external stressors or stimuli.

Relapse prevention therapy (RPT)
A variety of interventions designed to teach individuals who are trying to maintain health behavior changes how to anticipate and cope with the problem of relapse. RPT strategies can be placed in five categories: Assessment Procedures, Insight/Awareness Raising Techniques, Coping Skills Training, Cognitive Strategies, and Lifestyle Modification.

Remission
A state in which a mental or physical disorder has been overcome or a disease process halted.

RPT
See relapse prevention therapy

Schizophrenia
A type of psychosis. Persons diagnosed with schizophrenia are subject to hallucinations occurring in the absence of insight into their pathological nature, as well as disorganized speech and grossly disorganized or catatonic behavior. The disorder lasts for at least 6 months and includes at least 1 month of active-phase symptoms including two or more of the following: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms.

Screening
A formal process of testing to determine whether a client warrants further attention at the current time for a particular disorder and, in this context, the possibility of a co-occurring substance or mental disorder. The screening process for **co-occurring disorders** seeks to answer a "yes" or "no" question: Does the substance abuse [or mental health] client being screened show signs of a possible mental health [or substance abuse] problem? Note that the screening process does not necessarily identify what kind of problem the person might have or how serious it might be but determines whether further assessment is warranted.

Service integration

No one set of treatment interventions constitutes integrated treatment. The term refers to the availability and delivery of a comprehensive array of appropriate mental health and substance abuse services and interventions that are identified within a single treatment plan, coordinated by a single treatment team, and both effective and responsive to the high degree of severity of both mental illness and substance abuse experienced by the client. Under the "no wrong door" approach, integrated services should be available, as necessary, through both mental health and substance abuse treatment systems. (See also collaboration and informal collaboration.)

Single State Agencies

Systems that organize statewide services.

Skin abscess

A collection of pus formed as a result of bacterial infection. Abscesses close to the skin usually cause inflammation, with redness, increased skin temperature, and tenderness. Abscesses may be caused by injecting drugs and impurities into the body.

Slurred speech

A sign of depressant intoxication. When people consume significant amounts of sedative-hypnotics and opioids, their speech may become garbled, mumbled, and slow.

Stigma

A negative association attached to some activity or condition. A cause of shame or embarrassment.

Substance abuse

A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. Sometimes used interchangeably with the term substance dependence.

Substance abuse treatment program

An organized array of services and interventions with a primary focus on treating substance use disorders, providing both acute stabilization and ongoing treatment.

Substance abuse treatment system

A broad array of services organized into programs intended to treat substance use disorders. It also includes services organized in accord with a particular treatment approach or philosophy (e.g., methadone treatment or therapeutic community).

Substance dependence

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by a need for increasing amounts of the substance to achieve intoxication, markedly diminished effect of the substance with continued use, the need to continue to take the substance in order to avoid withdrawal symptoms, and other serious behavioral effects, occurring at any time in the same 12-month period.

Substance use disorders

A class of substance-related disorders that includes both **substance abuse** and **substance dependence**.

Suicidality

A measure or estimate of a person's likelihood of committing suicide. A high-risk behavior associated with COD, especially (although not limited to) serious mood disorders.

System

An organization of a number of different treatment programs and related services in order to implement a specific mission and common goals.

Therapeutic alliance

A type of relationship between client and clinician in which both are working cooperatively toward the same goals, with mutual respect and understanding; also called "helping alliance." The bond of

trust formed between client and clinician during therapeutic work that makes healing possible.

Therapeutic community (TC)

A social environment or residential treatment setting in which the social and group process is harnessed with therapeutic intent. The TC promotes abstinence from alcohol and illicit drug use, and seeks to decrease antisocial behavior and to effect a global change in lifestyle, including attitudes and values. The TC employs the community itself as the agent of healing. The TC views drug abuse as a disorder of the whole person, reflecting problems in conduct, attitudes, moods, values, and emotional management. Treatment focuses on drug abstinence, coupled with social and psychological change that requires a multidimensional effort involving intensive mutual self-help typically in a residential setting.

Toxicity

Poisonous nature; poisonous quality.

Transference

The feelings, reactions, biases, and images from the past that the client with COD may project onto the clinician.

Trauma

Violent mental or physical harm to a person, damage to an organ, etc.

Treatment

Substance abuse treatment is an organized array of services and interventions with a primary focus on treating substance abuse disorders. For the Treatment Episode Data Set, the Center for Substance Abuse Treatment defines treatment to include the following general categories: hospital, short- and long-term residential, and outpatient. Mental health treatment is an organized array of services and interventions with a primary focus on treating mental disorders, whether providing acute stabilization or ongoing treatment. These programs may exist in a variety of settings, such as traditional outpatient mental health centers (including outpatient clinics and psychosocial rehabilitation programs) or more intensive inpatient treatment units.

Treatment retention

Keeping clients involved in treatment activities and receiving required services.

Tremor

An involuntary and rhythmic movement in the muscles, most often in the hands, feet, jaw, tongue, or head. Tremors may be caused by stimulants such as amphetamines and caffeine, as well as by withdrawal from depressants.

TC

See therapeutic community

Unsteady gait

Crooked, meandering, and uncoordinated walk, typical of alcohol-impaired people.

Uppers

Slang term used to describe drugs that have a stimulating effect on the central nervous system. Examples include cocaine, caffeine, and amphetamines.

Wraparound services

Aspects of a treatment program that address difficult-to-treat problems, such as finding childcare while in treatment, arranging for proper housing, and finding employment.

Appendix D: Specific Mental Disorders: Additional Guidance for the Counselor

In This Appendix...

Suicidality

Nicotine Dependency

Personality Disorders (Overview)

Borderline Personality Disorder

Antisocial Personality Disorder

Mood and Anxiety Disorders

Schizophrenia and Other Psychotic Disorders

Attention Deficit/ Hyperactivity Disorder (AD/HD)

Posttraumatic Stress Disorder

Eating Disorders

Pathological Gambling

Overview

While substance abuse treatment counselors do not always have the advantage of an accurate diagnosis of every disorder for each of their clients with co-occurring disorders (COD), the consensus panel believes it is useful to have a working knowledge of the most common disorders seen in substance abuse treatment settings. In cases in which a diagnosis has not been made, the counselor may be able to detect a pattern of behavior that suggests further assessment is needed. For clients currently receiving care, the counselor's appreciation of the features and issues associated with each known disorder may improve coordination and mutual understanding between substance abuse treatment services and the mental health providers. Moreover, some knowledge of the disorder also will help the counselor understand the role of addiction within the framework of the client's experience and to see how the client's disorders are interrelated. This understanding may be helpful in relapse prevention. In addition, a general appreciation of the features of the disorder will help the counselor adapt the treatment strategy in meaningful ways that are more likely to be effective for the particular client. The consensus panel also acknowledges that people with COD may have multiple combinations of the various mental disorders presented in this appendix (e.g., a person with a substance use disorder, schizophrenia, and a pathological gambling problem). However, for purposes of clarity and brevity the panel chose to focus the discussion on the main disorders and not explore the multitude of possible combinations.

Known diagnoses should be documented. Such records will help the treatment agency gain a better understanding of this aspect of client demographics. If the substance abuse treatment agency seeks supplemental funding for its work with clients who have COD, it will be helpful, if not essential, to report the number and profile of such clients. Chapter 8 cites the diagnostic criteria used to identify many mental disorders by the standard diagnostic tool for professionals, *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision*

(DSM-IV-TR) (American Psychiatric Association [APA] 2000). These criteria are not duplicated in this appendix.

The disorders in this chapter are discussed mainly within the following framework of topics:

- *Description* of the disorder
- *Differential Diagnosis* for the disorder, including how to distinguish this mental disorder from substance-related disorders or medical conditions that present in a similar way
- *Prevalence*
- *Substance Use Among People With This Disorder*
- *Key Issues and Concerns* that arise in working with clients who have this disorder
- *Strategies, Tools, and Techniques*, including those relevant to engagement, assessment, crisis stabilization, short-term care and treatment, and longer term care

Case studies are presented when illustrative information is useful to the counselor. See appendix F for medications commonly used to treat various disorders and observations on appropriate management of pharmacology with clients who have substance use disorders. Readers should also consult the introduction to chapter 8 for an overview of the aims and limitations of both chapter 8 and this appendix.

Suicidality

Description

Though not a DSM-IV diagnosed mental disorder, per se, suicidality is a high-risk behavior associated with COD, especially serious mood disorders. Suicide is a complex behavior usually caused by a combination of factors. Research shows that most people who kill themselves have a diagnosable mental or substance use disorder, or both, and that the majority of them have depressive illness. Studies indicate that the most promising way to prevent suicide and suicidal behavior is through the early recognition and treatment of substance abuse and mental illnesses, especially depression (U.S. Public Health Service 1999). A wide range of self-harm and severely negative feelings and beliefs about the self can be induced or exacerbated by substance use. As a result, suicidal ideations, intentions, and behaviors can be potentially lethal complications of substance use disorders, especially for clients with co-occurring mental disorders.

Self-harm, often called *parasuicide,* can be expressed in a less extreme form than suicide, such as self-cutting, self-burning, and other self-mutilation behaviors. Poussaint and Alexander (2000) include "victim-precipitated homicide" as a form of suicidal behavior and recognize that drug and alcohol abuse often play a part in such tragic events. Researchers von der Stein and Podoll (1999) found that self-cutting acts were not accompanied by frank suicidal ideation in 18 percent of 100 male clients with alcoholism hospitalized for detoxification.

Differential Diagnosis

Suicide or suicide attempts can be the result of any substance use or mental disorder; however, suicide is more common in some disorders and more likely to be lethal with particular disorders. Acute suicidal planning or behavior requires immediate intervention; sorting out the differential diagnosis can occur later, once the client is safe. Note that being suicidal does not, in itself, mean that the person has an independent mental disorder.

Prevalence

A recent report from the Centers for Disease Control and Prevention's National Center for Health Statistics indicates that in 2002, suicide was the eleventh leading cause of death for all Americans and the third leading cause of death for people ages 15 to 24 (Kochanek and Smith 2004). Males are four times more likely to die of suicide than are females; however, females are more likely to attempt suicide than are males (U.S. Public Health Service 1999). There

are an estimated 16 attempted suicides for each completed suicide. The ratio is lower in women and youth and higher in men and the elderly. Women and youth try more often and with less success than men; men and the elderly succeed more frequently. In recent years, rates for young adults have soared. Significantly, 50 percent of people who commit suicide have alcohol in their blood (U.S. Public Health Service 1999).

Suicide rates increase with age and are highest among Caucasian males aged 65 and older. Older suicide victims are likely to have lived alone, have been widowed, and have had a physical illness (U.S. Public Health Service 1999). Other population groups also have elevated rates of suicide. Many communities of American Indians and Alaska Natives have elevated suicide rates. Between 1980 and 1996, the rate of suicide among African-American males ages 15–19 increased 105 percent (U.S. Public Health Service 1999).

Risk factors

It has been estimated that "25 to 30 percent of ambulatory clients in general medical practices have a diagnosable psychiatric condition, and a further 10 to 15 percent of people suffering from major psychiatric illnesses such as affective disorder, schizophrenia, and alcoholism will end their lives by suicide" (Blumenthal 1988, p. 937). Suicide rates are particularly high among persons with the following mental disorders (Blumenthal 1988, pp. 944–946):

- Bipolar disorder, particularly at the time of the switch from depression to mania or vice versa (as high as 20 percent)
- Schizophrenia—15 percent end life by suicide
- Antisocial personality disorder—5 percent die by suicide and as many as 46 percent attempt it
- Borderline personality disorder—5 to 10 percent eventually commit suicide, though they may also engage in self-destructive behavior without lethal intent
- Major depression—6 percent
- Substance-induced depression—7 percent

Suicide is also more likely among those with the personality traits of impulsivity, hopelessness, or cognitive rigidity (Blumenthal 1988).

Substance use disorders alone increase suicidality (Inskip et al. 1998), and rates of suicide among persons with the above mental disorders are even higher (roughly doubled) if co-occurring substance use disorders are present. In particular, there is a heightened risk of suicide when relapse occurs after a substantial period of abstinence—especially if there is concurrent financial or psychosocial loss.

Suicidality and chronic medical illness

The presence of a chronic medical illness also is a major risk factor, possibly by causing depression or by producing an organic disorder. Individuals at particular risk include people with epilepsy (who have a suicide rate of four times that of the population as a whole), people with cancer, people with peptic ulcers (probably because of the association of alcoholism with the formation of these ulcers), clients undergoing renal dialysis, people with Huntington's chorea (their suicide rate is six times greater), and people with AIDS. It appears that "severe or incapacitating medical status when associated with depression, alcoholism, organicity, and neurological impairment are important contributing factors leading to diminished judgment and increased impulsivity in medically ill clients" (Blumenthal 1988, p. 951).

Suicidality is a high-risk behavior associated with COD, especially serious mood disorders.

Suicidality and family history

A family history of suicide is a significant risk factor, and there is some evidence that biological factors, such as reduced serotonergic function, contribute to a likelihood of violence against oneself or others (Blumenthal 1988).

Substance Use Among Suicidal Persons

Alcohol and other drug abuse is a major risk factor in suicide, both for those with co-occurring mental disorders and for the general population. Alcohol abuse is associated with 25 to 50 percent of suicides; between 5 and 27 percent of all deaths of people with substance use disorders are caused by suicide, with the lifetime risk for suicide estimated to be 15 percent (Blumenthal 1988). There is a particularly strong relationship between substance abuse and suicide among young people. One study found that as many as 70 percent of adolescent suicide victims had alcohol or substance abuse problems. For people with substance use disorders, the incidence of suicide is 20 times greater than the general population (Blumenthal 1988).

Comorbidity of alcoholism and depression increases suicide risk (Clark and Fawcett 1992), perhaps because these agents exacerbate personality and cognitive problems, and add to environmental stressors. Alcohol also can impair cognitive functioning (Rogers 1992). Using alcohol in attempts to relieve depression, anxiety, and fear often creates more depression and psychological distress, an effect labeled *alcohol myopia* (Steele and Josephs 1990). Alcohol myopia involves narrowing or impaired perception that interferes with inferential thought and makes one "the captive of an impoverished version of reality in which the breadth, depth, and time line of our understanding is constrained" (Steele and Josephs 1990, p. 923).

All substance abuse treatment clients should receive at least a brief screening for suicide.

Thus, the link between alcohol use and suicide goes beyond the pharmacological and interpersonal effects. The association also may be a function of the capacity of alcohol to restrict attention to immediate situations, inhibit the ability to solve current problems, and limit hope for the future (Rogers 1992). "Alcohol and substance use and abuse exacerbate other environmental problems and lessen the ability to cope" (Westefeld et al. 2000, p. 453).

Key Issues and Concerns

The following are key elements of effective suicide prevention.

- All substance abuse treatment clients should receive at least a basic screening for suicidality. All substance abuse treatment professionals should know how to conduct at least basic screening and triage.
- The counselor should know his or her own skills and limitations in engaging, screening, assessing, and intervening with suicidal clients. Work out these issues *before* an emergency.
- Providers are advised to develop clear answers to the following questions: Do you or your agency have the knowledge, tools, skills, and personnel for crisis stabilization and/or ongoing work with suicidal clients? How suicidal can clients be and still be retained in your practice or agency? What about suicidality that emerges later in treatment or in conjunction with a relapse?
- The counselor should know what immediate onsite and offsite resources are available to help with someone identified as suicidal.
- Establish standardized protocols and staff training around suicide screening, assessment, intervention, and/or triage: (1) Who asks? (2) What is asked? (3) When is this

done? (4) Where does this take place? (5) How are findings documented? (6) What is done with the results?

- Suicide "contracts" are written statements in which the person who is suicidal states that he will not kill himself, but rather call for help, go to an emergency room (ER), etc., if he becomes suicidal. These contracts are not effective as the sole intervention for a client who is suicidal. While such contracts often help to make the client and therapist less anxious about a suicidal condition, studies have never shown these contracts to be effective at preventing suicide. What good contracts really do is help to focus on the key elements that are most likely to keep clients safe, such as agreeing to remove the means a client is most likely to use to commit suicide.

Strategies, Tools, and Techniques

Engagement

It is possible, though uncommon, for people with suicidality as their primary complaint to present to substance abuse treatment professionals; it is more likely for them to go to mental health agencies or ERs. Nonetheless, substance abuse treatment counselors should be prepared to detect suicidality. During the course of substance abuse assessment, the suicidal client may appear withdrawn, depressed, or even angry or agitated. It is important to inquire about these symptoms as they appear. For example

- "You know, you seem to be pretty down. How depressed are you?"
- The issue may arise in response to general questions: "Crack? No, I don't use that much any more. I get really down when I'm coming off it." The counselor might then ask, "How down have you gotten? Were you ever suicidal? How are you doing now?"

At issue is the principle that the suicidal client is more likely to engage with the counselor and reveal his or her suicidality if the counselor responds to clues given by the client and inquires sensitively about them. To say to an agitated client, "You seem pretty nervous and uncomfortable—is there something I can do to help?" opens a door to further assessment.

Screening and assessment

Screening

All substance abuse treatment clients should receive at least a brief screening for suicide, such as: "In the past, have you ever been suicidal or made a suicide attempt? Do you have any of those feelings now?" All substance abuse treatment staff should be able to screen for suicidality and basic mental disorders. It is expected that those at the intermediate or advanced levels of COD competence will have additional knowledge and skills.

Risk assessment

No generally accepted and standardized suicide assessment has been shown to be reliable and valid, but most established suicide assessments contain similar elements. A particularly easy-to-use method has been developed by the QPR Institute for Suicide Prevention. Further information and training is available at their Web site (www.qprinstitute.com/).

The QPR Institute's risk assessment interview is designed to elicit information about the individual's current risk of suicide, which then can be used to match the level of care with the level of risk (Quinnett and Bratcher 1996). The authors note that "client answers to an initial seven questions provide the database for clinical decision making, while the client's level of commitment to a safety/treatment management plan determines the level of care, e.g., outpatient, inpatient, evaluation for involuntary admission." See Figure D-1 (p. 330).

While the entire protocol includes 13 questions, the seven questions in Figure D-1 provide rich data that provide a basis for making clinical decisions.

Figure D-1
Key Questions in a Suicide Risk Review

What is wrong?

- Personal narrative about how bad things are and the nature of the problem(s)
- Personal construction of reasons for suicide
- Personal measure of psychological pain and suffering

Why now?

- Elements of the current crisis
- History of real or imagined losses or rejections
- Sudden and unacceptable changes in life circumstances; for example, the client just received a serious or terminal diagnosis, relapse, onset of possible symptoms (e.g., sleeplessness)

With what?

- The means of suicide under consideration
- Access to the means selected

Where and when?

- Possible location and timing of a suicide attempt
- Degree of planning
- Possible anniversary phenomena

When and with what in the past?

- Past history of suicidal behavior
- Past history of intense suicidal ideation and/or planning
- Whether rescue was avoided
- Timing of past attempts
- Social response to past attempts
- Potential protective factors (reasons for living)
- Comparison of current method versus old method

Who's involved?

- Others who may know or be involved
- Persons who may or may not be helpful in managing the client
- Names of potentially helpful third parties
- Possible presence of a suicide pact or murder-suicide plan

Why not now?

- One or more protective factors (reasons for living)
- Spiritual or religious prohibitions

Figure D-1 (continued)
Key Questions in a Suicide Risk Review

- Duties to others or pets
- Residual tasks to be completed before the attempt; for example, making out a will

Source: Quinnett and Bratcher 1996.

Instead of the common "no-suicide" contracts (e.g., "I will go to the ER before taking an overdose"), this protocol recommends a more complete informed consent, safety, and risk management process that requires the client's consent to six key elements. These are

- To remain clean and sober
- To follow medical advice
- To see to the removal of the means of suicide
- To commit to personal safety
- To seek help in case of emergency
- To follow through on referral and/or treatment (Quinnett and Bratcher 1996)

By using this evaluation format or other suicide evaluation tools, the clinician needs to determine whether the risk of imminent suicide is mild, moderate, or high. The clinician must also determine to what degree the client is willing and able to follow through with a set of interventions to keep safe.

Using many of the same indicators, counselors should also be prepared to probe the client's likelihood of inflicting harm on another person. Specifically

- On a scale of 0 to 10, with 0 meaning "not likely at all," how likely are you to harm this person in the next week?
- Do you have a plan for how you would do this?
- Would you be willing to agree not to harm this person during the next week?
- Would you be willing to agree to tell someone before you do this?
- How confident are you that you can remain sober over the next week? What can you do to increase the chances you will remain sober? (e.g., use of 12-Step meetings, supports, or treatment).

Screening personnel should also assess whether suicidal feelings are transitory or reflect a chronic condition. Factors that may predispose a client toward suicide and should be considered in client evaluation can be seen in "Risk Factors" above.

Documentation

In today's managed care environment, intakes are often preprinted with yes/no or other check-off items. For example, some State versions of the Addiction Severity Index (ASI) may include only whether the client has ever had psychiatric care (yes/no) and whether the client is on psychiatric medications (yes/no) or some other abbreviated psychiatric inventory. As noted, it is the view of the consensus panel that because suicidality is common in the substance abuse treatment population, all substance abuse treatment clients should receive at least a brief screening for suicide. If the screen is positive, the client should receive a more thorough assessment as discussed previously. Further screening/assessment should be documented to protect both the client and the counselor. This means writing information on evaluation forms or making additional notes, *even if suicide-related items are not included on the form used.*

Crisis stabilization

The first steps in suicide intervention, and thus crisis stabilization, are contained in the process

of a good engagement and evaluation. Asking suicide-related questions, exploring the context of those impulses, evaluating support systems, considering the lethality of means, and assessing the client's motivation to seek help are in themselves an intervention. Such an interview will often elicit the client's own insight and problem solving and may result in a decrease in suicidal impulses.

If, however, the client experiences little or no relief after this process, then it is clear that psychiatric intervention is required. This is especially true if it emerges that the client has a co-occurring mental disorder or medical disorder in which the risk of suicide is elevated (see "Risk Factors" above) or if the client has a history of suicide attempts. If either or both is true, arrangements should be made for transfer to a facility that is capable of more intensive psychiatric evaluation and treatment. Emergency procedures should be in place so the counselor can accomplish this transfer even when a psychiatrist or clinical supervisor/director are not available. Once the client is stabilized and is safe to return to a less restrictive setting, he or she should return to the program.

Short-term care and treatment

Treatment for the client who is suicidal should include supportive care aimed at helping the client vent feelings, discover alternatives, improve relationships, change negative thinking, and focus on the future (Blumenthal 1988). The clinician should be caring and supportive. The seriously suicidal client should have someone to contact 24 hours a day, and frequent telephone contact between the client and the contact person usually is indicated.

Management of a client who is suicidal "usually requires the assistance of a psychiatric consultant and is clearly indicated for all clients who have a serious plan for suicide or who have made an attempt" (Blumenthal 1988, p. 958). At a minimum, "consultation with a psychiatric colleague who has specialty training in the diagnosis of mental illness is often indicated and may be particularly helpful in the assessment and management of acutely suicidal persons" (Blumenthal 1988, p. 959). The client should be evaluated by a psychiatrist onsite immediately, or a case manager or counselor should escort the client to emergency psychiatric services. Where available, mobile crisis service, which includes a psychiatrist, is another quick response resource for the management of the client who is suicidal.

Case management

Interventions should seek to increase support available to the client from the family and community, and should provide immediate interventions, including medication to stabilize the client's mental state, if needed.

Psychoeducation

Families and individuals often benefit from education about depression and suicidality, including warning signs, resources for help, and the importance of addressing this problem. Education often provides individuals with a sense of hope and realistic expectations. Many individuals will have passive suicidal ideation at one point in their lives. Some individuals will feel reassured to know their feelings are not uncommon and be more willing to share their feelings about their thoughts.

Adapting mental health/substance abuse treatment approaches to specific disorder subtypes

The co-occurrence of substance abuse and suicidal thoughts increases the risk of suicide and requires clinicians to be more active in their management of the problem. People with chronic substance use disorders may need to undergo detoxification and may have cognitive limitations secondary to chronic usage.

Longer term care

Suicidality is not in itself a disease; rather, it is a short-term, acute, and potentially lethal behavior or set of behaviors. Longer term treatment issues for a client who has been suici-

dal focus on long-term treatment strategies for COD or on other risk factors that have culminated in a suicidal event. In this case, treatment becomes long-term prevention. Some persons who are chronically suicidal need special programs that can handle this chronic behavior (American Society of Addiction Medicine 2001).

Among clients with dependence on alcohol, "suicide frequently occurs late in the disease, often in relation to rejection or some interpersonal loss as well as to the onset of medical complications of the illness" (Blumenthal 1988, p. 945). Particular attention should be given to people with long-term dependence on alcohol who are developing medical symptoms, who are experiencing a personal loss or crisis, or who have had a relapse. It is wise to check for suicidal ideation regularly as it can recur. Since relapse is far and away the most dangerous suicide risk in long-term substance abuse treatment clients, the consensus panel recommends a solid long-term recovery plan as the best approach to suicide prevention. In persons with serious and persistent mental disorders, such as bipolar disorder, long-term medication compliance is a key element in preventing suicide. Just as essential as medication and medication compliance, however, is the need to rebuild a sense of hope in the future and engender the belief that recovery from co-occurring disorders is possible and that one has a sense of purpose, value, empowerment, and role in one's own recovery.

Nicotine Dependence

Tobacco dependence is the most common substance use disorder in the United States, and cigarette smoking is the primary preventable cause of disease and deaths in the United States. Smoking causes approximately 450,000 premature deaths among people who use tobacco and an additional 50,000 deaths in nonsmokers from exposure to environmental tobacco smoke (U.S. Public Health Service, Office of the Surgeon General 2004; Ziedonis and Fiester 2003).

Tobacco dependence is present in most clients in mental health and addiction treatment settings. Individuals with behavioral health disorders spend about $214 billion annually on tobacco, and account for 44 percent of all cigarettes smoked in the United States (Lasser et al. 2000). More people with alcohol use disorders die from smoking-related diseases than from alcohol-related diseases (Hurt et al. 1996). Smoking is also linked to depression and substance use disorders. Research repeatedly has shown that, compared with the general population, people who smoke are more likely to abuse substances, and people who abuse substances are more likely to smoke cigarettes. Those who abuse alcohol are two to three times more likely to smoke than the general population (Anthony and Echeagaray-Wagner 2000; Gilbert 1995), and up to seven times more likely to smoke heavily (Collins and Marks 1995). There is no simple reason why so many clients in mental health or substance abuse treatment smoke. As with other addictive disorders, it is likely a combination of complex biological and psychosocial factors (Ziedonis and Fiester 2003).

> Tobacco dependence is the most common substance use disorder in the United States.

Nicotine dependence was first included as a substance use disorder in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III) in 1980. The diagnostic criteria for dependence are the same as other substance use disorders. Of note, unlike all other substances, the DSM only recognizes nicotine dependence (there is no diagnosis of nicotine abuse) because most individuals transition quickly and directly from use to dependence and meet criteria of tolerance and withdrawal. The nicotine withdrawal syndrome develops

after abrupt cessation of or a reduction in the use of nicotine products and is accompanied by four of the following signs and symptoms: (1) dysphoria or depressed mood; (2) insomnia; (3) irritability, frustration, or anger; (4) anxiety; (5) difficulty concentrating; (6) restlessness or impatience; (7) decreased heart rate; and (8) increased appetite or weight gain (APA 2000, p. 266). The withdrawal symptoms also must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Although nicotine is thought to be the primary addictive component in tobacco, it is important to remember that not all forms of nicotine are equivalent. The pharmacology and potential for addiction to nicotine is dependent on its route of entry into the body. Smoking is an extremely efficient route of administration, and delivers the fastest and highest-spiking arterial dose of nicotine. Nicotine delivery from smoking produces levels of nicotine in the body that are many times higher than those achieved with use of nicotine replacement therapies (NRT). Therefore, NRT products do not replicate the perceived effect of smoking.

NRT has been found to be safe in cardiovascular disease and safe in persons who use it while continuing to smoke. Several forms are available without prescription (patches, gum, lozenge), since nicotine is not a carcinogen and there is little abuse potential for nicotine when it is administered in forms other than smoking. Nicotine has a pH of 8, making oral absorption poor. NRT products rely on administration through the skin, or buccal (cheek) or nasal mucosa, and are buffered to increase alkalinity and absorption. Nicotine absorption in the mouth is markedly reduced when it is administered with acidic beverages like sodas, coffee, and juices. Simple instructions not to use the gum, lozenge, or inhaler in conjunction with these beverages can greatly increase the nicotine absorption.

More than two thirds of people who abuse drugs smoke tobacco regularly.

Research has demonstrated that the vast majority of harm associated with cigarettes is attributable to the byproducts of smoking rather than to the effects of nicotine (Slade 1999). In addition to nicotine, unprocessed tobacco smoke includes more than 2,500 compounds, and when manufactured additives and other compounds are taken into account, about 4,000 compounds are present (U.S. Department of Health and Human Services 1988). Smoking is the cause of 90 percent of all lung cancers and nearly all cases of chronic obstructive pulmonary disease, and is associated with a two times greater risk of death from stroke and coronary heart disease. It is also associated with an increased incidence of cancer at a number of other sites, including the larynx, oral cavity, esophagus, cervix, bladder, pancreas, and kidney, and is associated with complications of pregnancy and negative effects on the fetus, including low birth weight (Ziedonis and Fiester 2003; U.S. Public Health Service Office of the Surgeon General 2004). Why do individuals with mental illness or addiction die? Most die of smoking-caused diseases, including cardiac and pulmonary problems, infections, and cancer. Among people who are addicted to narcotics who are in substance abuse treatment, the death rate of smokers is four times that of nonsmokers (Hser et al. 1994). Among people who are in recovery for alcohol abuse who die, 51 percent of mortality is attributed to smoking-related illness, and at 20-year followup the cumulative mortality was 48 percent versus 19 percent expected if a person never smoked (Hurt et al. 1994).

Differential Diagnosis

Unsuccessful quit attempts, difficulty controlling use, and previous withdrawal symptoms during abstinence are criteria for nicotine

dependence in both the DSM-IV (APA 1994) and the ICD-10 (World Health Organization 1992). These sources provide useful descriptions of clinically observed phenomena, and clinicians are advised to familiarize themselves with diagnostic criteria and withdrawal symptoms (see Figure D-2, p. 341). However, unlike other mental disorders, tobacco dependence diagnostic criteria are rarely used in clinical or research settings. Instead, tobacco dependence is usually conceptualized dimensionally rather than categorically. It should be noted that categorical diagnostic schemes based on DSM criteria are not highly correlated with dimensional assessments, such as the Fagerstrom Test for Nicotine Dependence (Moolchan et al. 2002).

Differential diagnosis is a less pressing clinical issue with tobacco dependence than with other substance use and mental disorders. Approximately 80 percent of all people who smoke, and virtually all people who smoke daily, are nicotine dependent. DSM-IV diagnostic criteria are identical to those for other substance use disorders, although DSM does not recognize Nicotine Abuse as a diagnostic category.

Prevalence

Although tobacco dependence is the most common substance use disorder, there are subgroups of individuals with particularly high rates of tobacco dependence. Individuals with mental illness and other substance use disorders are the most common subgroup; however, other important subgroups are known. The prevalence of cigarette smoking is higher at lower socioeconomic levels. Slightly more males than females smoke, although more males than females are successful in stopping smoking. There is evidence that the number of cigarettes smoked per person is increasing, leaving a more hard core and, potentially, more dependent group of people who smoke. There has also been a recent increase in the rate of smoking among adolescents, particularly in the number of teenage girls smoking. This increased smoking rate among adolescents is particularly alarming, as people who smoke typically start smoking at an early age, with more than 60 percent beginning by age 14, and nearly all by age 18 (Ziedonis and Fiester 2003).

Tobacco Dependence Among Individuals With Another Substance Use Disorder

Rates of smoking in people with substance use disorders consistently have been shown to be three to four times higher than in the general population (Berger 1972; Richter et al. 2000; Stark and Campbell 1993*b*), with heavier smoking linked to increased drug or alcohol severity (Hughes 1996; Sussman 2002). More than two thirds of people who abuse drugs smoke tobacco regularly, a rate double that of the rest of the population (Zickler 2000).

An 80 to 90 percent rate of smoking has been found in persons with active alcoholism (Patten et al. 1996). Similar results have been found in people who use illicit drugs, with recent studies finding smoking rates as high as 90 percent among outpatient substance abuse clients (Clarke et al. 2001; Clemney et al. 1997; Stark and Campbell 1993*b*). Heavy smoking is particularly linked with drinking, with 72 percent of people in treatment for alcohol use disorders smoking heavily, versus 9 percent of the general population (Hughes 1995). Smoking also has been shown to be a predictor of greater problem severity and poorer treatment response (Krejci et al. 2003).

People who smoke and have a history of an alcohol problem find nicotine more reinforcing, and meet more nicotine dependence criteria and withdrawal symptoms (Hughes et al. 2000; 2002). This may make consideration of pharmacological approaches crucial, although some clients in recovery from another addiction prefer to quit without medications. There is growing evidence to suggest that many people in substance abuse treatment are interested in smoking cessation treatment simultaneously (Joseph et al. 2002; Saxon et al. 1997), although there is still some debate as to the best time for tobacco treatment during substance

abuse treatment. A recent study by Joseph and colleagues (2003), comparing the timing of tobacco dependence treatment, showed no difference in number of quit attempts, smoking abstinence, or use of NRT between those who received tobacco treatment concurrent with substance abuse treatment, and tobacco treatment that was delayed for 6 months after initiating intensive substance abuse treatment. The overall quit rates were comparable to the general population, with about 18 percent achieving abstinence at 1 year.

Surveys have reported that prevalence rates of smoking in clients in methadone maintenance programs are between 85 and 98 percent (Berger 1972; Stark and Campbell 1993*a*). Smoking status is predictive of illicit substance use in methadone programs and increases in a stepwise fashion from people who do not smoke, to people who smoke but are nondependent, to people who smoke heavily (Frosch et al. 2002). There is a significant positive relationship during treatment between rates of change in heroin use and rates of change in tobacco use.

Tobacco Dependence Among Individuals With Mental Illness

The prevalence of smoking is high among people with all types of mental illnesses, including schizophrenia (70 to 90 percent), affective disorders (42 to 70 percent), and anxiety disorders, especially agoraphobia and panic disorder. Conversely, there is also evidence that affective, anxiety, and substance use disorders may be more common in individuals who smoke than in those who do not or in those who have never smoked. The presence of depressive symptoms during withdrawal is also associated with failed cessation attempts (APA 1996; Ziedonis and Fiester 2003).

Smokers with schizophrenia are more likely to be current smokers (58 to 88 percent versus 23 percent) (Centers for Disease Control and Prevention 2001; National Institute on Drug Abuse [NIDA] 1999), to smoke more (Kelly and McCreadie 1999), and to have ever smoked daily (De Leon et al. 2002). They also smoke more "efficiently" by inhaling more deeply and smoking more of each cigarette (Olincy et al. 1997). People with schizophrenia are less successful in quitting smoking, both in naturalistic settings (Lasser et al. 2000) and in tobacco-dependence treatment trials (Williams and Hughes 2003). Although smoking rates are elevated among all people with mental disorders, individuals with schizophrenia are more likely to smoke than those with other mental disorder diagnoses (De Leon et al. 2002). In addition, smokers with schizophrenia are more likely to experience smoking-related morbidity and mortality than the general population of smokers (Brown et al. 2000; Dalack et al. 1998). The effect of tobacco is that medications are metabolized faster and are cleared from the body more efficiently, causing smokers with schizophrenia to be prescribed higher medication doses. As a result, these people also experience greater medication side effects such as tremor (Kelly and McCreadie 1999), rigidity (Gideon et al. 1994), and possibly tardive dyskinesia (Nilsson et al. 1997).

Key Issues and Concerns

Timing of the quit attempt

A major clinical issue is the timing of the quit attempt. Should an individual try to quit all substances at the same time? Clinicians tend to endorse this strategy for all substances but tobacco. Although there is debate about the best time for tobacco treatment for people in substance abuse treatment, studies suggest that tobacco treatment does not jeopardize recovery from other substances and might improve the outcomes for the other substance use disorder.

Should nicotine dependence treatment be timed to a specific stage of recovery from a mental disorder? There are very limited data to guide this decision other than clinical judgment. Clinical experience suggests that treating tobacco dependence during outpatient treatment when mental disorder symptoms are somewhat

stable appears to be an excellent time to target interventions. Of note, managing tobacco dependence through forced abstinence because of environmental tobacco smoke concerns is necessary, and addressing this issue with appropriate dosages of NRT is warranted.

Effect of tobacco abstinence on psychiatric medication blood levels

Tobacco (not nicotine) is metabolized in the liver by the P450/1a2 isoenzyme, and tobacco's metabolism actually increases the metabolism rate of certain psychiatric medications such as haloperidol, fluphenazine, olanzapine, and clozapine. When an individual stops smoking tobacco, the liver enzymes P450/1a2 become less active and metabolize the psychiatric medications at a slower rate. Therefore there will be an increase in the blood levels of those medications, potentially causing an increase in the medication's side effects or other adverse events, including noncompliance with the medication due to the side effects (APA 1996; Ziedonis and Fiester 2003).

Effect of tobacco abstinence on mental disorders

Some clinicians are concerned about whether tobacco abstinence will worsen mental illness or jeopardize recovery from other substances. This is an important area that needs more research; however, research and clinical experience support the ability of people to quit and not induce relapses or severe worsening of their mental illness. The studies to date report that nicotine dependence treatment for this population is safe and usually well tolerated. However, there have been reports of some increases in psychiatric symptoms during the acute detoxification phase (APA 1996; Ziedonis and Williams 2003*b*).

Effect of trying to quit smoking on recovery from other addictions

Until recently, substance abuse treatment clinicians generally have not addressed the issue of tobacco dependence or provided treatment largely because of the belief that the added stress of quitting smoking would jeopardize the recovery from alcohol or other substances. Research has not confirmed this belief. One study evaluated the progress of residents in an alcoholism treatment facility who were concurrently undergoing a standard smoking cessation program (i.e., experimental group) (Hurt et al. 1994). A comparison group of people with alcohol use disorders who smoked participated in the same program but without undergoing the smoking cessation program. One year after treatment, results indicated that the smoking cessation program had no effect on abstinence from alcohol or other drugs. In addition, 12 percent of the subjects in the experimental group, but none of the subjects in the comparison group, had stopped smoking. Some data suggest that addiction recovery may facilitate nicotine abstinence. In one study, clients participating in concurrent treatment for nicotine addiction during residential treatment for alcohol and other drug abuse achieved at least a temporary reduction in smoking and an increased motivation to quit smoking (Joseph et al. 1990).

The prevalence of smoking is high among people with all types of mental illnesses.

Following the lead of other health facilities, many substance abuse treatment facilities are becoming smoke free, providing a "natural experiment" on the effectiveness of dual recov-

ery programs. Initial evaluations suggest that no-smoking policies are feasible in this setting (Martin et al. 1997). However, no outcome studies have been performed, and additional research is needed.

Effect of tobacco use on craving and other drugs

Researchers have found that craving for tobacco appears to increase craving for illicit drugs among people with substance use disorders who also smoke tobacco. This relationship suggests that people who smoke and are in drug treatment programs may be less successful in staying off drugs than people who do not smoke. Recent research has found that cues that elicited craving for tobacco also elicited craving for the person's drug of choice. This suggests that situations that produce tobacco craving also may result in craving for drugs of abuse (Taylor et al. 2000). The findings suggest that substance abuse treatment efforts will benefit from a more complete understanding of the interrelationships between tobacco and drug craving (Taylor et al. 2000). In a study among patients on methadone maintenance, tobacco craving and heavy smoking appeared to contribute to increased use of cocaine and heroin (Frosch et al. 2000). In a study of people with alcohol use disorders, researchers at Purdue University concluded that alcohol alone can prompt people who smoke to crave a cigarette. In a study of rats, Canadian scientists found evidence that the nicotine in cigarettes can induce a craving for alcohol (Le et al. 2000) among rats trained to drink alcohol. Alcohol consumption increased 20 percent after nicotine exposure and consumption decreased 30 percent after mecamylamine exposure. The researchers hypothesized that nicotine receptors are involved in alcohol consumption and/or self-administration (Le et al. 2000).

> Nicotine dependence can be thought of as a chronic, relapsing illness.

Motivation to quit among individuals with substance use or mental disorders

Many people in mental disorder and substance abuse treatment settings are interested in quitting tobacco, even if the interest is not immediate. In one study 75 percent of substance abuse treatment inpatients accepted the offer of smoking cessation treatment (Seidner et al. 1996). In another study, 53 percent of outpatients reported moderate interest in quitting (Kozlowski et al. 1989). Further, one study of methadone maintenance patients found that 61 percent planned to quit within 6 months, 57 percent were very interested in an on-site cessation program, and 80 percent were interested in nicotine replacement products (Clemmey et al. 1997). Still another study found that 72 to 94 percent of outpatients were not yet ready to quit (Abrams et al. 1996). In conclusion, there often is interest in quitting tobacco, but there is variability in the interest level and there is a need to provide encouragement and support to those who are considering quitting smoking.

Realistic expectations: Tobacco dependence is like other addictions

Nicotine dependence, like other substance use disorders, can be thought of as a chronic, relapsing illness with a course of intermittent episodes alternating with periods of remission for most people who smoke. Only about 3 percent of quit attempts without formal treatment are successful, and in recent years about 30 percent of people who smoke and who want to quit are seeking treatment. Outcomes for nicotine dependence treatment vary by the type of treatment and the intensity of treatment, with specif-

ic reports of 1-year abstinence rates following treatment ranging from about 15 to 45 percent. Cessation attempts result in high relapse rates, with the relapse curve for smoking cessation paralleling that for opioids. Most individuals relapse during the first 3 days of withdrawal and most others will relapse within the first 3 months (APA 1996; Ziedonis and Fiester 2003). Like any other substance, individuals can relapse to tobacco in any stage of recovery.

Strategies, Tools, and Techniques

Engagement

People entering treatment for substance use or mental disorders rarely intend to receive treatment for nicotine dependence. They may be surprised or even annoyed by questions about their smoking. It is important to initially integrate assessment questions about nicotine dependence into an overall assessment and treatment plan, and to be prepared to revisit the topic throughout the course of treatment. This should be done in an empathic and nonjudgmental manner, emphasizing the clinician's concern for the client's general health and well-being. Initial interventions should be tailored to the client's stage of change (Prochaska et al. 1992), with a focus in the earlier stages on providing information, exploring ambivalence, eliciting client concerns, and beginning to envision the possibility of quitting.

For people who smoke who are not yet ready to quit, the clinician can do effective motivational interventions that will keep the client thinking about quitting at some time in the future. Discussing reasons for the person to consider quitting—for example, carbon monoxide (CO) monitor readings, costs, short- and long-term health consequences of smoking, benefits of quitting specific to the individual, and the factors that may have prevented an attempt—is important. Written materials about tobacco dependence and treatment options with brief advice to quit is one method of providing such information and increasing motivation.

Another is to follow the "5 Rs" as outlined in the Surgeon General's guidelines (U.S. Public Health Service, Office of the Surgeon General 2004):

- **Relevance:** Encourage the client to indicate why quitting could be personally relevant, being as specific as possible.
- **Risks:** Motivational information has the greatest impact if it is relevant to a client's disease status or risk, family or social situation (e.g., having children in the home), health concerns, age, gender, and other important client characteristics (e.g., prior quitting experience, personal barriers to cessation).
- **Rewards:** Elicit from clients possible benefits of quitting, with a particular focus on identifying short-term benefits that they will notice immediately.
- **Roadblocks:** Help the client to identify barriers or impediments to quitting. Typical barriers might include withdrawal symptoms, fear of failure, weight gain, lack of support, depression, or enjoyment of tobacco.
- **Repetition:** The motivational intervention should be repeated every time an unmotivated client visits the clinical setting. People who use tobacco and who have failed in previous quit attempts should be informed that most people make repeated quit attempts before they are successful.

Preparation for quitting may include self-monitoring or keeping a diary of smoking, planning rewards for successful abstinence, seeking additional information about treatment, purchasing the medication to aid in quitting, attempting to not smoke in certain situations or locations (such as the car, in the house) to enhance perceived self-control over smoking, and making a list of reasons for and potential benefits of quitting. Sources of social support should also be identified.

Screening and assessment

All clients should be screened for tobacco use beginning with an assessment of current and

past patterns of tobacco use (number of cigarettes smoked per day, times during the day, location, and circumstances). For individuals who currently smoke, a more comprehensive assessment should be completed (see text box below).

In addition to self-reported amount of tobacco use, the amount of tobacco usage can be assessed more objectively through cotinine or CO levels. Cotinine levels can be obtained from the urine, blood, or saliva to assess the amount of nicotine ingested. Cotinine is a primary metabolite of nicotine and remains in the body for several weeks. The expired-air test for a CO level is inexpensive and can be obtained within a minute by any clinician with a CO meter. The CO meter is useful at intake and to monitor for relapse. Higher cotinine and CO levels are associated with a higher number of cigarettes per day and also severity of nicotine withdrawal. Despite the usefulness of these biochemical measures, they are frequently unavailable in clinical settings.

Assessment of tobacco withdrawal symptoms in the past and during the early abstinence period can be helpful. Clients can be educated that these symptoms will reduce substantially after 2 weeks (see Figure D-2).

The severity of nicotine dependence can be assessed with the Fagerstrom Test for Nicotine Dependence (FTND) (see Figure D-3, p. 342), a six-item, self-report measure that has been shown to predict withdrawal symptom and craving severity (Payne et al. 1994). Two questions from the FTND that assess the number of cigarettes per day and time elapsed before the first cigarette have been shown to perform about as well as the full scale (Hajek et al. 2001; Kozlowski et al. 2004). As a clinical guideline, those who smoke at least 10 cigarettes per day have moderate nicotine dependence, while those who smoke more than 20 cigarettes per day have high nicotine dependence. Similarly, those who smoke within 60 minutes of waking can be considered to have moderate dependence, and those who smoke within 30 minutes of waking can be considered to have high dependence. Because of the unique social circumstances of people with schizophrenia, the FTND may not be an ideal measure of nicotine dependence for this popu-

Assessing Nicotine Use and Nicotine Dependence

- Current and past patterns of tobacco use (include multiple sources of nicotine)
- Severity of tobacco dependence (e.g., Fagerstrom Scale)
- Current motivation to quit
- Breath CO level or cotinine level (saliva, blood, urine)
- Assess prior quit attempts (number of attempts and what happened in the more recent attempts), why the client quit, how long the client was abstinent, why the client relapsed, what treatment did the client use (how was it used and for how long)
- Assess withdrawal symptoms
- Psychiatric and substance use histories
- Medical conditions
- Common triggers (car, people, moods, home, phone calls, meals, etc.)
- Perceived barriers against quitting and supports for treatment success
- Preference for treatment strategy

Source: Ziedonis and Fiester 2003.

lation. For example, items intended to assess the need to smoke in response to overnight abstinence may elicit artificially low scores among people who smoke who are not permitted to smoke first thing in the morning by group home staff, day treatment staff, or family members with whom they live (Steinberg et al. 2004*a*).

Assessment of a client's prior tobacco treatment and cessation attempts should include the nature of the prior treatments, length of abstinence, timing of relapse, and factors specifically related to relapse (e.g., environmental or interpersonal triggers). Assessing prior treatments includes assessing medications and psychosocial treatments. Important information about medications includes asking about the dose level of medications and for how long they were taken; any side effects that developed; and how the client actually took the medication. Psychosocial treatments might include group or individual treatment, American Lung Association and other community support groups, hypnosis, acupuncture, or attendance at Nicotine Anonymous meetings. A history of specific withdrawal symptoms and their severity and duration is critical, as is an assessment of

Figure D-2
DSM-IV Criteria for Nicotine Withdrawal

A. Daily use of nicotine for at least several weeks.

B. Abrupt cessation of nicotine use, or reduction in the amount of nicotine used, followed within 24 hours by four (or more) of the following:

(1) dysphoric or depressed mood

(2) insomnia

(3) irritability, frustration, or anger

(4) anxiety

(5) difficulty concentrating

(6) restlessness

(7) decreased heart rate

(8) increased appetite or weight gain

C. The symptoms in criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Associated features:

- Craving for nicotine
- Desire for sweets
- Impaired performance on tasks requiring vigilance
- EEG slowing
- Decrease in catecholamine and cortisol levels
- Decreased metabolism of medications and other substances

Source: APA 2000, p. 266. Reprinted with permission.

the person's social and environmental contexts; for example, whether other household members smoke and the availability of family and social supports (Ziedonis and Fiester 2003).

An assessment should be made of the person's reasons for quitting and his or her motivation, commitment, and self-efficacy (perceived ability to quit). The individual's stage of readiness for stopping smoking is also important; that is, whether the person is not yet seriously considering stopping smoking (precontemplation), is considering attempting to quit but not for several months (contemplation), is seriously considering quitting in the next month and has begun to think about the necessary steps to stop smoking (preparation), or is actually attempting to stop smoking (action).

Patient motivation: Although 70 percent of people who smoke express an interest in quitting, only 8 percent are planning to make a quit attempt in the next month (Wewers et al. 2003). Stages of change can be assessed using the following simple algorithm:

- Client is not planning to quit in the next 6 months (precontemplation)
- Client is planning to quit in the next 6 months, but not the next month (contemplation)
- Client is planning to quit in the next month (preparation)

Client self-efficacy: Clients with little confidence in their ability to quit are less likely to make a quit attempt and less likely to succeed if they do.

Figure D-3
The Fagerstrom Test For Nicotine Dependence

Question	Answer	Score
How soon after you wake up do you smoke your first cigarette?	Within 5 minutes 6–30 minutes 31–60 minutes > 60 minutes	3 2 1 0
Do you find it difficult to refrain from smoking in places where it is forbidden?	Yes No	1 0
Which cigarette would you hate to give up the most?	The first one in the morning Others	1 0
How many cigarettes per day do you smoke?	< 10 11–20 21–30 > 31	0 1 2 3
Do you smoke more frequently during the first hours after waking than during the rest of the day?	Yes No	1 0
Do you smoke if you are so ill that you are in bed most of the day?	Yes No	1 0

Scores are totaled to yield a single value, with scores of 6 or more indicating high nicotine dependence.

Environmental factors and social support: People who smoke find it harder to quit when they live and work alongside other people who smoke, have a high current stress level, or have a history of mental disorders. This is particularly true in mental disorder treatment settings or communal living arrangements where clients are commonly exposed to staff and other clients who smoke.

Client beliefs about smoking and quitting: For example, older adults who smoke may believe that they are less likely to be able to quit, or that they will experience few health benefits if they do so. In fact, most studies find the opposite—that older adults who smoke, (i.e., who have smoked the longest) have a higher probability of success on any given quit attempt (Stapleton et al. 1995). Similarly, some clients and clinicians believe that nicotine causes cancer and that NRTs are dangerous. This is clearly not the case, and addressing this common misconception can help to increase motivation to quit.

Interventions

The U.S. Public Health Service Clinical Practice Guideline on Treating Tobacco Use and Dependence (Fiore et al. 2000*a*) advises clinicians to use the "5 A's" (Ask, Advise, Assess, Assist, Arrange Followup) with every person who uses tobacco who shows a willingness to quit (see chapter 8 for more information). The 5 A's are a brief and simple tobacco intervention that has been shown to increase the quit rates in primary care settings (Katz et al. 2002). Unfortunately, they are rarely implemented by clinicians treating clients in behavioral healthcare settings. This may be because clinicians are unsure how to implement them in daily practice, or because the guideline gives little information on the assessment of tobacco use in these complex clients.

Treatment Planning

All clients who smoke should have tobacco dependence as a problem listed in their treatment plans and motivation-based treatment plans written to match their motivation to address tobacco. Those with less motivation can receive written information and motivational interventions. For clients interested in tobacco dependence treatment a "quit date" should be selected. After cessation, close monitoring should occur during the early period of abstinence. Before the quit date, the person should be encouraged to explore and organize social support for the self-attempt. Plans to minimize cues associated with smoking (e.g., avoiding circumstances likely to contribute to relapse) are important, as is considering alternative coping behaviors for situations with a higher potential for relapse. A telephone or face-to-face followup during the first few days after cessation is critical because this is the time that withdrawal symptoms are most severe, and 65 percent of patients relapse within 1 week. A followup face-to-face meeting within 1 to 2 weeks allows a discussion of problems that have occurred (e.g., difficulties managing craving) and serves as an opportunity to provide reinforcement for ongoing abstinence. Even after the early period of abstinence, periodic telephone or face-to-face contacts can provide continued encouragement to maintain abstinence, allow problems with maintaining abstinence to be addressed, and provide feedback regarding the health benefits of abstinence. Figure D-4, p. 344, provides several strategies for counselors to use in helping clients stop smoking.

How To Treat Tobacco Dependence

Before making a quit attempt, clients should know the psychopharmacological options (i.e., NRT and bupropion) and what to expect while trying to quit. This knowledge may inoculate people who smoke from the frustration they might otherwise experience with the discomfort of quitting. Clients should know about the withdrawal symptoms they may experience, the fact that many people quit several times before quitting successfully, and the potential for minor weight gain. Clinicians should also discuss the timing of the quit attempt to maximize

Figure D-4
Brief Strategies for Smoking Cessation

Action	Strategies for Implementation
Help the client with a quit plan.	A client's preparations for quitting • *Set a quit date*—ideally, the quit date should be within 2 weeks. • *Tell* family, friends, and coworkers about quitting and request understanding and support. • *Anticipate* challenges to planned quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms. • *Remove* tobacco products from your environment. Prior to quitting, avoid smoking in places where you spend a lot of time (e.g., work, home, car).
Provide practical counseling (problem solving/skills training).	*Abstinence*—Total abstinence is essential. "Not even a single puff after the quit date." *Past quit experience*—Identify what helped and what hurt in previous quit attempts. *Anticipate triggers or challenges in upcoming attempt*—Discuss challenges/triggers and how client will successfully overcome them. *Alcohol*—Since alcohol can cause relapse, the client should consider abstaining from alcohol while quitting. *Other smokers in the household*—Quitting is more difficult when there is another smoker in the household. Clients should encourage housemates to quit with them or not smoke in their presence.
Provide intra-treatment social support.	Provide a supportive clinical environment while encouraging the client in his or her quit attempt. "My office staff and I are available to assist you."
Help client obtain extra-treatment social support.	Help client develop social support for his or her quit attempt in his or her environments outside of treatment. Have the client ask his or her spouse/partner, friends, and coworkers to support the client in the quit attempt.
Recommend the use of approved pharmacotherapy, except in special circumstances.	Recommend the use of pharmacotherapies found to be effective in this guideline. Explain how these medications increase smoking cessation success and reduce withdrawal symptoms. The first-line pharmacotherapy medications include bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and nicotine patch.
Provide supplementary materials.	*Sources*—Federal agencies, nonprofit agencies, or local/State health departments. *Type*—Culturally/racially/educationally/age appropriate for the client. *Location*—Readily available at every clinician's workstation.

Source Fiore et al. 2000*a*, *b*.

the chances for success. In contrast to other drugs of abuse, it is recommended that people who smoke take 2 to 4 weeks to prepare for the quit date. Clients with few mental health problems may be ready in 2 weeks, while people with more serious mental illnesses should take longer to prepare. Once a quit date is set, a decision must be made regarding making an abrupt or gradual change. Making a gradual change has the disadvantage of making each cigarette more enjoyable as the number of cigarettes decreases, with the result that the last few cigarettes may be very difficult to give up.

Other preparatory strategies include using "behavioral disconnects," publicizing the planned quit attempt, and creating a detailed coping plan for dealing with cravings after the quit date. Behavioral disconnects involve using the preparation time to practice not smoking in the client's usual contexts. For example, if the client is accustomed to smoking while speaking on the telephone, he or she can practice speaking on the phone without smoking cigarettes. This strategy has the dual benefit of increasing self-efficacy if done successfully and of decreasing psychological cravings in the presence of the client's usual smoking cues.

By publicizing the planned quit attempt, the client is likely to feel more committed to following through on the quit day. It is helpful to tell as many significant others as possible, including all friends, family, coworkers, and so on. Telling other treatment staff is also important, as supportive treatment staff can play a key role in encouraging the change. The client should also be informed of the potential effects of smoking on psychotropic medications, as aromatic hydrocarbons (tar) in the tobacco smoke increases the metabolism of many of the medications the client may be taking. Upon quitting smoking, the medications may need to be adjusted accordingly.

Publicizing the planned quit attempt will also help in gathering the social support needed to be successful. Significant others who do not smoke are likely to be supportive, and those who do smoke can be put on notice that they should not offer cigarettes or sabotage the quit attempt. The detailed coping plan should include having a reference sheet with several individualized reasons for quitting, names and phone numbers of supportive others to call, and a list of distracting activities, preferably those that are inconsistent with smoking (e.g., exercising, playing with children).

As the quit date approaches, stimulus control techniques should be implemented, such as removing all tobacco product cues (e.g., cigarettes, lighters, ashtrays) from the client's environment. The client should also make sure others do not smoke in the home, be prepared to sit in non-smoking areas, and avoid smoking cues that can be avoided.

Avoiding smoking cues is often difficult for people who smoke and have other substance use or mental disorders. Clients with other substance use disorders may be faced with smoke-filled 12-Step program meetings, sponsors who smoke, or even sponsors who discourage them from quitting. Clients with mental disorders may be faced with group home housemates who smoke and day treatment programs populated by people who smoke. It is helpful to have other supportive treatment staff to intervene in these circumstances to facilitate the quit attempt. Regardless of the co-occurring disorder, it is important to take into account the specific deficits or circumstances secondary to the disorder.

An in-person or telephone followup contact should occur within 2 days of the quit date. Clinicians and clients should have an action plan for managing a lapse or relapse, and this plan should be activated if the client slips and has a cigarette. After the client has quit, relapse prevention strategies should be used. Popularized by Marlatt and Gordon (1985), relapse prevention is a well-established, empirically based approach using cognitive–behavioral therapy techniques to teach people to avoid and/or cope with triggers to use addictive substances. Since cravings or urges to use addictive substances are common issues for clients seeking treatment for substance use dis-

orders (including nicotine dependence), clients are taught how to manage and cope with these feelings and avoid smoking cues whenever possible. Common cues for smoking include the people, places, and things associated with tobacco use as well as negative mood states like anger or sadness. These cues can trigger smoking behavior and can be lessened through psychosocial interventions.

Medications for nicotine dependence treatment

Six medications have received Food and Drug Administration (FDA) approval for nicotine dependence treatment, and the practice guidelines recognize these medications as first-line treatments (Fiore et al. 2000*a*). These treatments are effective for about 25 to 30 percent of people in the general population who smoke on any one attempt, and this rate increases with combined psychosocial treatment. These medications have similar success rates but have side effect differences.

The five types of NRTs are administered in a variety of ways: nicotine polacrilex (gum), nicotine transdermal patch, nicotine inhaler, nicotine nasal spray, and the nicotine lozenge. These medications are similar in how they reduce nicotine withdrawal and urge to smoke, and improve abstinence rates and client satisfaction. The only FDA-approved nonnicotine treatment is bupropion SR (marketed as Zyban SR) for tobacco addiction and Wellbutrin SR for treatment of depression. Bupropion's effect on tobacco dependence, however, is independent of depression status.

Relapse prevention uses social skills training to teach drug refusal skills.

Bupropion SR has proven effectiveness in clients with or without past depression medication treatment.

Most people who smoke and who have mental disorders smoke heavily. People who smoke heavily usually have higher CO and cotinine levels, higher Fagerstrom nicotine dependence scores, more nicotine withdrawal symptoms, and experience mood difficulties during withdrawal. There is some evidence to suggest titrating the dosage of NRT to the cotinine levels in the client. People who smoke heavily may have improved outcomes with higher NRT dosages (multiple NRTs simultaneously, multiple NRT patches), adding bupropion SR, and integrating behavioral therapies. There is one report that high-dose patch treatment resulted in 40 percent fewer withdrawal symptoms and 2.5 times greater reductions in craving in a pilot study of people with schizophrenia who smoked, and was well tolerated, although larger trials are needed.

Specific psychosocial treatments for tobacco dependence

Psychosocial treatments for nicotine dependence are among the first-line treatments in several practice guidelines (APA 1996; Fiore et al. 2000*a*). Because behavioral health treatment providers (i.e., those treating substance use and/or mental disorders) possess many of the skills needed to provide tobacco dependence services, intensive interventions may be well suited to a mental or substance use disorder treatment setting. Data support the use of psychosocial interventions for tobacco dependence as provided by various counselor disciplines (e.g., physicians or nonphysicians), and via multiple treatment modalities (e.g., telephone, group, and individual counseling). Although there is a clear dose-response relationship between counseling intensity and success, even very brief counseling can increase quit rates (Fiore et al. 2000*a*).

Despite the strong evidence that psychosocial treatments are effective for treating tobacco dependence, only 5 percent of people who smoke who make a 24-hour quit attempt receive counseling as part of their treatment (Zhu et al. 2000). Clients who are motivated to quit smoking should be taught general problemsolving skills, provided with social support as part of counseling, and assisted in gaining social support from family and friends for their quit attempt.

Psychosocial interventions have been successfully adapted for people with schizophrenia who smoke (Addington et al. 1998; George et al. 2000; Steinberg et al. 2004*a*; Ziedonis and George 1997), depression (Hall et al. 1994, 1995, 1996, 1998, 1999), and substance use disorders (e.g., Burling et al. 2001; Patten et al. 1998, 2001). Successful adaptation involves blending traditional mental health services with tobacco dependence treatments while addressing the unique problems associated with the specific mental disorder. Integrating medications with these psychosocial treatments is also very important, since these groups are often highly dependent on tobacco.

While clinicians are often hesitant to help clients with serious mental illness who smoke to quit smoking, the Clinical Practice Guideline (Fiore et al. 2000*a*) recommends that tobacco use be addressed in all clients who smoke. While many excuse smoking in this population, it should be recognized that smoking exacerbates many existing problems. When compared with people who do not smoke, those with schizophrenia who smoke exhibited more positive symptoms of schizophrenia (Goff et al. 1992; Ziedonis et al. 1994) and experienced more hospitalizations than their counterparts who did not smoke (Goff et al. 1992; Kelly and McCreadie 1999). People with schizophrenia who smoke often are prescribed more antipsychotic medication than people with schizophrenia who do not smoke, due to an increased metabolism of many psychiatric medications secondary to the "tar" or aromatic polynuclear hydrocarbons—not due to nicotine (Goff 1992; Hughes 1993; Ziedonis 1994). They also experience greater medication side effects such as tremor (Kelly and McCreadie 1999), rigidity (Ziedonis et al. 1994), and possibly tardive dyskinesia (Nilsson et al. 1997). Tobacco use also depletes their already scarce financial resources. Cigarettes may constitute up to 27 percent of the monthly budget for people with schizophrenia who smoke (Steinberg et al. 2004*a*). A recent study indicated that a brief motivational interviewing intervention was effective in motivating people with schizophrenia who smoked to seek formal tobacco dependence treatment (Steinberg et al. 2004*b*).

Relapse prevention also uses social skills training to teach drug refusal skills. Since seeing others smoke is a strong predictor for relapse, this approach is very important for those living in a group home or attending a substance abuse treatment or mental health services setting where smoking may be ubiquitous. Specialized treatments for this group should incorporate techniques for reducing the appeal of smoke breaks and learning to avoid "bumming" cigarettes or accepting an offered cigarette. Interactive teaching through role playing can enhance this type of learning and allow for real-world practicing. Raising awareness of the stigma related to these drug-seeking and drug-use behaviors can also help to change behavior. Creating a relapse analysis is helpful to understand the role of "seemingly irrelevant decisions" in the path toward a relapse. An example of a "seemingly irrelevant decision" might be a relapse to smoking after dining in the smoking section of a restaurant rather than sitting in the nonsmoking section.

Relapse prevention also distinguishes between a "lapse" and a "relapse" as a matter of degree and severity. There is a focus on trying to avoid letting a "lapse" become a "relapse" by quickly managing the situation and framing it as a learning opportunity in an effort to return to abstinence. This model allows for some mistakes as the client is working toward a goal of abstinence. Figure D-5 (p. 348) presents strategies for helping clients address situations that may lead to relapse.

Figure D-5

Brief Strategies 2. Components of Prescriptive Relapse Prevention

During prescriptive relapse prevention, a client might identify a problem that threatens his or her abstinence. Specific problems likely to be reported by clients and potential responses follow:

Problems	Responses
Lack of support for cessation Negative mood or depression	• Schedule followup visits or telephone calls with the client. • Help the client identify sources of support within his or her environment. • Refer the client to an appropriate organization that offers cessation counseling or support. • If significant, provide counseling, prescribe appropriate medications, or refer the client to a specialist. • If the client reports prolonged craving or other withdrawal symptoms, consider extending the use of an approved pharmacotherapy or adding/combining pharmacological medications to reduce strong withdrawal symptoms.
Strong or prolonged withdrawal symptoms	• If the client reports prolonged craving or other withdrawal symptoms, consider extending the use of an approved pharmacotherapy or adding/combining pharmacological medications to reduce strong withdrawal symptoms.
Weight gain	• Recommend starting or increasing physical activity; discourage strict dieting. • Reassure the client that some weight gain after quitting is common and appears to be self-limiting. • Emphasize the importance of a healthy diet. • Maintain the client on pharmacotherapy known to delay weight gain (e.g., bupropion SR and NRTs, particularly nicotine gum). • Refer the client to a specialist or program.
Flagging motivation/feeling deprived	• Reassure the client that these feelings are common. • Recommend rewarding activities. • Probe to ensure that the client is not engaged in periodic tobacco use. • Emphasize that beginning to smoke (even a puff) will increase urges and make quitting more difficult.

Source: Fiore et al. 2000*a*, *b*.

Personality Disorders (Overview)

Description

Personality disorders (PD) are rigid, inflexible, and maladaptive behavior patterns of sufficient severity to cause significant impairment in functioning or internal distress. Personality disorders are enduring and persistent styles of behavior and thought, rather than rare or unusual events in someone's life. Furthermore, as opposed to a response to a particular set of circumstances or particular stressors, people with personality disorders carry with them these destructive patterns of thinking, feeling,

and behaving as their way of being and interacting with the world and others.

Though sudden stressful circumstances might worsen the response of a client with a PD, such a client experiences the disorder regularly and often pervasively. Clients with PDs frequently are unaware of the impact of the disorder on their personality, behaviors, and interactions with others. Sometimes clients with PDs blame others or the world for misery that they clearly bring upon themselves.

The course and severity of PDs can be worsened by the presence of other mental disorders such as mood, anxiety, and psychotic disorders. Furthermore, of the roughly 10 different types of PDs that can be described, people with any one of the disorders are at an increased likelihood of having another—that is, though the different PDs can be discussed as if they were separate entities, in clinical practice, clients often have more than one PD and might well have features of many.

"Mixed personality disorder," the mental health equivalent of "polysubstance abuse," describes individuals who meet the diagnostic criteria for more than one PD. This TIP provides details about two of the PDs—borderline personality disorders (BPDs) and antisocial personality disorders (APDs). Before exploring BPD and APD in detail, a brief overview of the other PDs follows. However, the reader should keep in mind that the diagnostic approach to personality disorders is slated for significant change and refinement, as there have been numerous concerns expressed about the meaningfulness and utility of the current system for diagnosing personality disorders (see footnote[1] for more information).

Personality disorders grouped into clusters A, B, or C

The PDs include paranoid, schizoid, schizotypal, histrionic, narcissistic, antisocial, borderline, avoidant, dependent, and obsessive-compulsive. In the DSM-IV-TR (pp. 690–730), PDs are conceptualized as three distinct clusters, "A," "B," and "C:"

- Cluster A: Paranoid PD; Schizoid PD; and Schizotypal PD
- Cluster B: Antisocial PD; Borderline PD; Histrionic PD; and Narcissistic PD
- Cluster C: Avoidant PD; Dependent PD; and Obsessive-Compulsive PD

Cluster A

Cluster A PDs describe clients who may be seen as "odd-eccentric."

People with *paranoid personality disorder* are pervasively distrustful and suspicious to a degree that routinely interferes with their forming a correct perception of the motives and beliefs of others, and with their successfully forming positive relationships with others. They may interpret other people as trying to threaten, demean, or intimidate them, even when such behavior is not exhibited.

Schizoid personality disorder is descriptive of a person whom others often see as a "loner" and who commonly exhibits an indifference to the views and feelings of others. People with a schizoid personality disorder have a restricted range of emotional experience and expression.

People with a *schizotypal personality disorder* often behave in ways others see as weird, with possible peculiarities of speech, dress, and/or

[1]A group of clinicians committed to a research agenda for the development of DSM-V have given the following assessment of the status of personality disorders within the DSM-IV-TR (APA 2000): "… there is notable dissatisfaction with the current conceptualization and definition of the DSM-IV-TR (APA 2000). Problems identified by both researchers and clinicians include confusion regarding the relationship between the DSM-IV-TR personality disorders (especially those that are chronic and have their onset in childhood or adolescence); excessive comorbidity among the DSM-IV-TR personality disorder; arbitrary distinction between normal personality, personality traits, and personality disorders; and limited coverage (the most common diagnosed personality disorder is the residual diagnosis of personality disorder not otherwise specified)" (First et al. 2002).

beliefs. These strange or markedly unusual characteristics often produce avoidance or wariness in others, and the resulting difficulties in interpersonal relations may lead to anxieties and depression.

Cluster B

Cluster B PDs include histrionic PDs and narcissistic PDs, in addition to the borderline and antisocial PDs (which are discussed in detail in following sections). The general characterization of the Cluster B dimensions is "dramatic-emotional."

Histrionic personality disorder is expressed in excessive emotionality and attention seeking, often including inappropriate sexually seductive behaviors.

Clients with *narcissistic personality disorder* exhibit a "pervasive pattern of grandiosity, need for admiration, and lack of empathy" (APA 2000, p. 714). While a certain self-centeredness and falsity are common with addictive disease, a client with a true narcissistic disorder displays a grandiosity, over-inflates the value of his or her own abilities, and displays a superiority that is so distorted as to impair his or her judgment. People with narcissistic PD and substance use disorders will exhibit these features even after achieving and maintaining abstinence.

Antisocial personality disorder involves a history of chronic antisocial behavior that begins before the age of 15 and continues into adulthood (though the diagnosis cannot be made officially unless a person is at least 18 years old). The disorder is manifested by a pattern of irresponsible and antisocial behavior indicated by illegal activities, recklessness, impulsive behavior, academic failure, and poor job performance. Other features often include dysphoria, an inability to tolerate boredom, feeling victimized, and a diminished capacity for intimacy.

Borderline personality disorder is characterized by unstable mood and self-image, and unstable and intense interpersonal relationships. These people often display extremes of overidealization and devaluation, marked shifts from baseline to an extreme mood or anxiety state, and impulsiveness.

Though people with APD are more likely to be male and those with BPD female, APD and

Figure D-6

Characteristics of People With Antisocial and Borderline Personality Disorders

Characteristic	Antisocial	Borderline
Affect	Angry intimidation	Angry self-harm
World view	*If you don't do what I want, you'll be sorry.* *I deserve it all.* *They're the ones with the problem.*	*I've got to get you before you get me.* *I don't deserve to exist.* *Help me, help me, but you can't.*
Presenting problem	Legal difficulties, polysubstance abuse and dependence, parasitic relationships	Self-harm, impulsive behavior, episodic polysubstance abuse, hot-and-cold relationships
Social functioning	Episodic achievement	Gross dysfunctioning
Motivation	Self-esteem	Safety
Defenses	Rationalization, projection	Splitting, projection

BPD have a number of features in common. Both disorders tend to diminish in intensity with age, and sometimes even remit after a client reaches age 40 or so. People with APD or BPD are likely to show features of other PDs. Both APD and BPD are commonly associated with a co-occurring substance use disorder as well as with other significant (Axis I) mental health complaints. Characteristics of people with APD and BPD are presented in Figure D-6.

Cluster C

Cluster C PDs include avoidant PD, dependent PD, and obsessive-compulsive PD and describe clients who are "anxious-fearful."

People with *avoidant personality disorder* show extreme hypersensitivity to others, social discomfort, and timidity, often with accompanying depression, anxiety, and anger for failing to develop social relations.

People with *obsessive-compulsive personality disorder* display a preoccupation with orderliness, perfectionism, and control, and they may appear excessively conscientious, moralistic, scrupulous, and judgmental. Symptoms may include distress associated with indecisiveness and difficulty in expressing tender feelings, feelings of depression, and anger about feeling controlled by others.

Clients with *dependent personality disorder* live with a pervasive and excessive need to have others take care of them. Individuals with a dependent PD typically have severely low self-esteem, and their behavior often is submissive and clinging. Such individuals are at risk of forming abusive relationship and even of failing to protect their children from abuse.

Differential Diagnosis

The clinical situation often is challenging when working with clients who have both a PD and a substance use disorder. PDs should not be diagnosed during substance use or withdrawal as misdiagnosis can easily occur if the current and historical roles of substance use are not properly assessed. A period of abstinence is often required before the co-occurrence of a PD with a substance use disorder can be determined. If a PD coexists with substance use, the PD will remain during abstinence. When a *bona fide* co-occurring PD exists, during abstinence and recovery the PD symptoms can get worse and the functioning level of the client might even deteriorate, though over time improvement and greater stability are possible for the client with co-occurring personality disorder and substance use disorder who receives effective care for both.

Some criteria that describe PDs (e.g., dependency or insensitivity) are also characteristic of other Axis I disorders. Three PDs—paranoid, schizoid, and schizotypal—may be distinguished from psychotic disorders by being observed when the client is clearly not experiencing a psychotic episode (APA 2000).

Counselors are cautioned to take into account the individual's ethnic, cultural, and social background when judgments are made about personality functions. To make a sound judgment when working with a client who has an unfamiliar cultural background, it is a good idea to consult with someone who is familiar with that culture to gain a sense of norms and alternative, culturally consonant explanations of observed behaviors.

Prevalence

Nace (1990) contends that the prevalence of PDs is at least 50 percent in substance-abusing populations. Brooner et al. (1997) found that 35 percent of the 716 consecutive admissions to a methadone maintenance program had a personality disorder, while Flynn et al. (1996) in the large Drug Abuse Treatment Outcome Study of over 7,400 clients with substance dependence found antisocial personality disorder in 34.7 percent for alcohol-only clients, 27 percent for heroin only, 30.4 percent for cocaine only, percentages in the mid-40 percent range for clients dependent on two of these three drugs, and 59.8 percent for clients dependent on all three drugs. As noted, howev-

er, no diagnosis should be made during the acute phase of detoxification. The early phases of treatment involve addressing behaviors that may appear to be symptoms of PDs, especially BPD. Thus, counselors should exercise care not to rush to conclude that a patient or client has BPD.

Among Cluster A disorders ("odd-eccentric"), paranoid PD has been reported to be 0.5 to 2.5 percent in the general population, as high as 10 to 30 percent among those in inpatient mental health settings, and 2 to 10 percent among those in outpatient mental health clinics (APA 2000). One study found 44 percent of persons in treatment for alcoholism to have this disorder (Dowson and Grounds 1995). Another study (Verheul et al. 2000) found through semi-structured interviews that 13.2 percent of a group of 370 patients in treatment for substance abuse warranted a diagnosis of a paranoid personality disorder. Schizoid PD is believed to be uncommon in clinical settings (APA 2000). Similarly, although up to 3 percent of the general population may be affected by schizotypal PD (APA 2000, p. 699), the prevalence rate even in substance abuse treatment programs that treat clients with COD appears to be quite low.

Among Cluster B disorders ("dramatic/emotional"), about 1 percent of females and 3 percent of males in the general population are believed to have antisocial PD. In clinical settings, the prevalence is estimated to be anywhere from 3 percent to as high as 30 percent, with especially high prevalence in substance abuse treatment and prison settings (APA 2000). Among the male prison population, 20 percent or more may have antisocial PD. Borderline PD also is relatively common in mental health settings. Although only about 2 percent of the general population has this disorder, its incidence is about 10 percent of mental health clinic outpatients and 20 percent of mental health inpatients. From 30 to 60 percent of other clinical populations may have this disorder. One study of 370 clients in substance abuse treatment (Verheul et al. 2000) found that more had Cluster B diagnoses (27 percent antisocial PD and 18.4 percent borderline PD) than either Cluster A (13.2 percent) and Cluster C (18.4 percent avoidant).

The DSM-IV suggests prevalence rates of 2 to 3 percent for histrionic PD in the general population and 10 to 15 percent in mental health settings; there is reason to believe the 10 to 15 percent estimate would also be true of substance abuse treatment settings (APA 2000). Prevalence rates for narcissistic PD are estimated to be roughly similar to those for histrionic PD—from 2 to 16 percent in the clinical population (APA 2000) and about 10 to 15 percent in the clinical practice of a substance abuse counselor.

Among Cluster C disorders ("anxious/fearful"), avoidant PD and obsessive-compulsive PD probably each make up at most 10 percent of clients at mental health clinics. With a rate in the general population of less than 1 percent for each, substance abuse counselors seldom see pure forms of these types of PDs in clinical practice. On the other hand, persons with dependent PD are "among the most frequently… encountered in mental health clinics" (APA 1994).

Again, the reader is cautioned that the utility and meaningfulness of the Cluster groupings and/or the distinctiveness of the 10 separate "personality disorders" is in doubt. Bohn and Meyer (1999) report that frequencies of antisocial PD "in samples of alcoholic patients have ranged from 16 to 49 percent. Somewhat higher rates have been detected among opioid- and other drug-abusing populations. *The frequency of occurrence of ASPD [antisocial PD] varies depending on the type of sample and the diagnostic criteria used* [emphasis added] (Hesselbrock et al. 1985; Rounsaville et al. 1983). The higher reported prevalence rates of ASPD among substance-dependent patients since 1980 … are likely a function of the broad diagnostic criteria applied to this disorder by DSM-III, DMS-III-R, and DSM-IV, rather than of a real change in the patient population" (Bohn and Meyer 1999, p. 99). In fact, North and colleagues found that antisocial PD appeared to change little over 20 years within

the homeless population, with 10 to 20 percent of homeless women and 20 to 25 of homeless men receiving diagnoses of antisocial PD (see North et al. 2004).

Substance Use Among People With Personality Disorders

Substance use may trigger or worsen personality disordered behaviors. No single pattern of substance use or abuse can be identified for any one PD; the drug or drugs of abuse depend on many factors beyond the presence of a specific PD. For example, individuals with paranoid PD may prefer stimulants to augment their need to be vigilant or they may seek opioids to reduce the severe tension generated by their fear and distrust.

Plans to place the diagnosis of PDs on a solid research foundation (including the ever-growing body of neurobiological knowledge) that will yield diagnoses useful for clinical practice (Kupfer et al. 2002) envision significant changes to the DSM-IV-TR presentation of PDs. In brief, it seems that a more complex and psychometrically based set of categories and measurement dimensions will be utilized instead of 3 clusters and 10 PDs. The meaningful and useful relationships among the behaviors and treatment considerations relevant for people with personality disorders may well match up with categories and dimensions that are not clearly enough represented by the current schema to yield treatment decisionmaking information. Perhaps the future understanding of people with personality disorders and DSM-V will be useful to enhance the treatment responses of these individuals, as the one thing that is already clear from the available research is that these individuals can change and profit from treatment.

Key Issues and Concerns

Clients with PDs tend to have difficulty forming a genuinely positive therapeutic alliance. They tend to frame reality in terms of their own needs and perceptions and to be unable to understand the perspectives of others. Also, most clients with PDs are limited in terms of their ability to receive, accept, or benefit from corrective feedback. A further difficulty is the strong countertransference clinicians can have in working with these clients, who are adept at "pulling others' chains" in a variety of ways. Specific concerns will, however, vary according to the PD and other individual circumstances. In general, group therapies, therapeutic communities, and more rationally oriented, directive, behavioral forms of treatment have been thought to be particularly appropriate for people with PDs.

> Substance use may trigger or worsen personality disordered behaviors.

Borderline Personality Disorder

Description

One of the most prominent features of people with BPD is instability. Their relationships with others are likely to be unstable, with reports of how wonderful an individual is one day and expressions of intense anger, disapproval, condemnation, and even hate toward that same individual a week later. Then a month later the person with BPD is once again singing the praises of the same person. These reactions can be unsettling for a counselor, especially if it is the counselor who is being held in high esteem one minute and accused of every form of deceit the next. The severe instability experienced by the person with BPD includes fluctuating views and feelings about him- or herself. Those with BPD often feel quite good about themselves and their progress and optimistic about their future for a few days or

weeks, only to have a seemingly minor experience turn their world upside-down with concomitant plunging self-esteem and depressing hopelessness.

Basic instability extends to work and school, where it sometimes seems that people with BPD "snatch failure out of the jaws of success." Individuals with BPD might well be engaging and attempt to please initially, then become demanding, hostile, and exhausting. When experiencing emotional states they cannot handle, clients with BPD can be at risk of suicidal, self-mutilating, and/or brief psychotic states.

Since people with BPD typically seek mental health or substance abuse treatment based on their current life conditions and emotional state, it is likely that the person with BPD who seeks mental health treatment is acutely emotionally distraught, needing some relief from how she or he feels. Similarly, the client with BPD who chooses (or is directed to choose) a substance abuse treatment program probably is experiencing the substance use disorder as the immediate target for treatment. Consequently, the average admission of a person with BPD to a mental health environment might, in general, be considerably different from the average admission of a person with BPD to a substance abuse treatment setting.

Evidence is accumulating that BPD, posttraumatic stress disorder (PTSD), and a history of childhood abuse occur with regularity among women in substance abuse treatment (Gil-Rivas et al. 1996; Sullivan and Evans 1994). Women with BPD are more likely to have eating disorders or PTSD, while men are more likely to have co-occurring substance use disorders, along with PTSD and other personality disorders (Johnson et al. 2003).

Substance Use Among People With BPD

Individuals with BPD are often skilled in seeking multiple sources of medication that they favor, such as benzodiazepines. Once this medication has been prescribed in a mental health system, they may demand that it be continued. Confrontation or pressure to engage in detoxification or outpatient withdrawal can precipitate intense rage and various levels of client crises.

Individuals with BPD may well associate drugs with social interaction and use the same drugs of choice, route of administration, and frequency as the individuals with whom they are interacting. On the other hand, they often use substances in chaotic and unpredictable patterns. Polydrug use is common and may involve alcohol and other sedative-hypnotics taken for self-medication.

People with BPD usually have big appetites; they experience powerful, emotion-driven needs for something outside of themselves. If they do give up alcohol and other drugs, perhaps because they are experiencing a positive relationship to a service provider or a group, they are extraordinarily vulnerable to meeting their needs through other compulsive behaviors. Newly abstinent individuals with BPD must be monitored for compulsive sexual behavior, compulsive gambling, compulsive spending/shopping, or other out-of-control behaviors that result in negative or even dangerous consequences.

At the beginning of a crisis episode, a client with BPD might take a drink or a different drug in an attempt to quell the growing sense of tension or loss of control. What the client needs to learn is twofold: (1) that a drink/drug at that point *increases* the harm and real loss of control, and (2) that at the point where a drug/drink is desired some other, *positive* coping strategy needs to be put into play immediately.

Key Issues and Concerns

Progress with clients who have BPD can be slow. Therapists should be realistic in their expectations and know that clients will try to test them. To respond to such tests, therapists should maintain a matter-of-fact, businesslike attitude, and remember that people with PDs often display maladaptive behaviors that have

helped them to survive in difficult situations, sometimes called "survivor behaviors." (See TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* [Center for Substance Abuse Treatment (CSAT) 2000*d*].)

It is important to educate clients about their substance use and mental disorders. Clients should learn that treatment for and recovery from their substance use disorder may progress at a different rate than their treatment for and recovery from BPD. In addition, while many clients appear to fully recover from their substance use disorders, the degree of long-term recovery from BPD is less understood and characterized. Written and oral contracts that are simple, clear, direct, and time-limited can be a useful part of the treatment plan. Contracts can help clients create safe environments for themselves, prevent relapse, or promote appropriate behavior in therapy sessions and in self-help meetings.

Treatment of people with BPD requires attention to several issues, such as violence to self or others, transference and countertransference, boundaries, treatment resistance, symptom substitution, and somatic complaints.

Key Issues and Concerns in the Treatment of Borderline Personality Disorders

- Slow progress in therapy
- Suicidal behavior
- Self-injury or harming behavior
- Client contracting
- Transference and countertransference
- Clear boundaries
- Resistance
- Subacute withdrawal
- Symptom substitution
- Somatic complaints
- Therapist well-being

Strategies, Tools, and Techniques

Engagement

Safety is an anchor for clients with BPD, for whom abandonment and fear of rejection often are core issues. Counselors should recognize that acting-out behavior common to people with BPD is a maladaptive survivor response that expresses a need for safety. Indeed, the client's primary motivation for treatment may be a desire for safety. Therapists should discover what safety means to the client.

Soon after entering into a therapeutic alliance, the reliability of the counselor can have strong symbolic importance to the client and the strengthening of the relationship between client and counselor. Showing up on time, being there throughout the time period expected, and not allowing interruptions can have a strong and positive effect on the client and the client's response to treatment. Alternatively, disruptions in the sense of the counselor's reliability and trust can have negative fallout. Even what might seem to the counselor to be a minor event can be a blow to a client's shaky emotional state and interfere with the client–counselor relationship. The therapist's absence, even for brief periods, can prompt acting-out behavior.

Therapists can learn how clients create their own feelings of safety by asking them about safe spots, magic getaway places, closet-sitting, rocking or other repetitive movements, or other techniques the client may use to generate a sense of security. To help clients with BPD establish and maintain a sense of safety, counselors regularly should ask clients: "What do you need right now?" "What do you want right now?" Counselors can also help clients to develop a list of the conditions that they need to feel safe. Counselors might ask clients, "What would have been helpful (in a specific situation) to make you feel safe?" Through teaching cognitive skills to promote a client's sense of safety, counselors can help clients with BPD assume personal responsibility for their own safety. (See TIP 36, chapter 4, for a com-

plete discussion about counseling issues related to those clients with BPD and a history of childhood trauma [CSAT 2000*d*].)

Written and verbal contracts can identify specific ways to help clients stay safe physically and emotionally and to prevent relapse. Contracts for safety should be developed during the assessment process with simple and clear behavioral responses regarding the management of unsafe feelings and behaviors. These contracts can be very simple and direct:

- "If I feel like I want to get drunk, I will call my sponsor."
- "If I feel like getting high, I will go to the next NA meeting."
- "If I feel like hurting myself, I will call a crisis hotline and go to my sister's house."
- "I will report self-harm thoughts and behaviors to the therapist at the next session."

A discrepancy between the client and his or her clinical record or other source of information can reflect the client's inclination to deny, minimize, or hide what the service provider is trying to diagnose. Similarly, few addicted individuals come into an assessment and treatment planning session prepared to make a full disclosure of their patterns of substance use and the harm that results from such use. Similarly, few individuals with BPD acknowledge their maladaptive and provocative behaviors. Both disorders are misrepresented by client self-report and involve the client's insistence that the real problem lies elsewhere, usually in how they are being treated by others. Diagnosis and understanding of both disorders must come from observation, interpretation, extrapolation, information from objective instruments (e.g., assessment tools, urinalysis), and outside sources (e.g., family).

> Progress with clients who have BPD can be slow, and therapists should be realistic in their expectations.

Screening and assessment

Gathering historical information affords an opportunity to examine a client's strengths and weaknesses, which are especially important for clients with BPD. When things are going well, clients with BPD might have exceptional skills in various areas. Consequently, a discussion of what the client sees as weaknesses can be revealing. Any history of psychotic-like thinking that occurred under intense stress or that was drug-related should be noted. For example, a client may state, "I really believed the walls were bleeding."

The assessment of clients with BPD should elicit any history of self-harm, which is common among these clients. It is important to explore when and how such episodes, if any, occurred. Specifically, determine what is remembered about the period of time before, during, and after any episodes of self-harm. A list of potential means available to clients to injure themselves in their own homes, such as a large supply of medication, warrants review for clients with BPD who have any history of self-harm.

Assessment also should establish any history or evidence of dissociative experiences, such as trance states, rocking, flashbacks, or nightmares. Anniversary reactions also are common to survivors of abuse, whose memories or feelings may be triggered by certain dates, events, or objects. For no apparent reason, the survivor may become sick or suicidal when faced with a situation similar to a past reminder of abuse. The history of fugue states and losing time may also be significant. For example, clients with BPD might start watching a movie and suddenly reorient later in the middle of another movie, with no clear memory of the elapsed time.

Crisis stabilization

Safety issues are at the core of crisis stabilization. To ensure the client's safety or to detoxify a client, a brief psychiatric hospitalization may be necessary. Issues to be addressed during crisis stabilization might include an unwillingness or inability to contract for safety. A written release of medical information is important to coordinate care with physicians and substance abuse treatment counselors.

At this stage, counselors should avoid psychodynamic confrontations with clients and should not engage clients in further therapy for abuse or trauma. The treatment focus should be on addressing the client's need for safety, which is especially important with clients who have BPD. More complicated and emotionally charged material should be deferred until the client has better skills to manage emotional pain.

It may be helpful to describe out-of-control crisis behavior as a survivor response. Counselors and clients should avoid rigid black-or-white thinking. For example, describing events or issues as being more or less helpful may circumvent the inflexibility of seeing life's challenges and problems only as good or bad, while ignoring the numerous gray areas of experience.

The family should take part in this process. It may be useful to encourage written and verbal contracts with family members. These contracts can dissuade family members from assuming dysfunctional roles such as the victim, the persecutor, and the rescuer. The family should learn how to set boundaries with the client and avoid playing certain roles, especially that of rescuer.

Short-term care and treatment

Theorists and clinicians with expertise in PDs agree that BPD requires long-term, comprehensive, integrated treatment.

Recommendations for the early stages of treatment include developing "skills for managing negative emotions and memories, such as deep breathing, using time-outs, and centering through the senses" (Sullivan and Evans 1994, p. 374), focusing on emotional regulation, enhancing motivation, discussing what interferes with treatment (Dimeff et al. 1998), and carefully considering all medication issues (including the possible genuine need for assistance with pain control through medication or other techniques).

Group therapy

There are particular issues of concern when working with people with BPD in group therapy. Since group counseling regularly begins early in treatment, counselors should consider the following group-related issues in both short- and long-term treatment:

- Making contracts for all members to stay in the room.
- Making contracts for group rules that promote safe behavior.
- Discussing thoughts and feelings about other group members as they arise.
- Mentioning the time limits at the start of each session.
- Making mini-contracts for those who have issues to work on in each session.
- Having group members sign contracts for abstinence and reporting self-harm and substance use to the group.
- Making contracts for confidentiality.[2]

[2]Confidentiality is governed by the Federal "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations (42 C.F.R. Part 2) and the Federal "Standards for Privacy of Individually Identifiable Health Information" (45 C.F.R. Parts 160 and 164).

- Disallowing participants to form intimate or exclusive relationships with one another. Supportive activities, such as calling one another during crises or attending 12-Step meetings together, are acceptable and should be encouraged.
- Evaluating safety issues in screening people with BPD for group therapy. Clients should be safe from the predatory, manipulative behavior of others, and should not engage in such behaviors themselves.
- Promoting same-sex groups.

Longer term care

Individual counseling, continuing group therapy, 12-Step participation, and continuum of care components are the major forms of intervention for comprehensive treatment of clients with BPD. Dimeff et al. (1998) recommend that individual and group counseling concentrate on the development of new skills, balancing toleration of distress with how to change life circumstances (what they see as a "dialectical" interplay of the opposites of an emphasis on change and an emphasis on acceptance of things as they are), and targeting specific areas where control is lacking, such as impulsivity or suicidality.

People with BPD may benefit from skills development in anger management (Reilly et al. 1994). Linehan and colleagues' (1999) dialectical behavior therapy (DBT) solidly intertwines group counseling with the unique DBT terminology and therapeutic strategies. Linehan and her colleagues offer 2-day workshops that train counselors to use their skills training techniques in leading group counseling for clients with BPD and substance use disorders.

Individual counseling

Issues stemming both from BPD and substance use may emerge in individual therapy. Issues related to unsafe behavior or substance use will continue to be important. Longer term care is a stage in which teaching the client skills such as assertiveness and boundary setting can be useful. There is no pressing need for the discussion of early memories; rather the focus of therapy should be on behavior (Sullivan and Evans 1994). Complications at this stage can include a variety of compulsive and impulsive behaviors, such as eating disorders (obesity, anorexia, bulimia), compulsive spending and money mismanagement, relationship problems, inappropriate sexual behaviors, and unprotected sex (in regard to sexually transmitted diseases and pregnancy). Other maladaptive behaviors include sexual impulsiveness, which can cause confusion about sexual identity dramatized in experimental sexual relationships, adding to the crisis and drama to which people with BPD often seem drawn.

Counselors may want to avoid educational material about adult children of alcoholics or general self-help books for clients with BPD, as reading such material may be detrimental to some clients' recovery. For some clients, self-labeling can become counterproductive and in worst-case scenarios, it can lead to self-fulfilling prophecies. For example, books suggesting that some people self-mutilate in order to relieve pain may teach clients with BPD to self-mutilate. Some books offering "inner-child work" lead the client through age-regressive exercises that can cause an overwhelming flood of feelings the abused client may not yet be ready to manage.

Counselors should remember that progress in treating clients with BPD and substance abuse problems may be slow and may have many setbacks. Rather than looking for enormous changes in personality or behavior, counselors should look for small, observable signs of improvement.

In addition, counselors may want to consider the following in treating clients with BPD:

- Use mini-contracts for each session to encourage the client to stay focused.
- Immediately ask clients about any crises that have occurred and review the entire week, not just a particular day.
- State the purpose of each session.

- Run through a checklist that might include homework, failing tests, arguments with others, interactions with the criminal justice system, problems in school or work life, family relationships and friends, relapses, thoughts of self-harm, nightmares, flashbacks, painful situations, and bad memories. Questions should be specific.
- Keep and date all correspondence and notes from telephone conversations. Documenting conversations can help remind the client of earlier agreements and conversations.

Mutual self-help group participation

Although mutual self-help groups can be important for clients with BPD, some may not be able to attend them right away. Some individuals with BPD may find it helpful to participate in self-help group practice sessions. For example, for clients planning to attend a 12-Step meeting, they should be helped to organize their thoughts, to practice saying their name or "pass" for their first few 12-Step meetings. Counselors may want to use the step work handout (see Figure D-7, p. 360) as a treatment tool for working with people with BPD (see chapter 7 on the use of 12-Step programs and the use of other mutual support meetings). Other mutual self-help groups would require their own types of preparation.

Because of their problems with intimacy and trauma, and their own impulsiveness, clients with BPD should be encouraged to join same-sex mutual self-help groups when possible. People with BPD may find it helpful to use same-sex sponsors as guides to recovery. When possible, counselors should educate the sponsor about survivor behaviors. Since antidepressants or lithium may be an important part of the client's recovery, the sponsor might attend a counseling session to learn why the client is taking medications. Explaining how medications are helpful can enable sponsors to help improve medication compliance.

Sponsors who have problems setting boundaries or become overly angry when doing so should not be paired with clients with BPD. If such pairing does occur, the sponsor needs to understand how important boundaries are to help clients with BPD feel safe. Understanding this may keep them from taking on those with BPD, who may be more than the sponsor can handle. Material in the step program should be limited to the here-and-now. As previously stated, clients with BPD should not be asked to address sexual abuse issues until they are ready.

Issues stemming both from BPD and substance use may emerge in individual therapy.

Longer term care should include specialized 12-Step work. In using step one ("We admitted we were powerless over alcohol/our addiction, that our lives had become unmanageable") with clients who have BPD, counselors should encourage clients to recognize that "powerlessness" does not mean "helplessness." Instead, clients should focus on gaining personal control over the tools for recovery. Faith and hope concepts used in 12-Step work may also be difficult for this group to comprehend or integrate.

Figure D-7 shows a recovery model for treatment of BPD.

Antisocial Personality Disorder

Description

The essential diagnostic feature of APD is the pervasive disregard for and violation of the rights of others. Since most clients who are actively using substances display behaviors at one time or another that show disregard for the rights of others, it is not surprising that the dis-

Figure D-7
Step Work Handout for Clients With BPD

Step One: "We admitted we were powerless over alcohol, that our lives had become unmanageable."

- Describe five situations where you suffered negative consequences as a result of drinking or using other drugs.
- List at least five "rules" that you have developed to try to control your use of alcohol or other drugs. (Example: "I never drink alone.")
- Give one example describing how and when you broke each rule.
- Check the following that apply to you:

  ___ I sometimes drink or use drugs more than I plan.

  ___ I sometimes lie about my use of alcohol or drugs.

  ___ I have hidden or stashed away alcohol or drugs so I could use them alone or at a later time.

  ___ I have had memory losses when drinking or using drugs.

  ___ I have tried to hurt myself when drinking or using drugs.

  ___ I can drink or use more than I used to, without feeling drunk or high.

  ___ My personality changes when I drink or use drugs.

  ___ I have school or work problems related to using alcohol or drugs.

  ___ I have family problems related to my use of alcohol or drugs.

  ___ I have legal problems related to my use of alcohol or drugs.
- Give two examples for each item that you checked.

Step Two: "We came to believe that a Power greater than ourselves could restore us to sanity."

- Give three examples of how your drinking or use of drugs was "insane." (One definition of insanity is to keep repeating the same mistake and expecting a different outcome.)
- Check which of the following mistakes or thinking errors that you use:

  ___ Blaming

  ___ Lying

  ___ Manipulating

  ___ Excuse making

  ___ Beating up yourself with "I should have" statements

  ___ Self-mutilation (cutting on yourself when angry)

  ___ Negative self-talk

  ___ Using angry behavior to control others

  ___ Thinking "I'm unique"
- Explain how each thinking error you checked above is harmful to you and others.
- Give two examples of something that has happened since you stopped drinking or using drugs that shows you how your situation is improving.
- Who or what is your Higher Power?
- Why do you think your Higher Power can be helpful to you?

Figure D-7 (continued)
Step Work Handout for Clients With BPD

Step Three: "We made a decision to turn our will and our lives over to the care of God as we understood Him."

- Explain how and why you decided to turn your will over to a Higher Power.
- Give two examples of things or situations you have "turned over" in the last week.
- List two current resentments you have, and explain why it is important for you to turn them over to your Higher Power.
- How do you go about "turning over" a resentment?
- What does it mean to turn your will and life over to your Higher Power?
- Explain how and why you have turned your will and life over to a Power greater than yourself

Step Four: "We made a searching and fearless moral inventory of ourselves."

- List five things you like about yourself.
- Give five examples of situations where you have been helpful to others.
- Give three examples of sexual behaviors related to your drinking or use of other drugs, which have occurred in the last 5 years, about which you feel bad.
- Describe how beating yourself up for old drinking and drug-using behaviors is not helpful to you now.
- List five current resentments you have, and explain how holding on to these resentments hurts your recovery.
- List all laws you have broken related to your drinking and use of other drugs.
- List three new behaviors you have learned that are helpful to your recovery.
- List all current fears you are experiencing, and discuss how working the first three Steps can help dissolve them.
- Give an example of a current situation you are handling poorly.
- Discuss how you plan to handle this situation differently the next time the situation arises.

Source: Adapted with permission from Evans and Sullivan 1990.

tinction between addictive diseases and APD has been a difficult one for both the mental health and the substance abuse treatment fields.

Individuals with APD exhibit signs of antisocial behavior from 15 to 18 years of age, such as unlawful behavior, deceitfulness, consistent irresponsibility, and lack of remorse. Often there is evidence of similar behaviors even before the person turns 15. When antisocial behavior occurs without any signs of it during adolescence, the DSM-IV diagnosis is Adult Antisocial Behavior to distinguish the person who engages in such behaviors after 18 years of age—perhaps because of an alcohol-induced state or the development of substance dependency—from someone with a genuine APD. It is now widely recognized that "…although many delinquent youth abuse alcohol as part of their antisocial behavior, and some become alcoholic, the majority of alcoholics are not sociopathic except as a *result* of their addiction" (Vaillant 1995, p. 88).

One stigmatizing aspect of having a co-occurring APD is that the history of the terms sociopathic, psychopathic, and antisocial carry extremely negative connotations that might well be accurate in only a small percentage of those people with substance use disorders and a current DSM-IV-TR diagnosis of APD. Hare

The substance abuse treatment system encounters many people with APD and has developed effective treatment methods for them.

(1998) differentiates between more severe cases of APD by using the term psychopaths, or "predators who use charm, manipulation, intimidation, and violence to control others and to satisfy their own needs" (p. 104). Hare is careful to point out that probably only 1 percent of the general population can be classified as psychopaths according to his criteria and that most people with antisocial personality disorder are not psychopaths. Consequently, the number of individuals with both a co-occurring substance use disorder and psychopathy is quite small, and substance abuse treatment counselors are unlikely to see such clients outside of criminal justice settings (Hare 1998; Windle 1999). (See also the forthcoming TIP *Substance Abuse Treatment for Adults in the Criminal Justice System* [CSAT in development *e*] for a full discussion of psychopathy and its relationship to APD.)

More men than women are diagnosed with APD, although some women with APD may be misdiagnosed as BPD. Determining the type and extent of antisocial symptoms for women is not easy (Rutherford et al. 1999), but it is important because of the high prevalence of neglectful parenting in women with substance use disorders and APD (Goldstein et al. 1999).

Substance Use Among People With APD

Many people with APD use substances in a polydrug pattern involving alcohol, marijuana, heroin, cocaine, and methamphetamine. The illicit drug culture can correspond with their view of the world as fast-paced and dramatic, which supports their need for a heightened self-image. Consequently, they may be involved in crime and other sensation-seeking, high-risk behavior. Some may have extreme antisocial symptoms—for example, rapists with severe APD may use alcohol to justify conquest, and the small number of these individuals might warrant Hare's designation as psychopaths.

APD appears to be a failure to attach. The people with this diagnosis appear deficient in their ability to experience shared or reciprocal emotions such as guilt or love. Individuals with APD disdain society's rules; they know right from wrong but they do not care. They may be excited by the illicit drug culture and may have considerable pride in their ability to thrive in the face of the dangers of that culture. They are often in trouble with the law. If they are more effective, they may limit themselves to exploitive or manipulative behavior that does not make them so vulnerable to spending time in jail.

Key Issues and Concerns

As with co-occurring disorders in general, individuals with both a substance use disorder and APD have been perceived as exceptionally hard to treat, having poor prognoses, and warranting exclusion from treatment programs and/or group counseling.

These negative stereotypes do not hold up well on examination (Messina et al. 1999). It is true that as a group substance abuse clients with APD do worse than substance abuse clients who do not have APD. Indeed, many articles begin by correctly describing clients with both disorders as having a "worse" response to treatment or a "poor prognosis." Nonetheless, research suggests that clients with APD and substance use disorders can and do respond to treatment. Seivewright and Daly (1997) note that clients with APD "progress reasonably satisfactorily in methadone maintenance" (p. 247), and Vaillant (1995) found in his longitudinal study that after 10 to 15 years, 48 percent of men from an inner-city environment who had been classified as both alcoholic and socio-

pathic were abstinent. This is about the same percentage as an advantaged comparison group of college men without APD and a significantly higher percentage than the rate of 28 percent found in an inner city group of men who abused alcohol but did not have APD.

The substance abuse treatment system encounters many individuals with substance abuse and APD and has developed effective treatment methods for clients with this mental disorder. Key issues and concerns in the treatment of people with APD include

- Countertransference and transference
- Counselor/therapist well-being
- Resistance
- Contracting

Countertransference and transference

In working with clients with APD, countertransference issues might be of equal or greater concern than transference issues. That is, although it is usually of more clinical concern how the client reacts to, interprets, and misinterprets the counselor, when working with clients with APD, it is also important how the counselor reacts to, interprets, or misinterprets the client. Some clients with APD can be frightening to work with; some engage in behaviors that counselors may reject as criminal and antisocial; a few have histories of acts that counselors may abhor. Counselors should be wary of those clients with APD who can be charming and underhanded. The reactions of counselors to working with clients with APD in general, and each specific client with APD in particular, requires regular self-examination and supervision. (Again, the reader is referred to chapter 4 of TIP 36 [CSAT 2000*d*].)

Counselor well-being

Counselor well-being is critical for counselors serving individuals with substance use disorders and APD; counselors who are not provided with an environment that supports a sense of well-being are subject to burnout. A sense of well-being can be fostered by the availability of supervision, the coordination of duties in a team structure, and a clear understanding of roles and responsibilities for standard and crisis situations.

Carlson and Baker (1998) report briefly on efforts at the Portland Veterans Affairs Medical Center to establish a system to assist staff and improve care when managing clients who are dangerous, difficult, demanding, or drug-seeking. They describe a coordinated and focused approach with multidisciplinary meetings of administrators, clinicians, and others that serve to support consistent and systemwide methods of handling these types of situations. In examining 36 consecutive cases under the system, they noted that the 36 individuals committed 47 incidents of violence during the year prior to the implementation of their program, whereas the number of incidents dropped to 4 in the year following implementation. Moreover, their evaluations documented increased staff morale and confidence. Although not specifically targeting clients with substance use disorders and APD, their coordinated, top-to-bottom system for team-handling such stressful client–staff interactions is applicable to these clients.

Resistance

Clients with APD are often said to "act out" tension or conflict. Behaviors that interfere with treatment, which might even result in a client being sent immediately to jail, are seen by therapists as a form of resistance to whatever happens to be the focus of therapy at the time. Substance abuse treatment counselors working with clients with APD often sense resistance to substance abuse treatment and its goals. The counselor should not buy into this negative or pessimistic outlook. Instead, counselors can focus on how much better the client's life will be with successful treatment, and explain to the client that treatment can succeed without the client's complete commitment at the beginning.

It can be hard for a counselor not to blame the client for failing to seek a better life and better behavior. Counselors who fall into this countertransference reaction expect that the client simply has a choice he fails to make. Interestingly, some research (Raine et al. 2000) shows lower prefrontal gray matter volumes in clients with APD (compared to healthy controls, individuals with substance dependence, and other mental disorders). Thus, the extent of actual control clients with APD have over their responses and resistance might well be less than others due to this physiological deficit.

Contracting

Contracting is essential in working with clients with APD. Without contracts and clear expectations of what is to be done, when, how, and the consequences of failing to comply, the therapeutic relationship can become a constant argument about why something was not done and why it is unfair to be punished for an infraction or omission. As a general rule, when working with individuals with substance use disorders and APD, it is advised to put everything into writing.

Strategies, Tools, and Techniques

Engagement

In engaging the client with APD, it is useful to remain neutral toward the client's world view, which may include a need for control and a sense of entitlement. In this context, entitlement refers to people who believe their needs are more important than the needs of others. Entitlement may include rationalization of negative behavior (such as robbery or lying). People with APD may evidence little empathy for their victims. If incarcerated, they may believe they should be released immediately. In a substance abuse treatment program, they may describe themselves as being unique and requiring special treatment.

The primary motivation of the client with APD is to be right and to be successful. It is useful to work with this motivation, not against it. Although this motivation may not reflect socially acceptable reasons for changing behavior, it does offer a point from which to begin treatment. Wanting to be clean and sober, to keep a job, to avoid jail, and to become the chair of an Alcoholics Anonymous (AA) meeting are reasonable goals, despite a self-serving appearance. Counselors can help clients with APD by working with clients' world views, rather than by trying to change their value systems to match those of the therapist or of society. Of course, in therapeutic communities the expectation of eventually having a change in values and in self is part and parcel of the structure of the community, but early in a client's treatment those aspects of the program might well be kept on the "back burner."

Contracting is another effective strategy. Contracts establish rules for conduct during treatment and clarify the clients' role in the therapeutic process. The contract should state explicitly all expectations and rules of conduct and should be honored by all parties. Such an approach can be useful with people with APD, who often view relationships as unfair contracts in which one person attempts to take advantage of the other. Counselors may find that once a level of interpersonal respect has been established, working with antisocial clients can lead to important gains for the client.

Screening and assessment

In addition to an objective psychosocial and criminal history, the following steps may be useful in assessing the antisocial client:

- Taking a thorough family history.
- Finding out whether the client set fires as a child, abused animals, or was a bed-wetter.
- Taking a thorough sexual history that includes questions about animals and objects. Asking about any unusual or out-of-the-ordinary sexual experiences may serve as a lead-

in and as a means to gauge how the client responds to questions about such personal areas.

- Taking a history of the client's ability to bond with others. Counselors can ask, "Who was your first best friend?" "When was the last time you saw him or her?" "Do you know how he or she is?" "Is there any authority figure who has ever been helpful to you?"
- Asking questions to find out about possible parasitic relationships and taking a history of exploitation of self and others. In this context, parasitic refers to a relationship in which one person uses and manipulates another until the first has gotten everything he or she wants, then abandons the relationship.
- Taking a history of head injuries, fighting, and being hit. It may be useful to refer for neuropsychological testing.
- Testing urine for recent substance use.
- HIV testing.

The assessment should consider criminal thinking patterns, such as rationalization and justification for maladaptive behaviors. There is a special need to establish collateral contacts and to assess for criminal history and the relationship of substance use to behavior. Useful assessment instruments include

- The Minnesota Multiphasic Personality Inventory - 2 (MMPI-2)
- The Millon Clinical Multiaxial Inventory (MCMI), and Nadeau et al. 1999
- The PCL-R (Hare Psychopathy Checklist-Revised), and the forthcoming TIP *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT in development *e*)

Crisis stabilization

People with APD may enter treatment profoundly depressed, feeling that all systems have failed them. Often, their scams and lofty ideas have failed. They feel exposed and have no ego strength. They are at risk for suicide, especially during intoxication or acute withdrawal, and may require psychiatric hospitalization and detoxification. Containment in the form of a brief hospitalization may be indicated for clients experiencing acute paranoid reactions to avoid acting out against others. When paranoid reactions are less acute, counselors should avoid cornering clients, disengage from any power struggle, offer lower stimulus levels, and explore options, especially those suggested by the client. During this phase, clarification without harsh confrontation is recommended.

Counselors should be especially cautious when working with APD clients in crisis. These clients may engage in dangerous physical behavior to avoid unpleasant situations or activities. Counselors are advised avoid angry confrontations.

Short-term care and treatment

O'Connell (1998, pp. 123–124), acknowledging the historical contributions of Doren (1987) and Barley (1986), advises counselors to be prepared to be "amused by these clients, outraged by their lack of conscience, intrigued with the glamour of their high-risk lifestyle, or flattered by their praise of the therapist's skills and knowledge … excessively fascinated by the course of therapy." He recommends developing strategies to (1) get reliable information from others to counter misrepresentation of facts, (2) avoid being manipulated or having any intense interest in any of the client's escapades or old war stories, and (3) confront intimidation, criticism, and flattery through supervision and/or a

> In engaging the client with APD, it is useful to remain neutral toward the client's world view.

team approach. *Confronting antisocial behavior and its relationship to substance use is, of course, an ever-present part of treating clients with substance use disorders and APD.*

Group therapy

In group therapy, clients with APD can learn to identify errors not only in their own thinking but in the thinking of others, as well as thinking that makes them vulnerable to relapse. For example, when an individual begins to glamorize stories of substance use or criminal and acting-out behaviors, the group can help to limit that grandiosity. Counselors may also ask people with APD to discuss feelings associated with the behavior being glamorized.

Clients with APD may be asked to sign contracts that establish healthy and nonparasitic relationships with other group members. This means not becoming romantically involved with other members, not borrowing money from them, and not developing exploitive relationships. Role-play exercises can be useful tools in group counseling; however, counselors should be careful to prevent clients with APD from using newly learned skills to exploit or control other group members. In group therapy, clients with APD can be encouraged to model prosocial behaviors and to learn by practicing them. Role-play exercises can help these clients focus on their own shortcomings rather than on the faults of others.

Greene and McVinney (1997) describe anger, group cohesion, dependency/counterdependency, and overdeveloped/underdeveloped strategies as significant areas requiring the counselor's attention when running outpatient groups for male clients with Cluster B personality disorders and chemical dependency. They emphasize the importance of interrupting anger and hostility early in group formation by encouraging the clients to "talk through the therapist" rather than directly to each other, and by having members learn to monitor triggers and understand why some behaviors elicit a hostile response. Group cohesion can be threatened unless clients with PD also have individual counseling that helps them manage their reactions to the group and group membership. For clients with APD, issues related to dependency and counterdependency are likely to be long-term group issues, and group work will focus on overdeveloped combativeness, exploitiveness, and predation and underdeveloped strategies of empathy, reciprocity, and social sensitivity. Many theorists and clinicians employ cognitive–behavioral and "reality therapy" orientations for clients with APD, both with and without substance use disorders. Fisher (1995) offers an outline of Group Leadership Actions for a 4-week, 15-session cognitive–behavioral therapy group for clients with substance use disorders and APD.

Longer term care

Individual counseling

It is helpful to view working with clients with APD as a process of adaptation of thinking, rather than the restructuring of a client into a person whose morals and values match those of the therapist or society. Counselors may benefit from modifying their own expectations of treatment outcomes, realizing that they may not be able to help certain clients develop empathic and loving personalities—it is enough to guide clients to lead lives that follow society's rules. Figure D-8 offers tips for counseling clients with APD.

Individual counseling offers the counselor an opportunity to point out clients' errors in thinking without causing them to feel humiliated in the presence of the group. Other issues for individual counseling may include continued relapse management and identity of empathy. Three key words summarize a strategy for working with people with APD: corral, confront, and consequences.

1. Corral. Corralling with regard to clients with APD means coordinating treatment with other professionals, establishing a system of communications with other professionals and with clients, contracting clients to be responsible for their substance use in the recovery program, monitoring information about clients, and working toward specific treatment goals.

Clients may benefit by signing agreements to comply with the treatment plan and by receiving written clarification of what is being done and why. Interventions and interactions should be linked to original treatment goals. One approach to treatment that adds to the notion of "corralling" is to "expand the system." Spouses, family members, friends, and treatment professionals may be invited to participate in counseling sessions as a way to provide collateral data. This is sometimes called "network therapy."

2. Confront. In confronting clients who are antisocial, counselors can be direct and firm. They can be clear in pointing out antisocial thinking patterns. They can remark on contradictions between what clients say and what clients do. Random testing for substances is essential for monitoring clients with APD. Honest reporting of substance use should be an active part of treatment.

3. Consequences. Clients should bear the responsibility for the consequences of their behavior. For instance, violation of probation or rules should be recorded. Clients who are offenders should be encouraged to report behavior that violates probation, thus taking responsibility for their own actions. Positive consequences that demonstrate to clients the benefits of appropriate behavior should also be designed and incorporated into the treatment plan.

Case management

Case management may involve coordinating care with a variety of other professionals and individuals, including those in the criminal justice system, mental health providers, and family members. Clients need to understand that the counselor must talk to other providers and to family members. It is helpful for clients to sign consents for the release of information for all people involved in their treatment.

Terminating counseling

The question of terminating counseling can be puzzling for counselors treating clients with APD. Clients with APD frequently express a desire to end treatment. This desire should be closely examined to determine whether it is a manifestation of client resistance or a valid request. Reasons for termination on the counselors' part can include noncompliance with treatment, continued drug use without improvement, any aggressive behavior, para-

Figure D-8
Counseling Tips for Clients With APD

Corral:	• Coordinate treatment. • Communicate with other providers. • Make contracts with clients.
Confront:	• Be direct and firm. • Identify antisocial thinking. • Conduct random substance testing.
Consequences:	• Make clients responsible for their behavior. • Record violations of rules. • Allow clients to experience consequences of their behavior. • Designate positive consequences for prosocial behavior.

Figure D-9
Antisocial Thinking-Error Work

The group facilitator presents thinking errors and then asks each group member to identify two thinking-error examples that apply to him or her and to choose one to focus on with the group's help.

1. *Excuse making*. Excuses can be made for anything and everything. Excuses are a way to justify behavior. For example: "I drink because my mother nags me," "My family was poor," "My family was rich."
2. *Blaming*. Blaming is an excuse to avoid solving a problem and is used to excuse behavior and build up resentment toward someone else for "causing" whatever has happened. For example: "They forced me to drink it!"
3. *Justifying*. To justify an antisocial behavior is to find a reason to support it. For example: "If you can, I can," "I deserve to get high, I've been clean for 30 days."
4. *Redefining*. Redefining is shifting the focus on an issue to avoid solving a problem. Redefining is used as a power play to get the focus off the person in question. For example: "I didn't violate my probation. The language is confusing and the order is full of typos."
5. *Superoptimism*. "I think; therefore it is." Example: "I don't have to go to AA. I can stay sober on my own."
6. *Lying*. There are three basic kinds of lies: (1) lies of commission, or making things up that are simply not true; (2) lies of omission, or saying partly what is true but leaving out major sections; and (3) lies of assent, or pretending to agree with other people or approving of their ideas despite disagreement or having no intention of supporting the idea.
7. *"I'm unique*." Thinking one is special and that rules should not apply to oneself.
8. *Ingratiating*. Being nice to others, and going out of one's way to act interested in other people, can be used to try to control situations or get the focus off a problem. Also known as "apple polishing."
9. *Fragmented personality*. Some people may attend church on Sunday, get drunk or loaded on Tuesday, and then attend church again on Wednesday. They rarely consider the inconsistency between these behaviors. They may feel that they have the right to do whatever they want and that their behaviors are justified.
10. *Minimizing*. Minimizing behavior and action by talking about it in such a way that it seems insignificant. For example: "I only had one beer. Does that count as a relapse?"
11. *Vagueness*. This strategy is to be unclear and nonspecific to avoid being pinned down on any particular issue. Vague words or phrases such as: "I more or less think so," "I guess," "Probably," "Maybe," "I might," "I'm not sure about this," "It possibly was," etc.
12. *Power play*. This strategy is to use power plays whenever one isn't getting one's way in a situation. Examples include walking out of a room during a disagreement, threatening to call an attorney or to report the group facilitator to higher-ups.
13. *Victim playing*. The victim player transacts with others to invite either criticism or rescue from those around him.
14. *Grandiosity*. Grandiosity is minimizing or maximizing the significance of an issue, and it justifies not solving the problem. For example: "I was too scared to do anything else but sit," "I'm the best there is, so no one else can get in my way."
15. *Intellectualizing*. Using an emotionally detached, data-gathering approach to avoid responsibility. For example, when faced with a positive urine drug screen the client states, "When was the last time the laboratory had its equipment calibrated?" or "What is the percentage of error in this testing procedure?"

Adapted with permission from Evans and Sullivan 1990.

sitic relationship with other clients, or any unsafe behavior.

Breaking the rules

Clients with APD compulsively try to break rules. If a treatment plan is not devised to work with a person who wants to redefine rules, termination should be considered and transfer to more appropriate care arranged.

Continuum of care

A key to treating people with APD is to be flexible within an array of containment interventions. Counselors should have the ability to move a client quickly from a less controlled environment to a more controlled environment. Clients benefit from sanctions that match the degree of severity of behavior. Sanctions should not be "punishments" but responses to the need for containment and more intensive treatment. Clients with APD need a range of treatment and other services, from residential to outpatient treatment, from vocational education to participation in long-term relapse prevention support groups, and from jail to 12-Step programs.

Thinking-error work

Continued thinking-error work, as described in Figure D-9, may help clients identify various types of rationalizations that they may use regarding their behaviors. Ball (1998) and Ball and Young (2000) developed a 24-week manual guided cognitive–behavioral approach for people with substance use and PDs; research with an opioid-dependent group is being supported by NIDA.

Mood and Anxiety Disorders

Description

Mood disturbance and anxiety are ever-present features of many people in treatment for substance use disorders. A substance-abusing lifestyle regularly brings with it great cause for worries and sadness. Often, in recovery, these negative feeling states are, in time, replaced with hopefulness, a sense of renewal, and a general level of well-being. Many substances also cause mood and anxiety disorders through biochemical changes that may be alleviated when the client is no longer using. Sometimes, however, clients have anxiety and/or mood disorders that require treatment, both for their resolution and to remove the threats to recovery associated with these disorders.

Mood episodes

A mood episode is a cluster of symptoms that occur together for a discrete period of time, including

- *Changes in appetite or weight, sleep, and psychomotor activity.* The individual may report loss of interest in eating or may crave foods such as sweets or carbohydrates; the person may seem agitated or action may seem slowed down—for example, slowed speech and body movements. Frequently, the person has difficulty sleeping or sleeps too much. Waking up 90 minutes to 2 hours before usual and being unable to go back to sleep ("early morning awakening") and difficulty falling asleep are common manifestations of sleep problems.
- *Decreased energy.* Sometimes the person also reports decreased efficiency in performing tasks.
- *Feelings of worthlessness or guilt.* The individual may be preoccupied with past feelings and dwell on personal defects, often with cognitive distortion such as strong feelings of not living up to her or his potential even though the person has been very productive and others think well of her or his work.
- *Difficulty thinking, concentrating, or especially making decisions.* Sometimes people are easily distracted, have difficulty with memory, or perform normally but feel that it requires increased effort to do so.
- *Recurrent thoughts of death, suicidal ideations, and/or suicidal plans or attempts.*

Mood disorders

Bipolar I, bipolar II, and cyclothymia

While *Bipolar I and II* are classified in the DSM-IV as mood disorders, mania and bipolar disorders are addressed in the next section on schizophrenia and psychosis. The fundamental difference diagnostically between bipolar I and bipolar II disorders relates to whether the individual has experienced a manic episode. If a person has never experienced a manic episode, but has both periods of major depression and periods of at least 4 days of hypomanic states, the diagnosis is one of bipolar II disorder.

Though seemingly minor, the difference carries considerable prognostic value—people who experience a true manic episode along with alternating episodes of major depression have an extremely high probability of having another manic episode. Usually, the manic episode will occur immediately before or immediately after a major depressive episode (APA 2000). Thus, what can seem to be a small diagnostic matter can be significant, and in this case it is likely that bipolar I and bipolar II represent meaningfully distinct clinical entities.

Cyclothymic disorder is a mood disorder that involves fluctuating moods from above normal to below normal, but never has symptoms so severe or persistent as to meet the diagnostic criteria for a bipolar disorder. To be considered a disorder, the disturbance must reach a level great enough to have a negative impact on someone's interpersonal or vocational life. With a co-occurring substance use disorder, all forms of mood disorders can worsen acutely over the long run.

Major depression

Symptoms of major depression may occur at mild or moderate levels of severity. Major depression typically is experienced as a more intense and acute depression, often with strong physiological changes in appetite, sleep, energy level, and ability to think, as well as excessive feelings of worthlessness with possible suicidal ideation or plans. Though two thirds of people who experience a major depressive episode recover fully (APA 2000), one third may recover only partially and a number of individuals develop a persistent major depressive disorder, often meeting criteria for evidence of severe and/or persistent mental illness.

Severe depressive episodes can include psychotic features, such as an auditory hallucination of a voice saying that the person is "horrible," a visual hallucination of a lost relative mocking the person, or a delusion that one's internal body parts have rotted away. However, most people who have a *major depressive episode* do not exhibit psychotic symptoms even when the depression is severe (for more information see the next section on schizophrenia and psychosis).

Chapter 8 contains a full description of the characteristics of a Major Depressive Episode.

Dysthymia and generalized anxiety disorder (GAD)

GAD and *dysthymia* are, respectively, prevalent anxiety and mood disorders. Both are persistent disorders. GAD is characterized by at least 6 months of persistent and excessive anxiety and worry (APA 2000). Dysthymic disorder "is characterized by a depressed mood for most of the day, for more days than not, for at least 2 years" (APA 2000, p. 380). Dysthymic symptoms can include feelings of inadequacy, loss of interest and social withdrawal, irritability, excessive anger, and lethargy. At some time in their lives 5 percent of people will have GAD and 6 percent will have dysthymic disorder (APA 2000). Consequently, substance abuse counselors need to be alert to GAD or dysthymic disorder in their clients. The term *anxiety* refers to the sensations of nervousness, tension, apprehension, and fear. In GAD there is no specific focus to the anxiety—it is said to be "free-floating." Other common anxiety disorders are panic disorder, specific phobia, and social phobia; obsessive-compulsive disorder; and PTSD and acute stress disorder.

Anxiety disorders

Panic attack, panic disorder, specific phobia, and social phobia

A *panic attack* is a distinct period of intense fear or discomfort that develops abruptly, usually reaching a crescendo within a few minutes or less. Physical symptoms may include hyperventilation, palpitations, trembling, sweating, dizziness, hot flashes or chills, numbness or tingling, and the sensation or fear of nausea or choking. Psychological symptoms may include depersonalization and derealization (feeling as if things are not real) and fear of fainting, dying, doing something uncontrolled, or losing one's mind.

A *panic disorder* consists of episodes of panic attacks followed by a period of persistent fear of the recurrence of more panic attacks. Sometimes panic attacks are associated with fears of going places where rapid exit would be difficult or embarrassing, such as over bridges, in airplanes, or in stores or markets. When the focus of anxiety is an activity, person, or situation that is dreaded, feared, and probably avoided, the anxiety disorder is called a *phobia.* Panic disorders often are underdiagnosed at the beginning of treatment, or else are seen as secondary to the more significant disorders, which are the primary focus of treatment. However, panic disorders can impede significantly a person's ability to do the tasks of recovery, such as getting on a bus to go to a meeting or sitting in a 12-Step meeting. Sometimes these can erroneously be identified as manipulative or treatment-resistant behaviors.

Phobia-inspired avoidance behavior, with its associated travel and activity restrictions, may become intense and incapacitating. The phobias include agoraphobia, social phobia, and simple or specific phobia; panic attacks and panic disorders often are involved, but not necessarily. Specific phobia, also called single or simple phobia, describes the onset of intense, excessive, or unreasonable fear stimulated by the presence or anticipation of a specific object or situation. The causes may be naturally occurring (e.g., animals, insects, thunder, water), situational (such as heights or riding in elevators), or related to receiving injections or giving blood. Social phobia describes the persistent and recognizably irrational fear of embarrassment and humiliation in social situations. The social phobia may be quite specific (e.g., public speaking) or may become generalized to all social situations.

Though panic disorders, phobias, and social phobias may seem relatively straightforward, they are quite complex, as they often are historically intertwined for each and every person. For example, the client who says he or she is "claustrophobic" and fears getting into an elevator may have had a few panic attacks 20 years beforehand, has successfully avoided going into any elevators in the past 2 decades, and may barely remember the panic symptoms associated with the original reaction to elevators that led to the avoidant behavior. There is considerable evidence that both nonmedication behavioral approaches and medications can be useful, either alone or in combination in the treatment of these mental disorders.

> Mood disturbances and anxiety are ever-present features of many people in substance abuse treatment.

Obsessive-compulsive disorder (OCD)

OCD is an anxiety disorder involving obsessions or compulsive rituals, or both. Obsessions are repetitive and intrusive thoughts, impulses, or images that cause marked anxiety. They often involve transgressing social norms, harming others, and becoming contaminated, but they are more intense than excessive worries about real problems. Compulsions are repetitive rituals and acts that people are driven to perform and which they perform reluctantly to

prevent or reduce distress. The frequency and duration of their repetition make them inconvenient and often incapacitating. Examples include ritualistic behaviors (such as hand washing and rechecking) and mental acts (e.g., counting and repeating words silently). Obsessions are often time consuming and interfere significantly with daily functioning.

PTSD and acute stress disorder

Although PTSD is one of the anxiety disorders and many of the possible symptoms of PTSD are anxiety-like symptoms, PTSD has been identified as so prevalent in populations with COD that it is described in full in the following section. There is only a diagnostic difference between PTSD and acute stress disorder in that PTSD cannot be diagnosed until and unless a person experiences the symptoms for a month; therefore, if the symptoms last less than 1 month or it has been less than 1 month since the traumatic event, then acute stress disorder rather than PTSD would be diagnosed.

Except for these timeframe criteria, the symptoms of acute stress disorder that follow a traumatic event are, by and large, the same types of symptoms as PTSD. The client may have a subjective sense of "being in a daze" with emotional detachment, inability to recall aspects of the event, feeling as if things are not real (derealization), feeling that one is not oneself or disconnected from feeling oneself (depersonalization). The client may also report the phenomena of re-experiencing the event, avoidant behavior, increased arousal, distress, and interference with functioning. See the section on PTSD for a thorough description.

Differential Diagnosis

It comes as no surprise to the substance abuse treatment counselor that licit and illicit drugs of abuse cause symptoms that are identical to the depression and anxiety symptoms that have been discussed. In addition, many medications, toxins, and medical procedures can cause or are associated with an eruption of an anxiety and/or depressive reaction. Moreover, these reactions run the gamut from mild manifestations of short-lived symptoms to full-blown manic and other psychotic reactions, which are not necessarily short-lived.

For substance abuse counselors and clinicians, the role of personality, preexisting mood state, personal expectations, drug dosage, and environmental surroundings all warrant consideration in developing an understanding of how a particular client might experience a substance-induced disorder. While many people with substance use disorders will experience sensory and perceptual distortions, some will experience euphoric religious or spiritual states that may resemble aspects of a manic or psychotic episode. Others may have a deeply troubling introspective experience, causing symptoms of depression. Some may have a positive experience that they seek to repeat.

Diagnostic process

Diagnoses of mental disorders should be provisional and reevaluated constantly. Many apparent mental disorders are really substance-induced disorders that are caused by substance use. Treatment of the substance use disorder and an abstinent period of weeks or months may be required for a definitive diagnosis of an independent, co-occurring mental disorder. As described in chapter 4 on assessment, substance abuse treatment programs and clinical staff can concentrate on screening for mental disorders and determining the severity and acuity of symptoms, along with an understanding of the client's support network and overall life situation.

Anxiety and mood disturbance in other disorders

Anxiety and mood disturbance, often a regular part of the life of people with substance use disorders, are common, ubiquitous components of almost all mental disorders. People with schizophrenia or PDs, for example, typically experience ups and downs in anxiety, as well as waxing and waning of mood disturbance. Therefore, not only is it difficult to tell when

someone enters substance abuse treatment whether the person has a co-occurring mood or anxiety disorder that is separate from the substance use disorder, it is also hard to determine whether the symptoms of mood or anxiety disorders are part of the manifestations of another mental disorder or constitute a separate disorder.

Many psychiatric conditions can mimic mood disorders. Disorders that can complicate diagnosis include schizophrenia, brief reactive psychosis, and anxiety disorders. Clients with PDs, especially of the borderline, narcissistic, and antisocial types, frequently manifest symptoms of mood disorders. These symptoms often are fluid and may not meet the diagnostic criterion of persistence over time. In addition, all of the mental disorders noted here can coexist with substance use and mood disorders.

To make the initial evaluative situation even more challenging, discriminating between an acute anxiety disorder and an acute mood disorder can be difficult. Of course, where severe and acute symptoms exist, treatment personnel move ahead with treatment for all the presenting problems while awaiting the ultimate resolution over time of the diagnostic specifics. As noted in chapter 4, this is a major reason to repeat screening and assessment periodically as recovery proceeds.

Anxiety and mood disturbances versus substance use

Symptoms that look like anxiety or mood disturbances may appear either during use or withdrawal. Withdrawal from depressants, opioids, and stimulants invariably includes potent anxiety symptoms (see Figure D-10). During the first months of abstinence, many people with substance use disorders may exhibit symptoms of depression that fade over time and are related to acute withdrawal. Since depressive symptoms during withdrawal and early recovery may result from substance use disorders and not an underlying depression, a period of time should elapse before depression is diagnosed. Overall, the process of addiction per se can result in biopsychosocial disintegration, leading to chronic dysthymia or depression often lasting from months to years.

Acute manic symptoms may be induced or mimicked by intoxication with stimulants, steroids, hallucinogens, or polydrug combinations. They may also be caused by withdrawal from depressants such as alcohol. Individuals experiencing acute mania with its accompanying hyperactivity, psychosis, and often aggressive and impulsive behavior should be referred to emergency mental health professionals. This is true whatever the causes may appear to be.

Substance-induced mood alterations can result from acute and chronic drug use as well as from drug withdrawal. Substance-induced mood disorders, most notably acute depression

Figure D-10
Drugs That Precipitate or Mimic Mood Disorders

Mood Disorders	During Use (Intoxication)	After Use (Withdrawal)
Depression and dysthymia	Alcohol, benzodiazepines, opioids, barbiturates, cannabis, steroids (chronic), stimulants (chronic)	Alcohol, benzodiazepines, barbiturates, opioids, steroids (chronic), stimulants (chronic)
Mania and cyclothymia	Stimulants, alcohol, hallucinogens, inhalants (organic solvents), steroids (chronic, acute)	Alcohol, benzodiazepines, barbiturates, opioids, steroids (chronic)

lasting from hours to days, can result from sedative-hypnotic intoxication. Similarly, prolonged or subacute withdrawal, lasting from weeks to months, can cause episodes of depression, and sometimes is accompanied by suicidal ideation or attempts. Figure D-10 provides an overview of drugs that precipitate or mimic mood disorders.

Stimulant withdrawal

Stimulant withdrawal may provoke episodes of depression lasting from hours to days, especially following high-dose, chronic use. Stimulant-induced episodes of mania may include symptoms of paranoia lasting from hours to days. Stimulants such as cocaine and amphetamines cause potent psychomotor stimulation. Stimulant intoxication generally includes increased mental and physical energy, feelings of well-being and grandiosity, and rapid pressured speech. Chronic, high-dose stimulant intoxication, especially when combined with sleep deprivation, may prompt an episode of mania. Symptoms may include euphoric, expansive, or irritable mood, often with flight of ideas, severe impairment of social functioning, and insomnia.

Acute stimulant withdrawal generally lasts from several hours to 1 week and is characterized by depressed mood, agitation, fatigue, voracious appetite, and insomnia or hypersomnia (oversleeping). Depression resulting from stimulant withdrawal may be severe and can be worsened by the individual's awareness of substance-abuse–related adverse consequences. Symptoms of craving for stimulants are likely and suicide is possible.

Protracted stimulant withdrawal often includes sustained episodes of anhedonia (absence of pleasure) and lethargy with frequent ruminations and dreams about stimulant use. There may be bursts of dysphoria, intense depression, insomnia, and agitation for several months following stimulant cessation. These symptoms may be either worsened or lessened by the quality of the client's recovery program.

Mood and anxiety disorders versus medical conditions and medication-induced symptoms

Medical problems and medications can produce symptoms of anxiety and mood disorders. For example, acute cardiac disorders can produce symptoms that suggest generalized anxiety or panic disorders. Similarly, both prescribed and over-the-counter medications can precipitate depression. Diet pills and other over-the-counter medications can lead to mania. It is important to distinguish between the symptoms of a mental disorder and those accompanying a medical disorder or those associated with an over-the-counter or prescription medication. The counselor should be aware of these possibilities and seek information that helps make an accurate determination.

Prevalence

Approximately one quarter of U.S. residents are likely to have some anxiety disorder during their lifetime, and the prevalence is higher among women (30.5 percent) than men (19.2 percent) (Kessler et al. 1994). Estimates of lifetime prevalence for major depression range from 10 to 25 percent for women and half that for men. For dysthymic disorder, estimates are 6 percent for both women and men (APA 2000).

Data from the National Comorbidity Study indicate that about one half (41 to 65 percent) of individuals with a substance use disorder have an affective or anxiety disorder at some time in their lives (Kessler et al. 1996*b*). Among women with a substance use disorder, mood disorders may be prevalent, and women are more likely than men to be clinically depressed and/or to have PTSD. Research suggests that 4.5 percent of clients with substance use disorders have panic disorder and 16 percent of panic disorder clients have a co-occurring substance use disorder (DuPont 1997).

Assessment Case Studies: George M. and Teresa G.

George M.

George M. is a 37-year-old divorced male who was brought into the emergency room intoxicated. His blood alcohol level was .152, and the toxicology screen was positive for cocaine. He was also suicidal ("I'm going to do it right this time!"). He has a history of three psychiatric hospitalizations and two inpatient substance abuse treatments. Each psychiatric admission was preceded by substance use. George M. has never followed through with psychiatric treatment. He has intermittently attended AA, but not recently.

Teresa G.

Teresa G. is a 37-year-old divorced female who was brought into a detoxification unit with a blood alcohol level of .150. She was observed to be depressed and withdrawn. She has never used drugs (other than alcohol), and began drinking alcohol only 3 years ago. However, she has had several alcohol-related problems since then. She has a history of three psychiatric hospitalizations for depression, at ages 19, 23, and 32. She reports a positive response to antidepressants. She is currently not receiving mental health services or substance abuse treatment.

Differential diagnostic issues for case examples. Many factors must be examined when making initial diagnostic and treatment decisions. For example, if George M.'s psychiatric admissions were 2 or 3 days long, usually with discharges related to leaving against medical advice, decisions about diagnosis and treatment would be different if than if two of his psychiatric admissions were 4 to 6 weeks long with clearly defined manic and psychotic symptoms continuing throughout the course, despite aggressive use of psychiatric treatment and medication.

Similarly, if Teresa G. had abstained from alcohol for 6 months "on her own," had relapsed the night before while thinking about killing herself, had become increasingly depressed and withdrawn over the past 3 months, and had suffered from disordered sleep, poor concentration, and suicidal thoughts, a different diagnostic picture would emerge.

Certain populations are at risk for anxiety and mood disorders. American Indians, clients with HIV, clients maintained on methadone, and older adults may all have a higher risk for depression. The elderly may be the group at highest risk for combined mood disorder and substance problems (see TIP 26, *Substance Abuse Among Older Adults* [CSAT 1998*d*]). Episodes of mood disturbance generally increase in frequency with age. Older adults with concurrent mood and substance disorders tend to have more mood episodes as they get older, even when their substance use is controlled. Also, from 20 to 25 percent of individuals who have chronic or severe general medical conditions, such as diabetes or stroke, develop major depressive disorder. The data on high prevalence of these disorders and the information on the most vulnerable groups point to the need for counselors to consider in treatment planning that the observed behavior of depression, anxiety, and elation may likely be associated with a mental disorder.

Substance Use Among People With Mood or Anxiety Disorders

People with co-occurring mood or anxiety disorders and a substance use disorder probably have used many substances. Though those with depression may favor stimulation while those with anxieties may favor sedation, considerable overlap is apparent. The use of alcohol, perhaps because of its availability and legality, is ubiquitous.

The notion that substance use disorders are caused, in whole or part, by an individual's attempts to "self-medicate" specific symptoms with alcohol or illicit drugs has been a source of debate. Many prominent researchers and clinicians have concluded that substance use is a cause rather than an attempt to cure symptoms. Vaillant, for example, noted that "depression is a symptom caused by alcoholism more often than the reverse" (Vaillant 1995, p. 80). Both Brower and colleagues (2001) and Raimo (1998) point out that insomnia, depression, and other "psychiatric" symptoms often are more likely substance-use related, thus self-medication in this case becomes using alcohol (or other drugs) to block acute or protracted substance withdrawal symptoms.

The "self-medication hypothesis" first proposed by Khantzian (1997) did not focus on withdrawal symptoms, but proposed that those who abuse drugs do so to deal with core psychopathology that might range from anger to mania. While an attractive theory, research does not entirely support this hypothesis. For example, adolescents with attention deficit disorder should likely prefer to abuse stimulants such as cocaine or amphetamines; however, marijuana is by far the most commonly abuse drug in this population (Flory et al. 2003) and it has been demonstrated to make attention issues worse. Likewise, patients with bipolar disorder in either depressed or manic states should correspondingly use stimulants or depressives, but Strakowski and colleagues (1998), after following such patients for a year after acute hospitalization, could find no pattern to their use, nor types of substances used. In addition, there have been negative studies on schizophrenia (Scheller-Gilkey et al. 2003), and the only symptom/diagnosis in which data appear to support that core mental disorder symptoms lead to substance use, and substance use leads to decreased symptoms, is that of social anxiety, as demonstrated by Thomas and colleagues (Thomas et al. 2003), though even in this case there have been negative studies (e.g., Ham and Hope 2003).

> Clients with severe and persistent substance use and mood disorders should not be seen as resistant, manipulative, or unmotivated.

The consensus panel cautions that the term "self-medication" should not be used, as it equates drugs of abuse (which usually worsen health) with true medications (which are designed to improve health). Equating substances of abuse with medications can be taken quite concretely by some patients, especially those who are either psychotic or are looking for a clever rationalization for their addictive behavior. Thus, such patients might conclude, "Well, I'll use the doctor's medications during the week, but my 'medications' on the weekend (didn't the doctor say 'self-medication with alcohol?')."

Key Issues and Concerns

The key issues and concerns for the client with mild-to-moderate mood and/or anxiety disorders center on making the client comfortable with, or at least able to tolerate, the treatment environment. Often, the specific type of disorder and its symptoms need to be examined in light of treatment demands. How does the client get to the meeting? Are there any aspects of the treatment environment that duplicate or remind a client of a prior trauma experience? Can a client who wakes up 2 hours earlier than normal, say 5:00 a.m., develop some non-maladaptive way of coping with the monotony that can feed the client's feelings of depression? Do other clients make fun of the obsessive-compulsive rituals of a client? An insightful counselor and a dedicated staff can go a long way in assisting the anxious or depressed client.

The majority of clients receiving treatment for combined mood or anxiety disorders and substance use disorders improve in response to

treatment. When they don't improve, a re-evaluation of the treatment plan is warranted. A client receiving antidepressant medication who is abstinent from substances but anhedonic requires a careful evaluation and assessment to identify resistant psychiatric conditions that require treatment. Based on assessment, an additional treatment service such as psychotherapy may be added. Indeed, psychotherapy has been shown to improve the efficacy of substance abuse treatment and of mental health services that involve antidepressant medication.

When clients do not improve as expected, it is not necessarily because of treatment failure or client noncompliance. Clients may be compliant and plans may be adequate, but disease processes remain resistant. Clients with severe and persistent substance use and mood disorders should not be seen as resistant, manipulative, or unmotivated, but as extremely ill and in need of intensive support.

Strategies, Tools, and Techniques

Engagement

As observed in the section above on "Differential Diagnosis," a client who shows severe and acute levels of anxiety and mood disturbance may have another psychological disorder, such as psychosis, PTSD, or a PD. The client may also have a history of suicidality or may be suicidal currently. When this is the case, see the pertinent portions of the "Differential Diagnosis" section and the "Suicidality" section.

In general, counselors can engage clients with mood or anxiety difficulties by gathering enough information to empathize with the clients' experience and acknowledge the legitimacy of the client's feelings. Worried clients tend to know they are overly concerned compared to other people, and depressed clients often feel that they should not be depressed. Depressed clients may view depression as a personal shortcoming and imagine that they are bringing others down with them.

A model of engagement that can be instructive is the sympathetic physician who has seen it all before and is calm in the face of what she or he knows others find upsetting. That is, a substance abuse treatment counselor can attend to the symptoms and their effects on the client, while remaining an observant distance from the worry itself or the depressed mood. For example, the counselor could tell a client that he or she recognizes how painful and nerve-racking it is for the client to be so concerned about the possible loss of employment, while avoiding getting into the details of either the worst possible outcomes or the worries. Such a strategy can help with engagement.

Cognitive–behavioral therapy might help a client see how he or she has developed a way of viewing mainly the worst possible outcomes of events, or how he or she tends to emphasize the most negative aspect of a situation. However, the client's ability to recognize these patterns of behavior may be a long-term goal that can only be accomplished through time and trust. Trying too soon to address such entrenched habits of perception is not likely to be an effective engagement strategy. "Start low, go slow" is a cliché physicians use to describe beginning with a small amount of a medication to gauge side effects, then slowly increasing the medication to a therapeutically effective dose. A similar approach can help with the engagement phase of working with clients who have mood and anxiety concerns.

Screening and assessment

Medical assessment

Clients with mood/anxiety disorders, particularly older adults, may have life-threatening medical conditions, including hypoglycemia (insulin overdose), stroke, or infections. These conditions, as well as withdrawal and toxic drug reactions, always must be considered and require a thorough physical examination and laboratory assessment. Clinical staff should make appropriate referrals for medical assess-

ment and treatment. Facilities that have no medical component should train assessment staff in triage and referral, especially as part of the intake process.

Assessing mood and anxiety symptoms

During initial screening sessions, clients with substance use disorders may overemphasize or underemphasize their psychiatric symptoms. For instance, clients who feel depressed during the assessment may distort their past psychiatric experiences and unwittingly exaggerate the intensity or frequency of past depressive episodes. Some clients experience feelings of guilt that are excessive and inappropriate. Other clients do not accurately label their depression and fail to remember that they have experienced depression before. Since clients frequently confuse depression with sadness and other emotions, it is important to obtain collateral information from other people and from documents such as medical and psychiatric records. It is critical to continue the process of evaluation past the period of drug withdrawal.

For anxiety and mood symptoms especially, observation is an important component of screening and assessment. Does the client seem calm and relaxed or nervous and distraught? Often, with training in screening or assessment, the counselor will learn to recognize some of the features that provide clues to a client's mental status, such as rate of speech, affective tone, cooperativeness, and so on.

Assessment instruments

A differential diagnostic evaluation can include the clinical application of the DSM-IV, perhaps in the form of a structured clinical interview. Some specific and general standardized assessment measures are available for anxiety and mood disorders. The Beck Depression Inventory-II (BDI-II) (and its predecessor) has been used in a wide variety of settings for the past 25 years, and a Beck Anxiety Inventory is available; both have English and Spanish versions and are proprietary. Substance abuse treatment agencies need to provide training in the use of assessment instruments so that counseling staff can take full advantage of the information and can play the most effective roles possible in assessment processes.

Discussion of the case study (p. 379): While many clients are depressed and anxious at the onset of treatment—and someone in Jim R.'s position might well be expected to have these symptoms—it is still important to consider the possibility that the depression or anxiety might be a co-occurring mental disorder. The counselor notes the indications of depression and formally screens for depression using the BDI-II. Upon review at the next session the counselor notes and evaluates the increase in depression and refers the client to a psychiatrist when the symptoms persist and intensify. The psychiatrist establishes the co-occurring mental diagnosis and, with the counselor, develops a treatment plan that involves medication, cognitive–behavioral mental health counseling and continued substance abuse treatment and monitoring of medication. With this integrated treatment approach, based on a sound observation, rapid referral, and accurate diagnosis, the client begins making good progress in treatment.

Psychosocial assessment

A comprehensive psychosocial assessment, including an evaluation of the client's support system, is an important aspect of the overall assessment. Such information is essential for understanding the full context of anxiety and mood troubles. Effective treatment planning for both disorders depends on understanding the total life situation of the client.

Crisis stabilization

When a mood and anxiety disturbance is at mild or moderate levels, crisis stabilization should not be needed. Substance abuse counselors should use their clinical skills and be responsive to signs of an impending serious crisis, such as a moderately depressed client who has given away his or her belongings or who has begun to talk about wills or contacting old friends.

In terms of anxiety disorders, an immediate episode of panic (and to some degree a dissociative state) can represent a crisis. In some cases, the counselor may have to make arrangements for a client to get home. Two of the acute anxiety conditions most commonly encountered in emergency room settings are panic attacks and dissociative states that may resemble psychosis. However, some anxious clients misinterpret their symptoms of chronic anxiety as symptoms of an acute anxiety episode. Their misinterpretation may predispose the therapist to make the same misinterpretation.

Interventions for acute anxiety conditions include calming reassurance, reality orientations, breathing management, and when needed, sedative medications such as benzodiazepines. These interventions are nearly identical to those used for the two most common substance-related anxiety emergencies: withdrawal from sedative-hypnotics (including alcohol) and

Case Study: Assessment of Mood and Anxiety Disorders

Jim R. enters the substance abuse treatment center after detoxification at the hospital. He was admitted following a drinking and driving incident in which he hit the side of a building, fortunately injuring no one. The counselor immediately sees that Jim R. is depressed and somewhat anxious. He talks about how he has screwed up, will probably lose his license, and will then not be able to work. He says he has tried repeatedly to stop drinking and cannot succeed; his life is hopeless.

Jim R. is not thinking of suicide, but he has lost a great deal of weight recently, has difficulty concentrating, feels worthless, moves suddenly in an agitated way (he shifts his position in the chair continually), and admits to difficulty sleeping. The counselor senses that the client may be depressed and notes the indications of depression in the record. To obtain further collaboration, the counselor immediately uses the BDI-II and finds that Jim R. scores 15. A score of 15 represents a moderate level of depression, but the treatment program's protocol for the use of the BDI-II by counselors calls for weekly monitoring of moderately scoring clients with repeat administrations of the BDI-II. In the next session, the counselor notes signs of increased depression and reevaluates the symptoms. He finds that Jim R. now scores 40 on the BDI-II. According to the established protocol, he now refers him to a psychiatrist, suggesting that Jim R. may be in need of medication and a differential diagnosis.

The psychiatrist does a longitudinal assessment in which she explores Jim R.'s drinking and establishes a diagnosis of alcohol abuse disorder. The psychiatrist also explores when Jim remembers being depressed and gauges the severity and persistence of these depressions. Finding a pattern of persistent depression with anxious features, such as excessive worry, that precedes Jim R.'s drinking, she prescribes an antidepressant with a calming effect. She tells Jim R. the pills should help him feel less worried and sleep better even though the pills are neither tranquilizers nor sleeping pills, and she stresses the importance of taking them regularly. Noting that Jim R. is a college graduate, she prescribes a workbook on depression (David Burns, *The Feeling Good Handbook*) to help him learn about the disease. The psychiatrist informs the substance abuse treatment counselor of her action and asks the counselor to continue monitoring the client's depression. She also refers Jim R. for cognitive–behavioral sessions with a mental health clinician to help him overcome his negative thinking and regain his sense of worth.

On Jim R.'s next visit, the substance abuse treatment counselor checks Jim R.'s pill box and finds that many of the pills have not been taken. He uses motivational therapy techniques to encourage Jim R. to take the pills regularly. He also reinforces the work of the mental health counselor, pointing out that the "stinking thinking" discussed in AA as a bad rationale for drinking is similar to the thought patterns that drive his depression. Gradually, Jim R. is able to manage his disorder through medication and improved thought patterns.

intoxication from stimulants (including cocaine). While the use of benzodiazepines generally is not problematic during acute withdrawal, their use may become a problem for abstinent, recovering people. Such people may have abused benzodiazepines before they became abstinent, and the use of benzodiazepines to calm the anxiety disorder may lead to relapse of the addictive behavior. Interventions for acute anxiety conditions should include behavioral, cognitive, and relaxation therapies, often in combination with long-term serotonergic and depressant medications.

During an acute panic attack, people often believe that they are having a heart attack, feel dizzy, and are unable to catch their breath. Enforced regular breathing through the use of a paper bag helps to regulate breathing and diminish excess release of carbon dioxide. Such breathing exercises, education about symptoms, and reassurance will diminish panic symptoms for many clients. These clients also should be examined by a medical professional such as a nurse to identify any person who may be having an actual heart attack.

Short-term care and treatment

The acronym MASST, defined in the text box below, is a reminder for counselors of the areas of substance abuse recovery that need to be continually assessed.

MASST Areas of Recovery for Assessment

M: Meetings (12-Step or other recovery-oriented self-help)

A: Abstinence goals

S: Sponsor and other helping people

S: Social support systems

T: Treatment efforts

In terms of mood and anxiety problems, MASST can be used to incorporate specific strategies within the client's overall recovery efforts. Though there are many interventions for anxiety and mood disorders other than medications, medications often are a significant part of such treatment efforts. For clients with more than mild levels of disturbance, medications can be essential.

For many clients in early recovery from substance abuse, treatment of anxiety disorders can be postponed unless a certain or verifiable history shows that the anxiety preceded the addiction or is incapacitating. If symptoms are mild and do not interfere with functioning, including participation in treatment, it is judicious to wait to see if the symptoms resolve as the substance abuse treatment progresses. Antecedent traumas, as well as dysfunctional family situations that have been identified during the assessments, should be addressed in a supportive and calming manner. However, affect-liberating therapies probably should be deferred until the client is stable with respect to substance abuse and acute anxiety has been established. Issues of importance to the client and raised by the client should not be ignored, but exploration of underlying trauma should not be encouraged until the client is stabilized.

Supportive, cognitive, behavioral, and dynamic therapies all can be used, but in early recovery, clients need significant support and will have limited tolerance for anxiety and depression. The emphasis should be on supporting recovery, attending 12-Step meetings, and participating in other self-help and group therapies. Insight-oriented treatments must be measured carefully and limited early on by their potential to increase anxiety and trigger relapse. When psychotherapy is immediately essential, clients should be referred to recovery-oriented psychotherapists who will integrate psychotherapy with mutual self-help approaches.

Clients may overuse medications or relapse to illicit drugs. Certain medications that do not produce physical dependence or withdrawal and have much lower potential for abuse have

been found to be effective for treating anxiety disorders. Many are as effective as the benzodiazepines but without the abuse liability. The antidepressants fluoxetine (Prozac) and sertraline (Zoloft) and the antianxiety medication buspirone (BuSpar) are medications that can be used to treat symptoms of anxiety disorders, have good safety profiles, are not euphorigenic (producing euphoria), and have few drug interaction cautions. They can be used in the management of subacute withdrawal states. When these drugs do not produce the desired results, the tricyclic and monoamine oxidase inhibitor antidepressants may be used. (See appendix F for a discussion of psychiatric medications.)

Medications should be used in combination with nondrug treatment approaches. Although studies are still underway, acupuncture, aerobic exercise, stress reduction techniques, and visualization techniques may be useful components of treatment and recovery. These tools can be valuable adjuncts for the reduction of stress. Clients should be taught that efforts to improve their general health, such as eating more healthful foods and exercising regularly, can lead to better mental health.

It is beyond the scope of this TIP to provide comprehensive review on the use of psychotherapeutic treatment. However, there are numerous resources regarding counseling and psychotherapy for depression and anxiety (e.g., Barlow 2002).

Longer term care

Always foremost in longer term COD treatment are the issues of diagnosis and re-diagnosis. Once a patient has engaged in treatment and has been abstinent for over a month, most of the substance-induced depression/anxiety symptoms caused by either the substance or its withdrawal should have abated. This allows for the diagnosis of ongoing symptoms to be more certain. It should be recognized that just because psychiatric symptoms abate with abstinence and addiction treatment alone doesn't mean that such symptoms may not re-occur later and need specific mental health services, such as medications. It does, however, make this much less likely. If a patient is diagnosed with COD, is in active addiction treatment, but has been started on a psychiatric medication for depression, anxiety, or both by an outside prescriber (either a psychiatrist or primary care physician), then the substance abuse counselor should refer to chapter 5 of this TIP (the section titled "Monitor Psychiatric Symptoms") to identify strategies for monitoring symptoms and supporting medications.

While medications are useful for anxiety disorders, they are not a substitute for substance abuse treatment or other activities related to recovery. Cognitive and behavioral techniques used in substance abuse treatment often are as effective as medications in treatment of anxiety disorders, though they generally take longer to achieve an equivalent response for the mental illness component of the disorder.

It should also be noted that certain depressions may become so severe that they can cause symptoms of mental disorders, such as delusions (e.g., "I'm so evil that I was responsible for starting World War II") or hallucinations (e.g., "When I'm alone I hear my name being called and the voices tell me that I am bad"). These types of depression need immediate psychiatric consultation and medication treatment. Patients who are significantly anxious or depressed should always be evaluated for suicide: Counselors are referred to chapter 5, the subsection "Potential for harm to self or others" within the section titled "Monitor Psychiatric Symptoms," as well as to the suicidality sections in chapter 8 and this appendix, for details on evaluation and management.

The consumption of foods containing stimulants should not be overlooked. People who consume significant amounts of caffeine and sugar may have a higher risk for episodes of anxiety and depressive symptoms. Chocolate, large quantities of refined carbohydrates, and any diets that cause significant variations in blood sugar levels should be avoided, since this condition will tend to aggravate or induce both mood and anxiety states. It is important to be

sure that eating habits do not imitate the rushes and crashes of substance abuse.

Use of 12-Step and other mutual self-help programs

Participation in 12-Step programs provides valuable therapeutic experiences for many recovering people who have mood or anxiety disorders. People who have a social phobia and the fear of public speaking often are extremely resistant to attending self-help meetings. Yet, such people can make tremendous recovery gains in terms of anxiety desensitization and substance abuse recovery.

Few situations are as safe, supportive, predictable, and undemanding as the average 12-Step group meeting. For this reason, groups such as AA and Narcotics Anonymous (NA) provide constructive opportunities to help clients desensitize social fears. However, anxious clients must not simply be thrust unprepared into 12-Step group meetings. Counselors should educate and prepare such clients regarding the process and approach of 12-Step and other self-help group meetings.

A stepwise approach to using mutual self-help

It is important for substance abuse treatment staff to appreciate the difficulty and distress that are experienced by people who have social phobias and fears of speaking in public. Staff who assist such clients with 12-Step group participation should become knowledgeable about the signs and symptoms, course, and treatment of generalized anxiety disorder, panic disorder, and the phobias, especially social phobia and other anxieties related to public speaking and social situations.

Staff can help socially anxious clients participate in 12-Step group meetings by using a stepwise approach of progressively active exposure and participation based somewhat on the principles of systematic desensitization:

- One of the least intense levels of preparation involves the use of mock AA/NA meetings consisting of staff and clients. This process makes it possible to stop the meeting frequently, discuss various meeting components, examine group methods, and allow potential participants to observe and practice.
- The next level of intensity involves attending a 12-Step group meeting as a nonspeaking observer. Staff should help clients to understand that being a nonspeaking observer is a transitional phase and is not a substitute for active participation. For this reason, it may be helpful to limit nonspeaking observation by the client to a specific number of meetings. At first clients can attend meetings with someone they know and trust, and they can stay in the back of the meeting room close to an exit door.
- The next level of intensity involves clients attending a limited number of 12-Step meetings during which they identify themselves but do not talk about themselves. The counselor can give assistance by providing easily rehearsable suggestions for self-introductions such as, "Hi, my name is Mary. I'm an alcoholic and I am glad to be here, although I am a little nervous."

Since the mutual support associated with the 12-Step group meetings can occur outside of the meeting, anxious clients should be encouraged to do more than merely attend and participate in the meetings. Rather, they should arrive before the meeting begins and should linger and mingle with others following the meeting. Clients can be encouraged to volunteer to help set up the room, make the coffee, or clean up afterward. In particular, socially phobic clients can be encouraged to join others for coffee and conversation after the meetings on a more one-to-one basis, a traditional aspect of 12-Step group involvement.

By participating in step-by-step, rehearsed activities, many anxious and depressed clients seem to break through an internal barrier. As they do, participation in self-help group meetings becomes an integral aspect of recovery from substance use disorders and mental health problems.

Case Study: Phobia, Tranquilizers, and Alcohol

Lan S. has been referred to the substance abuse treatment clinic by her physician because of abuse of prescribed tranquilizing drugs and alcohol. The counselor finds Lan S. somewhat nervous but apparently in stable condition and willing to discuss her substance abuse problems. During the course of conversation, she mentions her discomfort in restaurants and malls. When the counselor refers her to a 12-Step group, Lan S. seems hesitant and uncomfortable. The counselor identifies her symptoms as resistance to treatment and strongly emphasizes the importance of attendance if she wants to change.

In future sessions, however, the counselor finds her refusal to go to group remains steadfast. After conferring with a mental health counselor, she probes Lan S.'s discomfort about going to group and explores the possibility of other similar problems. She finds that Lan S. orders all her clothes online to avoid going to stores and that she rarely appears in public. Coming to the counseling session is an ordeal made possible only by the fact that her mother takes her to the clinic and waits for her in the counseling center.

The counselor refers Lan S. to the psychiatrist, who finds that Lan S. has a social phobia. He prescribes Zoloft, a selective serotonin reuptake inhibitor (SSRI) antidepressant, and arranges for a course of treatment with a mental health counselor who specializes in phobias. He asks the substance abuse treatment counselor to coordinate closely with the mental health counselor to develop a strategy to enable Lan S. to attend meetings. Together, they work out a phased approach to regular attendance at meetings in which she first attends a meeting at the clinic, then is escorted to a meeting at another part of town. The counselors also provide psychoeducation for both Lan S. and her mother to help them understand her mental disorder. The substance abuse treatment counselor works with Lan S.'s sponsor to ensure understanding of her limitations. Gradually, Lan S. is able to attend AA regularly on her own.

Discussion: Counselors should be aware that some "resistance" may actually indicate a mental disorder. Until the disorder is treated, this obstacle will remain in the client's path and deter recovery. At the same time, some clients with social phobia or other anxiety disorders may choose not to attend 12-Step groups; this is a legitimate choice. Such clients should be offered alternatives, such as increased amounts of individual therapy. As long as they can engage in such treatment alternatives, it is important not to convey to clients that they are "wrong" or "bad" or "not doing recovery right" by choosing not to attend 12-Step groups.

The stepwise approach described for clients with anxiety disorders can be adapted for clients who are depressed. Anxious clients often avoid group participation and public speaking, saying to themselves, "If I talk or if I am noticed, I will freak out." Similarly, depressed clients often avoid group participation and other recovery activities, perhaps thinking, "I just don't have the energy to go. Why bother?" The counselor must elicit comments, understand them, and help clients to reverse these internal barriers to recovery and participation in group and other social activities.

Case Study: OCD and Alcohol

Marla W. is a 40-year-old woman with a secret: She has been compulsively washing her hands for many years, and cannot stop. She began drinking to try to relax, but found herself gradually drinking more and more in an attempt to cope with what she knew was very unhealthy behavior. She feels triggered to wash her hands whenever she thinks of "germs," and feels that she cannot get them clean enough. She sometimes washes up to 100 times a day, and has constricted her life so others will not see her. When she drinks, she is alone.

The substance abuse treatment counselor discovers Marla W.'s obsession when she notices Marla W.'s repeated trips to the rest room. She discusses Marla W.'s symptoms and assures her that some medication and therapies may be able to help her overcome the disorder. She refers Marla W. to the psychiatrist for assistance.

Discussion: Substance abuse treatment counselors often consider compulsive behaviors (gambling, shopping, overeating, sex, work, etc.) to be addictions. However, they should also consider that some compulsive behaviors may be part of an OCD and clients may benefit by having further evaluation and the knowledge that specific medication and therapies are available to assist them.

Case Study: GAD and Protracted Withdrawal

Ray Y., a 50-year-old husband and father of teenagers, is going through protracted alcohol withdrawal. He appears "edgy" and irritable, sometimes sad, and complains to his substance abuse treatment counselor of insomnia, headaches, and an upset stomach. He tells the counselor he can barely stand not to drink: "I'm jumping out of my skin." Although these symptoms are common during protracted withdrawal, because they have persisted for over a month, the counselor begins a more detailed exploration.

The counselor asks Ray Y. whether he had these symptoms before he used alcohol and Ray Y. says he's "always been this way." He worries about everything, even events that are weeks away. His family vacations are nightmares because every aspect of vacation planning troubles him and keeps him awake. During family therapy, it becomes apparent that his daughter deeply resents his controlling and distrustful behavior, as well as his overprotective stance toward all her social commitments. The counselor refers Ray Y. to the psychiatrist, who diagnoses generalized anxiety disorder and begins a course of medication and initiates mental health counseling. The family receives help coping with Ray Y.'s disorder and the daughter is referred for short-term counseling to help her address the mental problems she is beginning to develop as a result of her father's excessive control.

Discussion: Even though anxiety symptoms are quite common during protracted withdrawal, counselors are advised to consider the possibility that an anxiety disorder is sometimes indicated. Symptoms should be tracked to see whether they persist beyond the normal time that might be expected for protracted withdrawal (about a month). Counselors should also be aware of the effect of such disorders on close family members. Children and adolescents may not understand that a parent has a mental disorder and may be relieved to have a way of understanding and coping with difficult behavior.

Schizophrenia and Other Psychotic Disorders

Description

Psychosis is the term for a severely incapacitated mental and emotional state involving a person's thinking, perception, and emotional control. Psychosis refers to distorted thoughts in which an individual has false beliefs, sensations or perceptions that are imagined, and/or very extreme and unusual emotional states along with deterioration in thinking, judgment, self-control, or understanding. In everyday terms, people who are acutely psychotic cannot tell the difference between what is real and what is not, but this common distinction is too simplistic to be clinically useful. Psychosis usually is expressed clinically as a combination of one or more of the following symptoms:

- Belief in delusions (such as that one is being followed by people from Mars, or that one is a very important person whom the President wants to talk to right away, or that one is eternally damned).
- Hearing or seeing things that are not there (hallucinations) and being unable to recognize that what is being experienced is not real, such as hearing voices that say self-condemning or other disturbing things, or seeing a mocking or threatening face of the Devil.
- Severe emotional excitement, which can manifest as a "manic" state with feelings of exuberance, invincibility, grandiosity. Often this state is accompanied by poor judgment and prolonged functioning with little sleep, as is seen in people with bipolar disorder during the manic phase. Alternatively, an emotional state reflecting psychosis may manifest as severe agitation, sometimes with vaguely expressed worries or fears and/or with tears and depressive consternation.
- On rare occasions, a very different type of psychotic reaction can occur, one that manifests as immobility, stupor, or rigid body position over extended periods of time. This is known as catalepsy, one of several forms of catatonic states that occur during certain types of schizophrenic episodes.

Although schizophrenia is the illness most strongly associated with psychotic disorders, people with bipolar disorder (or what used to be termed "manic-depressive illness") may experience psychotic states during periods of mania—the heightened state of excitement, little or no sleep, and poor judgment described above. Other conditions also can be accompanied by a psychotic state, including toxic poisoning, other metabolic difficulties (infections [e.g., late-stage AIDS]), and other mental disorders (major depression, dementia, alcohol withdrawal states, brief reactive psychoses, and others).

For the purpose of this TIP, the focus will be on schizophrenia and bipolar disorder. Although schizophrenia is a "thought" disorder and bipolar disorder is a "mood" or "affective" disorder, these often are the diagnoses that States and/or other funding agencies use to establish special programs for people with "severe and persistent mental illness" or the "severely mentally ill." In practice, however, eligibility for such programs often is more largely determined by the mental health problems and their impact on the basics of the client's life—living arrangements, employment, hospitalizations, ability to care for self—than by the client's specific diagnosis.

Substance abuse treatment counselors typically do not see clients in the throes of an acute psychotic episode, as such psychotic patients more likely present, or are referred to, ERs and mental health treatment facilities. Counselors are more likely to encounter such clients in a "residual" or later and less active phase of the illness, the time at which these individuals may receive treatment for their substance use disorders in an addiction treatment agency. Even if the substance abuse treatment counselor never sees a client during an actively psychotic period, knowing what the client experiences as a psychotic episode will enable the counselor to understand and assist the client more effective-

ly. On the other hand, counselors are increasingly treating clients with methamphetamine dependence who often have residual paranoid and psychotic symptoms, and may need antipsychotic medications. These clients may continue with such psychotic symptoms for months, or even years (Chen et al. 2003).

Schizophrenia

Schizophrenia is best understood as a group of disorders that can be divided into subtypes: (1) paranoid type, in which delusions or hallucinations predominate; (2) disorganized type, in which speech and behavior peculiarities predominate; (3) catatonic type, in which catalepsy or stupor, extreme agitation, extreme negativism or mutism, peculiarities of voluntary movement or stereotyped movements predominate; (4) undifferentiated type, in which no single clinical presentation predominates; and (5) residual type, in which prominent psychotic symptoms no longer predominate.

Symptoms of schizophrenia include delusions, hallucinations, disorganized speech (e.g., frequent derailment or incoherence), grossly disorganized or catatonic behavior, and deficits in certain areas of functioning—for example, the inability to initiate and persist in goal-directed activities. These symptoms regularly develop before the first episode of a schizophrenic breakdown, sometimes stretching back years and often intensifying prior to reactivations of an active, acutely psychotic state.

Relatively subtle indicators may exist. For example, a clinician may notice a client's tendency toward loose associations, a symptom that is exhibited when ideas expressed appear to be disconnected or only very loosely connected. A similar disturbance, called tangentiality or tangential thinking, occurs when a client gets lost in telling a story and cannot get to the point. As with many of the behaviors discussed, isolated occurrences of these phenomena are unremarkable, but their repetition can be a cause for concern.

Clinicians generally divide the symptoms of schizophrenia into two types: positive and negative symptoms. *Acute course* schizophrenia is characterized by *positive symptoms*, such as hallucinations, delusions, excitement, and disorganized speech; motor manifestations such as agitated behavior or catatonia; relatively minor thought disturbances; and a positive response to neuroleptic medication. *Chronic course* schizophrenia is characterized by *negative symptoms*, such as lack of any enjoyments ("anhedonia"), apathy, very little emotional expressiveness ("flat affect"), and social isolation. Some clients will live their entire lives exhibiting only a single psychotic episode; others may have repeated episodes separated by varying durations of time.

Brief reactive psychosis describes a condition in which an individual develops psychotic symptoms after being confronted by overwhelming stress.

Bipolar disorder

Bipolar disorder, formerly termed "manic-depressive illness," is meant to characterize the fluctuations in mood from one end or "pole" to the other—severe depression to mania. Unlike schizophrenia, bipolar illness might have little effect on the client's ability to think; that is, it does not necessarily include the symptoms of a "thought disorder," whereas schizophrenia at some point always shows disturbances of thought (such as delusions, bizarre beliefs, or loose associations).

Depressive phases in bipolar clients are similar to those in clients who are severely depressed—that is, the person feels sad; might feel life is not worthwhile; gets little or no enjoyment from anything, even from involvement with children or family/friends; and has altered appetite and sleep needs, for example, waking up early in the morning almost 2 hours before normal or oversleeping. Similarly, the client may overeat or have little or no appetite. The person might experience lethargy; fatigue easily; have feelings of guilt or worthlessness (sometimes for seemingly trivial things) or show

strong feelings disproportional to the acts or thoughts involved; and experience recurrent thoughts of death, illness, or manifest suicidal thoughts, plans, or attempts.

Manic episodes for someone with bipolar disorder also vary in intensity. Full-blown, intense mania (during which a client might, for example, take off all his or her clothes and run to a church to declare that the secrets of the universe have been revealed) is relatively rare and, especially with medication, usually short-lived. An evolving manic episode might be hard to detect, especially in someone who is drinking and/or using drugs; some people with mania can get by on a day-to-day basis, partying and barely sleeping, telling tall tales others might ignore, and even being intact enough to persuade others that their delusion of vast wealth is true. People in a manic state have been known to get yachts to take to sea for a trial run or to run up thousands in bills at expensive hotels before anyone recognizes that the individual has not changed clothes in 6 days and cannot carry on a conversation without stating outlandish impossibilities (such as owning Nebraska or being married to the queen of England).

In between the extremes of elation and depression, some clients with bipolar disorder are likely to struggle almost all the time with mild-to-moderate depression and, on occasion, with "hypomanic" (mildly elevated) states that can carry deterioration in judgment, leading to legal trouble, financial loss, or relapse to abusing substances. For the 20 to 30 percent of people with bipolar illness who are not fully functional between episodes of mania and/or depression, the residual phase is usually characterized by mood instability, interpersonal problems, and/or occupational difficulties (APA 2000). However, clients with bipolar disorder who are successfully treated frequently return to positive and productive lives without any future disruption.

Differential Diagnosis

Psychosis versus substance-induced psychotic disorder

Differential diagnosis among psychotic disorders can be challenging, even for experienced clinicians and diagnosticians, especially when drugs and alcohol are involved. When a client presents in a psychotic state, any immediate or recent substance use is difficult to determine, and it may be impossible to discern whether the hallucinations or delusions are caused by alcohol or other drug use. If the hallucinations or delusions can be attributed to substance use, but are prominent and beyond what one might expect from intoxication alone, the episode would be described as a "substance-induced psychotic disorder." Hallucinations that the person knows are solely the result of substance use are not considered indicative of a psychotic episode; instead, they are considered part of what DSM-IV-TR calls *Substance Intoxication*.

Psychedelic, hallucinogenic, and stimulant drugs can produce reactions with psychotic features, especially in clients with co-occurring schizophrenia and bipolar disorders. People who use phencyclidine (PCP) and who experience one psychotic episode are "more likely to develop another with repeated use" (Goldsmith and Ries 1998, p. 971). In addition, withdrawal from some substances, especially alcohol, can produce states that can mimic psychosis. Consider the following descriptions by Goldsmith and Ries (1998, p. 970) of the known concomitants of withdrawal:

Schizophrenia is a "thought" disorder and bipolar disorder is a "mood" or "affective" disorder.

- *Sedatives:* "A protracted withdrawal syndrome has been reported to include anxiety, depression, paresthesias [a tingling, prickling, or burning sensation on the skin], perceptual distortions … headache, derealization and depersonalization, and impaired concentration."
- *Amphetamines:* Many people who abuse stimulants report a state of hopelessness, discomfort, and unhappiness that includes little or no pleasure. This state may persist for weeks. "Some stimulant addicts report hallucinatory symptoms that are visual (e.g., coke snow) and tactile (e.g., coke bugs). Sleep disturbances are prominent in the intoxicated and withdrawal states, as is sexual dysfunction."
- *Opioids:* "There are reports of an atypical opiate withdrawal syndrome consisting of delirium following the abrupt discontinuation of methadone."
- *Alcohol:* "A few chronic heavy drinkers experience hallucinations, delusions, and anxiety during acute withdrawal, and some have grand mal seizures. Brain damage of several types is associated with alcohol-induced dementias and deliriums."

Some clinicians have developed clues to differentially discriminate one type of disorder from another. For example, DSM-IV (APA 2000, p. 300) advises that "certain types of auditory hallucinations (i.e., two or more voices conversing with one another or voices maintaining a running commentary on the person's thoughts or behavior) have been considered to be particularly characteristic of schizophrenia…." Mendoza and Miller (1992) suggest that people who abuse cocaine and become paranoid maintain their abstract thinking and basic clear thinking; they have delusions that are poorly developed and of a non-bizarre nature (Goldsmith and Ries 1998). Fortunately, both the substance abuse treatment clinician and the physician responsible for the management of a client with psychotic-like symptoms can attend directly to the symptoms presented and begin by treating those symptoms without requiring an exact diagnosis beforehand.

Physical illnesses and reactions to medication

Any number of physical illnesses or medication reactions, from brain tumors to steroid side effects, can cause a psychotic episode or psychotic behavior. These are situations when the thorough diagnostician, one who follows a client until the details of the disorder and the correct differential diagnosis are clear, earns his or her keep.

Schizophrenia versus bipolar disorder

Detailed and complex strategies for conducting a differential diagnosis take into consideration the typical "natural" histories of both substance use disorders and schizophrenia or bipolar disorder and the pattern of presenting symptoms (see, e.g., Rosenthal and Miner 1997). Often, continued input from the substance abuse counselor and treatment team staff will help clarify the diagnosis or lead a psychiatrist to change a diagnosis from schizophrenia to bipolar disorder. This may also lead the psychiatrist to switch a client's medication from one of the "antipsychotic" medications to a "mood stabilizer" such as lithium.

Collateral information can be important in making an accurate diagnosis. For example, Sloan and colleagues (2000) found that a self-report of having been hospitalized with a diagnosis of bipolar disorder and/or a report of a prior positive therapeutic response to a mood stabilizer were better measures of bipolar disorder than questions about symptoms. Some types of delusions brought on by drinking (often delusions of jealousy) or by methamphetamine use can be recognized easily with input from collateral sources that clarify the situation. Without such information, staff can be misled into believing the delusion is true.

Prevalence

Schizophrenia

The lifetime prevalence rate for adults with schizophrenia is between 0.5 and 1.5 percent (APA 2000). The Epidemiologic Catchment Area (ECA) studies reported that among clients with schizophrenia, 47 percent met criteria for some form of a substance use disorder (Regier et al. 1990). Fifteen years earlier, McLellan and Druley (1977) also found that about half of male inpatients with schizophrenia could be expected to have a co-occurring addiction to amphetamines, alcohol, or hallucinogens. Research by Fowler et al. (1998) reviewed prior studies and assessed 194 Australian outpatients with schizophrenia, finding similar results with more than 59 percent of the group having lifetime alcohol abuse/dependence. In an almost all-male study of the medical records of 1,027 veterans treated for some form of schizophrenia, Bailey and colleagues (1997) found that 50.8 percent of the clients had received a diagnosis of a substance use disorder.

Bipolar disorder

The lifetime prevalence of bipolar disorder also is roughly 1 percent of the general U.S. population (APA 2000), so both schizophrenia and bipolar disorder are relatively rare compared to major depressive illness, which has lifetime incidences in the general population of 10 to 25 percent for women and 5 to 12 percent for men (APA 2000). People with bipolar disorder also are subject to high rates of co-occurring substance abuse and dependence, with even higher rates in specific populations. In the ECA study, nearly 90 percent of those with bipolar disorder in a prison population had a co-occurring substance use disorder (Regier et al. 1990).

Substance Use Among People With Bipolar Disorder or Schizophrenia

The search for specific patterns of use among clients with schizophrenia or bipolar disorder has not led to any clear pattern of drug choice. Instead, there appears a strong likelihood that whatever substances happen to be available will be the substances used most typically (Galanter et al. 1988). In research on the substance use of Australian and American patients with schizophrenia, Fowler and coworkers (1998) attributed the "slightly different pattern of substances abused (i.e., absence of cocaine)" to the "relative differences in the availability [of] certain drugs" (p. 443).

There is evidence of increasing use of alcohol and drugs among persons with schizophrenia. Fowler and colleagues reviewed studies on the substance use of people with schizophrenia, concluding that alcohol abuse and dependence increased "from 14 to 22 percent in the 1960s and 1970s … to 25 to 50 percent in the 1990s" (1998, p. 444). The same analysis showed that stimulant abuse or dependence also may have nearly doubled from the 1970s to the 1990s, from about 13 percent to between 17 percent and 31 percent, respectively. However, Fowler and coworkers also found that hallucinogen abuse or dependence declined from roughly 12.5 percent in the 1970s to 7 percent in the 1990s, and they estimate that cannabis use has remained stable at an estimated range of 12.5 to 35.8 percent.

Sonne and Brady (1999, p. 611) report that some individuals with bipolar disorder use cocaine to "intensify and lengthen euphoric mood states

Family members and community supports, when appropriate, should be included in a client's overall treatment process.

rather than to self-medicate depressive episodes." However, other clinicians see the use of alcohol by people with manic behaviors as their way of trying to sedate the heightened emotional state. Many authors report that clients will claim to use substances to counteract feelings of hopelessness or other symptoms of illness, but a majority of clients report that they use drugs or alcohol in a manner similar to persons who are not mentally ill—that is, to "get high" and/or to be sociable and fit in with others. It seems likely that clients can be confused about their substance use. Addington and Duchak (1997) report that clients state they use substances to feel less depressed—even though 65 percent of them indicated that alcohol increased their symptoms of depression.

Key Issues and Concerns

Suicide and suicidal behaviors are major, ongoing concerns for this client population, and the substance abuse counselor should have a thorough understanding of her or his role in preventing suicide. Medication compliance should be emphasized strongly and monitored at every session. The cyclical nature of bipolar disorder, frequently punctuated by bouts of deliberate medication noncompliance, can test a counselor's patience, and it is crucial to cultivate and convey an understanding of the allure of the manic episode.

Individuals with bipolar disorder do not have the same cognitive limitations as individuals with schizophrenia. Therefore, people with bipolar disorder can function at a high level in the work environment, and the maintenance of their work position can be a key factor in their long-term, successful treatment. Consequently, quick attention to signs of depression or mania can be critical, especially as medication might be able to ward off the worsening of the client's condition. For developing mania, which is virtually nonresponsive to psychosocial interventions, a variety of mood stabilizers have demonstrated remarkable efficacy. Their timely use can avert potentially life-altering, negative events.

Family members and community supports, when appropriate, should be considered for inclusion in the overall treatment process for these clients. The psychoeducational component of treatment should include both mental health and substance use disorder information, from causes and the natural histories of the disorders to the recovery process and how the illnesses can interact.

A recovery perspective and a compassionate attitude toward clients can convey hope and allow them to envision significant recovery and improvement in their lives. For example, in a focus group study of 18 clients with schizophrenia and a substance use disorder, 16 had received a course of individual therapy, and all cited contact with their individual therapist as "…helpful in their efforts to change substance abuse patterns." Many of the focus group participants stressed the importance of the human-to-human nature of their relationship with the therapist and the key role of family members and friends (Maisto et al. 1999, p. 223).

Strategies, Tools, and Techniques

Engagement

For clients with psychosis, as for others with co-occurring disorders, it is essential to build a relationship. Actively helping them to secure basic needs such as medical assistance and housing helps with the engagement process, and also helps create the level of stability needed for treatment to proceed successfully (see Figure D-11). It also is helpful to increase client motivation for treatment through involvement of the client's family.

Screening and assessment

Clinicians experience a common difficulty in determining whether psychotic symptoms represent a primary mental disorder or are secondary to substance use. In the early phase of assessment, the goal is to stabilize the crisis rather than to establish a diagnosis, which is

often best determined during a multiple-contact, longitudinal assessment process. The best assessments include direct client interviews, collateral data, observations of the client, and a review of available documented history. Especially with clients who have bipolar or schizophrenic disorders, the counselor will profit from always actively inquiring how they are feeling and how things have been going. These clients might sometimes inexplicably fail to describe the most significant events or changes spontaneously, even though they are forthright and open about such matters when asked.

Assessment of high-risk conditions

The initial step of every assessment is to determine whether the individual has an imminent life-threatening condition. Three domains of high risk require assessment: biological (or medical), psychological, and social. At any given time, one aspect of this biopsychosocial approach may be more urgent than the others.

Medical risks

The goal of medical or biological assessment is to ensure that clients do not have life-threatening disorders such as substance-induced toxic states or withdrawal, delirium tremens, or delirium.

Clients may exhibit symptoms that represent an exacerbation of their underlying chronic mental illness. Their symptoms may be due to an aggravation of medical problems such as neurological disorders (e.g., brain hemorrhage, seizure disorder), infections (central nervous system infection, pneumonia, AIDS-related complications), and endocrine disorders (diabetes, hyperthyroidism). The presence of cognitive impairment (such as acute confusion, disorientation, or memory impairment), unusual hallucinations (such as visual, olfactory, or tactile), or signs of physical illness (such as fever, marked weight loss, or slurred speech) show a high risk for an acute medical illness. Clients who exhibit this degree of risk need to be referred immediately for a comprehensive medical assessment.

Social risks

The primary goal is to ensure that clients have access to adequate supports and that their basic needs are met. Clients with COD involving psychosis are particularly vulnerable to homelessness, housing instability, victimization, poor nutrition, and inadequate financial resources. Clients who lack basic supports may require aggressive crisis intervention, such as the provision of food and assistance with locating a safe shelter. Lack of these social supports can be life threatening and can exacerbate and intensify both medical and psychiatric emergencies.

Figure D-11
Engaging the Client With Chronic Psychosis

Positive Engagement Techniques	Coercive Engagement Techniques
• Assistance obtaining food, shelter, and clothing • Assistance obtaining entitlements and social services • Drop-in centers as entry to treatment • Recreational activities • Low-stress, nonconfrontational approaches • Outreach to client's community	• Involuntary commitment • Use of a representative payee • Mandated medications

Psychological risks

The primary goal of psychological assessments must be an evaluation of the danger to self or others and other manifestations of violent or impulsive behavior. Clients with COD involving psychosis have a higher risk for self-destructive and violent behaviors, and should be assessed for plans, intents, and means of carrying out dangerous intent. Clients who are imminently suicidal, homicidal, or otherwise pose a danger need to be placed in a secure setting for further assessment and treatment (see Figure D-12). Some clients may have a cognitive impairment related to their disorder and be unable to attend adequately to basic needs. An assessment for these types of problems need to be conducted by appropriately trained and experienced graduate-level professionals. When a substance abuse counselor participates in these assessment processes, he or she can provide vital information on the client's behavior and emotional state.

Clinician's observations

The clinician's observations are an important aspect of the assessment. The clinician should make careful note of the client's overall behavior, appearance, hygiene, speech, and gait. Of particular interest are any acute changes in these behaviors, as well as the emergence of disorganized or bizarre thinking and behavior. A long-term therapeutic relationship with the client increases the opportunity to make clinical observations that assist in making the differential diagnosis. Within this context, clinicians can better understand the relationships between the substance use and the symptoms of mental disorders.

Collateral resources

As previously mentioned, data obtained from direct interviews and self-reports, as well as observational data, are limited. One important way of augmenting these approaches is to obtain information from collateral sources by direct interviews with family members and significant others concerning the psychiatric and substance-related behavior of clients. The family interview can also be a useful means of obtaining further information regarding a family history of psychiatric and substance use disorders.

Useful documentation includes medical and criminal justice records, as well as information gathered from other sources such as landlords, housing settings, social services, and employers. Case managers are in a unique position to compile aggregate reports from these various sources, since they follow clients over an extended period of time in a variety of settings.

Laboratory tests

Laboratory tests for drug detection can be valuable both in documenting substance use and in assessing substance use in relation to psychotic symptoms. Objective urine and blood toxicology screens and alcohol Breathalyzer tests can be useful. Besides being a diagnostic

Figure D-12
Biopsychosocial Assessment of High-Risk Conditions

Biological risks: Assess for life-threatening medical problems

Psychological risks: Assess for violent and impulsive behaviors

Social risks: Assess basic needs and life supports

Clients should be asked direct questions about past and current access to basic needs such as food, shelter, money, medication, or clothing. Clients should be assessed for past and recent episodes of victimization and of exchanging sex for money, drugs, and shelter.

tool, data from urine screens may be particularly important for clients who deny regular use of substances and who can benefit from objective evidence of substance use. Toxicology screens that document the absence of drug use can provide positive feedback for abstinent clients who are actively working to maintain sobriety.

Social issues

While psychiatric, medical, or substance-induced disorders may be more visible to the clinician than social problems, the latter can contribute significantly to the elaboration of the disorder and to the client's receptivity to treatment. Indeed, the client with a co-occurring substance use disorder is more likely than not to have significant impairment in the social area. Thus, identifying the problem areas of a specific client's social life becomes a core component of the service or treatment plan.

Primary health care

A current or recent comprehensive medical evaluation is an essential aspect of the overall assessment for clients with psychotic disorders, since they generally have a high prevalence of medical problems. It is also important to evaluate the relationships between clients' medical problems and their psychotic and substance use disorders. For example, medical problems may: (1) coexist with co-occurring disorders, (2) prompt or exacerbate psychotic and/or substance use disorders, or (3) be the direct or indirect result of perpetuating co-occurring disorders.

It is especially important for these clients to have easy access to treatment for medical conditions that are strongly associated with substance use, such as tuberculosis, hepatitis, diabetes, and HIV/AIDS. They should also have easy access to primary care treatment for basic medical needs, such as hypertension, as well as cardiovascular, respiratory, and neurological disorders. Prenatal care and monitoring should be available to pregnant women who may be especially at risk for relapse when her regular antipsychotic medication regimen is contraindicated.

For clients who are taking prescribed medications, it is important to assess the types of medications, whether the medications are being taken as prescribed, and the types of side effects they may cause. Clients should be asked specifically about the frequency, dosage, and duration of any prescription medication.

Medication noncompliance is the rule, not the exception, for people with co-occurring disorders. Psychiatric medication noncompliance is particularly associated with co-occurring disorders that involve psychosis, and has a significant impact on presenting symptoms and level of function. Because of this common association between substance use and noncompliance, and the limited utility of self-reports in this area, prescribing physicians often order serum drug level tests for psychiatric medications.

In addition to considering substance use as a primary factor that affects the use of psychiatric medications, it is also important to consider the potential role of psychiatric medications in subsequent substance use. For example, side effects such as akathisia (severe restlessness) or sedation may be caused by antipsychotic medications, and clients may take alcohol and/or other drugs in an attempt to medicate these unwanted side effects.

Frequently, clients spend money on psychoactive substances rather than on adequate and nutritious food; the resulting nutritional impairment can lead to impaired cognition. A lack of regular meals and poor nutrition are common occurrences among clients with COD; therefore, access to regular meals should be assessed. Acute dental problems as well as regular periodic dental care also should be assessed. Because this group frequently experiences financial difficulties, dental care often is limited or nonexistent. Attention should be given to the social and emotional consequences of poor dental health, such as poor self-esteem and diminished social interaction.

Crisis stabilization

The most important initial step in treatment is to identify high-risk conditions that require immediate attention. Within the area of acute management it is useful to differentiate between acute management of crises and the resolution of subacute problems that may be severe but not life threatening.

High-risk conditions

The initial critical consideration for high-risk conditions is to determine if a client requires emergency medical treatment, psychiatric treatment, or both. If the client is found to require hospitalization, it is then necessary to determine the type of treatment that is required (e.g., primary health care, detoxification, or psychiatric care). Such determinations necessarily involve medical assessment and intervention. Coordination with emergency mental health services and the local police department may be necessary to ensure the immediate safety of the client and others. Substance abuse treatment programs should have clear and readily available policies and procedures for addressing these situations, and staff members should be thoroughly familiar with their roles and responsibilities.

> Clients with severe or persistent mental and substance use disorders require dually focused, integrated treatment.

With regard to high-risk social conditions (homelessness, housing instability, victimization, and unmet basic needs), the priority is to implement aggressive case management. Meeting clients' basic needs is critical to the treatment of COD, including psychosis. High-risk conditions may be related to medical, substance use disorder, and/or psychiatric crises, and often will require followup upon hospital discharge. Regardless of the priority of the immediate needs, the overall biopsychosocial needs of clients must be addressed in a holistic manner, considering both the psychosis and the substance use disorder. The approach must be integrated and comprehensive despite the higher visibility of one of the disorders at a given time.

Therapeutic coercion

Those clients with severe mental or substance use disorders who do not respond to these initial attempts at engagement in the treatment process may require the use of therapeutic coercive approaches. Clients with severe COD may have gross cognitive impairment due to substance dependence and may be severely disorganized due to mental illness. They may be impulsive, exhibit extremely poor judgment, or be subject to repeated episodes in which they are dangerous to themselves or others. Without therapeutic coercive interventions, some of these clients may be at substantial risk of catastrophic outcomes, including death, injury, violent behavior, or long-term incarceration.

Examples of therapeutic coercive approaches include the appointment of a representative payee, guardian, or conservator, and the use of parole or probation. Legal advocacy by a case manager for court-mandated treatment services may be essential for engaging in and maintaining treatment services. Other mechanisms include commitment to outpatient treatment services, conditional discharge, and commitment to appropriate inpatient treatment.

Therapeutic coercive efforts should be temporary and reserved for clients for whom other interventions have failed. The long-term goal for these clients is to regain control over their lives. Even when coercion is necessary, the counselor can focus on the dangerous or harmful circumstances and avoid having the client take commitment or other coercion as a sign of personal failure, or as an indication of the counselor rejecting the client. Although at the time the client may protest, claiming to be mistreated and misunderstood, he or she often

later expresses appreciation to the counselor for the concern shown in seeing that the client's basic needs were met. This turnabout especially is likely when the counselor is able to convey compassion and understanding (though not agreement) throughout the process involving coercive elements.

Short-term care and treatment

Following the resolution of the acute crisis, subacute conditions must be addressed before long-term management can occur. (Subacute conditions can also occur as a precursor to acute relapse of psychiatric symptomatology or substance use.) Examples of specific management issues that may arise in regard to subacute conditions include resuming or adjusting psychotropic medication, clients' comfort with the medication, medication compliance, addressing acute psychiatric symptoms, establishing early substance abuse treatment intervention, and establishing or sustaining clients' connection with support systems and services for obtaining housing and meeting basic needs.

The subacute phase offers an opportunity to reassess the diagnosis and overall treatment needs. The ultimate goal should be to establish a long-term treatment plan, avert imminent decompensation or relapse, and plan to address long-term needs. Both short-term and long-term plans should be developed with the client and should be subject to periodic review and revision.

Group treatment

Group process is a core element of substance abuse and mental health treatment. However, for clients with psychosis, group treatment should be modified and provided in coordination with a comprehensive service plan. Clients who have accepted the goal of abstinence, have maintained mental health stability, and have essential social skills may benefit from carefully selected traditional 12-Step programs that are sensitive to the needs of people with serious mental illness. However, during the early phases of treatment, an unfacilitated referral to traditional 12-Step programs could result in a poor response. Fortunately, the growing movement for dual recovery mutual self-help groups (as described in chapter 7) is providing an attractive alternative for clients with COD. The core approach should include psychoeducational, supportive, behaviorally oriented, and skill-building activities.

Longer term care

The overall goal of long-term management should involve: (1) providing comprehensive and integrated services for both the mental and substance use disorders, and (2) doing so with a long-term focus that addresses biopsychosocial issues in accord with a treatment plan with goals specific to a client's situation. The following cases exemplify some of the diverse issues that may arise in treatment planning.

Discussion of case examples

Louisa F. and James T. (see text box, p. 396) have different long-term needs. Louisa F.'s brief reactive psychosis and depression may never recur, but the relationship between her alcohol use and mental disorder symptoms should be explored. James T.'s chronic psychosis and frequent substance abuse episodes are woven together intricately and require combined treatment.

These case examples are valuable to demonstrate how the absence of a dual-focus approach can lead to treatment failure. While Louisa F.'s psychotic episode was related to overwhelming stress, her alcohol use might be underemphasized in a traditional mental health setting. Doing so may obscure the possibility that her drinking severely deepened her depression, increased daytime agitation, and exacerbated the psychotic episode.

While James T. has ongoing psychosis and substance abuse problems, focusing on only one set of these problems means that he bounces back and forth between the mental health and substance abuse treatment programs, depending on his current symptoms. His involvement with the

Case Studies: The Importance of a Dual Recovery Approach for Two Clients With Psychosis

Louisa F.

Married for more than 15 years, Louisa F. was responsible for most of the duties related to raising four children and maintaining the home. In the past, she had been treated for an episode of postpartum psychosis, but until recently she had not required any psychiatric medications or mental health services.

Her husband, a successful businessman, was the family's only source of financial support and was emotionally distant. While Louisa F. believed that her husband was frequently out of town on business trips, he was actually nearby having an affair with a woman whom Louisa F. had known for many years. One day, he abruptly informed Louisa F. of the affair and moved out of the house.

During the next 3 days, Louisa F. was intensely depressed and agitated. Her normally infrequent and low-dose alcohol use escalated as she attempted to diminish her agitation and insomnia. During this time, she ate and slept very little. She began to feel extremely guilty for even the smallest problem experienced by her four children. She felt burdened by what she called her "transgressions, faults, and sins." She expressed fears about being doomed to "eternal damnation." Loudly and inconsolably, she declared that she "had lost her soul" and would have to repent for the rest of her life. While being taken to a nearby clinic for evaluation, she passionately described a conspiracy by members of the Catholic Church to steal her soul.

James T.

In his inner-city neighborhood, James T. was well known by the local medical clinic, the substance abuse treatment program, and the community mental health program. During the day he spent much of his time walking around the neighborhood, frequently talking to himself or arguing with an unseen individual. He spent most of his evenings in the park in a wooded area away from other people, except in the winter when he slept in community-run shelters.

James T. has a prominent scar in the center of his forehead. When asked about it, he described in great detail his "third eye," and how he could see into the future through the eye. When asked about his stated reluctance to live in an apartment, he described an aversion to "electromagnetic fields" that drain his "life force" and make it difficult for him to "think about good things." For extended periods lasting several months, James T. appeared disheveled and agitated, and he could be seen drinking heavily or using whatever drugs were available. During other periods, he did not use drugs and alcohol heavily and appeared well-groomed.

In general, James T. was pleasant and well-liked, although he was known to become hostile and potentially violent when he used substances.

local medical clinic for treatment of physical injuries that are sustained during episodes of impaired thinking often complicates his already uncoordinated treatment, especially if he is given psychoactive agents for pain relief or what seems to the medical clinic staff to be anxiety.

As these case examples illustrate, clients who experience psychosis and substance abuse or dependency often are highly symptomatic and may have multiple psychosocial and behavioral problems. It is common for such clients to have undergone different approaches to treatment by different providers without long-term success. Furthermore, clarifying the diagnosis and "underlying disorder" is extremely complicated in the early phases of assessment. The first step in treatment of a person with COD is an assess-

ment that addresses biological, psychological, and social issues.

Clients with severe or persistent mental and substance use disorders, such as James T., require dually focused, integrated treatment. Clients like Louisa F., who have mild or brief symptoms of mental illness, may benefit from consultations, collaborations, and mutual self-help groups.

Long-term perspective

Both psychotic and substance use disorders tend to be chronic disorders with multiple relapses and remissions, supporting the need for long-term treatment. For clients with COD involving psychosis, a long-term approach is imperative. Research has shown that individuals become abstinent and gain control over psychiatric symptoms through a process that frequently takes years, not days or months. Front-loaded, intensive, expensive, and highly stimulating short-term treatment modalities are likely to have limited success with this group of clients. Also, an accurate diagnosis and an assessment of the role of substances in the client's psychosis necessitate a multiple-contact, longitudinal assessment and treatment perspective.

Treatment teams

Especially for programs that treat clients with psychotic and substance use disorders, it is important that the program philosophy be based on a multidisciplinary team approach. Ideally, team members should be cross-trained, and the team should include representatives from the medical, mental health, and substance abuse treatment systems. All staff members—clinical, administrative, and operational—should learn to use gentle or indirect confrontation techniques with these clients when necessary. Many clients with co-occurring schizophrenia require a temperate approach all the time, and some people with bipolar disorder can take any criticism as an extreme insult, particularly if they are experiencing the grandiosity that often accompanies hypomanic, manic, or residual states of the illness.

Assertive case management

Team members should endorse an assertive case management approach, wherein the case manager is expected to provide services to clients in their own environments as well as at the treatment site. The case manager must not attempt to be the sole broker of treatment services or the exclusive provider of office-based treatment. A supportive and psychotherapeutic approach to individual, group, and family work should be employed.

Flexible hours are necessary to provide services to these clients. Services need to be available during evening and weekend hours when crises frequently occur. In addition, alternative social activities and peer group activities often take place in the evening and on weekends.

Using a behavioral and psychoeducational perspective

The individual and group programs for clients whose COD involves psychosis should be based on a behavioral and psychoeducational perspective, not a psychodynamic approach. Educational information should be repeated often and presented in concrete terms using a multimedia format. Programs should be modified to include frequent breaks and shorter sessions than normal.

Special care should be taken with regard to client education and group discussion about "Higher Power" issues. If a program has this focus, staff members should be trained to teach clients and lead group discussions about spirituality and the concept of a Higher Power. Staff members should understand the difference between spirituality and religion, and especially the differences between spirituality, religion, and delusional systems that have a religious or spiritual content.

Associated psychosocial needs

Even intensive, carefully designed substance abuse treatment is likely to have limited success if the extensive psychosocial problems faced by the client are not addressed concurrently. Common psychosocial concerns of this group include housing, finances and entitlements,

legal services, job assistance, and access to adequate food, clothing, and medication.

A particularly common complication of clients with psychosis and substance use disorders is housing instability and homelessness. Among the possible housing services that may be particularly useful are shelters, supervised housing settings, congregated living settings, treatment milieu settings, and therapeutic communities. Ideally, residential options and placements should be long term, with the goal of promoting independent, stable, and safe housing. However, short-term options that are less than ideal should be explored to ensure the client's basic safety from weather and violence.

Vocational services

Vocational services also are essential for long-term stabilization and recovery. Both substance abuse and mental health services have traditionally referred clients to generic vocational rehabilitation services; however, to be effective these services must be integrated and modified for the specialized needs of the individual with psychosis and substance use disorders. Temporary hire placements and job coaching options are important elements to incorporate into rehabilitation services for this group.

Alternative support groups

An essential part of treatment for clients is the development of alternative peer group relationships that do not include substance use. Developing these non–substance-using social networks can be enhanced by programs that provide social club activities, recreational activities, and drop-in centers onsite, as well as linkages to other community-based social programs. At the same time, clients should be encouraged to establish and maintain relationships, including family relationships, that are supportive of treatment goals.

Family

Treatment can be substantially supported and enhanced by direct involvement of the client's family. Services can include family psychoeducational groups that focus on education about substance use disorders and psychosis, including those multifamily treatment groups that the individual with the COD attends with his or her family members.

Families also may be helpful in identifying early signs of mental disorder or substance use relapse symptoms. They can work with the treatment team in initiating acute relapse prevention and intervention. Confidentiality[3] needs to be addressed at the beginning of treatment, with the goal of identifying a significant support person who has the client's permission to be involved in the long-term treatment process.

Relapse prevention

An essential component of relapse prevention and relapse management is close monitoring of clients for signs of substance abuse relapse and a return of psychotic symptoms. Relapse prevention also includes closely monitoring the development of clients' substance refusal skills and their recognition of early signs of psychiatric problems and substance use. The goals of relapse prevention are (1) identification of clients' relapse signs, (2) identification of the causes of relapse, and (3) development of specific intervention strategies to interrupt the relapse process.

Close monitoring involves the long-term observation of clients for early signs of impending psychiatric relapse. Such signs may include the emergence of paranoid symptoms and symptoms related to substance use, such as hostile or disorganized behavior. For example, a sign of paranoid symptoms may be the client's sudden and constant use of sunglasses. Additional important clues may involve changes in daily

[3]Confidentiality is governed by the Federal "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations (42 C.F.R. Part 2) and the Federal "Standards for Privacy of Individually Identifiable Health Information" (45 C.F.R. Parts 160 and 164).

routine, changes in social setting, loss of daily structure, irritation with friends, and rejection of help. Family members who reside with the client often are the first to detect early signs of psychotic or substance use relapse. Even routine daily stressors may have an intense impact on the client with chronic psychosis and may prompt relapse.

Objective laboratory tests also may be useful in detecting relapse. These include the use of random urine toxicology screens, current noninvasive measures of alcohol use (e.g., saliva or breath analysis), and blood tests to detect street drugs. As medication noncompliance is associated strongly with both substance use and psychotic relapse, blood medication levels (including antipsychotic and lithium levels) particularly may be useful. Finally, the use of intramuscular forms of antipsychotic medications may be particularly useful with very difficult noncompliant clients for ensuring long-term compliance with antipsychotic medications.

In addition to close monitoring by healthcare professionals, family members, and significant others, an important component of relapse prevention is assisting the client with developing skills to anticipate the early warning signs of mental and substance use disorders. These skills can be acquired through direct individual psychoeducation and participation in role-play exercises and psychoeducation groups. These clients should be trained in substance refusal skills and to recognize situations that place them at risk for substance use.

Similarly, these clients may benefit significantly from behavioral therapy; development of relaxation, meditation, and biofeedback skills; exercise; use of visualization techniques; and use of relapse prevention workbooks. Pharmacologic strategies may include the use of disulfiram or naltrexone for certain clients.

Weiss and colleagues (1999) have developed a promising relapse prevention model for group therapy with persons who have a bipolar disorder. The treatment consists of 20 weekly therapy groups, each of which focuses on a topic relevant to both disorders. Topics include (1) denial, ambivalence, and acceptance; (2) self-help groups; and (3) identifying and fighting triggers. The group is based on a relapse prevention model, which was adapted to integrate the treatment of bipolar and substance use disorders by focusing on similarities between the recovery and relapse processes for each. For instance, just as many people with substance use disorders are tempted to abandon attempts at abstinence after a "slip," those with bipolar disorder may feel like stopping their medications after experiencing a mood episode despite medication compliance. The group reviews strategies for coping with a temporary setback in either disorder, emphasizing the role of thoughts and behaviors that can either improve or worsen such a situation in either disorder. (For a more detailed account of this approach see Weiss et al. 1999.)

> An important component of relapse prevention is helping the client learn to anticipate the early warning signs of mental and substance use disorders.

Medication

With clients who have COD that involve psychosis, lack of attention to medication issues is a common provider mistake that often leads to mental disorder or substance use relapse. Most important, treatment programs must provide aggressive treatment of medication side effects, as ignoring the side effects of prescribed medication often results in clients using substances to diminish such effects.

Equally important, clients should be educated and thoroughly informed about (1) the specific medication being prescribed, (2) the expected results, (3) the medication's time course, (4) possible medication side effects, and (5) the expected results of combined medication and substance use. Whenever possible, family members

and significant others should be educated about the medication.

Medication should not simply be prescribed or provided to the client with psychosis. Rather, it is critical to discuss with clients (1) their understanding of the purpose for the medication, (2) their beliefs about the meaning of medication, and (3) their understanding of the meaning of compliance. It is important to ask clients what they expect from the medication and what they have been told about the medication. Overall, it is important to understand the use of medication from the client's perspective. Indeed, informed consent relative to a client's use of medication requires that the client have a thorough understanding of the medication as described above.

It also is important to help clients prepare for peer reaction to the use of medication during participation in certain 12-Step programs. Clients should be taught to educate other people who may have biases against prescription medications or who may be misinformed about antipsychotic medications.

Ideally, clients receiving medication should participate in professionally led medication education groups and medication-specific peer support groups. These groups will help clients to manage the emotional and social aspects of medication, promote medication compliance, and help clinicians and clients identify and address early noncompliance and side-effect problems.

Overall, a specific and aggressive treatment strategy that helps make medication use simple and comfortable is essential. The scheduling and administration of medication should be simple and convenient for clients. The ideal schedule for oral medications is once per day. The use of depot scheduling may be the most comfortable and effective option for some clients with COD involving psychosis.

Case Studies

Individuals with psychosis and substance use disorders more often present for treatment in the mental health setting. However, in some situations individuals with psychosis will report to substance abuse treatment settings. For example, counselors may encounter a paranoid disorder that does not become apparent until the client has been in treatment for some time, as in the case study "A Hidden Psychosis."

Case Study: A Hidden Psychosis

John R. was a 33-year-old client who had been treated for about 2 months in the substance abuse treatment clinic. He was mostly quiet in treatment groups and had limited, though appropriate, social interaction with his peers. His affect was somewhat restricted, but he initially denied a history of mental health services. He was single, attended community college part time, and lived with his parents. During the first 2 months he complained about somatic symptoms and cravings. During discussions in group treatment, he started to become more vocal. He laughed inappropriately at times and often appeared to be laughing quietly at his own jokes. Later, he confided in his therapist that he thought he was ugly and that his nose was disfigured because he lied. He was also focused on the fact that he was 5 feet 5 inches; he wanted to have a surgical procedure to increase his height because he would never get a girlfriend if he wasn't taller.

Discussion: Some cases of schizophrenia are mild and are only uncovered over time. A case this mild might be treatable in the substance abuse treatment setting, with a consultation with the psychiatrist to evaluate the need for medication.

Case Study: Denial of Psychosis

Bob K. was a 31-year-old client who was homeless and living in and out of shelters. He stated that he loved smoking pot but that the cocaine was taking a toll on him. Cocaine binges would cause him to hear voices and become suspicious of others. Bob K. presented disheveled, with poor hygiene. He denied prior mental health services and refused to see the psychiatrist because he didn't want to be put on any medications. He admitted later that he had some mental health services previously, but didn't agree with the therapist's diagnosis of schizophrenia. He did have periods of hallucinations and paranoia even when he had not used cocaine for several weeks. He stated that the voices he heard were due to a bad LSD trip when he was 21 years old and that since then God has been punishing him for doing drugs and not listening to his mother.

Discussion: With an unmotivated client like Bob K., it is best to go easy and not challenge his belief system head-on. The initial goal is to keep him in treatment, not to insist on his acceptance of the label of "schizophrenic." It would be best to assure him, for example, that even if his symptoms are a result of drug use, medication could be helpful. The psychiatrist would do well to start him at a low dose of medication, because he might bolt from treatment if he experienced side effects.

Case Study: Aftereffects of Drug Use

Sue P. was a 24-year-old who became extremely frightened and agitated upon returning from a "rave" party. Her mother brought her to the emergency room because of her daughter's strange behaviors and odd comments. Sue was a college graduate who was working in sales and living at home. She wanted to stay in a fetal position, was fearful of others, and worried that the police had planted listening devices in her home. After about 48 hours Sue was less paranoid and more relaxed. She then was able to admit to doing ecstasy and ketamine at the rave.

Discussion: Sue will probably recover well in a quiet room with supervision, possibly from her mother or possibly as an inpatient. She should have a low dose of antipsychotic medication for about a week and should be carefully assessed for suicidal tendencies. She should be told clearly that the effects she is experiencing are the result of drug use.

Case Study: Counseling a Binge Drinker With Bipolar Disorder

Francisco H. has come for treatment after losing his job because of binge drinking. Francisco H. has little energy and his voice is so low the counselor can barely hear it. Probing for depression, the counselor learns that Francisco H. has at least five symptoms of depression and has previously been diagnosed as having bipolar disorder. He says he sometimes drinks to calm down "when he's flying too fast." However, he has not taken his medication regularly and believes if he can just stop drinking he will be fine. He has been attending AA meetings sporadically and has been told that medication is just another form of drug.

The counselor gives Francisco H. a brochure from AA on medication for mental illness (Alcoholics Anonymous World Services 1984). He points out that acceptance of medication is an important step in recovery, suggesting that Francisco H.'s bipolar disorder and alcohol abuse interact with each other. Using

Case Study: Counseling a Binge Drinker With Bipolar Disorder (continued)

motivational interviewing techniques, he finds that Francisco H.'s major concern is his need for work; his wife is pregnant, and his loss of a job has put the family in a precarious position. He suggests that taking the medication will help Francisco H. level out mentally and enable him to seek employment. If he uses the medication consistently along with other recovery supports, including a 12-Step group that meets at the center, he may be able to break the interactive cycle between the two disorders. The counselor cautions that 3 or 4 weeks may be needed to feel the full effects of the medication and alerts him to the possibility of side effects, which should be reported immediately. He lets him know, however, that if Francisco H. does experience side effects with one antidepressant, he may be able to take others. Francisco H. accepts a consultation with the psychiatrist to explore the possibility of medication.

Discussion: Often, a client is motivated to address one disorder but not the other. The counselor should help the client recognize the possible relationship between the two. When the use of medication is a concern, the counselor should be prepared to explain the difference between drugging or drinking to get high and using a prescription drug to stay at a normal level of functioning. AA literature that addresses this topic is often helpful (see appendix J for information).

Attention Deficit/Hyperactivity Disorder (AD/HD)

Description

AD/HD is "a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than typically is observed in individuals at a comparable level of development" (APA 2000, p. 85). People with AD/HD may fail to give close attention to details, be easily distracted, shift among activities without completing tasks, have disorganized work habits, and forget obligations. Hyperactivity may be indicated by "fidgetiness," difficulty engaging in quiet activities, and general restlessness. Individuals with AD/HD may be impatient and engage in dangerous activities without thinking of the consequences. Strictly speaking, those with attention deficit do not have a deficit in attention but "a lack of consistency in direction and control." They have been described as "attending to everything" (Waid et al. 1998, p. 394). Often, individuals with AD/HD have poor self-esteem, are demoralized, and may be rejected by their peers.

Symptoms of this disorder are most likely to be evident in a group setting. Usually symptoms lessen as children mature, though adults may continue to have difficulty participating in sedentary activities. Many adults diagnosed with AD/HD complain of having a hot temper, low self-esteem, inability to relax, inability to complete tasks, poor driving skills, family violence, and difficulty sustaining jobs or relationships. Their key "neuropsychological weakness" has been termed "executive dysfunction," which includes difficulties with planning, sequencing, and organizing activities. Some adults with AD/HD learn to channel their energy into sports-related activities or find other means of coping with the disorder.

There are three types of AD/HD: a "combined type" in which a person has both difficulty paying attention and hyperactivity, a type that is "predominantly inattentive," and a type that is "predominantly hyperactive-impulsive." It is important to note that "the validity of the diagnosis of AD/HD, particularly in adults, has been questioned" (Waid et al. 1998, p. 393). However, AD/HD is now recognized as a disorder by DSM-IV, the standard guidance on diagnosis for mental disorders (APA 2000).

Symptom clusters for inattention and for hyperactivity-impulsivity are illustrated in Figures D-13 and D-14.

Differential Diagnosis

A number of other mental disorders may produce symptoms similar to AD/HD, including substance-related cognitive impairment, bipolar disorder, major depression, anxiety disorder, dissociative identity disorders, social phobia, and personality disorders, especially obsessive-compulsive personality disorder. AD/HD must also be distinguished from personality change that may occur as a result of a medical condition, such as a stroke, head trauma, or hypothyroidism. Both alcohol and marijuana abuse can produce symptoms that mimic AD/HD.

It is important to rule out other causes of inattention or hyperactivity. People with substance use disorders who are newly abstinent or those in active or protracted withdrawal may experience some impairments similar to AD/HD. Some persons with low IQs may also exhibit AD/HD symptoms.

Further adequate assessment and treatment for potential withdrawal syndromes should occur before concluding that the client is either cognitively impaired or has AD/HD (see also TIP 29, *Substance Use Disorder Treatment for People with Physical and Cognitive Disabilities* [CSAT 1998*e*]). Keys to reliable diagnosis of AD/HD in adults include the following:

- Childhood history
- Corroboration by an outside source
- Proof of impairment, such as problems with certain types of work or study
- Persistence of symptoms over time without fluctuation
- Taking into account the effect of the context (e.g., inability to focus on reading matter in a crowded, noisy subway car does not imply AD/HD)
- Cognitive testing
- Questionnaires

Figure D-13
AD/HD Symptom Cluster: Inattention

- Failure to attend to detail, careless mistakes
- Difficulty sustaining attention
- Does not listen
- Poor follow through, failure to finish
- Difficulty organizing tasks and activities
- Avoidance of effort-demanding tasks
- Losing things
- Easily distracted
- Forgetful in daily activities

Figure D-14
AD/HD Symptom Cluster: Hyperactivity-Impulsivity

- Fidgets, squirms
- Unable to remain seated
- Runs or climbs excessively (restless in adults)
- Inability to play (relax) quietly
- "On the go," "driven by a motor"
- Talks excessively
- Blurts out answers
- Can't wait for turn
- Interrupts, intrudes

Prevalence

A recent review reports the prevalence of AD/HD among children as wide as 2 to 19 percent (Rowland et al. 2002). Between 10 and 65 percent of individuals who have AD/HD as children continue to have debilitating symptoms of the disorder as adults (Waid et al. 1998). Studies of the adult substance abuse treatment population have found AD/HD in 5 to 25 percent of persons, suggesting that about one in six clients may have this co-occurring problem

(Clure et al. 1999; King et al. 1999; Levin et al. 1998; Schubiner et al. 2000; Weiss et al. 1998). Waid and colleagues (1998) estimate that 33 percent of adults with AD/HD have histories of alcohol abuse or dependence, and 20 percent have other drug abuse or dependence histories. A history of childhood AD/HD has been found in 17 to 50 percent of people with substance use disorders and from 17 to 45 percent in people who abuse cocaine and opioids (Waid et al. 1998). Adults with persistent symptoms of AD/HD who have a history of conduct disorder or have co-occurring APD are at the highest risk for having substance use disorders as well.

Substance Abuse and Dependence Among Adults With AD/HD

Adults with AD/HD have been found to abuse primarily alcohol, with marijuana being the second most common drug of abuse (Waid et al. 1998). While early studies hypothesized that these clients used stimulants in an effort to self-medicate, their preferences seem to be the same as those of the general population (Waid et al. 1998). The relationship between AD/HD and substance use disorders is important because "clients with these combined disorders may require and respond differentially to various therapeutic approaches" (Waid et al. 1998, p. 393). The presence of AD/HD complicates the treatment of substance abuse, since clients with these co-occurring disorders have "more treatment difficulties, poorer substance abuse treatment outcomes, and a greater risk for relapse than clients diagnosed with substance use disorder alone" (Waid et al. 1998, p. 412). Obviously, such clients have more trouble in didactic, lengthy sessions that require focus and sustained attention.

Key Issues and Concerns

Though controversial, AD/HD appears to be a real disorder and must be considered seriously as a possibility for clients who show the symptom clusters depicted in Figures D-13 and D-14 (p. 403).

Though stimulants are the pharmacological treatment of choice for AD/HD in children, clinicians should be aware that antidepressants such as bupropion or desipramine are preferable for chemically dependent adults. Research is lacking on longer term outcomes, and better biopsychosocial treatments remain to be developed.

Strategies, Tools, and Techniques

Engagement

During engagement, a problem can emerge if the client divulges a previous AD/HD diagnosis to a counselor who does not believe the problem exists. Another problem can occur if the client has the hyperactive version of AD/HD, which makes interaction difficult, and poses many of the same challenges as hypomanic clients. Such clients have trouble staying focused and maintaining a dialogue. Eliciting information and keeping the client on task for the duration of the intake interview is difficult. These clients may have a "short fuse" and become irritable when the counselor has to bring them back to the intake process repeatedly. During group, this type of behavior and habitual side conversations can lead to intragroup conflict.

These engagement problems are in fact the beginning stages of differential diagnosis and assessment. Adult AD/HD has not been widely recognized or accepted in either the substance abuse or mental health treatment communities, but occupies a position similar to that of PTSD in the last decade—clients with complaints, a small amount of research, and often active resistance by therapists to acknowledging that AD/HD is a real disorder. Substance abuse treatment counselors who hear clients say, "I was just self-medicating my AD/HD with cocaine," as a convenient rationalization for substance abuse may be even more suspicious, but about one in six of these "rationalizers" may have real attention deficit problems that undermine their treatment and abstinence. At

this stage, the best engagement strategy for such clients is to keep an open mind to the possibility the client does have AD/HD and develop services or referrals for clients who are legitimately affected by AD/HD.

Engaging the hyperactive client

The counselor may use an adapted form of motivational techniques for the invasive, talkative, hyperactive client. The counselor might tell the client which elements of discussion he or she has successfully completed, then reframe the remainder. For example, during the initial intake question concerning what it was that brought the client to the clinic, a client may begin to talk about his alcohol and marijuana use, but rapidly move into a discussion of the argument he and his wife have been having about his poor work history (he gets jobs but then loses them), then switch to talking about what is wrong with the automobile industry in the United States and pollution control. After a few attempts to redirect, the counselor is left thinking, "How can I get this guy to focus? Why does he talk so fast and always ends up off-topic? Is this denial, resistance, hypomania, or attention deficit disorder?"

In such a situation, the counselor might respond, "You sure pack a lot of information into one answer. It's hard for me to keep up! So can we take things a bit slower? Now, let's go back to when you first started to use alcohol." In this case, the client with AD/HD will more likely be able to focus with frequent gentle reminders. The hypomanic client will most likely keep "revving up" and require more active management. The school histories of these two clients should be different, with the client with AD/HD showing early school problems *before* substance abuse began.

Screening and assessment

Strictly speaking, it is not possible to diagnose an adult as having AD/HD unless there is a childhood history of the disorder. Basic screening for this possibility can be as simple as asking, "When you were in grade school, before you used drugs or alcohol, did you have learning or behavior problems? Were you ever diagnosed with AD/HD? Did you ever take medications for this? How much did the medications help?"

The clinician is advised to "focus on the primary symptoms of inattention, impulsivity, and hyperactivity because secondary symptoms such as procrastination, disorganization, forgetfulness, chronic lateness, or underachievement do not necessarily indicate that the client suffers from AD/HD" (Waid et al. 1998, p. 406).

Since people with substance use disorders are not always good historians, whenever possible it is useful to interview others who knew them well as children. Evidence should also be sought "via review of records, reports from parents or significant others, and use of behavioral checklists and questionnaires" (Waid et al. 1998, p. 412). Scales and checklists currently available for use in assessing behavioral symptoms of AD/HD include the Hyperkinesis-Minimal Brain Dysfunction Childhood Symptom Checklist, the Wender Utah Rating Scale (Ward et al. 1993), the Client Behavior Checklist, and the Conners Abbreviated Symptom Questionnaire. When using these instruments, the clinician should be aware that they have not been validated for use in substance-abusing populations.

There is no "definitive test battery" to assess the neuropsychological impairments associated with AD/HD, but much can be learned by observing clients' behavior in testing situations. Frequent false starts, off-task behavior, and concentration problems are suggestive (Waid et al. 1998), and continuous per-

> The presence of AD/HD complicates the treatment of substance abuse.

Education about AD/HD may be useful and enlightening to many clients.

formance tests—the Gordon Diagnostic System (GDS), the Test of Variables of Attention (TOVA), and the Conners Continuous Performance Test—can be used to measure distractibility.

The most common attention problems in people with substance use disorders occur as a result of short-term toxic effects of substances. Such difficulties should improve with each month of abstinence. With this in mind, Waid and colleagues suggest that "frequent reassessments as abstinence is maintained may result in the detection or disappearance of other psychiatric and cognitive disorders, including learning disabilities" (Waid et al. 1998, p. 415). If attention symptoms do not improve over time, the client should be referred for further assessment.

Crisis stabilization

Adult AD/HD is not an emergency condition. Rather, it usually is chronic, subtle, and difficult to separate from the client's substance use or its consequences. The most likely crisis that might emerge is from the significant abuse of prescription stimulants obtained illegally or from a doctor outside the client's established healthcare providers. For example, a client might arrive at a group intoxicated, on stimulants, hyperactive, and evasive. The client might have a positive urine test, but refuse to accept the incident as serious because "the medication was prescribed." The second part of the crisis would then require consultation with the outside prescribing doctor; the client must sign a consent form for the release of information held by this doctor.

If the client is found to be taking psychoactive and abusable prescription medications such as amphetamines, Ritalin, and pemoline outside of the substance abuse treatment agency treatment plan, an immediate treatment conference is needed to determine and discuss

- Client safety: Does the client need hospitalization or detoxification?
- If not, is the client willing to discontinue the outside medications and continue substance abuse treatment?

Preferably, medical personnel at the substance abuse treatment agency will obtain the appropriate consent from the client, contact the outside doctor, discuss the case, and make the best clinical decisions around the welfare of the client. This typically includes consideration of other, nonabusable AD/HD medications such as bupropion or desipramine, preferably prescribed by internal agency substance abuse treatment staff (if available).

Short-term care and treatment

Unless the client already has been diagnosed with valid AD/HD, which is possible but rare, AD/HD cognitive and behavioral problems begin to become apparent during this initial phase of treatment. Poor attention and impulsive behavior are most likely due to continued substance use or withdrawal; however, if the client is found to be clean and has no history of a mental disorder, *then* AD/HD should be considered, and the client should be referred to an expert diagnostician. Since AD/HD expert diagnosticians are rare, especially as available to substance abuse treatment agencies, the field faces a serious challenge. Individual clinicians need to do the best they can with their limited resources.

Factors leading to *underdiagnosis* of AD/HD at this stage include

- Reluctance on the part of staff or the client to considering or accepting the diagnosis, or lack of familiarity with the disorder.

- Difficulties stemming from the client's lack of recall or having no family to help with the diagnosis of a childhood AD/HD condition, whether or not the diagnosis was made officially.
- The client's life habits have compensated partially for AD/HD symptoms, though AD/HD was present in childhood and symptoms may emerge in the treatment process.

Factors leading to *overdiagnosis* include

- Attributing cognitive or behavioral abnormalities prematurely to AD/HD, rather than considering the most usual causes (continued substance use, withdrawal, or other disorders noted above).
- Using results of standardized screens such as the AD/HD Behavior Checklist for Adults without considering that many positive responses can be caused by substance use or other mental disorders.

Assuming that the AD/HD diagnosis is reasonably and accurately made, sensible treatment for adults with co-occurring substance dependence and AD/HD include the following:

- Abstinence from substances of abuse or dependence.
- A psychosocial treatment plan that takes into account the client's AD/HD profile—for example, an increased use of visual aids (Dansereau et al. 1995; Dees et al. 1994).
- The use of medications to increase attention.

Though substance-dependent AD/HD clients may be able to take abusable stimulants in highly monitored clinics, much as opioid-dependent clients can take methadone in highly controlled clinics, this approach should not be attempted by other substance abuse treatment clinics. Rather, when medication is indicated, bupropion, tricyclics such as desipramine, or other antidepressants should be used. These medications have been found to be about as effective as stimulants, but are not abusable and have little if any street value. The substance abuse treatment counselor helps to monitor compliance, asks about side effects, and communicates any clinical responses to the prescriber.

Case management

Case management of suspected adult AD/HD begins by arranging adequate diagnostic assessment. If AD/HD is confirmed as the co-occurring disorder, the counselor should employ the elements of treatment as discussed below in this section (see "Adapting Mental Health and Substance Abuse Treatment Approaches") and monitor outcomes over time.

Psychoeducation

Education about AD/HD may be useful and enlightening to many clients; self-help books and AD/HD support groups also can be very helpful (Waid et al. 1998). Waid and colleagues suggest that "modalities other than auditory/verbal ones may be constructive in this population" (Waid et al. 1998, p. 413). For example, consider the use of pamphlets (especially those with diagrams and pictographs) and dramatic videos. In fact, many of the typical alternatives used in standard substance abuse treatment—Alcoholics Anonymous meetings (60 to 90 minutes versus all-day classes), dramatic videos (versus textbooks), relapse diagrams, and standardized short group check-ins—help to focus those with impaired attention rather than overwhelm them with details.

Adapting mental health and substance abuse treatment approaches

Waid and colleagues recommend "structured and goal-directed sessions, with the therapist actively enhancing the client's knowledge about AD/HD and substance abuse and examining false beliefs about the history of his or her difficulties" to "serve as the framework for an effective intervention" (Waid et al. 1998, p. 413). They caution that "long verbal exchanges, extended group therapy, and overstimulating environments should be avoided, as they often overtax the AD/HD substance abusing client" (Waid et al. 1998, p. 413). Frequent brief sessions are preferable to a few long intense ones. The usual 3 hours, three times weekly in Intensive Outpatient Programs will be difficult for many people with AD/HD, even when the AD/HD is being treated. These clients should be assigned to therapists knowledgeable

about both disorders so that appropriate adjustments in treatment strategies can be made as needed.

Longer term care

Even if response to medications and structure occurs, the effects may be subtle and slow to develop—it is primarily in longer term care that the real benefit of integrated AD/HD care emerges. The client will be more likely to stay sober and in treatment within the framework of longer term care. Gradually, the impulsiveness and inattention should lessen. Coaching about how to handle taking medications while attending 12-Step or other mutual self-help programs also may be advisable.

Posttraumatic Stress Disorder

Description

PTSD follows the experience of a psychologically traumatic stressor such as witnessing death, being threatened with death or injury, or being sexually abused. At the time of the stressful event, the individual experiences intense fear, helplessness, or horror. PTSD entails three sets of symptoms that last longer than 1 month and result in a decline in functioning (e.g., work, social):

- *Intrusion:* a persistent reexperiencing of the trauma in the form of intrusive images and thoughts, recurrent nightmares, or experiencing episodes during which the trauma is relived, as in flashbacks
- *Avoidance:* persistent avoidance of stimuli related to the trauma such as activities, feelings, and thoughts associated with the traumatic event
- *Arousal*: persistent symptoms of increased arousal such as insomnia, irritability, hypervigilance, and exaggerated startle response

Many physical, cognitive, and emotional disruptions can occur in response to an acute traumatic event and/or PTSD. The DSM-IV-TR (APA 2000, p. 465) lists the following associated descriptive features:

- Impaired affect modulation
- Self-destructive and impulsive behavior
- Dissociative symptoms (Note: Dissociation represents a psychic defense in which a person is so overwhelmed by a traumatic memory or feeling that the mind simply "shuts down," literally removing itself [disassociating] from the present reality. The person may become suddenly quiet, or stare into space, as if they have entered a trance. Patients have described dissociation as "being out of it," "losing time," or "floating away.")
- Somatic complaints
- Feelings of ineffectiveness, shame, despair, or hopelessness
- Feeling permanently damaged
- A loss of previously sustained beliefs
- Hostility
- Social withdrawal
- Feeling constantly threatened
- Impaired relationships with others
- Change from the individual's previous personality characteristics

The two conditions may coexist for decades, particularly if both disorders are not addressed adequately in treatment. Interest in the role of trauma and PTSD have increased with the recognition that they are common among substance abuse clients. This co-occurring disorder is particularly prevalent among women, who typically experienced childhood physical or sexual abuse. It also is prevalent in combat veterans and many veterans' hospitals have PTSD treatment units (Forbes et al. 2003; Steindl et al. 2003). The Department of Veterans Affairs' National Center for PTSD has been a leading clinical and research resource for both the trauma and substance abuse fields (see www.ncptsd.org and the forthcoming TIP *Substance Abuse Treatment and Trauma* [CSAT in development *d*]).

Prevalence

Community-based studies indicate the lifetime prevalence of PTSD among adults in the United States is about 8 percent (APA 2000). Among high-risk individuals (those who have survived "rape, military combat and captivity" or "ethnically or politically motivated internment and genocide"), the proportion of those with PTSD ranges from one-third to one-half (APA 2000, p. 466).

Among clients in substance abuse treatment, this co-occurring disorder is two to three times more common in women than in men (Brown and Wolfe 1994). The rate of PTSD among people with substance use disorders is 12 to 34 percent; for women who abuse substances, it is 30 to 59 percent. A review of the literature found that PTSD often goes undetected due to lack of screening (Leskin et al. 1999). See below for suggestions on conducting a basic screening for PTSD.

Most women with this co-occurring disorder experienced childhood physical and/or sexual abuse; men with both disorders typically experienced crime victimization or war trauma (Kessler et al. 1995). Clients sometimes are perceived as "crazy," "lazy," or "bad" by others and by themselves (Najavits 2002). They may carry a great burden of shame and guilt, as both PTSD and substance abuse may be associated with keeping secrets and denial. Clinicians are advised not to overlook the possibility of PTSD in men; in Kessler's major study of a community sample, rates for men were higher than for women (Kessler et al. 1995).

People with PTSD and substance abuse also are more likely to experience another trauma than people with substance abuse alone (Dansky et al. 1998). Repeated trauma is common in domestic violence, child abuse, and some substance abuse lifestyles (e.g., the drug trade). Helping protect the client against future trauma may be an important part of work in treatment. It is also noteworthy that in a high percentage of rape cases (37.9 percent), those who perpetrated the violent assault were using substances at the time (Bureau of Justice Statistics 2002).

Substance Abuse and Dependence Among People With PTSD

People with PTSD tend to abuse the most addictive substances (cocaine and opioids); however, abuse of prescription medications, marijuana, and alcohol also is common. Substance abuse often is viewed as "self-medication" to cope with the overwhelming emotional pain of PTSD (Chilcoat and Breslau 1998*b*; Cottler et al. 1992; Goldenberg et al. 1995; Grice et al. 1995; Najavits et al. 1997). From the client's perspective, PTSD symptoms are a common trigger of substance use (Brown et al. 1995). The combination of PTSD and substance abuse may present in combat veterans, those with acute PTSD related to terrorist attacks, those with chronic PTSD related to childhood events, and others (Breslau et al. 2003; Forbes et al. 2003; Grieger et al. 2003; Riggs et al. 2003; Simpson 2003; Steindl et al. 2003). While under the influence of substances, a person may be more vulnerable to trauma—for example, the woman drinking at a bar who goes home with a stranger and is assaulted.

> Many physical, cognitive, and emotional disruptions can occur in response to an acute traumatic event and/or PTSD.

As a counselor, it is important to recognize—and help clients to understand—that becoming abstinent from substances does not resolve PTSD; indeed, some PTSD symptoms might become worse with abstinence at first (Brady et al. 1994; Kofoed et al. 1993; Root 1989). As clients give up substance use, they may be overwhelmed by a flood of memories and feelings that their substance use had kept at bay. "You will feel better once you are clean and

sober" is not an accurate message to give a client with PTSD and substance use disorders. A more accurate statement would be, "Getting clean and sober will help you, but initially you may find yourself facing feelings and memories of your trauma. We can get through this together, and eventually you can achieve recovery from both the substance abuse and PTSD issues."

A variety of medications are used in the treatment of PTSD, and since other anxiety disorders (often panic, generalized anxiety) and mood disorders (major depression, dysthymia, bipolar II) often accompany PTSD, patients can be on several medications at once, most often an antidepressant, such as a sertraline or paroxetine (SSRIs—see appendix F, Common Medications for Disorders), which is frequently combined with a sedative medication, such as an anticonvulsant, or even an antipsychotic (Ballenger et al. 2004; Davidson 2004). Especially as a client with PTSD becomes abstinent, medications targeting mood, anxiety, or severe nightmares may be of crucial importance. While benzodiazepines such as clonazepam and alprazolam often have been prescribed to such clients for anxiety, and though a few case reports exist that document the safe use of these medications, the consensus panel recommends that benzodiazepines usually be avoided, as panel members have observed a great many problems with the use of benzodiazepines. Consensus panel members reported their own experiences with clients who abused benzodiazepines—clients experienced escalating tolerance, had periods of confusion, and became dependent on a medication that is among the most dangerous in its withdrawal symptoms (seizures, etc.), especially if used along with alcohol, as it often is. Recent research has found both prazocin and propranolol, which are older, generic antihypertensives that decrease overactivity in the autonomic nervous system, to hold great promise in decreasing nightmares and flashbacks (Raskind et al. 2002, 2003; Vaiva et al. 2003).

Several well-developed, research-based, and clinically tested models of treatment exist for PTSD.

Key Issues and Concerns

Treatment of PTSD with co-occurring substance use disorders requires careful planning and supervision. As the client faces painful trauma memories, the desire for intoxication can be overwhelming. By exploring trauma memories, well-intentioned counselors inadvertently may drive a client back to the substance by urging her to "tell her story" or "let out the abuse." Even if a client wants to talk about trauma and seems safe during the session, after-effects may well ensue, including a flood of memories she is not prepared to handle, increased suicidality, and "retraumatization" where she feels as though she is reliving the event. Such treatment approaches should be undertaken only with adequate formal training in both PTSD and substance abuse and only under careful clinical supervision.

These clients need stability in their primary therapeutic relationship; hence, this work should not be undertaken in settings with high staff turnover, and should never be undertaken without training and supervision. The substance abuse counselor should not try to provide trauma-exploration treatment, in view of the potential for highly destabilizing effects (including worsening of substance use). However, the substance counselor can play an important role in helping to identify PTSD and in providing present-focused psychoeducation about PSTD, such as teaching the client to recognize symptoms of the disorder and how to cope with them. For severe cases of PTSD, treatment typically is long term.

Several well-developed, research-based, and clinically tested models of treatment exist for

PTSD (for example and reviews, see Foa et al. 2000; Follette et al. 1998; Yehuda 2002). Some of these models are particularly suited for use with clients who also have a substance use disorder (such as the Seeking Safety model discussed below). For example, the Trauma Adaptive Recovery Group Education and Therapy (TARGET) (Ford et al. 2000) has developed a strengths-based approach to education and skills training for trauma survivors that presents a seven-step approach both for changing the PTSD alarm response and for relapse prevention during each of the sessions.

Other models (e.g., Abueg and Fairbank 1992; Klever and Brom 1992) are eclectic—that is, they mix a variety of strategies, techniques, and models. Several of these eclectic approaches and various research studies focus on specific interventions or problems, such as Meisler (1999) on group therapy for PTSD with alcohol abuse; Brady et al. (1995) on the possible use of sertraline; and Nishith et al. (2003) regarding alcohol use for sleep by female rape victims. Of course, this brief review of models barely begins to cover the immense amount of work related to trauma and substance abuse. Many people working with clients on issues of childhood abuses have long known of the importance of including substance abuse in treatment (e.g., Covington 2003; Evans and Sullivan 1995; Trotter 1992). For more information, see the forthcoming TIP *Substance Abuse Treatment and Trauma* (CSAT in development *d*).

The following sections are based on the Seeking Safety (Najavits 2002) model, which the consensus panel deems a practical and helpful approach for most counselors. While Seeking Safety was developed for women, the consensus panel feels it is broadly appropriate for both men and women with PTSD and co-occurring substance use disorders. Several issues need to be considered when working with PTSD/substance abuse treatment clients:

- Develop a plan for increased safety where appropriate (e.g., this is less critical for chronic PTSD secondary to childhood trauma or war trauma)
- Establish trust
- "Listen" to a client's behavior even more than his or her words
- Recognize that a client with PTSD and substance use disorder may have a more difficult time in treatment
- Help the client access treatment for PTSD
- Recognize the importance of one's own trauma history
- Help the client learn to de-escalate intense emotions
- Reinforce the taking of appropriate medications

Develop a plan for increased safety. Some clients with PTSD have a variety of safety issues, including risk for further trauma, suicidality, and self-destructive behavior (e.g., self-harm such as cutting, unsafe sex that may lead to HIV, and involvement with people who exploit them). Helping the client become aware of these patterns, and identifying concrete actions the client can use to cope with them, may be highly beneficial. For example, a client who is living with a partner who is battering her (domestic violence) needs careful assistance, often through consultation with a domestic violence hotline or other expert who can help advise on this difficult situation (see TIP 25, *Substance Abuse Treatment and Domestic Violence* [CSAT 1997*c*]). See below for specific treatment resources for safety-oriented work with people with PTSD.

Establish trust. Sometimes clients who have lived through trauma have difficulty trusting others. The trauma may have been a violation of an important relationship (e.g., in child abuse or domestic violence), or the trauma may have felt like something that could not be talked about (e.g., war, rape). Substance abuse, too, may have isolated the client. Therefore, a key element of successful treatment involves helping the client build trust, never forcing her to talk about something she does not want to, asking permission to talk about sensitive issues, conveying respect and empathy in tone, avoiding harsh confrontation,

and generally acting as her advocate and ally, even when difficult behaviors arise.

"Listen" to a client's behavior even more than words. Clients with PTSD often are not fully conscious of the depth of their inner feelings. They may be prone to internal "splitting" as well, where their feeling-states are not integrated (e.g., they shift between anger and depression). They may find themselves acting in ways that suddenly "happen," rather than acting in ways that are chosen. They also may keep their feelings to themselves out of the fear of burdening others. Monitoring the client's actual behaviors is key: Is she using substances more or less? Is he showing up for treatment? Is she able to follow through on commitments?

Recognize that a client with PTSD and substance use disorders may have a more difficult time in treatment. Treatment outcomes for clients with PTSD and substance use disorders typically are worse than for other clients with COD, and worse than for clients with substance use disorders alone (Ouimette et al. 1998, 1999). Moreover, as compared to clients with substance use disorders alone, clients whose substance use disorder co-occurs with PTSD have more problems in general (e.g., other Axis I and II disorders, interpersonal and medical problems, HIV risk) (Brady et al. 1994; Brown and Wolfe 1994), and their treatment may be more fragile and prone to relapse, unstable alliances, and erratic attendance (Root 1989; Triffleman 1998). If the counselor is to work effectively with such clients, extra support and encouragement is needed, along with a positive, optimistic tone and strong outreach.

Help the client access treatment for PTSD. It is recognized widely that integrated treatment—treatment of both PTSD and substance abuse—is likely to be more successful and more sensitive to clients' needs than substance abuse treatment alone. Yet most clients with PTSD receive only substance abuse treatment, despite the fact that they prefer treatment for both (Brown et al. 1998). The counselor should inquire whether the client would like to address her PTSD, and if so, the counselor can play a pivotal role in providing a referral to such treatment and the encouragement to participate. To help locate a PTSD specialist, the International Society for Traumatic Stress Studies has a listing of members (www.istss.org).

Recognize the importance of one's own trauma history. Counselors may have their own histories of trauma, which can have an impact on their work both for better (increased empathy) and worse (feeling triggered by clients). Honest self-evaluation and self-care skills are important, as well as seeking supervision and support as needed.

Help the client learn to de-escalate intense emotions. The nature of PTSD and substance use is a frequent experience of overwhelming feelings. Clients may find a seemingly small comment or event to be a trigger, which can set off a craving to use substances. Teaching the client to do grounding and to soothe himself can be an important means to regain control. Grounding (also called "centering," "looking outward," "distraction," or "healthy detachment") uses a set of simple strategies that facilitate detachment from emotional pain, such as drug cravings, self-harm impulses, anger, and sadness. The technique distracts one from the impulse to use substances or to hurt oneself by directing the mental focus outward to the external world, rather than inward toward the self. Figure D-15 provides a basic overview of what is involved in grounding. (For a lesson plan and other materials on grounding, see Najavits 2002.)

Strategies, Tools, and Techniques

It may be difficult for clients with PTSD to form a trusting therapeutic alliance. They often have great shame about both their illnesses and may hide, minimize, or even lie about their past as a means of psychological self-protection. Particularly in the case of people with severe PTSD arising from child abuse, distrust of others and fragile treatment alliances are common. Clients often are full of anger, which can be directed at self or at others, including

Figure D-15
Grounding: A Coping Skill for Clients With Emotional Pain

Three major ways of grounding will be described—mental, physical, and soothing. "Mental" means focusing your mind; "physical" means focusing on your senses (e.g., touch, hearing); and "soothing" means talking to yourself in a very kind way. You may find that one type works better for you, or all types may be helpful. Note that grounding is different from relaxation training or meditation. In grounding, it is essential to keep your eyes open the entire time and to keep talking out loud. These strategies keep you focused on the outside world.

Mental Grounding

- *Describe your environment in detail using all your senses.* For example, "The walls are white, there are five pink chairs, there is a wooden bookshelf against the wall…" Describe objects, sounds, textures, colors, smells, shapes, numbers, and temperature. You can do this anywhere. For example, on the subway: "I'm on the subway. I'll see the river soon. Those are the windows. This is the bench. The metal bar is silver. The subway map has four colors…"
- *Play a "categories" game with yourself.* Try to name "types of dogs," "jazz musicians," "States that begin with 'A'," "cars," "TV shows," "writers," "sports," "songs," or "cities."
- *Do an age progression.* If you have regressed to a younger age (e.g., 8 years old), you can slowly work your way back up (e.g., "I'm now 9," "I'm now 10," "I'm now 11"…) until you are back to your current age.
- *Describe an everyday activity in great detail.* For example, describe a meal that you cook (e.g., "First I peel the potatoes and cut them into quarters, then I boil the water; I make an herb marinade of oregano, basil, garlic, and olive oil…").
- *Imagine.* Use an image: Glide along on skates away from your pain; change the TV channel to get to a better show; think of a wall as a buffer between you and your pain.
- *Say a safety statement.* "My name is ____; I am safe right now. I am in the present, not the past. I am located in _____; the date is _____."
- *Read something, saying each word to yourself.* Or read each letter backward so that you focus on the letters and not on the meaning of words.
- *Use humor.* Think of something funny to jolt yourself out of your mood.
- Count to 10 or say the alphabet, very s..l..o..w..l..y.

Physical Grounding

- Run cool or warm water over your hands.
- Grab onto your chair as hard as you can.
- Touch various objects around you: a pen, keys, your clothing, the table, the walls. Notice textures, colors, materials, weight, temperature. Compare objects you touch: Is one colder? Lighter?
- Dig your heels into the floor-literally "grounding" them. Notice the tension centered in your heels as you do this. Remind yourself that you are connected to the ground.
- Carry a grounding object in your pocket—a small object (a small rock, clay, ring, piece of cloth or yarn) that you can touch whenever you feel triggered.
- Jump up and down.

Figure D-15 (continued)
Grounding: A Coping Skill for Clients With Emotional Pain

- Notice your body: The weight of your body in the chair; wiggling your toes in your socks; the feel of your back against the chair. You are connected to the world.
- Stretch. Extend your fingers, arms or legs as far as you can; roll your head around.
- Clench and release your fists.
- Walk slowly, noticing each footstep, saying "left" and then "right," with each step.
- Eat something, describing the flavors in detail to yourself.
- Focus on your breathing, noticing each inhale and exhale. Repeat a pleasant word to yourself on each inhale (e.g., a favorite color or a soothing word such as "safe" or "easy").

Soothing Grounding

- *Say kind statements, as if you were talking to a small child.* For example, "You are a good person going through a hard time. You'll get through this."
- *Think of favorites.* Think of your favorite color, animal, season, food, time of day, or TV show.
- *Picture people you care about* (e.g., your children), and look at photographs of them.
- Remember the words to an inspiring song, quotation, or poem that makes you feel better, such as the Serenity Prayer.
- *Remember a safe place.* Describe a place that you find very soothing (perhaps the beach or mountains, or a favorite room); focus on everything about that place—the sounds, colors, shapes, objects, and textures.
- *Say a coping statement.* "I can handle this." "This feeling will pass."
- *Plan out a safe treat for yourself*, such as a piece of candy, a nice dinner, or a warm bath.
- *Think of things you are looking forward to in the next week*, perhaps time with a friend, going to a movie, or going on a hike.
- *Create a cassette tape of a grounding message* that you can play when needed; consider asking your therapist or someone close to you to record it if you want to hear someone else's voice.
- *Think about why grounding works.* Why might it be that by focusing on the external world, you become more aware of an inner peacefulness? Notice the methods that work for you—why might those be more powerful for you than other methods?
- Don't give up.

counselors. They are likely to engage in power struggles, especially when they feel helpless.

Counselors must try to maintain professionalism, composure, and empathy in working with such clients, no matter how difficult. If the counselor can stay calm, clear, and understand the relational problems in light of the PTSD, the client is likely to become engaged. However, if the clinician argues, gives ultimatums, or tries to coerce clients, clients are more likely to drop out of treatment prematurely. Harsh confrontation, particularly for PTSD clients, can feel like a reexperiencing of childhood trauma and emotional abuse.

The counselor's role in reinforcing medications has been discussed extensively in chapter 5 and will not be repeated here.

Screening and assessment

It is important to emphasize that, in obtaining a preliminary diagnosis of PTSD, *it can be damaging to ask the client to describe traumatic events in detail.* When screening it is important to limit questioning to very brief and general questions, such as "Have you ever experienced childhood physical abuse? Sexual abuse? A natural disaster such as a hurricane or tornado? A serious accident? Violence or the threat of it? Seeing a dead body?" Once a brief and general identification of such traumas has occurred, the substance counselor should *not* seek to obtain detailed description of such events, which can be extremely destabilizing for the client and is unnecessary for screening purposes. Indeed, it has been found that having the client complete a written questionnaire leads to higher reporting of traumas and may be less upsetting for clients (Najavits et al. 1998).

Assuming the client has a trauma, the Modified PTSD Symptom Scale (Falsetti et al. 1993) is a good screening instrument. The scale asks about each of the DSM-IV symptoms for PTSD and is useful for monitoring and tracking PTSD over time. Although it is relatively rare for clients to become upset when answering a written questionnaire about trauma, if such a questionnaire is used, the client should know how to locate clinical staff for help if the process becomes too upsetting. Both childhood and adult traumas should be identified; for example, a rape experience within the last year and early childhood incest both could lead to the development of anxiety disorders. Because people living in violent situations, such as prostitutes who have been raped, can manifest anxiety symptoms, it is a mistake to ignore proximal violence and look solely at early traumas. Abuse of males as well as females must be considered, as the issue of physical and sexual abuse of males historically has been overlooked.

Crisis stabilization

Danger to self is a particular risk for clients with PTSD and substance abuse; the self-harm may include suicidality, which is common in this population, as well as self-injurious behavior such as cutting or burning. People in dissociated states may put themselves in danger to which they remain unaware, thus may require involuntary commitment. Finally, the potential for harm to others needs to be considered, particularly in clients with PTSD who show high levels of aggression and poor impulse control. The clinician should establish a written plan that details what the client will do if he feels the impulse to act out any self-harm behavior; this plan should include who to call after hours (for outpatient care), as well as strategies that may help the client reduce the impulse. The client and the clinician should each keep a copy of the plan.

Short-term care and treatment

Safety-oriented, skill-building treatment

For clients with PTSD and substance abuse, providing psychoeducation about the disorders and teaching coping skills to gain control over the symptoms usually form an essential foundation of treatment. For example, the client with PTSD can learn to identify symptoms of "intrusion, avoidance, and arousal" and be trained to use grounding to manage these symptoms. Other skills include rethinking, activity scheduling, seeking out interpersonal support, identifying and fighting PTSD and substance abuse triggers, and learning to communicate with others. Helping clients understand the link between their PTSD and substance use is also part of such treatment; specifically, how each may trigger the other, and how mastery of one disorder can help with overcoming the other.

Notice that such treatment directly addresses PTSD but doesn't push the client to describe or explore trauma memories. It is considered the safest and most essential "first-stage" approach, and is likely the best choice for most substance abuse treatment settings, particularly those that are short-term, have clients with PTSD and substance use disorders with acute suicidality or self-harm, and/or have staff who

have not undergone formal training in PTSD treatment. For treatment manuals, see Najavits' Seeking Safety model (2002), which has undergone empirical testing, and two manuals in the 12-Step tradition, Evans and Sullivan (1995) and Trotter (1992).

Trauma exploration work

This type of treatment involves having clients face their painful trauma memories, telling the story of what happened, and facing the associated intense emotions. These treatments, all initially developed on clients who did not abuse substances, include exposure therapy (Foa and Rothbaum 1998), mourning (Herman 1997), eye movement desensitization reprocessing (Shapiro 1989), and the counting method (Ochberg 1996). Such treatments are considered high-risk for substance abuse clients and should be conducted (or at least supervised) only by providers with formal training in PTSD, and then only when the client is ready. Readiness for such work depends on a variety of factors, including the context of treatment (i.e., length of stay), the client's safety level, and the availability of staff to manage the intense feelings that surface (often after hours). As noted above, even if the client wants to talk about trauma, he or she may not be ready to do so safely and may underestimate the destabilizing effect such work will have.

Only a few pilot studies so far have evaluated trauma-exploration therapies in substance abuse clients (Brady et al. 2001; Triffleman 2000). While some positive results have been found, generally it is believed that more work is needed to define which clients, under what conditions, and with what staff training, are needed for this type of work.

Longer term care

For clients with a severe trauma history, treatment is likely to be long term. If possible, refer the client with PTSD to an individual therapist who can work with the client consistently over a long period. Individual therapy generally is needed (in addition to the standard group treatments typical of substance abuse treatment programs) to permit confidential discussion of, and adequate attention to, trauma.

Case Study: Counseling a Client with Polysubstance Abuse and PTSD

Carlos F. is a 34-year-old man who repeatedly has been admitted to detoxification and substance abuse treatment for polysubstance abuse. He appears aggressive and defensive and tends to isolate. Since childhood, he has a long history of starting fights, and does not like to talk about his past. He was not assessed for PTSD until the present admission, where a counselor found out that he was physically and sexually abused by his mother during childhood. Carlos F. had never heard of PTSD, but when presented with education about the symptoms he was able to recognize them in himself immediately. Carlos F. stated, "I always thought there was just something wrong with me—bad genes, or just a bad attitude. It is a relief to know there's a reason why I feel and act the way I do."

Discussion: Counselors often are more likely to diagnose PTSD in women, with the single exception being soldiers or survivors of kidnapping or torture. It is important to screen for PTSD for all clients—men and women—and for all types of trauma. For more information on PTSD and trauma, see the forthcoming TIP *Substance Abuse Treatment and Trauma* (CSAT in development *d*).

Eating Disorders

Description

Dieting and concern about body weight and shape are ever-present among people (especially women) in Western cultures. Young women who are of normal weight report high rates of dissatisfaction with their body weight and size. Dieting, which is nearly universal among female youth, often is the first step toward developing an eating disorder; however, only a small percentage of women who diet actually progress to an eating disorder. The primary eating disorders are *anorexia nervosa* and *bulimia nervosa*; however, the classification system has not yet been perfected, as the majority of individuals who seek treatment for an eating disorder fall under the diagnostic heading of "eating disorders not otherwise specified."

Anorexia nervosa

Anorexia nervosa, the most visible eating disorder, is marked by a refusal to maintain body weight above the minimally normal weight for age and height (currently operationalized as 85 percent of expected weight for height). Anorexia nervosa ("nervous loss of appetite") is a misnomer. Only in extreme stages of inanition (i.e., exhaustion as a result of lack of nutrients in the blood) is appetite actually lost.

Individuals with anorexia nervosa have a dogged determination to lose weight and can achieve this in several ways. Individuals with the classic restricting subtype of anorexia nervosa achieve this weight loss solely through severe food restriction, exercise, and fasting. Others augment their dieting with vomiting, laxative use, diuretic use, diet pills, and other methods of purging. In addition to these purging behaviors, women with the bulimic subtype also exhibit binge eating.

Individuals with anorexia nervosa have an intense fear of gaining weight even when emaciated, place undue importance on weight and shape in terms of self-evaluation, deny the seriousness of their illness, and may experience a distortion of the manner in which they perceive their own body size (i.e., they may see themselves as fat even when emaciated). In women, the cessation of menstrual periods for 3 or more months officially is required to diagnose anorexia nervosa; however, this criterion should be viewed with caution because there is great variation in the reproductive system's response to starvation.

The age of onset of anorexia nervosa usually is during the teenage years (Lucas et al. 1991). However, it can occur earlier and may emerge at any time.

Bulimia nervosa

The core symptoms of bulimia nervosa are bingeing and purging. A binge is regarded as the rapid consumption of an unusually large amount of food by comparison with social "norms" in a discrete period of time. Integral to the notion of a binge is feeling out of control. An individual with bulimia may state that he or she is unable to postpone the binge or stop eating willfully once the binge has begun. The binge may only end when she is interrupted, out of food, exhausted, or physically unable to consume more. Although the current DSM-IV diagnostic criteria require the presence of binge eating at least twice per week for at least 3 months (see chapter 8), bingeing and purging clearly are unhealthy behaviors and should not be ignored when present at lesser frequencies.

The second feature of bulimia nervosa is purging. There are many different ways that individuals with bulimia nervosa compensate for overeating. Between 81 and 88 percent of women with bulimia self-induce vomiting (Hoek and van Hoeken 2003; Johnson et al. 1982; Mitchell et al. 1985; Rome 2003; Sigman 2003). Other methods of purgation include the abuse of laxatives, diuretics and emetics, saunas, excessive exercise, fasting, and other idiosyncratic methods that people believe will lead to weight loss. Many of these auxiliary methods are dangerous and ineffective as they promote loss of water and valuable electrolytes (see the

section on crisis stabilization below). Finally, individuals with bulimia nervosa place undue emphasis on shape and weight in their sense of identity.

The age of onset of bulimia nervosa is generally somewhat later than for anorexia nervosa; however, many women have bulimia for up to 5 years prior to seeking treatment.

Other eating disorders

There are several alternative and subthreshold presentations of disordered eating. Among these are individuals who purge in the absence of binge eating, as well as individuals who meet some but not all formal diagnostic criteria for anorexia or bulimia nervosa. Binge-Eating Disorder (BED) is being scrutinized as a potential third discrete eating disorder. BED is associated with binge eating in the absence of compensatory behaviors and commonly is associated with obesity.

Prevalence

Anorexia nervosa primarily is a disorder of females, with a gender ratio of approximately 10:1. The disorder is found across social classes and ethnic groups. Epidemiological studies suggest a prevalence of between 0.1 to 0.7 percent of females, although subclinical conditions are more prevalent (Hoek 1991; Hoek and van Hoeken 2003; Rome 2003; Sigman 2003). Anorexia nervosa is more prevalent in sports and professions that value thinness (e.g., jockeys, ballet dancers, gymnasts). Males who develop the disorder have presenting symptoms and clinical profiles similar to females.

The gender ratio for bulimia nervosa is also approximately 10:1, with higher prevalence in females. Epidemiological studies suggest that the prevalence of bulimia nervosa is somewhere between 1 and 3 percent across a range of Western cultures (Bushnell et al. 1990; Drewnowski et al. 1988; Garfinkel et al. 1995; Johnson-Sabine et al. 1988; Kendler et al. 1991; King 1986; Rand and Kuldau 1992; Schotte and Stunkard 1987). Again, subclinical forms of the disorder are more prevalent. Bulimia is found across all ethnic groups and social classes. Indeed, recent epidemiological evidence suggests that binge eating may be becoming more common in the lower socioeconomic classes and that the gender disparity may be diminishing.

Substance abuse and dependence among people with eating disorders

Estimates of the prevalence of co-occurring substance abuse and/or dependence in clinical samples of women with bulimia nervosa have varied widely. The prevalence of comorbid substance abuse ranges between 3 percent and 49 percent. A review of 25 studies of the prevalence of substance abuse in women with bulimia nervosa in clinical samples calculated a median prevalence of 23 percent (Corcos et al. 2001; Holderness et al. 1994; Specker and Westermeyer 2000; Westermeyer and Specker 1999). Parameters affecting the estimates differ according to the nature of the clinical service (inpatient versus outpatient), the definition of the disorder, assessment procedures for both eating disorders and substance dependence, whether current or lifetime diagnoses are assessed, the distorting effects of any exclusion criteria for clinical trials, and the age of clients seen.

Overall, the majority of studies have observed an elevated prevalence of substance abuse in clinical samples of women with bulimia nervosa. Most studies have observed comorbidity that exceeds that expected in the general population of women of similar age, as well as higher rates than in women with major depression. Population-based studies also have observed elevated substance abuse in women with bulimia nervosa (although not as extreme as in clinical samples), suggesting that the observed co-occurrence is not merely the result of focusing studies on treatment-seeking populations.

The frequently observed co-occurrence of substance abuse in women with bulimia nervosa

warrants routine screening for the presence of substance abuse when women with bulimia nervosa are assessed. The screening ideally would address both current and lifetime presence of alcohol and other substance use disorders and would seek to develop an indepth understanding of the relation between the eating disorder and substance use.

Substance abuse appears to be much less frequent in women with the restricting subtype of anorexia nervosa than in other subtypes of eating disorders (Corcos et al. 2001; Specker and Westermeyer 2000; Westermeyer and Specker 1999). In most studies, the prevalence of substance abuse in women with anorexia nervosa was less than in women with bulimia nervosa and not significantly different from women in the general population. Substance use disorders are observed primarily in women with the bulimic subtype of anorexia. Across studies, the prevalence of substance-related disorders in anorectic women with bulimic features appear to be comparable to or exceed those of women with normal weight bulimia nervosa (Corcos et al. 2001; Specker and Westermeyer 2000; Westermeyer and Specker 1999).

In summarizing the data regarding the prevalence of substance abuse in clinical samples of women with eating disorders, several issues must be considered. First, although the prevalence of comorbid substance abuse is high, it is not the most frequently diagnosed comorbid condition. Most studies have reported more frequent lifetime comorbid affective and anxiety disorders. Thus, comorbidity of a range of disorders, not just substance abuse, commonly is observed in women with bulimia nervosa.

In addition, with some exceptions, most studies have been cross-sectional and have determined the eating disorder diagnosis based on current clinical presentation. This approach is conceptually problematic as the boundary between anorexia and bulimia nervosa often is fluid. Although a percentage of women with the restricting subtype of anorexia never binge or purge, between 37 and 48 percent of clinical samples of women with anorexia nervosa display features of bulimia nervosa at some point during their illness. The distinction between current anorexia nervosa with or without current bulimic symptoms has been codified in the DSM-IV into "restricting" and "binge-eating/purging" types. It is difficult, if not impossible, to predict accurately which women are likely to recover, maintain a chronic course of restricting anorexia, or develop bulimia nervosa. Therefore, when examining the prevalence of substance abuse in women with eating disorders, counselors must be mindful that the clinical features on which groups are defined are multifaceted, and that a cross-sectional examination of the same sample at a later date may yield different groupings, and therefore, different estimates of the prevalence of comorbidity.

> Eating disorders and disordered eating appear to be overrepresented in clinical samples of women presenting for treatment of substance abuse.

Eating disorders among individuals with substance use disorders

To what extent are eating disorders a problem in individuals with primary substance use disorders? Studies examining prevalence of eating disorders in substance-dependent treatment samples have used both questionnaires and interview designs. With some exceptions, the prevalence of bulimia nervosa is elevated in women presenting for treatment of substance dependence (Corcos et al. 2001; Specker and Westermeyer 2000; Westermeyer and Specker 1999). The characteristics of people with substance use disorders and bulimia included younger age at presentation, onset of problem drinking at an earlier age, higher self-report scores on eating pathology, decreased chance of

a family history of alcoholism, and heavier weight.

A study of callers to a national cocaine hotline (122 men and 137 women) via a structured telephone interview found that 22 percent of callers met DSM-III criteria for bulimia, 7 percent for anorexia and bulimia, 2 percent anorexia nervosa, and 9 percent met criteria for bulimia plus vomiting. Among female callers, 23 percent met criteria for bulimia and 13 percent met criteria for bulimia with purging (Jonas et al. 1987).

Studies of individuals in inpatient substance abuse treatment centers suggest that approximately 15 percent of women and 1 percent of men had a DSM-III-R eating disorder (primarily bulimia nervosa) in their lifetime as assessed via questionnaire (Hudson et al. 1992). Individuals with eating disorders were significantly more likely to use stimulants and significantly less likely to use opioids than individuals undergoing substance abuse treatment without comorbid eating disorders.

In summary, eating disorders and disordered eating appear to be overrepresented in clinical samples of women presenting for treatment of substance abuse. Further studies are required to assess how the presence of an eating disorder affects treatment for substance abuse and how best to integrate treatment for those with both conditions.

Substance Use Among Individuals With Eating Disorders

Studies of bulimic women with co-occurring alcohol use disorders often have used retrospective interviews to determine the chronology of the onset of both disorders. Patterns vary, with approximately one third of women recalling bulimia beginning first, one third recalling the alcohol abuse beginning first, and one third recalling onset of both problems within the same year (Bulik et al. 1997).

Several investigations have found no differences in the core clinical features of bulimia nervosa (i.e., frequency of bingeing and purging) in women with and without co-occurring substance use disorders (Bulik et al. 1997), although those with comorbid substance use disorders showed greater use of diuretics and laxatives, more food restriction, greater disruption in financial and work areas, more stealing, more suicide attempts, and more inpatient treatment (Hatsukami et al. 1986).

Personality differences also appear to exist between bulimic women with and without substance use disorders. Women with bulimia nervosa and substance dependence also report higher novelty seeking and lower cooperativeness, higher impulsivity, and a tendency to use more immature defenses. Overall, women with bulimia nervosa and alcohol dependence exhibited a pattern of greater impulsiveness across a broad array of response domains (Bulik et al. 1997).

The subgroup of women with bulimia who exhibit these traits have been referred to as "multi-impulsive bulimics," defined as a combination of bulimia plus other impulsive behaviors such as excessive alcohol use, regular street drug use, stealing, overdosing, self-harm, borderline features, and sexual promiscuity (Lacey 1993). Approximately 40 percent of bulimic women seen in clinical settings display substance abuse, stealing, overdosing, or self-harm (Lacey 1993). This group of individuals requires higher clinical vigilance and is at higher risk for self-harming and parasuicidal behaviors.

In summary, the core clinical features of the eating disorder (i.e., frequency of bingeing and purging) do not appear to differ significantly whether substance abuse or dependence is present. Individuals with the comorbid pattern do appear to display more frequent impulsive behaviors, use of other drugs, and possibly more Axis II pathology. These data suggest that it is important to consider the critical role of impulsivity in the development of both eating

disorders and substance abuse in this group of women. See Figure D-16 for a summary of how eating and substance use disorders are related.

Key Issues and Concerns

In addition to "traditional" drugs of abuse and alcohol, women with eating disorders are unique in their abuse of pharmacological agents ingested for the purpose of weight loss, appetite suppression, and purging. Among these drugs are prescription and over-the-counter diet pills, laxatives, diuretics, and emetics. Nicotine and caffeine also must be considered when assessing substance abuse in women with eating disorders.

Drugs related to purging, such as diuretics, laxatives, and emetics, have been shown to be ineffective and potentially dangerous methods of accomplishing weight loss or maintenance. The literature suggests that, like more common drugs of abuse, tolerance and withdrawal occur with laxatives, diuretics, and possibly diet pills and emetics.

A critical message for clinicians is that women with eating disorders often will go to dangerous extremes to lose weight and a comprehensive assessment must document the individual's full repertoire of weight-loss behaviors. Clinicians also must be mindful of excessive consumption of sugar substitutes, as the long-term effect of consumption of large quantities of these substances in humans is yet to be determined.

Strategies, Tools, and Techniques

Though the presence of a *history* of alcohol abuse or dependence appears not to affect outcome in trials of cognitive–behavioral or pharmacological therapy for bulimia nervosa, much less is known regarding the effects of *current* substance use on treatment outcome for bulimia nervosa. Practically, the management of individuals with concurrent active bulimia and substance abuse can be challenging. Given that few treatment programs specialize in the treatment of concurrent eating and substance abuse problems, the phenomenon of treatment ping-pong often is observed. Individuals may alternate between eating disorders and substance abuse treatment programs without ever benefiting from treatment that targets both problems simultaneously.

Figure D-16
How Are Eating Disorders and Substance Use Disorders Related?

- Individuals with eating disorders experience urges (or cravings) for binge-foods similar to urges for drug or alcohol use.
- Many individuals alternate between substance abuse and eating disorders.
- Bingeing and purging can be secretive and shameful behaviors.
- Relapse prevention is critical for individuals with bulimia nervosa.
- Abstinence from bingeing and purging is an essential treatment goal.
- For individuals with bulimia nervosa, alcohol and drugs such as marijuana can diminish normal appetite restraints and increase the risk of binge-eating as well as relapse.
- Individuals with eating disorders experience cravings, tolerance, and withdrawal from drugs associated with purging, such as laxatives and diuretics.
- There is an increased risk of alcohol and drug abuse and dependence in family members of individuals with bulimia nervosa.

Engagement

No controlled trials have yet been conducted to determine the optimal intervention strategy for women with co-occurring eating disorders and substance use disorders, although a variety of treatments have been described (Bergh et al. 2003; McElroy et al. 2003; Trotzky 2002; Weiner 1998). Few specialist services exist that are designed to treat eating disorders and substance abuse concurrently. In the absence of such services, staff on specialty services for substance use or eating disorders should have specific training in working with individuals with this particular pattern of comorbidity. Even less is known about men with eating disorders, and almost nothing has been written recently about their treatment (Mangweth et al. 2004).

Screening and assessment

Even though a client may not have an eating disorder currently, the past presence of bulimia or anorexia could become a factor in the successful treatment of her substance abuse, or vice versa. To detect this possibility, clinical interviews may be supplemented with structured eating disorders interviews such as the Eating Disorders Examination. A number of medical investigations might be warranted, depending on the findings on physical examination and based on the nature and severity of the substance-related disorder.

Figure D-17 suggests general and specific screening questions that may be used to probe the possibility that the client has an eating disorder. The general questions simply explore the individual's attitudes toward shape, weight, and dieting. Sometimes it is best to start with such questions rather than begin immediately with questions focused specifically on the behavior patterns associated with anorexia and bulimia because clients may feel shame about these behaviors. Easing into the topic sometimes is the best approach.

Once the co-occurrence of eating and substance use disorders has been established, then a complete behavioral analysis can be informative, if consistent with the philosophy and approach of the treatment service. The critical questions to be addressed in this portion of the assessment include foods and substances of choice, high-risk times and situations for engaging in disor-

Figure D-17
General and Specific Screening Questions for Persons With Possible Eating Disorders

General Screening Questions

- How satisfied are you with your weight and shape?
- How often do you try to lose or gain weight?
- How often have you been dieting?
- What other sorts of methods do you use to lose weight?

Specific Screening Questions

- Have you ever lost a lot of weight and weighed less than other people thought you should weigh?
- Have you had eating binges where you eat a large amount of food in a short period of time?
- Do you ever feel out of control when eating?
- Have you ever vomited to lose weight or to get rid of food that you have eaten?
- What other sorts of methods have you used to lose weight or to get rid of food?

dered eating and substance abuse behaviors, and the nature, pattern, and relationship of disordered eating and substance use. Examples of appropriate areas of inquiry are

- What sorts of situations could prompt the client to diet/binge/drink?
- What times of the day are high-risk times for each behavior?
- What are the cues that prompt disordered eating behavior/substance use?

In addition, counselors must address how dieting and bingeing are related to substance abuse. For example, does the client drink or use drugs to curb appetite when dieting? What is the effect of drinking on eating behavior? Does alcohol use lead to unrestrained eating? From the client's perspective, do bingeing and drinking serve similar or different "functions?"

Crisis stabilization

Crisis situations differ somewhat between women with anorexia and bulimia nervosa. In both cases, the presence of substance abuse intensifies the crisis. Presenting symptoms include dehydration, electrolyte abnormalities, cardiac or gastrointestinal complications, secondary to extreme inanition, and suicidality. Women with bulimia nervosa may present in crisis with dehydration, electrolyte abnormalities, gastrointestinal crises secondary to purging (e.g., esophageal ruptures or instruments used for purging lodged in the throat), or suicidality.

In the case of both disorders, medical stabilization is of primary importance. Anorexia nervosa, in particular, is the most lethal of all mental disorders, with a mortality rate of approximately 6 percent per decade (Sullivan 1995). Deaths associated with anorexia nervosa are most commonly complications of starvation followed closely by suicide. Hospital admission with vigilant monitoring for disordered eating behaviors (e.g. bingeing, purging, excessive exercising) is critical. In their terror of weight gain, clients might attempt to engage in disordered eating behaviors in the hospital and sneak substances such as laxatives and diuretics into treatment facilities.

Short-term care and treatment

Once a diagnosis has been established and the behavioral parameters identified, three potential approaches have been outlined for the treatment of the individual with eating disorders and substance abuse. First, both disorders can be treated concomitantly on a unit specializing in this particular pattern of COD. Second, detoxification and treatment for substance abuse can be completed first, followed by specialized treatment for the eating disorder. Third, specialized treatment for the eating disorder can be followed by specialized treatment for the substance abuse.

There are several factors that can dictate which of these approaches is followed; however, no empirical data exist to inform the decision. Specialty services for clients with COD are scarce and hence the opportunity for concurrent treatment is limited. In the absence of such a service, counselors must attempt to determine which disorder currently is most troublesome and requires the most immediate attention. Perhaps the most important treatment goal is to encourage the client to *complete* treatment for both disorders, although detoxification is an essential first step for some individuals. Completion should be emphasized throughout the treatment process.

Whichever treatment approach is chosen, the other disorder cannot be compartmentalized and ignored. It is critical to address the presence of the eating problem, even if the substance-related problem is the initial target of treatment. Failure to integrate treatment leads to the "ping-pong" phenomenon where clients bounce back and forth between eating and substance abuse treatment services, never addressing the relation between the two disorders. The re-emergence of binge eating following detoxification from opioids and alcohol has been observed. It has also been noted clinically that the frequent behavioral pairing between disor-

dered eating behaviors and substance abuse can lead to a situation in which relapse in one domain fuels relapse in the other. Thus, an integrated relapse prevention plan that acknowledges the similarities and differences in relapse risk for each behavior is essential.

Individuals with eating disorders who are being treated in substance abuse treatment facilities should participate fully in the substance abuse treatment program. Their treatment may be augmented with nutritional consultation, the setting of a weight range goal, and observations at and between meal times for disordered eating behaviors. If a treatment program has sufficient numbers of clients who have eating disorders or disordered eating behavior, special eating disorders psychoeducation or basic cognitive–behavioral strategy groups can be used to augment the substance abuse treatment plan.

The available literature supports the inclusion of clients with past or current mild or moderate substance-related disorders in eating disorders treatment programs. Cognitive–behavioral techniques targeted toward bulimic symptoms such as psychoeducation, identification of automatic thoughts, thought restructuring, chaining, and relapse prevention, often generalize to substance-related problems.

Treatment of individuals with severe substance-related disorders and eating disorders poses a more significant clinical challenge. In addition to traditional cognitive–behavioral approaches, many individuals find 12-Step approaches beneficial in controlling their drinking or drug use and disordered eating behavior. Traditionally, the 12-Step approach of Overeaters Anonymous focuses on abstinence from high-risk foods (i.e., sugar, wheat), which are believed to have the ability to trigger a binge. In direct contrast, the cognitive–behavioral approach emphasizes empowerment over food and minimizes avoidance.

Although it is possible to abstain from alcohol and drugs, it is virtually impossible to abstain from foods, given their obvious relationship to survival and the frequency with which high-risk foods are encountered in daily life. In an integrated model that tries to merge cognitive–behavioral techniques with the beneficial 12-Step approach, one can encourage clients to abstain from high-risk behaviors (i.e., dieting or bingeing) rather than high-risk foods. Empirical data are required to substantiate the efficacy of this approach; however, it holds intuitive appeal for those individuals who find a 12-Step approach beneficial and who see similarities between their disordered eating and substance-related problems.

Pharmacological approaches to treatment also may be considered. The SSRI fluoxetine has been shown to be of some efficacy in the treatment of bulimia nervosa (Fluoxetine Bulimia Nervosa Collaborative Study Group 1992), although its specific efficacy in individuals with comorbid substance use disorders has not been documented. The opioid antagonist naltrexone appears to decrease the reinforcing efficacy of alcohol and has been approved by the Food and Drug Administration for the treatment of alcohol dependence because of its efficacy in reducing alcoholic relapse. Preliminary data suggest that naltrexone may decrease the frequency of bingeing and purging and the preoccupation with food in women with bulimia (Jonas and Gold 1988). The possible utility of naltrexone in the treatment of individuals with comorbid bulimia nervosa and alcohol dependence is an empirical question worthy of further investigation.

No clinical trials exist that identify the optimal approach to the treatment of comorbid eating disorders and substance-related disorders. Such trials clearly are needed to determine the most effective approach to individuals who present with severe co-occurring eating and substance-related disorders.

Longer term care and treatment

Relapse is a major concern in eating disorders. Anorexia nervosa is particularly difficult to treat, with the average duration of treatment being 5 years. Even women who have recov-

ered from anorexia nervosa continue to maintain relatively low body weight and retain cognitive features of the disorder.

Although relatively successful treatments for bulimia nervosa have been developed (primarily cognitive–behavioral therapy), which lead to abstinence in between half and two thirds of clients, relapse is common within the first year following therapy. Thus, concrete relapse prevention strategies are critical both to prevent the re-emergence of disordered eating symptoms as well as to prevent the ping-pong effect in symptom expression. Techniques that can be incorporated into a successful relapse prevention program include

- Booster therapy sessions
- Participation in both 12-Step groups and more unstructured support groups for eating disorders and for substance abuse
- Use of self-help manuals and programs when slips occur and regularly throughout the recovery intervals
- Development of strategies that enhance self-awareness of imminent slips and relapses

Pathological Gambling

Description

Pathological gambling (PG) has been best described as "a progressive disorder characterized by a continuous or periodic loss of control over gambling; a preoccupation with gambling or obtaining money with which to gamble; irrational thinking, and a continuation of the behavior despite adverse consequences" (Rosenthal 1992). The American Psychiatric Association's criteria for the diagnosis of PG (DSM-IV-TR) (APA 2000) are in many ways similar to those for alcohol and other drug dependence (see Figure D-18, p. 426).

Many clients with PG display what amounts to tolerance, needing to gamble with increasing amounts of money (or make increasingly risky bets with what money is available to them) to achieve the desired effect. For some gamblers, often referred to as "action" gamblers, this effect may be excitement (Cocco et al. 1995; Lesieur and Rosenthal 1991). For other gamblers, thought of as "escape" gamblers, the sought-for effect is relief from painful emotions or stress. Consequently, gambling may act as a stimulant such as amphetamine or cocaine for some clients with PG, while acting as a sedative or tranquilizer for others. (See Figure D-19 on p. 427 for a list of differences between action and escape gamblers.)

Pathological gamblers often report withdrawal-like symptoms when attempting to stop gambling. These may include symptoms such as irritability, problems focusing or concentrating, difficulty sleeping, and even physical symptoms such as nausea, vomiting, headaches, and muscular pain (Rosenthal and Lesieur 1992; Wray and Dickerson 1981). Currently, there are no DSM criteria for gambling disorders that compare directly to criteria for substance use disorders. However, in practice, the term "problem gambling" is most commonly considered to apply to those individuals who meet one to four of the DSM-IV criteria for pathological gambling (National Research Council [NRC] 1999). Problem gamblers are individuals who do not meet full criteria to be diagnosed as pathological gamblers, but who meet some of the criteria and indicate that gambling is contributing to some level of disruption in their lives.

While there are similarities between PG and substance use disorders, there are some significant differences between these disorders. Research comparing individuals diagnosed with PG to individuals with substance use disorders is still in early stages, but there have been clinical reports on such differences. To begin with, it may be more difficult to define what constitutes gambling than to define a drug or an alcoholic drink. Gambling can encompass a variety of behaviors: buying lottery tickets, playing cards for money (even in friendly family games), investing in the stock market, participating in a charity raffle, betting on a golf game, betting on horse races, or playing scratch-off games to win money at a fast food restaurant.

Figure D-18
Diagnostic Criteria for Pathological Gambling Compared to Substance Dependence Criteria

Diagnostic Criteria for Pathological Gambling	Comparable Substance Dependence Criteria
Persistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the following:	*Maladaptive pattern of substance use, leading to clinically significant impairment of distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:*
• Is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)	• A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects
• Needs to gamble with increasing amounts of money to achieve the desired excitement	• Tolerance
• Has repeated unsuccessful efforts to control, cut back, or stop gambling	• There is a persistent desire or unsuccessful efforts to cut down or control substance use
• Is restless or irritable when attempting to cut down or stop gambling	• Withdrawal
• Gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)	• N/A
• After losing money gambling, often returns another day to get even ("chasing" one's losses)	• The substance is often taken in larger amounts or over a longer period than was intended
• Lies to family members, therapist, or others to conceal the extent of involvement with gambling	• The substance use is continued despite knowledge of having persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
• Has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling	
• Relies on others to provide money to relieve a desperate financial situation caused by gambling	
• Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling	• Important social, occupational, or recreational activities are given up or reduced because of substance use

Source: APA 2000.

Figure D-19
Comparison of Action and Escape Pathological Gamblers

Action	Escape
• Gambles for excitement, competition • More likely to engage in "skilled" forms of gambling such as poker, horse racing, sports • More likely to have early onset of gambling • Longer progression from regular gambling to addictive/out of control gambling • More likely to be male • More likely to present narcissistic or antisocial traits	• Gambles for relief, escape from stress or negative affect • More likely to engage in "luck" forms of gambling such as lottery, slots, video poker, bingo • Later onset of gambling • Shorter progression from regular gambling to addictive/out of control gambling • More likely to be female • More likely to be dysthymic

One of the main differences between PG and substance use disorders is that there is no biological test to screen for PG. The absence of a clear physical sign of the disorder enables a person to hide gambling behavior for longer periods of time. This also may contribute to the severe and entrenched lying and deception that are included in the diagnostic criteria for PG.

Because no substance is being ingested, often it is very difficult for individuals diagnosed with PG and their families/significant others to accept PG as a medical disorder. Research is beginning to establish a biological/genetic predisposition to PG that is similar to that found in severe alcohol and drug addictions, and that gambling may affect the central nervous system in ways similar to substance use (Breiter et al. 2001; Comings et al. 1996; Potenza 2001; Slutske et al. 2000). However, it is still difficult for individuals with PG, as well as the general public, to accept a medical model for this disorder. It is easier to accept that people with substance use disorders may behave badly (become aggressive or violent) while intoxicated than for gamblers to accept that their harmful behavior can be attributed to their gambling. This possibility could exacerbate the gambler's sense of shame and guilt and contribute to the development of rigid defense mechanisms to ward off these feelings and to allow gambling to persist. These hypothesized differences need to be investigated empirically.

Prevalence

Legalized gambling is available in 47 States and the District of Columbia. The great majority of adults (81 percent) have gambled sometime during their life. This compares to recent studies of alcohol use in the United States that estimate 91 percent of adults have drunk alcohol. Between 1974 and 1995, the amount of money spent on legal gambling increased 3,100 percent in the United States, from $17.4 billion to $550 billion. A national study estimated the lifetime prevalence of pathological gambling among adults in the United States to be 1.1 percent, while the past-year estimate for problem or pathological gambling combined was 2.9 percent. This can be compared to past-year estimates of alcohol abuse/dependence of 9.7 percent and drug abuse/dependence of 3.6 percent (NRC 1999).

Information on the prevalence of pathological gambling among adolescents has been controversial, with reported rates higher than for adults (Shaffer et al. 1997). However, adolescent rates of problem or pathological gambling,

which range from 9 to 23 percent in various studies, are comparable to rates of adolescent alcohol use (8 to 23 percent). Also, past-year adolescent pathological gambling rates of 1 to 6 percent are comparable to past-month rates of marijuana use of 3 to 9 percent (NRC 1999).

Gambling prevalence studies also illuminate demographic variables and risk for gambling problems. As suggested above, younger age seems to be a risk factor. Adults under the age of 30 report higher proportions of gambling problems. Men, ethnic minorities, and paradoxically, those with household incomes below $25,000 also tend to be overrepresented among problem/pathological gamblers. Employment status did not seem to have any relationship to risk for gambling problems. However, educational level had a moderate relationship with problem gambling, with those with a high school education or less being at higher risk for gambling problems (NRC 1999).

The rate of co-occurrence of PG among people with substance use disorders has been reported as ranging from 9 to 16 percent (Crockford and el-Guebaly 1998; Lesieur et al. 1986; McCormick 1993). Among pathological gamblers, alcohol has been found to be the most common substance of abuse. At a minimum, the rate of problem gambling among people with substance use disorders is 4 to 5 times that found in the general population.

> In individuals with COD, it is particularly important to evaluate patterns of substance use and gambling.

People with substance use disorders and co-occurring PG have been compared to people with substance use disorders without PG. While some findings appear contradictory, there is some evidence that people with co-occurring substance use and PG may have higher levels of negative affect, overall psychiatric distress, impulsivity, higher rates of antisocial personality disorder, AD/HD, and risky sexual behaviors (APA 2000; Crockford and el-Guebaly 1998; Langenbucher et al. 2001; McCormick 1993; Petry 2000*b*, *c*). The high rates of co-occurrence of substance use disorders and gambling problems clearly emphasize the need for screening and assessment of gambling problems in substance-abusing populations.

Key Issues and Concerns

Despite the high prevalence, treatment services for PG are limited or lacking in many areas. According to a survey conducted by the National Council on Problem Gambling, only 21 States provide some level of funding for addressing problem and pathological gambling. According to the Association of Problem Gambling Service Administrators (www.apgsa.org), only 16 States provide some public funding specifically for gambling treatment. Additionally, only about 1,000 Gamblers Anonymous meetings are held in the United States, fewer than the number of AA meetings found in some major metropolitan areas.

It is important to recognize that even though PG often is viewed as an addictive disorder, clinicians cannot assume that their knowledge or experience in substance abuse treatment qualifies them to treat persons with a PG problem. Training and supervision should be obtained to work with pathological gamblers, or referral should be made to specific gambling treatment programs.

A second consideration is that clients with PG problems seeking treatment have high rates of legal problems. Research has shown that in most settings, two thirds of people with PG problems report engaging in illegal activities to obtain money for gambling or to repay gambling debts. Pathological gamblers often fail to report such activities as embezzling from their job as an illegal activity. In their own minds they label what they are doing as borrowing rather than stealing, as they are certain that they will make

a winning bet and be able to pay the money back. Persons with substance use disorders also have many of these same problems.

Transference and countertransference issues in the treatment of pathological gambling can have a significant impact. Competitive, action-oriented gamblers may attempt to make treatment a competitive sport, and clinicians may become distracted by debating and arguing. Relapsing may become a way for the pathological gambler to "beat" the therapist. The lack of physical signs or biological tests for gambling can contribute to countertransference reactions, such as the therapist becoming overly zealous in trying to "catch" gamblers in their lies or overly accepting of self-reports. Either extreme can impede the therapeutic relationship.

Strategies, Tools, and Techniques

Engagement

In an initial contact with a pathological gambler, it is important to begin developing rapport quickly. Counselors should remember that when a pathological gambler makes an initial phone call to access treatment or comes in for an initial evaluation, he or she is likely to be feeling a great deal of shame, guilt, anxiety, or anger. To acknowledge gambling problems is to admit to being a "loser," an extremely difficult admission for most gamblers. The gambler whose family and friends have failed to acknowledge that he or she has a legitimate disorder also is likely to be sensitive about being judged, criticized, and condemned. Consequently, the clinician must demonstrate knowledge of the signs, symptoms, and course of pathological gambling; present a nonjudgmental attitude and empathy regarding the emotional, financial, social, and legal consequences of gambling; and convey hope regarding the potential for recovery.

It is also important for the clinician to understand how and when to probe for greater detail regarding the severity of the gambling disorder and its consequences, since as with substance abuse, the gambling client is likely to minimize the negative impact of gambling. Clients with COD are likely to minimize or deny the disorder for which help is not being sought.

Screening and assessment

There are several valid and reliable instruments that have been developed for the screening and assessment of pathological gambling.

Screening

The South Oaks Gambling Screen (SOGS) (Lesieur and Blume 1987) is one of the most widely researched instruments. This is a 20-item questionnaire designed to screen for gambling problems and has been found to be effective in substance abuse populations. It can be conducted as a structured interview or a self-report questionnaire in both lifetime and past 6-month versions. The drawbacks are its length and the fact that the items are not specifically based on DSM-IV criteria, which precludes its use as a diagnostic instrument. Someone who scores above the cut-off on the SOGS would then require a more detailed diagnostic assessment.

A brief screening tool, the Lie/Bet Questionnaire, has been found to be effective in identifying probable pathological gamblers (Johnson et al. 1997). The questionnaire consists of two questions:

1. Have you ever felt the need to bet more and more money?

2. Have you ever had to lie to people who are important to you about how much you gamble?

A "yes" response to either question suggests potential problem gambling. Again, this instrument is likely to over-identify individuals with gambling problems and a positive screen needs to be followed by a more detailed clinical/diagnostic interview.

A computerized problem gambling screening tool that may be particularly useful in criminal justice populations is the Gambler Assessment

Index (GAI), which incorporates a problem gambling scale as one of seven scales—truthfulness, attitude, gambler, alcohol, drugs, suicide, and stress). It takes about 20 minutes to complete and includes a descriptive computerized printout of risk levels for all scales (Behavior Data Systems 2000).

Assessment

A more comprehensive problem gambling assessment needs to be part of a broader biopsychosocial and spiritual evaluation. Only two instruments have been studied and used to evaluate issues of problem gambling severity. An addendum to the ASI, the Gambling Severity Index has been developed and validated (Lesieur and Blume 1991). Another instrument that has been found to be valid and reliable is the Gambling Treatment Outcome Monitoring System, or GAMTOMS (Stinchfield et al. 2001). This is a battery of four questionnaires designed to be used in assessment of problem gambling and in treatment outcome evaluation.

The Gambling Treatment Admission Questionnaire (GTAQ) is particularly useful. A 162-item self-report questionnaire that incorporates the SOGS and DSM-IV criteria, the GTAQ evaluates the range of gambling behaviors and frequency of gambling, gambling debt, treatment history, substance use, and gambling-related financial, legal, occupational, and psychosocial problems.

Structured interviews for the diagnosis of pathological gambling based on DSM-IV criteria currently are being researched and developed, but are not yet publicly available (Cunningham-Williams 2001; Potenza 2001). Most clinicians conduct a clinical interview based on DSM-IV criteria to establish the diagnosis of pathological gambling.

In individuals with COD, it is particularly important to evaluate patterns of substance use and gambling. Among those who abuse cocaine, for example, there seem to be several common patterns of interaction between gambling and drug use. Cocaine use and gambling may coexist as part of a broader antisocial lifestyle. Someone who is addicted to cocaine may see gambling as a way of getting money to support drug use. A pathological gambler may use cocaine to maintain energy levels and focus during gambling and sell drugs to obtain gambling money. Cocaine may artificially inflate a gambler's sense of certainty of winning and gambling skill, contributing to taking greater gambling risks. Cocaine may be viewed by the gambler as a way of celebrating a win or may be used to relieve depression following losses.

Cocaine and pathological gambling may be concurrent or sequential addictions. With cocaine in particular, it often is difficult to have enough money for both disorders at the same time. There is no clear evidence that one addiction is likely to precede another, although one recent study reported that in a population of people with substance use disorders who are in treatment, the onset of gambling behavior was likely to precede the use of addictive substances (Hall et al. 2000).

Several patterns of interaction may emerge for individuals who are alcohol dependent and are pathological gamblers. One of the more common clinically observed patterns is sequential addiction; for example, someone who has had a history of alcohol dependence—often with many years of recovery and AA attendance—who develops a gambling problem. Such individuals often report that they did not realize their gambling was becoming another addiction, or that gambling could be as addictive as alcohol and drugs. It is not uncommon for such individuals to seek treatment only after a relapse to alcohol (or recognizing they are close to a relapse), secondary to the gambling-related stresses. Other individuals have developed alcohol problems only after their gambling has begun to create serious adverse consequences; they begin using drinking as a response to such problems. Since alcohol is readily available (and often free) in most gambling settings, drinking and gambling may simply "go together" for some individuals.

It often is helpful, if not critical, to obtain collateral information from family and significant others. One scale that is helpful in this process, the Victorian Problem Gambling Family Impact Scale, is undergoing validation (Research Evaluates Gambling's Impact 1998).

Obtaining collateral information often can be challenging, as the gambler may want to control both what the clinician knows and what the family knows. The gambler may not want the clinician to know how angry and devastated the family is feeling, or the gambler may not want the family to know the extent of his or her gambling and gambling debt. Also, the gambler may give specific instructions to family members about what to tell or not to tell the clinician. This may be related to gambling or finances, but it also may relate to substance use.

Therefore, while it is advisable to involve family members as early as possible in the assessment and treatment process, it may take time to develop a trusting clinical relationship with the gambler before he or she gives consent to family involvement. The clinician needs to consider carefully the best way to involve family members or significant others in the assessment and treatment process. Initial sessions with both the gambler and family present may help to alleviate the gambler's anxiety. Such sessions can be followed up with meetings without the gambler present. It is essential that the therapist not be viewed as taking sides in this process.

Crisis stabilization

Pathological gamblers frequently come into treatment in a state of panic and crisis. The attempted suicide rate among gamblers in treatment is high (20 percent) (NRC 1999), which makes a careful evaluation of suicide potential essential. A common suicide plan for PG clients is to have an automobile accident so that family can collect life insurance to pay off gambling debts. Concurrent substance use adds to the risk potential for self-harm, so it is important that the gambler who is at risk for suicide contracts not to use any mind-altering substances in addition to not endangering

Case Study: Pathological Gambling Assessment

A 36-year-old, married male, Andy J. entered treatment for pathological gambling. An initial assessment involving questionnaires and structured diagnostic interviews found indications of excessive alcohol use and use of cocaine. On a family assessment interview, Andy J.'s wife denied knowledge of any excessive alcohol use or any cocaine use on her husband's part.

As treatment proceeded, it became apparent that Andy J.'s substance use was more extensive and problematic than first presented. Staff members were particularly concerned about his apparent hiding of his substance use from his spouse. Andy J. became angry and agitated, threatening to discontinue treatment when staff indicated that the issue of his substance abuse needed to be addressed at the next family session. Andy J. was given the choice of communicating the extent of his substance use to his wife prior to the session or waiting until the session.

Andy J. initially withdrew consent to communicate with his wife. However, after intensive group and individual work focusing on relapse potential, dishonesty as a relapse risk factor, and assessment of further negative consequences, he decided to tell his wife. In the next joint session, his wife expressed relief and reported that she had been aware of and concerned about his substance use. She had lied at the initial assessment at her husband's request, as he had convinced her that it would be best for his treatment not to get the therapist distracted by his substance use so that he could fully focus on his gambling problem. Andy J., once the initial anger and anxiety had subsided, acknowledged that he was holding onto his substance use for fear of living life without an addiction to fall back on. He realized that continued substance dependence would continue to maintain all the problems he was attributing only to his gambling.

him/herself or others. (However, as noted in the discussion of suicide, counselors should not rely solely on such contracts.) Placement in a structured environment, inpatient, or residential setting may be necessary in some cases.

Addressing financial and legal issues

Financial crises may involve eviction and homelessness; inability to pay for food or utilities; or families discovering that savings accounts, college funds, and so on are totally depleted. It is important in handling financial crises to make sure the basics of food and shelter are met for the gambler and his family. This may mean referring the family to homeless shelters or finding temporary living quarters with extended family. Resolving the entire extent of financial problems takes more time; however, in the crisis situation it is essential to convey to the gambler and family that coping with financial stress is a part of treatment, and to outline the process for addressing the problems. It is important to help the gambler and family prioritize immediate needs (i.e., food, shelter) separately from those that can be managed later to relieve the feelings of being overwhelmed. The counselor can help the client make specific lists of what can be done now and what can wait until later. For example, if the family is being evicted, the clinician could provide a list of shelters to call or have the client call shelters from the clinician's office.

Legal issues can create an additional crisis for the pathological gambler and the family. Embezzling from an employer or writing bad checks are two common illegal practices of pathological gamblers. When facing potential legal charges for such activities, the gambler often is in a state of panic, looking for money to borrow from family or friends to pay off the checks or pay the employer back to avoid legal consequences. It often is difficult for the family or friends of the gambler to refuse such requests when they fear the result will be sending the gambler to jail. In such cases, the clinician needs to direct the gambler to obtain legal counsel prior to making impulsive decisions. The clinician needs to work with both the gambler and potential "bail out" sources to explore other options.

Financial and legal issues also can trigger domestic violence. The pathological gambler may face physical violence from a spouse or significant other when he or she confesses to the extent of gambling debt. Alternatively, a spouse or significant other may face violence if he or she attempts to withhold money from the pathological gambler. The clinician needs to assess the history of domestic violence or potential for violence very carefully before suggesting any plan for dealing with money management or financial disclosure.

Self-banning

To assist a client with a PG problem to abstain from gambling, some gambling venues (mainly casinos and some race tracks) offer "self-banning." This is a process of completing a written document indicating a desire to be prohibited from entering a casino or race track. Some States have made this a legal process with criminal consequences if a gambler who has self-banned is found gambling at the banned location. Information on this process can be obtained from the gambling venue's responsible gaming office, from State Councils on Problem Gambling, or from State-funded problem gambling treatment programs.

Short-term care and treatment

This section will first discuss specific treatments that have been used in the treatment of pathological gambling, then explore how this knowledge can be applied to the pathological gambler with a substance use disorder. Although a broad range of treatment modalities have been applied to the treatment of pathological gamblers, to date there has been little research to support one type of treatment over another.

Psychodynamic therapies

Some of the earliest clinical writing on the successful treatment of pathological gambling was based on psychodynamic approaches. Such

Case Example: Counseling a Pathological Gambler

Michael B. was a gambler who relished the competitiveness of card playing and had developed a reputation as a tough player and as a winner early in his gambling career. His gambling gradually became out of control and it was clear that he was unable to stop gambling until he had lost all his money. However, when he attempted to abstain from gambling he would feel depressed. In treatment he confessed to feeling increasing anxiety when he was winning, and to feel relief only when he had lost everything.

Michael B.'s father had been a successful business executive who had been very demanding and critical of Michael B. throughout his life. Michael B. had been determined to "beat his father at his own game" and become even more successful. While Michael B. had developed many businesses, they always seemed to collapse after an initial success, a pattern that mimicked his gambling. In therapy, it became clear that Michael B. felt guilty at thoughts of "beating" his father, which contributed to the destructive pattern of his gambling and of his unsuccessful businesses.

Treatment helped Michael B. let go of his guilt-producing fantasy of spectacular success and focus on how he could enjoy his life without feeling a need to compete with his father. He was able to set more realistic goals to achieve a sense of accomplishment and was able to abstain from gambling without feeling depressed and inadequate.

approaches emphasize identifying the underlying conflicts and psychological defenses that contribute to addictive gambling. Therapy involves helping the gambler gain insight into the psychological meaning of his or her gambling (Rosenthal and Rugle 1994), decreasing defenses that support denial and irrational thinking, and developing more adaptive coping skills to resolve internal conflicts. Such dynamic therapies generally are incorporated into a comprehensive treatment approach with the therapist taking a more active and directive role than in traditional dynamic approaches.

Cognitive–behavioral treatment

While early reports of behavioral treatment of pathological gambling focused exclusively on gambling behaviors using aversive conditioning and systematic desensitization, more recent approaches involve a range of cognitive as well as behavioral interventions. Similar to approaches to substance use disorders, these include relapse prevention strategies, social skills training, problem solving, and cognitive restructuring (Sharpe 1998).

A component that is specific to pathological gambling in this strategy involves modifying irrational beliefs about gambling and the odds of winning. Research repeatedly has shown that gamblers hold beliefs in "the illusion of control," biased evaluation, and the gambler's fallacy (Ladouceur and Walker 1998).

- The *illusion of control* is the belief that one can control or influence random or unpredictable events, such as picking winning lottery numbers or controlling the fall of the dice by how they are thrown.
- *Biased evaluation* involves attributing wins to one's special skill or luck, while losses are blamed on external circumstances.
- The *gambler's fallacy* is the misunderstanding of independent probabilities. For example, if a coin is tossed 10 times resulting in 10 heads, one would think it more likely to get a tail on the next toss, rather than realizing the odds of a head or tail is the same for any one toss.

Cognitive–behavioral interventions are targeted at identifying and correcting such irrational thinking and erroneous beliefs.

As with substance abuse, relapse prevention includes identifying gambling-related internal and external triggers. Money is a common trigger and interventions generally involve remov-

ing money from the gambler's control. This can include removing the gambler's name from joint checking and savings accounts, limiting the amount of cash the gambler carries, discontinuing credit cards, and choosing a trusted family member or friend to become the gambler's money manager. As might be anticipated, this can be a difficult and conflictual process; successful use requires creativity and sensitivity to issues of power and control. The goal is not only to remove the trigger of money from the gambler, but also to protect the gambler's and the family's finances. It can be helpful if this is explained as a process of assisting the gambler in regaining financial control of his or her life. Negotiating a workable and tolerable system of financial accountability and safety is a key therapeutic task in the treatment of pathological gamblers, regardless of therapeutic approach.

With clients with co-occurring PG and substance use disorders, it often is essential to identify specific triggers for each disorder. It also is helpful to identify ways in which use of addictive substances or addictive activities such as gambling act as mutual triggers.

Increasing evidence supports the effectiveness of treatment approaches with the goal of reduced or limited gambling, particularly for problem gamblers who do not meet all criteria for a diagnosis of pathological gambling or who are low-severity pathological gamblers. This approach generally involves money management along with cognitive–behavioral interventions to set and achieve goals for controlled or limited gambling. Manuals are available to guide this type of treatment, and a self-help manual also has been published (Blaszczynski 1998).

Psychopharmacological treatment

Two main types of medication have been reported to reduce gambling cravings and gambling behavior: SSRIs, such as fluvoxamine (Luvox), and opiate antagonists, such as naltrexone, which has also been found to be effective in treating people with substance use disorders (Hollander et al. 2000; Kim et al. 2001). As people with co-occurring substance use and PG disorders may be more likely to experience a broad range of additional mental disorders, psychiatric medication to address affective disorders, anxiety disorders, and attention deficit hyperactivity disorder may sometimes be needed.

Integrated multimodal treatment

Treatments combining 12-Step, psychoeducation, group therapy, and cognitive–behavioral approaches have been found to be effective in the treatment of pathological gamblers with co-occurring substance use and mental disorders (Lesieur and Blume 1991; Taber et al. 1987).

Gamblers Anonymous

It is advisable for persons with substance use and PG disorders to attend separate support groups for gambling *and* for alcohol and/or drug dependence. While the groups can supplement each other, they cannot substitute for each other.

It may be difficult for some individuals to adjust to both types of groups, as Gamblers Anonymous (GA) meetings can be different from AA. It is not uncommon for people with substance use disorders who have had extensive experience with AA, Narcotics Anonymous, or Cocaine Anonymous to find fault with GA groups. While GA often places less emphasis on step work, sponsorship, and structure than other 12-Step programs, it still provides a unique fellowship to address gambling issues. GA also can be useful in helping gamblers and their families cope with money management, debt, and restitution issues through a process called "Pressure Relief." Clinicians new to the treatment of pathological gambling are advised to attend open GA and Gam-anon meetings in their area to gain a better understanding of this support system.

The experience of some clinicians is that initially, limited gambling may be an approach for those with substance use disorders and gambling problems who are willing to work on abstinence goals for their substance use, but who are less motivated to abstain from gam-

bling. Rather than distracting from the substance abuse treatment, the clinician can suggest either a limited gambling approach or a time-limited period of abstinence from gambling. These may be presented as experiments. Cravings for both gambling and substances can be monitored in either approach to help clients understand the potential interactions of both disorders and to make better informed decisions about whether they can gamble at all. The same can be done with the client who is motivated to abstain from gambling but more ambivalent about the need to reduce his or her substance use or abuse. This approach may help minimize a client's defensiveness toward treatment in general and reduce the risk of dropping out of treatment or denying a problem altogether.

Longer term treatment

PG, like substance use disorders, may be conceptualized as a chronic, recurring disorder. Potential for lapses and relapses must be recognized for both disorders—and perhaps particularly for people with both disorders. It is important to educate clients about this possibility, if not likelihood, and to develop a plan for re-engaging in treatment if a lapse or a relapse occurs. Professionally facilitated continuing-care groups that focus on recovery maintenance skills can be effective, particularly in combination with mutual self-help groups.

Continuing-care groups often can be facilitated by peer counselors or treatment program alumni with several years of abstinence. Such continuing-care groups particularly may be useful for clients with COD to maintain contact with therapy resources, to help "catch" a relapse in the making, and to supplement limited availability of GA in many communities. Development of a treatment alumni network also can be a useful strategy to maintain contact with clients over longer periods of time and to increase the likelihood of using supportive resources in times of stress, vulnerability, or crisis.

Case Study: Counseling the Client With Pathological Gambling and Substance Use Disorders

Jan T. is a 32-year-old divorced, single parent with a history of cocaine and marijuana dependence, alcohol abuse, and two prior treatments for her substance use disorders. She entered treatment following a bout of heavy drinking resulting in a citation for Driving Under the Influence (DUI). During assessment, she screened positive on the SOGS for probable pathological gambling. She had been going to casinos several evenings per week, losing on average $200 to $500 per week playing video poker. Her rent and utilities were past due, and she feared losing her job due to tardiness and inefficiency because often she would go to work after staying up all night gambling. She had begun drinking while gambling after a 2-year abstinence from substances, and her drinking had increased as her gambling problems progressed.

Jan T.'s DUI occurred while driving home from an all-night gambling episode. Her gambling had begun to increase following her first substance abuse treatment and she acknowledged that her alcohol relapse after her first treatment was related to her gambling, as was her current relapse. She reported having increased her gambling due to feelings of stress and loneliness. As her gambling increased, she discontinued going to continuing care and AA and Cocaine Anonymous meetings. However, in her second substance abuse treatment, no one had asked her about her gambling and she did not recognize it as a problem at the time.

Current treatment emphasized her gambling problems as well as substance abuse. She attended gambling-specific education and therapy groups as well as AA, Cocaine Anonymous, and GA meetings. Due to serious, continuing financial problems and debt, Jan T. moved in with an older sister who had a 12-year history of abstinence from alcohol and attended AA meetings regularly. This sister also agreed to be her money manager.

Since Gam-anon groups are even less prevalent than GA groups, continuing-care groups for family members or for family members and PG clients jointly particularly can be useful to provide support for coping with financial issues that may persist for many years despite gambling abstinence.

Resolving financial problems and accomplishing debt repayment also can be a relapse trigger for pathological gamblers, so often it is important to schedule a "check up" visit around the anticipated time when gambling debts may be paid off. In general, it may be advisable to attempt to maintain therapeutic contact beyond the gambler's 1-year anniversary of abstinence, since often this seems to be a time of vulnerability, overconfidence, and complacency regarding recovery.

Appendix E: Emerging Models

Part I of this appendix provides information on where to seek further information for models referenced in the main body of the TIP. Part II describes models of care for people with COD that *were evaluated or are currently being evaluated* with funding by the Substance Abuse and Mental Health Services Administration (SAMHSA) or other Federal agencies. Because these models are undergoing evaluation, they are not endorsed by the consensus panel as consensus-based practices. Rather, the models are intended to augment those described in the main body of the TIP and to represent some initiatives. It is hoped that these models will suggest ways in which readers working with a variety of client populations, disorders, or severities in different settings can improve their capacities to assess and treat clients with COD.

Material for this chapter was derived from responses to a request for information sent to programs listed in SAMHSA initiatives in 2002. The programs were invited to describe essential aspects of their programs and empirical information on outcome data. All initiatives canvassed are listed at the end of this appendix. The models included in this appendix are from programs that responded to the request.

Part I: Addresses for Models Referenced in the Text

Arapahoe House

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(For more description see Part II of this appendix.)

The Dual Assessment and Recovery Track (DART)

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Evaluation of a Treatment Model for Co-Occurring and Traumatic Stress Disorder

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Foundations Associates

Contact information, detailed program materials, and research findings may be obtained via Foundations' Web site at www.dualdiagnosis.org.

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Homelessness Prevention TC for Addicted Mothers

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Triad Women's Project

For more information on the Triad Women's Project, consult the following Web site: www.fmhi.usf.edu/cmh/research/exemplary/triad.html.

Part II: Other Emerging Models

Case Management for Rural Substance Abuse

This project evaluates the effectiveness of case management with adult clients in residential treatment for drug abuse. The results of this study will be helpful to service providers and policy developers as they plan drug treatment interventions, especially in rural areas.

Contact information

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Description of intervention

The overall goal of this study is to provide insight into the development of case management models for substance abuse treatment and to improve quality of life for rural substance abuse clients. The purpose of this project is to conduct a full study of case management treatment services and to evaluate the

effectiveness of three case management models: brokerage (IBCM), comprehensive (ICCM), and standard treatment (SCM). The conceptual model used is the health services framework of Aday et al. (1993). In this framework, the population at risk is evaluated for predisposing, enabling, and need variables.

Setting

Clients were recruited for the study from the residential program at the Mid-Eastern Council on Chemical Abuse (MECCA), which was also the site for our earlier study on case management. As a facility receiving State funds, MECCA participates in the State-funded managed care program. MECCA has a catchment area comprising four counties and is governed by community representatives from the four-county area. MECCA's main office is in Iowa City, IA, with satellite offices in Coralville, Marengo, and Washington, IA. Total population for MECCA's catchment area is 148,000 (1990 census), comprising 90 percent white, 2 percent African American, and 3 percent other races. Roughly 75 percent of MECCA's clients are insured by a source that falls under the IDPH managed care plan.

MECCA has a 20-bed residential unit with additional beds in a halfway house, a detoxification unit, and outpatient and educational programs for adults and adolescents. Adult clients are referred to MECCA from a variety of sources, including hospitals (7 percent), other health and social service agencies (7 percent), the legal system (30 percent), family and friends (6 percent), committals (10 percent), and self-referrals (40 percent). Approximately 2,400 people are evaluated in person by MECCA intake counselors annually to determine a treatment recommendation. The intake screening uses Iowa's Level of Care (LOC Determination Form), which determines treatment placement according to American Society of Addiction Medicine (ASAM) Criteria.

Client characteristics

The target population for this study of rural clients in substance abuse treatment is residential clients of one Midwestern not-for-profit substance abuse treatment center, MECCA. Approximately 380 clients per year meet criteria required for an admission to MECCA's adult residential program. Clients in the residential program may receive up to 50 hours of treatment services weekly, including group and individual therapy, life skills training, and other education classes. The average age of MECCA residential clients is 33.9. Forty-two percent are female, 84 percent are white, 12 percent are African American, 4 percent are other races. Fifty-eight percent are unemployed. Sixty-one percent have no health insurance, 19 percent have Medicaid, Medicare, or other public coverage. Eight percent are homeless. Forty-nine percent of residential clients have been diagnosed with a psychiatric condition prior to the admission. Ninety percent have used alcohol steadily for at least 1 year in their lifetime, 70 percent have used marijuana, 47 percent have used cocaine, and 48 percent have used amphetamines. Residential clients have been arrested an average 7.8 times in their lifetime. Data collected at MECCA during our previous study indicates that 49 percent of female and 13 percent of male residential clients have been sexually abused in their lifetime; 72 percent of female and 42 percent of male residential clients reported being physically abused in their lifetime. Regarding HIV-associated behaviors, 29 percent of MECCA clients have used substances intravenously and 29 percent have had sex with someone they knew was using substances intravenously.

Resources needed for implementation

In this study, we are evaluating two models of case management, comprehensive and brokerage, compared with standard treatment. Case managers who use the comprehensive model provide mental health counseling as part of that service. For those clients receiving services

with the brokerage case manager, they are referred for mental health services (if needed) based on their ability to pay; those with insurance have more options in our area than those on public funding.

We have a manual for both models, but training would be needed to carry out either model with competency. In our area, cultural competency also includes working with those from rural areas as well as smaller towns. We have found that our case managers can help clients overcome barriers to services through education, direct referral, and transportation.

Empirical data

The primary analysis of outcome data focuses on drug use by condition. Preliminary analysis shows overall drug use decreased from intake through both follow-up evaluation points for each drug class. The main drugs of use were alcohol, cocaine, marijuana, and methamphetamine. For these four drug classes, clients receiving comprehensive case management reported a significant decrease from intake to the 3-month followup and then reported a smaller decrease by the 6-month session. Clients in the standard treatment condition also reported a significant decrease in use of these four drugs from intake to the 3-month session, although no decreases were noted by the 6-month session. Clients receiving brokerage case management reported a significant decrease in use from intake to the 3-month session, but at the 6-month point, they reported moderate increases.

Publications

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Vaughn, T., Vaughan, M.S., Saleh, S., and Hall, J.A. Participation and retention in drug abuse treatment services research. Submitted to *Journal of Substance Abuse Treatment*.

CMHS/CSAT Collaborative Effort to Prevent Homelessness

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Description of intervention

The Boley Homelessness Prevention Project provides quality housing, housing-related support services, and linkages to a wide array of psychosocial, clinical, and medical services. Services range from immediate needs (food, shelter, clothing) to permanent housing and vocational training for individuals who are homeless and have mental illnesses or co-occurring substance use disorders. The program provides housing or assists clients in finding housing of their choice, and then provides housing-related support services. The Boley Centers employ a psychiatric rehabilitation approach that incorporates the Fellowship House and Fountain House models and the case manager specialist model.

Setting

Located in West Central Florida, Boley Centers for Behavioral Healthcare, Inc., is a private nonprofit agency providing psychosocial rehabilitation services since 1970 for people with severe mental illnesses who may also have substance use disorders. Boley provides an array of residential and supportive services to over 600 persons at any given time and about 1,000 people in any given year.

Patient characteristics

The Boley Homelessness Prevention Project is an important program of Boley Centers. Of the 92 individuals served in 1996, all individuals had been homeless or at risk of homelessness when they entered the program. The "model" person served would be male, white, never married, in his forties, with a primary diagnosis of a psychotic disorder and a secondary diagnosis of a substance use disorder.

Resources needed for implementation

The most important aspect of staff training is training in a psychosocial rehabilitation model. This may come either from formal training outside the agency or through mentoring within the agency. Staff-resident interactions are considered vital to the effectiveness of the intervention and are based on mutual respect. The model emphasizes providing services as needed and or/requested rather than mandatory or prescribed services.

Funding for services in the project follows a fairly typical pattern of community mental health agencies, i.e., a combination of State ADM (alcohol, drugs, or mental disorders) and Medicaid funding with some county and other patient fees. Boley Centers is a model of innovation for funding the acquisition and rehabilitation of housing. Each housing site may have a different combination of HUD, City Revitalization, County, private gifts, and client fees. Although initially met with a "NIMBY" attitude, they have developed a reputation for revitalizing urban neighborhoods and are now sought-after partners in housing and planning.

Empirical data

The results of the meta-analysis of eight sites studied in the CMHS/CSAT Collaborative Program to Prevent Homelessness strongly supported programs, including Boley, that guarantee housing and provide housing support services. These significant effects are being written up have not been published to date.

In addition, our local analysis demonstrated that, for people with relatively high levels of psychiatric symptoms and substance use, the Boley intervention was more effective than specialized case management in helping to maintain stable housing. For people with relatively low or moderate levels of symptoms and substance use, specialized case management was equally effective. These findings are summarized in publications below.

Publications

Descriptive publications

Boley Centers for Behavioral Health Care, Inc.: The Homelessness Prevention Project—1996-1997: A Descriptive Manual.

This is a comprehensive description of the conceptual framework, environmental context, development of the intervention, client population, structure, and process of the intervention, the agency/community network, evaluation activities, residents' stories, and lessons learned and recommendations. It is available from Colleen Clark (see above for contact information).

Clark, C., and Rich, A. "Boley Centers for Behavioral Health Care, Inc.: Housing Related Support Services." Reinforcing Upstream: Interim Status Report of the Center for Mental Health Services and Center for Substance Abuse Treatment Collaborative Effort to Prevent Homelessness, 1999.

Clark, C., and Rich, A. "Boley Homelessness Prevention Project: Final Report." Final project deliverable to the CMHS/CSAT Collaborative Program to Prevent Homelessness, 2000.

Clark, C., Teague, G., and Henry, R. Prevention of Homelessness in Florida. Co-published simultaneously in *Alcoholism Treatment Quarterly* 17(1/2): 73–91; and in Conrad, K. et al., eds. *Homelessness Prevention in Treatment of Substance Abuse and Mental Illness; Logic, Models, and Implementation of Eight American Projects.* The Haworth Press, Inc., 1999. pp. 73–91.

Publications of the outcomes

Clark, C. *Policy Brief 14: Ending Homelessness Among Person with Serious Mental Illness: What Works Best for Whom?* Louis de la Parte Florida Mental Health Institute Series. November, 2001.

Clark, C., and Rich, A. Ameliorating homelessness for adults with mental illness: What works for whom? *Psychiatric Services*, in press.

CODAC Behavioral Health: Managing Co-Occurring Disorders in an Opioid Agonist Setting

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Description of intervention

This program provides uninsured methadone clients with psychiatric evaluation, care, medication, and casework, all at no cost. It was developed on the premise that a client seeking treatment should find "no wrong door" that might impede progress in finding help of this nature. Given this, a client seeking help for emotional problems, lacking the means to access these services, is referred, evaluated, and treated onsite in the *Co-Occurring Disorders Program*. The program is a collaborative effort of CODAC Behavioral Health, a substance abuse and behavioral disorders treatment facility, and Gateway Healthcare, a large, multi-site, mental health center. It is

staffed by a Psychiatrist (Gateway), Licensed Mental Health Professional (CODAC), and Caseworker (Gateway). Twice per week, onsite at the CODAC Providence methadone clinic, clients are seen and treated on referral from the methadone treatment staff. As a result, CODAC clients receive "methadone friendly" psychiatric care, in a timely fashion, onsite at their primary clinic. They are followed after-hours as if they were ordinary clients of the prescribing psychiatrist at Gateway Healthcare.

Setting

The *Co-Occurring Disorders Program* is located at CODAC Behavioral Health's Providence, RI, location. Gateway Healthcare, the collaborative psychiatric treatment component, is located in nearby Pawtucket, RI. CODAC Behavioral Health, historically a substance abuse treatment facility, is in its 30th year. CODAC serves approximately 2,200 clients, out of which 1,050 are agonist clients, utilizing both methadone and LAAM.

Client characteristics

All of the clients who participate in the *Co-Occurring Disorders Program* are opioid agonist clients of CODAC Behavioral Health. They are referred on a voluntary basis. None have health insurance or related benefits.

The gender breakdown is 60 percent female, 40 percent male. The average client age range is late thirties to early forties. The racial breakdown, from most to least, is Caucasian, Hispanic, and African American.

The most common diagnosis treated is that of Mood Disorder. This would include depressive disorders, dysthymic disorders, bipolar I and II, and cyclothymic disorders. Also common are Anxiety Disorders, to include panic, agoraphobia, obsessive-compulsive disorder, and posttraumatic stress disorder. Many clients also carry the diagnosis of Personality Disorder, coded on Axis II.

In terms of severity, all clients are outpatient and are required to make multiple trips to the clinic each week. Several clients have been hospitalized while under our care, and aggressive casework managed to provide continuity of treatment.

Resources needed for implementation

This project is entirely funded by a grant from the Department of Mental Health, Retardation, and Hospitals, Division of Substance Abuse, State of Rhode Island. We are in the first year of a 3-year project.

Medication is provided free of charge, through a State-administered program, the Community Mental Health Medication Assistance Program (CMAP).

Successful implementation required cooperation on a number of levels. CODAC and Gateway needed to effectively collaborate to design the program and win a competitive bid process. That accomplished, we desired regulatory cooperation to site the program at an existing methadone treatment facility, and practice psychiatric medicine. Further, we required regulatory approval to qualify our clients for CMAP, and free medication, if within a restricted formulary. Finally, the program was designed to be attractive to clients, and existing methadone staff. It needed to fit well with the present services and be accessible to referring staff and clients. Built into the program was a series of inservice trainings designed to educate the staff regarding the service, and its obvious benefits.

In summary, establishing a program of this nature requires collaboration between multiple systems. One must have the expertise to design and fund a project. Cooperation between three or more regulatory bodies is involved as you site a non-traditional service in an established, substance abuse treatment facility. Finally, the value of the service must be stressed to the ultimate consumers, and the intrasystem referral sources. Dependent on the demographics of

your locale, it may be essential to have bilingual, culturally competent staff. The program's credibility will depend on it.

Empirical data

Program evaluation provides for a number of measures to assess the level of success. As these are clients on a methadone treatment program, some well-defined indicators emerge. First, *toxicology screening* tells us whether the client is drug-free. It is hoped an effective mental health intervention will reduce illicit drug use. Second, an *empirical, 32-item scale*, the BASIS-32, is administered at 3- and 6-month intervals. This scale rates a client's progress along five areas of difficulty: relation to self/others, depression/anxiety, living skills, impulsive/addictive, and psychosis. Third, the *overall behavior and demeanor of the client is evaluated* by the behavioral health specialist. We are still early on in the data collection process; however, the first set of results appears to be trending positive.

The data are unpublished at this point. Our plan is to collect 12 months' worth of evaluation data prior to publication.

Publications

There are no publications associated with this program.

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Description of Intervention

Community Connections, a provider of comprehensive human services in Washington, DC, is the lead agency for the DC Trauma Collaboration Study (DCTCS). This project was funded by SAMHSA to develop and evaluate the effectiveness of services for women trauma survivors with co-occurring substance use and mental disorders. Agency staff developed a comprehensive, integrated, trauma-focused network of services with four key intervention components: Trauma Recovery and Empowerment Model (TREM) groups, Integrated Trauma Services Teams (ITSTs), Collateral Groups (on issues such as substance abuse, parenting, domestic violence, and spirituality), and a peer support program.

Setting

The experimental sites are two community mental health and substance abuse treatment programs in Washington, DC: Community Connections and Lutheran Social Services. The control sites are two similar programs in Baltimore, MD: North Baltimore Center and People Encouraging People.

Client characteristics

Women enrolled in the study had histories of trauma (physical and/or sexual abuse) as well as a substance abuse diagnosis and a mental illness diagnosis (at least one current and one within the past 5 years).

Resources needed for implementation

Primary clinicians received cross-training in trauma, mental health, and substance abuse problems and related interventions. Consumer-survivors were involved in planning, implementing, and evaluating the project; they also developed a Women's Support and Empowerment Center to provide peer support services.

Empirical data

Preliminary findings from the DCTCS indicate that the TREM intervention is feasible (that clinicians can learn to implement it in a consistent way with fidelity to the treatment manual); that consumers complete it at high rates (over 75 percent of the women involved in the first eight groups completed more than 75 percent of the sessions); and that consumer satisfaction is very high. Other early outcome data suggest that this integrated package of services built around the central TREM group intervention is helpful to participants in both substance abuse and mental health domains. Pilot data collected in other program evaluation projects suggest potential benefits for TREM participants in a number of outcome domains: decreased mental health symptoms, increased recovery skills, and enhanced overall functioning; reduced utilization of inpatient hospitalization and emergency rooms; and decreased high-risk behavior.

Publications

Copeland, M.E., and Harris, M. *Healing the Trauma of Abuse: A Women's Workbook*. New Harbinger Press, 2000.

Fallot, R.D., and Harris, M. The Trauma Recovery and Empowerment Model (TREM): Conceptual and practical issues in a group intervention for women. *Community Mental Health Journal,* in press.

Goodman, L.A., Dutton, M.A., and Harris, M. Physical and sexual assault prevalence among episodically homeless women with serious mental illness. *American Journal of Orthopsychiatry* 65(4):468–478, 1995.

Goodman, L.A, Dutton, M.A., and Harris, M. The relationship between dimensions of violent victimization and symptom severity among episodically homeless, mentally ill women. *Journal of Traumatic Stress* 10(1):51–70, 1997.

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Harris, M. Modifications in service delivery and clinical treatment for women diagnosed with severe mental illness who are also the survivors of sexual abuse trauma. *Journal of Mental Health Administration* 21:397–406, 1994.

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Harris, M., ed. *Sexual Abuse in the Lives of Women Diagnosed with Severe Mental Illness*. Newark, NJ: Harwood Academic Publishers, 1997.

Harris, M., and the Community Connections Trauma Work Group. *Trauma Recovery and Empowerment: A Guide for Clinicians Working with Women in Groups*. New York: The Free Press, 1998.

Harris, M., and Fallot, R.D., eds. *Using Trauma Theory to Design Service Systems.* New Directions for Mental Health Services Series. San Francisco: Jossey-Bass, 2001.

The Dual Assessment and Recovery Track (DART)

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Description of intervention

Consistent with findings from the literature, the Dual Assessment and Recovery Track (DART) uses the conceptual framework, structure, and principles of TC treatment found effective for clients with co-occurring substance abuse and mental disorders (e.g., fostering personal responsibility and self-help to cope with life difficulties, use of the peer community as the healing agent and as an essential support for attaining and sustaining recovery, and promoting a change in lifestyle) and (1) adds critical COD interventions ("Understanding the Inter-relationship of Mental Health and Substance Abuse Issues," "Trauma-Informed Addictions Treatment"), (2) builds case management skills to help clients obtain appropriate services, and (3) improves comorbidity assessment and treatment planning to improve service delivery for individuals with COD in outpatient substance abuse treatment settings.

Staffing

DART is provided as a special treatment track within an Intensive Outpatient Program (IOP) that the clients attend 3 days a week for 5 hours per day; the IOP is part of a community-based substance abuse treatment program. One counselor, trained and experienced in providing treatment services for individuals with co-occurring disorders, provides the DART interventions that are incorporated within the standard IOP treatment program. The DART counselor reports to the IOP Program Supervisor. The DART counselor provides the two specialized weekly treatment groups (cited above) as well as individual case management services for 25 clients.

Setting

Gaudenzia, Inc. is a private, not-for-profit agency that was incorporated in Pennsylvania in 1968 to provide treatment, prevention, and other services to those with substance abuse treatment needs. Gaudenzia employs 350 people, operating 34 programs at 20 facilities, to provide residential services, traditional outpatient services (e.g., counseling, outreach), and intensive outpatient services. Target groups include adults, women with children, the homeless, people who are HIV/AIDS symptomatic, and those with co-occurring disorders.

The program is located in downtown Philadelphia on two floors of a recently renovated 8-story facility that houses the outpatient treatment program, administrative offices, and several specialized residential treatment programs.

Client characteristics

The DART program is designed to serve men and women who abuse substances and who have co-occurring mental disorders. The clients are primarily minority (75 percent African American; 12 percent Hispanic) adults, unmarried (71 percent) with an average age of 35. They are undereducated (on average, 11 years of education), unemployed (25 percent were employed in the last year), and 48 percent are on probation or parole. Cocaine is the major drug of choice (50 percent of the clients), followed by cannabis (32 percent). Eighty-three percent of clients report depression at some time; 24 percent have attempted suicide. Female clients report a high incidence of physical (76 percent) and sexual abuse (44 percent).

Resources needed for implementation

Training. The treatment program is best implemented by a substance abuse counselor trained and experienced in providing interventions for individuals with COD. Additionally, since DART is operated as a specialized treatment track within a standard outpatient treatment program, staff cross-training plays a key role in strengthening the dual diagnosis orientation of DART. Monthly training seminars were conducted to prepare staff for implementing DART. The cross-training curriculum included formal didactic training and technical assistance in program modification for co-occurring disorders.

Stakeholder Participation. The following principles were utilized to facilitate participation by key administrative and program staff: program planning and modification for COD are conducted within agency and system guidelines; all key stakeholders are involved in planning for implementation; and a collaborative relationship is fostered between administrative, service, and training staff.

Empirical data

The DART program is currently being evaluated for program effectiveness, costs, and cost-effectiveness. The examination of effectiveness compares DART with the standard substance abuse outpatient program.

Clients with COD are randomly assigned to either the DART program model, with enhanced interventions for individuals with COD, or to the standard outpatient substance abuse program. The study employs both GAIN M90 scales recommended by CSAT to assess client outcomes across several critical domains (Substance Use, Physical Health, Mental and Emotional Health, Environment and Living Situation, Legal, and Vocational), and two main standardized psychological scales—Brief Symptom Inventory, and Beck Depression Inventory-II (Beck et al. 1996)—to assess outcomes related to psychological, as well as other areas, of client functioning. Findings from the evaluation of this program will be applicable to both TC and non-TC agencies, thereby increasing the impact of the model.

Evaluation of a Treatment Model for Co-Occurring Addictive Treatment Stress Disorder

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Description of intervention

This eight-session TARGET model integrates cognitive–behavioral, motivational enhancement, relational/emotional focuses, and relapse prevention principles and procedures for trauma recovery and substance abuse recovery. It provides an alternative to exposure-based treatment for posttraumatic stress disorder that is based on recent research and clinical evidence.

Setting

Study participants are recruited from three outpatient substance abuse clinics in Connecticut: the Morris Foundation in Waterbury, the Rushford Center in Middletown, and LMG Inc. in Stamford. These private, non-profit agencies have extensive experience working with persons with co-occurring mental disorders. The Morris Foundation, in addition to outpatient services, operates a therapeutic shelter, a residential substance abuse program, and a women and children's residential program. Clients receive intense outpatient services with group therapy and psychoeducational groups, typically for 4 weeks.

The Rushford Center provides a continuum of progressive, multi-modal inpatient and outpatient treatment programs for adult men and

women. Services include detoxification, residential programs, day and evening partial hospitalization, and a halfway house.

LMG offers outpatient and residential services for men, women, youth, and seniors. Services include detoxification, methadone maintenance, family treatment, and career development.

Patient characteristics

Study participants are adults (age 18 and over) with co-occurring substance use and trauma-related disorders. In order to enter the study, a participant must

1. Have a history of exposure to an event(s) fulfilling the conditions for DSM-IV post-traumatic stress disorder (PTSD) Criterion A psychological trauma.
2. Meet criteria for a substance use disorder.
3. Meet DSM-IV criteria for one of the following: (1) PTSD within the past year; or (2) Disorders of Extreme Stress, Not Otherwise Specified (DESNOS) plus at least one or more DSM-IV Axis I or II disorders including: major depressive disorder, dysthymic disorder, dissociative disorder.

Resources needed for implementation

In addition to the cost of the group clinician and center costs, we needed the following:

- Consultation with trauma expert (first year of implementation)
- Training in model and cultural competence
- Art supplies for creative arts exercises
- Gift incentives for group participation
- Snacks for groups
- Drug test supplies

Only the time of clinicians and related charges are reimbursed by most insurance plans; however, we cannot charge because of Medicare rules regarding research.

Empirical data

This study is still in the field; no findings are available at this time.

Publications

The TARGET manual is now available from the above address.

Homelessness Prevention TC for Addicted Mothers

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Description of the intervention

The program, for mothers and their children, uses TC principles and methods to address the problem of substance abuse, to provide a foundation for a full personal recovery or change, and to furnish an environment within which homelessness prevention interventions occur. The specific homelessness prevention activities include 14 distinctive interventions that address family preservation, work, housing stabilization, and building a supportive community. The mothers progress through program stages and typically move from residential to permanent housing.

Staffing

The residential program is staffed 24 hours a day, 7 days a week, with a combination of supervisors, counselors, and house managers. Three staff members, including at least one supervisor, are present during peak program-

ming hours (9 a.m. to 9 p.m.); two staff members are present overnight. The Director and Clinical Supervisor are available for consultation on an emergency pager system when they are not on-site. The Prevention Specialist provides special parenting skills training groups on weekdays and substance abuse prevention groups for children during the family education activities on Sunday, enriching the staffing at those times. The Transitional program is staffed with one counselor/case manager for approximately 20 individuals. A Prevention Specialist and Child Care Worker staff the Child Care program with the help of two or three mothers who are assigned to participate in the Child Care program each day as part of their parenting training.

Setting

Gaudenzia is a private, not-for-profit TC-oriented agency, incorporated in Pennsylvania in 1968 to provide treatment, prevention and other services to people with substance abuse and related problems. Two of Gaudenzia's 34 programs, New Image in Philadelphia and Kindred House in West Chester, were developed in 1989 (in cooperation with the City of Philadelphia Health Department and the U.S. Public Health Service) as programs to prevent homelessness among those homeless, substance-abusing women who were pregnant and/or who were parenting at least one child. Each mother entering the program is allowed to bring up to two of her dependent children with her.

Both program sites share similar physical design elements, including: bedroom space occupied by two or three mothers and their young children; gender-specific dormitory bedrooms shared by up to four older children; communal dining and recreational space; infant and pre-school nursery/day care space; group meeting rooms and office space for administrative work, and individual counseling.

Client characteristics

The program is for homeless substance-abusing mothers (most with COD) and their children. The clients can be characterized as predominantly minorities (80 percent), average age 33, never married (66 percent), from broken homes (71 percent) and with less than a high school education (53 percent). The women reported three children on average, with only one child having primary residence with the mother at baseline. The women show a history of drug use (97 percent), arrest (76 percent), homelessness 62 percent), and moderate levels of psychological symptoms, as indicated by average Beck Depression Inventory (BDI) scores of 17.69 (SD=10.2) and average Symptom Check-List 90-Revised Global Severity Index (SCL 90-R) scores of 65.07 (SD=10.27).

Resources needed for implementation

Follow six principles for successful program implementation.

1. Work within the guidelines of agency and system.
2. Involve stakeholders in the project.
3. Use a strategic program planning approach and involve all key staff in program planning and refinement.
4. Employ active training and technical assistance during the refinement and implementation of new elements.
5. Review program fidelity periodically.
6. Develop ownership and a firm collaborative relationship among service, training, and evaluation staff.

Empirical data

This women's therapeutic community enhanced with programming focused on the prevention of homelessness was evaluated using a quasi-experimental design. Propensity analysis was used to select a subgroup in which the Experimental (E) and Comparison (C) participants were comparable. At the domain level, statistically significant

relative improvement for the E group was found in psychological dysfunction and health. In the former domain, significant improvement was found on two standard psychological inventories measuring symptoms, for example, depression. In the latter domain, significant improvements included ratings of the women's health and adherence to medication regimens. No significant difference was found at the domain levels of family preservation and housing stabilization, but the results were mixed over specific outcomes in each; e.g., mothers in the E group showed better outcomes on the number of children residing with the mother and the number of children for whom the mother assumes financial responsibility. These results show the feasibility of extending the range and applicability of the TC model to address the specific problems of homeless mothers with COD and their children.

Publications

Sacks, J.Y., Sacks, S., Harle, M., and De Leon, G. Homelessness prevention therapeutic community (TC) for addicted mothers. In: Conrad, K.J., Matters, M.D., Hanrahan, P., and Luchins, D.J. (eds). Homelessness prevention in treatment of substance abuse and mental illness: Logic models and implementation of eight American projects. *Alcoholism Treatment Quarterly* 17(1/2):33–51, 1999.

Sacks, S., Sacks, J.Y., Bernhardt, A.I., Harle, M., and De Leon, G. Homelessness Prevention TC for Addicted Mothers: A Program Manual. Center for Mental Health Services (CMHS)/Center for Substance Abuse Treatment (CSAT), Rockville, MD, GFA SM 96-01, CFDA #93.230—Grant #1 UD9 SM51969-01. New York, NY: NDRI/CTCR, 1997.

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Improving Services for Substance Abusers With Comorbid Depression

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Description of intervention

The overall goal of the study is to document the effectiveness of a program to increase the identification of depression among people who abuse substances and to improve the treatment services offered to people with these complex co-occurring conditions. This goal is being addressed by conducting in-person psychiatric assessments on 500 consecutive adult admissions to the Chestnut Health Systems substance abuse treatment programs in Madison County, MO, using the Diagnostic Interview Schedule IV (DIS).

Setting

The program is located in rural Madison County, MO. Illinois Chestnut Health System is a community mental health agency.

Client characteristics

The populations are diverse—probation/parole, Department of Family Services, Department of Corrections, and public and private programs. This is primarily a population with substance use disorders, and 27 percent are currently diagnosed with depression.

Resources needed for implementation

Chestnut Health System is self-supportive through grants and State funding. Most barriers have been overcome by the staff from Washington University working closely with the Chestnut staff to solve problems on a weekly basis.

Empirical data

Outcome measures have not been evaluated as there is a 6-month and 12-month followup. Currently only baseline data are available, which do not lead to outcome measures.

Publications

Compton, W. Improving treatment services for substance abusers with comorbid depression. *Journal of Substance Abuse Treatment*, 2001.

Multi-Disciplinary Mental Health and Substance Abuse Treatment

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Description of intervention

Multi-disciplinary mental health and substance abuse treatment team with case management to coordinate HIV/AIDS primary care and other services. Study participants randomly assigned to integrated services or care-as-usual, which consists of limited availability of mental health and substance abuse services, and case management. To date, 159 individuals are enrolled in the study. Results are not yet available.

Setting

Community-based integrated mental health, substance abuse, and case management services provider.

Client characteristics

Multiply diagnosed individuals recruited from metropolitan area, Ryan White-funded case management providers.

Resources needed for implementation

Keys to successful implementation include (1) steering committee of target populations, Ryan White program staff, and other service providers; (2) assertive community treatment team that coordinates care of triple-diagnosed clients.

Orange County Needs-Based Treatment Intervention for Mothers' Engagement (ON TIME) Project

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Description of intervention

The ON TIME project, a partnership of researchers and public and private agencies, is designed to address the need for timely intervention with women affected by substance abuse and child welfare. The goals of the project are: (1) to assess the ability of alcohol and other drug (AOD) and social service systems to respond to the new timelines of the Adoption

and Safe Families Act (ASFA) among women who need AOD treatment; (2) to test the effectiveness of outreach, intervention, engagement, and re-engagement strategies with women who abuse substances under ASFA; and (3) to measure four primary outcomes: decrease substance use, increase treatment compliance, increase family stability, and increase participation in employment activities. This intervention is provided by outreach Recovery Mentors who are extensively trained in Motivational Enhancement Therapy and have personal experience in recovery and social service systems.

Setting

The ON TIME project is a county-wide program serving women in Orange County, California. The project is a collaboration among organizations in the county that serve in the best interests of children and their families. Orangewood Children's Foundation is the grantee, providing administrative support to the project through its role as a community leader on children's issues. Children and Family Futures is a non-profit organization that offers strategic planning and evaluation to local and State entities that provide services to children whose parents have substance abuse issues. Southern California Alcohol and Drug Programs run several substance abuse treatment agencies in surrounding areas and employ the Recovery Mentors. Finally, UCLA Drug Abuse Research Center provides the analysis of data involving follow-up interviews. These agencies work in collaboration with Children and Family Services, the county child welfare organization. The Recovery Mentors are outstationed at the dependency court. They provide Motivational Enhancement Therapy and serve as liaisons to treatment providers in the community.

Client characteristics

Women over the age of 18 are eligible for the project if they have substance abuse allegations in the dependency court petition. These women have a multitude of issues co-occurring with substance use such as mental health issues, domestic violence involvement, criminal backgrounds, and welfare and employment issues.

Resources needed for implementation

The key to implementation for ON TIME was the need for a communication protocol among partner agencies. Due to confidentiality[1] concerns, as well as the research protocol involving human subjects, clients sign a consent form for participation and to allow communication between social services, attorney groups, and the ON TIME project staff. The Recovery Mentors were extensively trained in Motivational Enhancement Therapy techniques, the Addiction Severity Index, ASAM Patient Placement Criteria, and other tools for intervention. Resources required for implementation include the curriculum and training materials for these tools as well as purchase of the tools themselves. It was essential in the recruitment of Recovery Mentors that they reflect the cultural diversity of the community. One of the mentors is bilingual in Spanish, reflecting the 50 percent Hispanic/Latino population in the county, and all four mentors are women in recovery from addiction.

Empirical data

Preliminary findings include: significantly fewer ON TIME mothers had positive urine toxicology tests between the Detention Hearing and the 21-day hearing than the comparison group of mothers who did not receive these services; a higher percentage of ON TIME women entered treatment prior to their 6-month

[1]Confidentiality is governed by the Federal "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations (42 CFR Part 2) and the federal "Standards for Privacy of Individually Identifiable Health Information" (45 CFR Parts 160 and 164).

review than the comparison group. Among current ON TIME clients, they significantly increased their readiness to make lifestyle changes in the first 3 weeks of participation; 86 percent and 82 percent of the clients had follow-up interviews at 3 and 9 months; mothers reported a significant decrease in illicit substance use and alcohol consumption at the 3- and 9-month interviews; and the ASI scores significantly decreased between baseline and 9-month interviews in all areas except employment.

Project SPIRIT: Seeking the Pathways Into Recovering Integrated Treatment

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Description of intervention

Project SPIRIT is an evaluation study designed to document and demonstrate the effectiveness of integrated treatment approaches for treating persons with co-occurring substance abuse and mental health problems. Study participants are naturalistically or quasi-randomly assigned to one of six treatment agencies depending on the recruitment source. Study participants are currently being recruited from central locations (i.e., family health clinic, detoxification agency) that subsequently refer these individuals to treatment and directly from the participating treatment agencies themselves. Each participating agency has been categorized as an integrated treatment program, a COD track program, or a nonspecialized program based on preliminary process information collected from each site.

Setting

The agencies involved in the study are all located in the Portland (Oregon) metropolitan area. They range from a small SA/MH treatment service-only agency to a large, multi-program social service agency dedicated to meeting the array of needs of the city's most indigent, disadvantaged individuals.

Patient characteristics

All potential study clients are screened using the Millon Clinical Multiaxial Inventory III (MCMI). Client eligibility is defined as having a clinically diagnosed alcohol or drug dependence or addiction treatment determined by a certified clinician and a suspected Axis I or Axis II mental health program detected by MCMI. The agencies range from 50 percent to 77 percent of their COD clients evidencing Axis I severe clinical syndromes.

Resources needed for implementation

MH services are covered in a managed care system that differs from the managed care system that governs substance abuse services. This poses serious obstacles to providers trying to treat individuals with co-occurring SA and MH disorders.

Empirical data

Baseline data collection is complete. Documentation of the three treatment approaches is ongoing and includes provider surveys, provider interviews, client focus groups, and document reviews. The baseline sample size is N=280, split among the three models under study: Integration (n=109), serial/parallel (n=98), and no MH services (n=73). As of September 1, 2002, the 6-month follow-up response rate is approximately 86 percent.

Publications

A progress report on Project SPIRIT activities will include the evolution of the client recruitment strategy to include multiple sources, modifications to the original study design and analysis plan, a detailed description of the screening process, current description of the study population, experiences working with health clinic physicians, and preliminary results from the provider survey. Current project reports include a Study Methods Report, detailing the design and instrumentation of the study; and a Baseline Report, characterizing the sample in terms of their demographics, treatment history, alcohol and drug use, MH symptomatology, and criminal justice history.

The Rural HIV/AIDS, Substance Abuse, Mental Health Outcomes Study

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Description of intervention

Twelve months of intensive outpatient mental health and substance abuse counseling in conjunction with rural case manager contracts and transportation services to promote treatment adherence. Subgroups of study participants compared across time; care-as-usual for those who do not engage in intervention services consists of the limited amount of counseling available at the HIV/AIDS clinics.

Setting

Two integrated outpatient mental health and substance abuse service providers linked to nearby HIV/AIDS primary care clinics. One is based in Durham, NC (The Duke Addictions Program), the other in Fayetteville, NC (county mental health agency).

Client characteristics

Multiply diagnosed individuals from rural counties who receive care from one of the HIV/AIDS clinics.

Resources needed for implementation

This model program receives funding from NIDA, SAMHSA, HRSA, NIMH, and NIAAA. All of our staff have experience in a variety of settings in points of diverse backgrounds. Our main barrier is transportation costs, which are continually being addressed by various AIDS-related service agencies. The addition of a recruitment and retention specialist who follows up on contacts has greatly increased the retention rate.

Trauma Adaptive Recovery Group Education and Therapy for Addiction Recovery (TARGET-AR)

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Description of intervention

This nine-session model integrates neurobiological, developmental, cognitive–behavioral, motivational enhancement, relational/emotion focuses, and relapse prevention principles and procedures for trauma recovery and substance abuse recovery. It provides an alternative to exposure-based treatment for PTSD that is based on recent research and clinical evidence. Participants learn a structured set of skills for managing traumatic stress symptoms in their current life, described by the acronym "FREEDOM" (Focusing to reduce anxiety and increase mental alertness; Recognizing specific stress triggers; identifying primary Emotions; Evaluating primary thoughts/self-statements; Defining an organizing personal goal; identifying one Option that represents a successful step toward that goal that the individual actually accomplished during a current stressful experience; recognizing how that option had the added benefit of Making a contribution), by reflecting the person's core values and making a difference in others' lives. The model assists participants in understanding the effects of trauma on the body, emotions, mind, relationships, and spirituality, and in using the FREEDOM skills to manage current stressors in ways that enable the person to shift away from "survival" coping to productive living. Participants are encouraged to focus on dealing with the impact that trauma experiences have had on their current lives rather than recounting detailed trauma memories, and the FREEDOM skills are used as a way to enable participants to examine trauma memories in a contained manner—and only if the participant feels that this would be helpful in dealing with current stressors. Most participants choose to examine trauma memories using the FREEDOM skills with an individual counselor rather than in the group, or in order to share a specific limited aspect of a key trauma memory in the group.

The TARGET model has the following theoretical/clinical base: Recovery from trauma is possible when a person is able to shift from living in "survival" mode to focusing on personal growth and effectiveness in intimate, family, friendship, and work relationships. Recovery is not based on "getting through" or becoming "desensitized" to trauma memories, but on having access to a support system and a way of making fully informed life decisions that fundamentally shift a person's bodily processes and mindset from surviving trauma to personal growth and development. Recovery is unique for each gender and each individual, but always involves three basic changes that occur gradually: isolation, betrayal, and abandonment, gradually changing to trust, mutuality, and engagement within safe, reliable, and emotionally sustaining relationships. Terror, hypervigilance, dissociation, and powerlessness gradually change to a realistic sense of personal effectiveness with a clear focus on immediate emotions, thoughts, and goals in each experience. Emotional numbing, spiritual alienation, and hopelessness gradually shift to involvement, self-esteem, faith, and hope as the person becomes able to recognize how she or he actually is living according to her or his true values and making a unique contribution to the safety and well-being of other people.

Setting

Study participants are recruited from three outpatient substance abuse clinics: the Morris Foundation in Waterbury, and The Connection and Rushford Center in Middletown. These private, non-profit agencies have extensive experience working with persons with co-occurring mental disorders. The Morris Foundation, in addition to outpatient services, operates a therapeutic shelter, a residential substance abuse program, and a women and children's residential program. Clients receive intense outpatient services with group therapy and psychoeducational groups, typically for 4 weeks.

The Rushford Center provides a continuum of progressive, multi-modal inpatient and outpatient treatment programs for adult men and women. Services include detoxification, residential programs, day and evening partial hospitalization, and a halfway house.

The Connection is a statewide agency operating over 30 separate programs. It offers assistance with a wide variety of behavioral and social problems, including homelessness, sex offenses, problem gambling, HIV-related needs, child abuse/neglect, and substance abuse.

Client characteristics

Study participants are adults (age 18 and over) with co-occurring substance use and trauma-related disorders. In order to enter the study, a participant must:

- Have a history of exposure to an event(s) fulfilling the conditions for DSM-IV PTSD Criterion A psychological trauma.
- Meet criteria for a substance use disorder.
- Meet DSM-IV criteria for one of the following: (1) PTSD within the past year, or (2) Disorders of Extreme Stress, Not Otherwise Specified plus at least one or more DSM-IV Axis I or II disorders including major depressive disorder, dysthymic disorder, and dissociative disorder.

Resources needed for implementation

In addition to the cost of the group clinician and center costs, the following were needed:

- Consultation with trauma expert (weekly during first year of implementation)
- Training in model and cultural competence
- Art supplies for creative arts exercises
- Incentives for group participation
- Snacks for groups
- Drug test supplies

Only the time of clinicians and related charges are reimbursed by most insurance plans; however, Medicare rules regarding research prevents the program from charging clients.

Empirical data

TARGET-RMI is in the second phase of a qualitative evaluation at Capitol Region Mental Health Center, with groups ongoing for hearing-impaired women, hearing women, hearing-impaired men, and hearing men. Between March and June 2002, three additional community mental health centers and one additional addiction agency received training and began 1 year of clinical pilot work in preparation for a multi-site controlled trial in the mental health sector to complement and extend the 3-year randomized controlled trial (separate men's and women's groups). The three addiction agencies now underway are under the auspices of the Co-Occurring Disorders study. Both versions of TARGET are being pilot tested by clinicians in Holland who were trained (April 2000) by Dr. Ford; a controlled clinical trial is scheduled to begin later this year.

Publications

The TARGET manual will be available soon; it is currently being modified. It is being translated into Spanish and has been translated into Dutch.

Programs

Following is a full listing of programs that were asked to provide more information for this appendix. The models described in this appendix came from the responses that were received.

- Orange County Needs-Based Treatment Intervention for Mothers' Engagement (ON TIME) Project
- Access to Medical and Substance Abuse Treatment in the Setting of Prescribing Syringes to Active Injection Drug Users
- Case Management for Rural Substance Abuse
- Improving Services for Substance Abusers With Comorbid Depression
- Rural HIV/AIDS, Substance Abuse, Mental Health Outcomes Study

- Multi-Disciplinary Mental Health and Substance Abuse Treatment
- Trauma Adaptive Recovery Group Education and Therapy for Addiction Recovery (TARGET-AR)
- Managing Co-Occurring Disorders in an Opioid Agonist Setting
- College Drinking
- Outreach-Assisted Case Management: A Model for HIV and STD Prevention
- Linkages of Primary Care Patients to Substance Abuse Treatment
- Evaluation of ADMIRE Plus Program for Co-Occurring Disorders
- Evaluation of a Treatment Model for Co-Occurring Addictive and Traumatic Stress Disorders
- Managing Co-Occurring Disorders in Methadone Clinics
- Increasing Substance Abuse Treatment Compliance for Persons With Traumatic Brain Injury
- Project SPIRIT: Seeking Pathways Into Receiving Integrated Treatment
- Dual Assessment and Recovery Track (DART)
- Facilitating Substance Abuse Treatment for HIV Patients
- Linking Female Sex Workers to Substance Abuse Treatment
- Multiple Diagnoses Cost Study and Intervention Study
- Project to Reduce Overutilization of Detoxification services (PROUD)
- Integrated Service Agency (ISA) Home Visit Family Intervention Model
- Boley Homelessness Prevention Project
- Gaudenzia
- The Housing Continuum
- Representative Payee-Money Management Program
- Consumer Preference Independent Living (CPIL)
- Project HOME (Housing, Opportunities, Medical care, and Education)

Appendix F: Common Medications for Disorders

This appendix contains the Pharmacological Management section from TIP 9, *Assessment and Treatment of Clients With Coexisting Mental Illness and Alcohol and Other Drug Abuse* (Center for Substance Abuse Treatment 1994*a*, pp. 91–94). This section is followed by an adaptation of the text of *Psychotherapeutic Medications 2004: What Every Counselor Should Know*, a publication of the Mid-America Addiction Technology Transfer Center. Many of the terms are highly technical; however, to define them is beyond the scope of the TIP. The counselor can understand the fundamental information contained in each section without knowing the definition of every term. This appendix provides the counselor with a handy reference on various psychotropic medications and their use.

Pharmacologic Risk Factors

Addiction is not a fixed and rigid event. Like mental disorders, addiction is a dynamic process, with fluctuations in severity, rate of progression, and symptom manifestation and with differences in the speed of onset. Both disorders are greatly influenced by several factors, including genetic susceptibility, environment, and pharmacologic influences. Certain people have a high risk for these disorders (genetic risk); some situations can evoke or help to sustain these disorders (environmental risk); and some drugs are more likely than others to cause psychiatric or substance use disorder problems (pharmacologic risk).

Pharmacologic effects can be therapeutic or detrimental. Medication often produces both effects. Therapeutic pharmacologic effects include the indicated purposes and desired outcomes of taking prescribed medications, such as a decrease in the frequency and severity of episodes of depression produced by antidepressants.

Detrimental pharmacologic effects include unwanted side effects such as dry mouth or constipation resulting from antidepressant use. Side effects

perceived as noxious by clients may decrease their compliance with taking the medications as directed.

Some detrimental pharmacologic effects relate to abuse and addiction potential. For example, some medications may be stimulating, sedating, or euphorigenic and may promote physical dependence and tolerance. These effects can promote the use of medication for longer periods and at higher doses than prescribed.

Thus, prescribing medication involves striking a balance between therapeutic and detrimental pharmacologic effects. For instance, therapeutic antianxiety effects of the benzodiazepines are balanced against detrimental pharmacologic effects of sedation and physical dependency. Similarly, the desired therapeutic effect of abstinence from alcohol is balanced by the possibility of damage to the liver from prescribed disulfiram (Antabuse).

Side effects of prescription medications vary greatly and include detrimental pharmacologic effects that may promote abuse or addiction. With regard to clients with co-occurring disorders, special attention should be given to detrimental effects, in terms of (1) medication compliance, (2) abuse and addiction potential, (3) substance use disorder relapse, and (4) psychiatric disorder relapse (Ries 1993).

Psychoactive Potential

Not all psychiatric medications are psychoactive. The term *psychoactive* describes the ability of certain medications, drugs, and other substances to cause acute psychomotor effects and a relatively rapid change in mood or thought. Changes in mood include stimulation, sedation, and euphoria. Thought changes can include a disordering of thought such as delusions, hallucinations, and illusions. Behavioral changes can include an acceleration or retardation of motor activity. All drugs of abuse are by definition psychoactive.

In contrast, certain nonpsychoactive medications such as lithium (Eskalith) can, over time, normalize the abnormal mood and behavior of clients with bipolar disorder. Because these effects take several days or weeks to occur, and do not involve acute mood alteration, it is not accurate to describe these drugs as psychoactive, euphorigenic, or mood altering. Rather, they might be described as *mood regulators.* Similarly, some drugs, such as antipsychotic medications, cause normalization of thinking processes but do not cause acute mood alteration or euphoria.

However, some antidepressant and antipsychotic medications have pharmacologic side effects such as mild sedation or mild stimulation. Indeed, the side effects of these medications can be used clinically. Physicians can use a mildly sedating antidepressant medication for clients with depression and insomnia, or a mildly stimulating antipsychotic medication for clients with psychosis and hypersomnia or lethargy (Davis and Goldman 1992). While the side effects of these drugs include a mild effect on mood, they are not euphorigenic. Nevertheless, case reports of misuse of nonpsychoactive medications have been noted, and use should be monitored carefully in clients with co-occurring disorders.

While psychoactive drugs are generally considered to have high risk for abuse and addiction, mood-regulating drugs are not. A few other medications exert a mild psychoactive effect without having addiction potential. For example, the older antihistamines such as doxylamine (Unisom) exert mild sedative effects, but not euphoric effects.

Reinforcement Potential

Some drugs promote *reinforcement*, or the increased likelihood of repeated use. Reinforcement can occur by either the removal of negative symptoms or conditions or the amplification of positive symptoms or states. For example, self-medication that delays or prevents an unpleasant event (such as withdrawal) from occurring becomes reinforcing. Thus, using a benzodiazepine to avoid alcohol withdrawal can increase the likelihood of continued use. *Positive reinforcement* involves

strengthening the possibility that a certain behavior will be repeated through reward and satisfaction, as with drug-induced euphoria or drug-induced feelings of well-being. A classic example is the pleasure derived from moderate to high doses of opioids or stimulants. Drugs that are immediately reinforcing are more likely to lead to psychiatric or substance use problems.

Tolerance and Withdrawal Potential

Long-term or chronic use of certain medications can cause tolerance to the subjective and therapeutic effects and prompt dosage increases to recreate the desired effects. In addition, many drugs cause a well-defined withdrawal phenomenon after the cessation of chronic use. Clients' attempts to avoid withdrawal syndromes often lead them to additional drug use. Thus, drugs that promote tolerance and withdrawal generally have higher risks for abuse and addiction.

A Stepwise Treatment Model

As can be seen, there are pharmacologic as well as hereditary and environmental factors that influence the development of substance use disorders. All of these factors should be considered before prescribing medication, especially when the client is at high risk for developing a substance use disorder. High-risk clients include people with both psychiatric and substance use disorders, as well as clients with a psychiatric disorder and a family history of substance use disorders.

One aspect of this issue relates to the pharmacologic profile of certain medications that are used in the treatment of specific psychiatric disorders. For instance, many medications used to treat symptoms of depression and psychosis are not psychoactive or euphorigenic. However, many of the medications used to treat symptoms of anxiety, such as the benzodiazepines, are psychoactive, reinforcing, have potential for tolerance and withdrawal, and have an abuse potential, especially among people who are at high risk for substance use disorders. Other antianxiety medications, such as buspirone (BuSpar), are not psychoactive or reinforcing and have low abuse potential, even among people at high risk.

Thus, decisions about whether and when to prescribe medication to a high-risk client should include a risk-benefit analysis that considers the risk of medication abuse, the risk of undertreating a psychiatric problem, the type and severity of the psychiatric problem, the relationship between the psychiatric disorder and the substance use disorder for the individual client, and the therapeutic benefits of resolving the psychiatric and substance abuse problems.

For example, the early and aggressive medication of high-risk clients who have severe presentations of psychotic depression, mania, and schizophrenia is often necessary to prevent further psychiatric deterioration and possible death. For these clients, rapid and aggressive medication can shorten the length of the psychiatric episodes. In contrast, prescribing benzodiazepines to high-risk clients with similarly severe anxiety involves a substantial risk of promoting or exacerbating a substance use disorder. For these high-risk clients, the use of psychoactive medication should not be the first line of treatment. Rather, for some high-risk clients, treatment efforts should involve a stepwise treatment model that begins with conservative approaches and progressively becomes more aggressive if the treatment goals are not met (Landry et al. 1991*a*). For example, the stepwise treatment model for treating high-risk clients with anxiety disorders may involve three progressive levels of treatment: (1) nonpharmacologic approaches when possible; (2) nonpsychoactive medication when nonpharmacologic approaches are insufficient; and (3) psychoactive medications when other treatment approaches provide limited or no relief (Landry et al. 1991*a*).

Nonpharmacologic Approaches

Depending on the psychiatric disorders and personal variables, numerous nonpharmacologic approaches can help clients manage all or some aspects of their psychiatric disorders. Examples include psychotherapy, cognitive therapy, behavioral therapy, relaxation skills, meditation, biofeedback, acupuncture, hypnotherapy, self-help groups, support groups, exercise, and education.

Nonpsychoactive Pharmacotherapy

Some medications are not psychoactive and do not cause acute psychomotor effects or euphoria. Some medications do not cause psychoactive or psychomotor effects at therapeutic doses but may exert limited psychoactive effects at high doses (often not euphoria, but sometimes dysphoria).

For practical purposes, all of these medications can be described as nonpsychoactive, since the psychoactive effect is not prominent. Medications used in psychiatry that are not euphorigenic or significantly psychoactive include but are not limited to the azapirones (for example, buspirone), the amino acids, beta-blockers, antidepressants, monoamine oxidase inhibitors, antipsychotics, lithium, antihistamines, anticonvulsants, and anticholinergic medications.

Psychoactive Pharmacotherapy

Some medications can cause significant and acute alterations in psychomotor, emotional, and mental activity at therapeutic doses. At higher doses, and for some clients, some of these medications can also cause euphoric reactions. Medications that are potentially psychoactive include opioids, stimulants, benzodiazepines, barbiturates, and other sedative-hypnotics.

Stepwise Treatment Principles

One of the emphases of stepwise treatment is to encourage nondrug treatment strategies for each emerging symptom before medications are prescribed. Nondrug treatment strategies alone are inappropriate for acute and severe symptoms of schizophrenia and mood disorders, but nondrug strategies do have their place in the treatment of virtually any psychiatric problem and may provide partial or total relief of some symptoms related to severe psychiatric disorders. For example, relaxation therapy can minimize or eliminate somatic symptoms of anxiety that may accompany an agitated depression.

A second emphasis of stepwise treatment is to encourage the use of medications that have a low abuse potential. This conservative approach must be balanced against other therapeutic and safety considerations in acute and severe conditions, such as psychosis or mania. On the other hand, a conservative approach is not the same as undermedication of psychiatric problems. Undermedication often leads to psychiatric deterioration and may promote substance abuse relapse. There should be a balance between effective treatment and safety.

A third emphasis of stepwise treatment is to encourage the idea that different treatment approaches should be viewed as complementary, not competitive. For example, if psychotherapy or group therapy does not provide complete relief from a situational depression (such as prolonged grief), then antidepressants should be considered as an adjunct to the psychotherapy, but not as a substitute for psychotherapy.

In practice, treatment providers often use a combination of drug and nondrug strategies. This practice includes medication to treat the acute manifestations of the disorder while the individual learns long-term management strategies. For example, an individual may be prescribed nonpsychoactive buspirone to reduce anxiety symptoms while learning stress reduction techniques and attending group therapy.

These guidelines are broad, general, and more applicable to chronic than to acute psychiatric problems. Also, these guidelines have limited application to severe psychiatric problems.

Psychotherapeutic Medications 2004: What Every Counselor Should Know

Following is the text of Psychotherapeutic Medications 2004: What Every Counselor Should Know, a publication of the Mid-America Addiction Technology Transfer Center (MATTC), which was adapted for this TIP. This brochure is updated annually and is available via the MATTC Web site at www.mattc.org. The brochure addresses the following areas:

- Antipsychotics/Neuroleptics
- Antimanic Medications
- Antidepressant Medications
- Antianxiety Medications
- Stimulant Medications
- Narcotic and Opioid Analgesics
- Antiparkinsonian Medications
- Hypnotics
- Addiction Treatment Medications

For physicians desiring a more in-depth discussion regarding the challenges of treating specific population groups with substance use disorders (e.g., homeless, older adults, people with HIV/AIDS or hepatitis, pregnant or nursing women, etc.), which includes medication compliance, adverse drug interactions, and relapse with the use of potentially addictive medications, readers are referred to the current edition of the American Society of Addiction Medicine's (ASAM's) *Principles of Addiction Medicine*, Third Edition (ASAM 2003).

Tips For Communicating With Physicians About Clients and Medication

Send a written report

The goal is to get your concerns included in the client's medical record. When information is in a medical record, it is more likely to be acted on. Records of phone calls and letters are rarely placed in the chart (readers may go to www.mattc.org to download a sample form).

Make it look like a report—and be brief

Include date of report, client name, and Social Security Number. Most medical consultation reports are one page. Longer reports are less likely to be read. Include and prominently label sections:

- Presenting Problem
- Assessment
- Treatment and Progress
- Recommendations and Questions

Keep the tone neutral

Provide details about the client's use or abuse of prescription medications. Avoid making direct recommendations about prescribed medications. Allow the physician to draw his or her own conclusions. This will enhance your alliance with the physician and makes it more likely he or she will act on your input.

Talking with clients about their medication

Untreated psychiatric problems are a common cause for treatment failure in substance abuse treatment programs. Supporting clients with mental illness in continuing to take their psychiatric medications can significantly improve substance abuse treatment outcomes.

Getting started

Take 5–10 minutes every few sessions to go over these topics with your clients:

- Remind them that taking care of their mental health will help prevent relapse.
- Ask how their psychiatric medication is helpful.
- Acknowledge that taking a pill every day is a hassle.
- Acknowledge that everybody on medication misses taking it sometimes.
- Do not ask if they have missed any doses, rather ask, "How many doses have you missed?"
- Ask if they felt or acted different on days when they missed their medication.
- Was missing the medication related to any substance use relapse?
- Without judgment, ask "Why did you miss the medication? Did you forget, or did you choose not to take it at that time?"

For clients who forgot, ask them to consider the following strategies

- Keep medication where it cannot be missed: with the TV remote control, near the refrigerator, or taped to the handle of a toothbrush. Everyone has two or three things they do everyday without fail. Put the medication in a place where it cannot be avoided when doing that activity, but always away from children.
- Suggest they use an alarm clock set for the time of day they should take their medication. Reset the alarm as needed.

For clients who admit to choosing not to take their medication

- Acknowledge they have a right to choose NOT to use any medication.
- Stress that they owe it to themselves to make sure their decision is well thought out. It is an important decision about their personal health.
- Ask their reason for choosing not to take the medication.
- Don't accept "I just don't like pills." Tell them you're sure they wouldn't make such an important decision without having a reason.
- Offer as examples reasons others might choose not to take medication. For instance, they:
  1. Don't believe they ever needed it; never were mentally ill
  2. Don't believe they need it anymore; cured
  3. Don't like the side effects
  4. Fear the medication will harm them
  5. Struggle with objections or ridicule of friends and family members
  6. Feel taking medication means they are not personally in control

Transition to topics other than psychiatric medications

Ask what supports or techniques they use to assist with emotions and behaviors when they choose not to take the medication.

General Approach

The approach when talking with clients about psychiatric medication is exactly the same as when talking about their substance abuse decisions.

- Explore the triggers or cues that led to the undesired behavior (either taking drugs of abuse or not taking prescribed psychiatric medications).
- Review why the undesired behavior seemed like a good idea at the time.
- Review the actual outcome resulting from their choice.
- Ask if their choice got them what they were seeking.
- Strategize with clients what they could do differently in the future.

Note to Practitioners

Name brand medications have a limited patent. When the patent expires the medication may be made as a generic. The generic name of a medication is the ***actual name of the drug and never changes***. Do not be surprised to see a generic drug made by many different manufacturers.

Manufacturers can make many forms of a single drug with only slight variations. Several drugs have been made in an extended release form (CR, controlled release; ER or XR, extended release; and SR, sustained release). Extended release drugs act over a long period of time and do not have to be dosed as often.

A new formulation for drugs is a quick, orally dissolving tablet that can be taken without water. Two patent drugs that have been formulated as quick dissolving tablets are Remeron SolTab and Zyprexa Zydis.

Antipsychotics/Neuroleptics

Generic and brand names

Generic	Brand
Traditional antipsychotics	
chlorpromazine	Thorazine, Largactil
fluphenazine	Prolixin+, Permitil, Anatensol
haloperidol	Haldol
loxapine	Loxitane, Daxolin
mesoridazine	Serentil
molindone	Moban, Lidone
perphenazine	Trilafon, Etrafon
pimozide	Orap
thioridazine	Mellaril
thiothixene	Navane
trifluoperazine	Stelazine
Novel or atypical antipsychotics	
aripiprazole	Abilify
clozapine	Clozaril+
olanzapine	Zyprexa, Zyprexa Zydis
quetiapine	Seroquel*
risperidone	Risperdal
risperidone long-acting injection	Risperdal Consta
ziprasidone	Geodon

+ Can cause a serious side effect in the blood system; must have regular blood tests to monitor potential side effects. Approximately 1 to 2 percent of patients who take clozapine develop a condition called *agranulocytosis,* in which their white blood cell count drops drastically. As a result, the patient is at high risk for infections due to a compromised immune system, and this could be fatal. However, most patients can be treated successfully by stopping clozapine treatment. To maintain safety, white blood cell count must be checked each week for 6 months and every 2 weeks thereafter. The results must be sent to the patient's pharmacy before the patient can pick up the next supply of medication.

* Seroquel is often used for insomnia.

Purpose

Antipsychotics are most typically used for persons who experience psychotic symptoms as a result of having some form of schizophrenia, severe depression, or bipolar illness. They may

be used to treat brief psychotic episodes caused by drugs of abuse or other conditions. Psychotic symptoms may include being out of touch with reality, "hearing voices," and having false perceptions (e.g., thinking you are a famous person, thinking someone is out to hurt you). These medications can be effective in either minimizing or stopping the appearance of these symptoms altogether. In some cases, these medications can shorten the course of the illness or prevent it from happening again.

The newest antipsychotics—risperdone, olanzapine, quetiapine, ziprasidone, and aripiprazole—are showing positive effects across a range of disorders. These medications also seem to have a mood-stabilizing effect and are used for bipolar disorder, as well as being added to antidepressants for severe depressions. Some have been shown to be effective at relieving anxiety in low doses, but this use is not approved by the Food and Drug Administration (FDA).

Usual dose, frequency, and side effects

All drugs have specific doses and frequencies. The physician will specify the exact amount of medication and when it should be taken. How much medicine and how often to take it are specified on the prescription bottle. Many medications are taken once a day, some at bedtime to take advantage of the drowsiness side effect of some antipsychotic medications. Some medications are taken in pill form or liquid form. Other medications are given by injection once or twice per month to ensure that the medication is taken reliably. It is important to take medications on schedule. It is important that patients talk to their doctor so that they know about side effects of medications and what they need to do to monitor their health.

Prolixen, like other medications marked with +, can very rarely cause serious side effects in the blood system called blood dyscrasias (abnormalities or irregularities in the blood cells). Persons taking any medications marked with a + may need to have blood tests on a regular basis to check for these blood disorders. Novel or atypical antipsychotics like Clozaril, Risperdal, Seroquel, and Zyprexa are different from traditional antipsychotics. Novel or atypical antipsychotic medications are more powerful with treatment-resistant schizophrenia but may also be used with severe depression or other psychiatric illness. Because the atypical antipsychotics work in a slightly different way than traditional antipsychotics they are less likely to produce serious side effects, such as tardive dyskinesia or neuroleptic malignant syndrome (NMS). The most common mild side effects are either sedation or agitation, especially when starting the medications. The most worrisome side effects are weight gain and elevated blood sugar and lipids. There is also some evidence that the use of atypical neuroleptics may lead to the development of diabetes mellitus (Sernyak et al. 2002). These issues can be medically worrisome as well as lead to medication noncompliance. Since both the effectiveness and side effect profiles vary across both medications and patients, matching the right medication to the right patient is the key. The older antipsychotics are cheap, and the newer ones expensive. People taking Clozaril must have a blood test every two weeks in order to monitor for a potential side effect, agranulocytosis, which is a serious blood disorder. In general, the newer antipsychotics, when taken in proper dosage, have fewer clinical side effects and a broader treatment response than traditional antipsychotics.

Tardive dyskinesia

- Involuntary movements of the tongue or mouth
- Jerky, purposeless movements of legs, arms, or entire body
- Usually seen with long-term treatment using traditional antipsychotic medications, sometimes seen with atypical antipsychotic medications
- More often seen in women
- Risk increases with age and length of time on the medication

Neuroleptic malignant syndrome

- Blood pressure up and down
- Dazed and confused
- Difficulty breathing
- Muscle stiffness
- Rapid heart rate
- Sweating and shakiness
- Temperature above normal

Diabetes mellitus

- Associated with atypical neuroleptics
- Excessive thirst
- Headaches
- Frequent urination
- Cuts/blemishes heal slowly
- Fatigue

Other

- Blurred vision
- Changes in sexual functioning
- Constipation
- Diminished enthusiasm
- Dizziness
- Drowsiness
- Dry mouth
- Lowered blood pressure
- Muscle rigidity
- Nasal congestion
- Restlessness
- Sensitivity to bright light
- Slowed heart rate
- Slurred speech
- Upset stomach
- Weight gain

Note: Any side effects that bother a person need to be reported to the physician and discussed with him or her.

Anticholinergic/antiparkinsonian medications like Cogentin and Artane may be prescribed in order to control movement difficulties associated with the use of antipsychotic medications.

Abilify is a new antipsychotic released in December 2002. The medication acts as both an enhancer and an inhibitor of dopamine production by "sensing" when there is too little or too much dopamine in the brain. Useful in the treatment of schizophrenia and other psychotic disorders, side effects include headache, anxiety, and insomnia. Risperdal Consta, approved in November 2003, is an injection of microencapsulated medication that releases into the body at a constant level. An injection is usually given every two weeks. Side effects are similar to those for Risperdal.

Emergency conditions

Contact a physician and/or seek emergency medical assistance if the person experiences involuntary muscle movements, painful muscle spasms, difficulty in urinating, eye pain, skin rash, or the symptoms noted under neuroleptic malignant syndrome and tardive dyskinesia.

Cautions

- Doctors and pharmacists should be told about all medications being taken (including dosage), including over-the-counter preparations, vitamins, minerals, and herbal supplements (e.g., St. John's wort, echinacea, ginko, ginseng, etc.).
- People taking antipsychotic drugs should not increase their dose unless this has been *checked with their physician and a change is ordered.*

Special considerations for pregnant women

For women of child-bearing age who may be or think they may be pregnant, the physician should discuss the safety of this medication before starting, continuing, or discontinuing medication treatment. Substance abuse counselors may have a role in encouraging this discussion by suggesting this to their clients.

Antimanic Medications

Generic and brand names

Generic	Brand
Lithium products	
lithium carbonate*	Eskalith, Eskalith CR, Lithane, Lithobid, Lithonate, Lithotabs
lithium citrate*	Cibalith
Anticonvulsant products	
Carbamazepine*	Tegretol
divalproex sodium*	Depakote, Depakote Sprinkle, Depakote ER
gabapentin	Neurontin
lamotrigine	Lamictal
levetiracetam	Keppra+
oxcarbazepine	Trileptal
tiagabine hydrochloride	Gabitril
topiramate	Topamax, Topamax Sprinkle
valproate sodium*	Depakene, Depacon
valproic acid*	Depakene
Other	
olanzapine	Zyprexa, Zyprexa Zydis (see antipsychotics for side effects)
quetiapine fumarate	Seroquel
risperidone	Risperdal
ziprasidone	Geodon

*Needs blood level monitoring

+ Keppra is noted for causing mood changes, primarily depression and anger in some people. This may limit its use as a mood stabilizer.

It is likely that all of the newer atypical antipsychotics mentioned above will soon be FDA approved for mania.

Purpose

Antimanic drugs are used to control the mood swings of bipolar (manic–depressive) illness, leveling mood swings so that the client operates in a moderate mood zone. These medications even out mood swings, which can decrease some of the suicidal and other self-harm behaviors seen with bipolar disorders. Additionally, appropriate treatment with antimanic drugs can reduce a patient's violent outbursts toward others or property. Bipolar illness is characterized by cycling mood changes from severe highs (mania) to severe lows (depression). Cycles of mood may be predominantly manic or depressive with normal moods between cycles. The "highs" and "lows" vary in intensity, frequency, and severity. Mania, if left untreated, may worsen into a psychotic state. The depression may result in thoughts of suicide. Bipolar cycles that occur more often than three times a year are considered "rapid cycling," a condition often found in those people with higher rates of substance abuse. Antimanic medications even out the mood swings so that the person operates in a more moderate zone. By leveling mood swings, some of the suicidal and

other self-harming behaviors seen with bipolar disorder can be decreased.

Usual Dose Frequency and Side Effects

All drugs have specific doses and frequencies. The physician will specify the exact amount of medication and when it should be taken. How much medicine and how often to take it are specified on the prescription bottle. Most medications in this class are given two to four times per day. Some extended release formulations may be given every 12 hours. Dosage is determined by the active amount of the drug found in the person's blood after taking the medication and by his or her response to the medication. Expect a check of monthly blood levels until the person is well established at the optimal dose. The most common side effects to the anticonvulsants are sedation and weight gain. Some anticonvulsants are generic and relatively inexpensive, others are quite expensive. Lithium's most common side effects are tremor, acne, and weight gain. The most common side effects for the atypical antipsychotics are mentioned above in that section.

Potential side effects

- Blurred vision
- Coma*
- Diarrhea*
- Drowsiness
- Fatigue
- Hand tremor*
- Increased thirst and urination*
- Inflammation of the pancreas
- Irregular heart beats
- Kidney damage*
- Liver inflammation (hepatitis)
- Nausea or vomiting
- Problems with the blood (both red and white blood cells)
- Rash and skin changes
- Seizures
- Under- or overactive thyroid*
- Weakness
- Weight gain

* Lithium, anticonvulsants, and atypical antipsychotics only. Effects vary greatly between patients.

Note: People taking lithium may require more fluids than they did before taking lithium. Too much fluid in a person's diet can "wash" the lithium out of his or her system. Too little fluid can allow the lithium to concentrate in the system. Additionally, anything that can decrease sodium in the body (i.e., decreased table salt intake, a low-salt diet, excessive sweating during strenuous exercise, diarrhea, vomiting, etc.) could result in lithium toxicity. People taking any antimanic drugs should have blood levels tested regularly to check the concentration level of the drug in their bodies.

Emergency conditions

Lithium overdose is a life-threatening emergency. Signs of lithium toxicity may include nausea, vomiting, diarrhea, drowsiness, mental dullness, slurred speech, confusion, dizziness, muscle twitching, irregular heartbeat, and blurred vision.

Cautions

- Doctors and pharmacists should be told about all medications being taken (including dosage), including over-the-counter preparations, vitamins, minerals, and herbal supplements (e.g., St. John's wort, echinacea, ginko, ginseng, etc.).
- People taking antimanic drugs should not increase their dose unless this has been ***checked with their physician and a change is ordered***.
- Take medications as ordered and at the prescribed times.
- Persons taking antimanic drugs are particularly vulnerable to adverse medical conse-

quences if they concurrently use alcohol and/or illicit drugs.

- Lithium can cause birth defects in the first 3 months of pregnancy.
- Thyroid function must be monitored if a person takes lithium.
- Heavy sweating or use of products that cause excessive urination (e.g., coffee, tea, some high caffeine sodas, diuretics) can lower the level of lithium in the blood.
- Blood tests for drug levels need to be checked every 1 to 2 months.
- Use of these drugs will lower the effectiveness of birth control medications.

Special considerations for pregnant women

Generally, the use of antipsychotic medications should be avoided in the first trimester unless the mother poses danger to herself, to others, or to the unborn child, or if the mother exhibits profound psychosis (Cohen 1989). Some, such as valproic acid, are associated with several disfiguring malformations if taken during pregnancy. If this type of medication must be used during pregnancy, the woman must be told that there is substantial risk of malformations (Robert et al. 2001). Lithium is also a suggested teratogen; children who were exposed before week 12 of gestation should be apprised of the increased risk of cardiac abnormalities. For women taking lithium, the medication should be monitored every 2 weeks and ultrasound should be performed on the fetus to exclude goiter (Mortola 1989).

Tapering and discontinuation of antipsychotic medication 10 days to 2 weeks before delivery is generally advised, though the protocols vary by medication (Mortola 1989). For all women of child-bearing age who may be or think they may be pregnant, the physician should discuss the safety of this medication before starting, continuing, or discontinuing medication treatment. Substance abuse counselors may have a role in encouraging this discussion between their clients and the prescribing clinician.

Antidepressant Medications

Generic and brand names

Generic	Brand
Monoamine oxidase inhibitors	
isocarboxazid	Marplan
phenelzine	Nardil
tranylcypromine	Parnate
Tricyclics and quatracyclics	
amitriptyline	Elavil
amoxapine	Asendin
clomipramine	Anafranil
desipramine	Nopramin, Pertofrane
doxepin	Sinequan
imipramine	Tofranil
maprotiline	Ludiomil
nortriptyline	Pamelor
protriptyline	Vivactil
SSRIs—selective serotonin reuptake inhibitors	
citalopram	Celexa
escitalopram oxalate	Lexapro
fluoxetine	Prozac, Prozac Weekly, Sarafem
fluvoxamine	Luvox
paroxetine	Paxil, Paxil CR
sertraline	Zoloft

Others

bupropion	Wellbutrin, Wellbutrin SR
mirtazapine	Remeron, Remeron SolTab
nefazodone	Serzone
trazodone	Desyrel
venlafaxine	Effexor, Effexor ER

Purpose

Antidepressant medications are used for moderate to serious depressions, but they can also be very helpful for milder depressions such as dysthymia. Most antidepressants must be taken for a period of 3 to 4 weeks to begin to reduce or take away the symptoms of depression but a full therapeutic effect may not be present for several months. Treatment for a single episode of major depression should continued for two years before discontinuing, and since major depression is a chronic recurrent illness in many patients, chronic use of antidepressants is often indicated. Discontinuing antidepressant therapy before the depression is completely resolved may result in the client decompensating and possibly becoming medication resistant. Untreated depression may result in suicide. Therefore, treatment for depression must be taken as seriously as treatment for any other major life-threatening illness. Antidepressants are also the first line medications for certain anxiety disorders such as panic disorder, social phobia, and obsessive-compulsive disorders.

Types of antidepressants

Older and less commonly used (due to safety and side effects) antidepressants include the tricyclic and quatracyclic antidepressants (named for their chemical structures) and the monoamine oxidase (MAO) inhibitors. MAO inhibitors are used for "atypical depressions," which produce symptoms like oversleeping, anxiety or panic attacks, and phobias. MAO inhibitors may also be used when a person does not respond to other antidepressants. The most frequently used class of antidepressants is the selective serotonin reuptake inhibitors (SSRIs). They are often prescribed because of their broad effectiveness, low side effects, and safety. The SSRIs are thought to affect the serotonin system to reduce symptoms of depression, and include fluoxetine, paroxetine, sertraline, citalopram, and escitalopram. Prozac Weekly is an extended release formula of Prozac (fluoxetine) that can be dosed once per week. Sarafem is fluoxetine under another label used for treatment of premenstrual dysphoric disorder. Other new antidepressants, such as venlafaxine (Effexor) work on both the serotonin and norepinephrine levels. Bupropion (Wellbutrin) is an antidepressant unrelated to other antidepressants; it has more effect on norepinephrine and dopamine levels than on serotonin levels in the brain. In addition, bupropion can be "activating" (as opposed to sedating) and, although not associated with weight gain or sexual dysfunction like many other antidepressant medications, it should be avoided by people who are at risk for or who currently have a seizure disorder.

Usual dose and frequency and side effects

All drugs have specific doses and frequencies. The physician will specify the exact amount of medication and when it should be taken. How much medicine and how often to take it are specified on the prescription bottle. Several factors are considered before an antidepressant is prescribed: the type of drug, the person's individual body chemistry, weight, and age. Clients are generally started on a low dose, and the dosage is slowly raised until the optimal effects are reached without the appearance of troublesome side effects. The most usual side effects to the older tricyclics are common and include dry mouth and sedation, but these drugs are inexpensive. For SSRIs, both mild sedation and mild agitation are sometimes found and this class includes both generic mod-

erate-expense and brand-only (expensive) versions. The most difficult SSRI side effect is decreased sexual performance, which may be difficult for many patients to discuss. Sleeplessness and agitation are the most common side effects for both bupropion and venlafaxine (both expensive, but bupropion is soon to be generic with decreased cost).

Potential side effects

MAO inhibitors

- Blood cell problems (both white and red cells)
- Dizziness when changing position
- Fluid retention
- Headache
- High blood pressure crisis
- Insomnia
- Lack of appetite
- Rapid heart beat

Tricyclics and quatracyclics

- Allergic reactions
- Blood cell problems (both white and red cells)
- Blurred vision
- Change in sexual desire
- Changes in heartbeat and rhythm
- Constipation
- Decrease in sexual ability
- Difficulty with urination
- Dizziness when changing position
- Dry mouth
- Fatigue
- Heart block
- Increased sweating
- Kidney failure (with Asendin)
- Muscle twitches
- Neuroleptic malignant syndrome (with Asendin)
- Seizures
- Stroke
- Weakness
- Weight gain

SSRIs

- Anxiety, agitation, or nervousness
- Change in sexual desire
- Confusion
- Decrease in sexual ability
- Diarrhea or loose stools
- Dizziness
- Dry mouth
- Headache
- Heart rhythm changes
- Increased sweating
- Insomnia or sleepiness
- Lack or increase of appetite
- Shakiness
- Stomach upset
- Taste disturbances (with Wellbutrin)
- Weight loss or gain

Emergency conditions

An overdose of any of the MAO inhibitors, tricyclics, quatracyclics, or other antidepressants is serious and potentially life threatening and ***must be reported to a physician immediately***. While the potential for a fatal outcome is much less with the SSRIs, the possibility that a person has attempted suicide should be dealt with as an emergency situation that needs immediate intervention.

Symptoms of tricyclic and quatracyclic overdose may include rapid heartbeat, dilated pupils, flushed face, agitation, loss of consciousness, seizures, irregular heart rhythm, heart and breathing stopping, and death.

Cautions

- Doctors and pharmacists should be told about all medications being taken (including dosage), including over-the-counter prepara-

tions, vitamins, minerals, and herbal supplements (e.g., St. John's wort, echinacea, ginko, ginseng, etc.).

- People taking antidepressant drugs should not increase their dose unless this has been ***checked with their physician and a change is ordered***.
- Withdrawal from SSRIs and other new antidepressants can cause flu-like symptoms. Discontinuting antidepressant therapy should be done gradually under a physician's care.
- Take medications as ordered and at the prescribed times.
- Persons taking MAO inhibitors must avoid all foods with high levels of tryptophan or tyramine (aged cheese, wine, beer, chicken liver, chocolate, bananas, soy sauce, meat tenderizers, salami, bologna, and pickled fish). High levels of caffeine must also be avoided. If eaten, these foods may react with the MAO inhibitors to raise blood pressure to dangerous levels.
- Many drugs interact with the MAO inhibitors. Largely for this reason they are rarely used. Do not take any other medications unless they are approved by the treating physician. Even a simple over-the-counter cold medication can cause life-threatening side effects.
- Clients using MAO inhibitor antidepressants should check all new medications with a physician or pharmacist before taking them.
- People taking antidepressant drugs are particularly vulnerable to adverse medical consequences if they concurrently use alcohol and/or street drugs.
- If there is little to no change after 3 to 4 weeks, talk to the doctor about raising the dose or changing the antidepressant.
- Treatment with antidepressants usually lasts a minimum 9 to 12 months. Many patients are on long-term antidepressant therapy to avoid the frequency and severity of depressive episodes.

Special considerations for pregnant women

The use of SSRIs, a class of antidepressant medication, is safer for the mother and fetus than are tricyclic antidepressants (Garbis and McElhatton 2001). Fluoxetine (Prozac) is the most studied SSRI in pregnancy and no increased incidence in malformations was noted, nor were there neurodevelopmental effects observed in preschool-age children (Garbis and McElhatton 2001). However, possible neonatal withdrawal signs have been observed. Given that the greatest amount of data are available for fluoxetine (Prozac), this is the recommended SSRI for use during pregnancy (Garbis and McElhatton 2001). MAO inhibitors use is contraindicated in pregnancy, and its use should be discontinued immediately if a woman discovers she is pregnant (Mortola 1989). The physician should discuss the safety of this medication before starting, continuing, or discontinuing medication treatment with all women of child-bearing age who may be or think they may be pregnant. Substance abuse counselors may have a role in encouraging this discussion between their clients and the prescribing physician.

Antianxiety Medications

Generic and brand names

Generic	Brand
Antidepressants see above	
Benzodiazepines	
alprazolam	Xanax
chlordiazepoxide	Librium, Libritabs, Librax
clonazepam	Klonopin
clorazepate	Tranxene
diazepam	Valium

lorazepam	Ativan
oxazepam	Serax
Beta-blockers	
propranolol	Inderal
Other	
buspirone	BuSpar
hydroxyzine embonate	Atarax
hydroxyzine pamoate	Vistaril
meprobamate	Miltown
olanzapine	Zyprexa, Zyprexa Zydis
quetiapine fumarate	Seroquel
risperidone	Risperdal

Purpose

Antianxiety medications are used to help calm and relax the anxious person as well as remove troubling symptoms associated with generalized anxiety disorder, posttraumatic stress disorder, panic, phobia, and obsessive-compulsive disorders. The most common antianxiety medications are the antidepressants and the benzodiazepines. The SSRI antidepressants have become first line medications for the treatment of panic, social phobia, and (in higher doses) obsessive-compulsive disorders. Both benzodiazepines and meprobamate (no longer readily available) are cross tolerant with alcohol, are abusable, and have a market as street drugs; thus most addiction medicine physicians only use them acutely as alcohol withdrawal medicines, or as sedatives in acutely psychotic or manic psychiatric patients. If used in outpatients, these patients would need careful monitoring for tolerance and abuse. They both have a depressant effect on the central nervous system and are relatively fast acting. Miltown, rarely prescribed anymore, is a non-benzodiazepine but works very much like one to quickly calm anxiety.

Beta-blockers work on the central nervous system to reduce the flight or fight response. Inderal is occasionally prescribed for performance anxiety and is nonaddictive.

BuSpar works through the serotonin system to induce calm. BuSpar takes 3 to 4 weeks to get into the brain to successfully combat anxiety. Atarax and Vistaril are antihistamines that use the drowsiness side effect of the antihistamine group to calm and relax. Vistaril and Atarax work within an hour of being taken and, like BuSpar, are not addictive.

Low doses of Risperdal, Seroquel, and Zyprexa may be used (though this is expensive, off-label and is not FDA approved) as non-addictive antianxiety medications, usually in cases in which several other medications have failed. Their special formulation works to reduce anxiety and help the person think more clearly, though the mechanism for this is unclear.

Usual dose, frequency, and side effects

All drugs have specific doses and frequencies. The physician will specify the exact amount of medication and when it should be taken. How much medicine and how often to take it are specified on the prescription bottle. Inderal is taken as needed for performance anxiety or regularly if it is being used for treatment of a heart condition. People are usually started on a low dose of medication, which is raised gradually over time until symptoms are removed or diminished. Major factors considered in establishing the correct dose are individual body chemistry, weight, and ability to tolerate the medication. Clients taking benzodiazepines for longer than 4 to 8 weeks may develop physical tolerance to the medication. Benzodiazepines have a moderate potential for abuse. Withdrawal symptoms may occur even when taken as directed, if regular use of benzodiazepines is abruptly stopped. Withdrawal from high dose abuse of benzodiazepines may be a life-threatening situation. For these reasons benzodiazepines are usually prescribed for brief periods of time—days or weeks—and

sometimes intermittently for stressful situations or anxiety attacks. Ongoing continuous use of benzodiazepines is not recommended for most people, especially those with a past or current history of substance abuse or dependence.

Beta-blockers act on the sympathetic nervous system and are not considered addictive. They also are used to treat hypertension, thus side effects might be low blood pressure or dizziness. Beta-blockers may enhance the effects of other psychotropic medications and are inexpensive.

BuSpar is often used for control of mild anxiety and is considered safe for long-term therapy but is expensive.

Vistaril and Atarax are both antihistamines, are used as safe nonaddictive medications to reduce anxiety, and are inexpensive. They may be used for longer-term therapy. They enhance the sedative effect of other drugs that cause drowsiness, and their most common side effects are dry mouth and sedation, but in older men, urinary retention may develop and is serious.

Potential side effects

- Blood cell irregularities
- Constipation
- Depression
- Drowsiness or lightheadedness
- Dry mouth
- Fatigue
- Heart collapse
- Irregular heart beat (Miltown)
- Loss of coordination
- Memory impairment (Inderal)
- Mental slowing or confusion
- Slowed heart beat (Valium)
- Stomach upset
- Suppressed breathing
- Weight gain

Potential for abuse or dependence

Between 11 and 15 percent of the American public takes a form of antianxiety medication—including benzodiazepines—at least once each year, and if antidepressants are included, this figure is doubled. Benzodiazepines may cause at least mild physical dependence in almost everyone who uses the medication for longer than 6 months (i.e., if the medicine is abruptly stopped, the person will experience anxiety, increased blood pressure, fast heart beat, and insomnia). However, becoming physically dependent on benzodiazepines does not mean abuse or addiction. Fewer than 1 percent of those without an addiction history who take benzodiazepines develop a substance abuse problem. In general, abuse and dependence occur at lower rates with long-acting antianxiety medications (e.g., Klonopin, Serax, and Tranxene). Abuse and dependence are more likely to occur with faster-acting, high-potency antianxiety medications (e.g., Ativan, Valium, and Xanax).

Emergency conditions

High doses of Valium can cause slowed heartbeat, suppression of breathing, and heart stoppage.

Withdrawal from regular use of any of the benzodiazepines and similar medications must be done slowly over a month's time. Abrupt withdrawal from these drugs can cause hallucinations, delusions and delirium, disorientation, difficulty breathing, hyperactivity, and grand mal seizures. To avoid these acute withdrawal symptoms, a protocol for decreasing or tapering off doses of benzodiazepine is needed. Overdose on the older tricyclic medications, which are often used for combined anxiety depression disorders, can be life threatening and immediate referral to emergency care is indicated.

Cautions

- Doctors and pharmacists should be told about all medications being taken (including dosage), including over-the-counter preparations, vitamins, minerals, and herbal supplements (e.g., St. John's wort, echinacea, ginko, ginseng, etc.).
- People taking antianxiety drugs should not increase their dose unless this has been ***checked with their physician and a change is ordered***.
- People should not discontinue use of these medications without talking to a doctor.
- People taking antianxiety medication are particularly vulnerable to adverse medical consequences if they concurrently use alcohol and/or illicit drugs.
- Using alcohol in combination with benzodiazepines may result in breathing failure and sudden death.

Special considerations for pregnant women

For use of the antidepressants in pregnancy, see above section. The current state of knowledge suggests that benzodiazepine therapy in general does not have as much of a teratogenic (producing a deformed baby) risk as do other anticonvulsants as long as they are given over a short time period. It appears that short-acting benzodiazepines, like those used to treat alcohol withdrawal, can be used in low doses for acute uses such as detoxification, even in the first trimester (Robert et al. 2001). Long-acting benzodiazepines should be avoided—their use during the third trimester or near delivery can result in a withdrawal syndrome in the baby (Garbis and McElhatton 2001).

During pregnancy, the protein binding of many drugs, including methadone and diazepam (a benzodiazepine), is decreased (e.g., Adams and Wacher 1968; Dean et al. 1980; Ganrot 1972) with the greatest decrease noted during the third trimester (Perucca and Crema 1982). This decreased binding may be due to the decreased levels of albumin reported during pregnancy (Yoshikawa et al. 1984). From a clinical standpoint, it may be that pregnant women could be at risk for developing greater toxicity and side effects, yet at the same time an increase in metabolism of the drug may result (such as found with methadone). This may result in reduced therapeutic effect from the drug, since many women require an increase in their dose of methadone during the last trimester (Pond et al. 1985). It should be noted that there is a documented withdrawal syndrome in neonates who have been prenatally exposed to benzodiazepines (Sutton and Hinderliter 1990) and this syndrome may be delayed in onset more than that associated with other drugs. For more information, see the forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT in development *b*).

For all women of child-bearing age who may be or think they may be pregnant, the physician should discuss the safety of this medication before starting, continuing, or discontinuing medication treatment. Substance abuse counselors may have a role in encouraging this discussion by suggesting this to their clients.

Stimulant Medications

Generic and brand names

Generic	Brand
d-amphetamine	Dexedrine
l & d-amphetamine	Adderall, Adderall CII, Adderall XR
methamphetamine	Desoxyn
methylphenidate	Ritalin, Ritalin SR, Concerta, Metadate ER, Metadate CD, Methylin ER, Focalin
pemoline	Cylert
modafinil	Provigil

Non-stimulants for AD/HD

atomoxetine hydrochloride	Strattera+
bupropion	Wellbutrin++
guanfacine	Tenex

+ Strattera is FDA approved

+ + Studies have shown bupropion to be effective, but it is not FDA approved for this use

Purpose

Used to treat attention deficit/hyperactivity disorder (AD/HD), which is typically diagnosed in childhood but also occurring in adults. Symptoms consistent with AD/HD include short attention span, excessive activity (hyperactivity), impulsivity, and emotional development below the level expected for the client's age. The underlying manifestation of AD/HD is that it severely impacts and interferes with a person's daily functioning. Other conditions that may be treated with stimulants are narcolepsy, obesity, and sometimes depression. While stimulants have been shown to reduce substance abuse onset in children, for adult populations with substance abuse problems, most addiction medicine doctors use antidepressants or atomoxitine. People with AD/HD generally report that they feel "normal" when taking stimulants. They cite increased concentration, focus, and ability to stay on task and behave appropriately when taking the medications.

Non-stimulant medications differ somewhat. Strattera blocks the reuptake of norepinephrine. It works by leaving more norepinephrine in the brain, which in turn reduces the symptoms of AD/HD. Tenex and Wellbutrin are non-stimulants that have been used successfully to treat symptoms of AD/HD. The advantage of these medications is that they are non-addictive.

Usual dose, frequency, and side effects

All drugs have specific doses and frequencies. The physician will specify the exact amount of medication and when it should be taken. How much medicine and how often to take it are specified on the prescription bottle. With stimulants there may be periods when the medication is not to be taken. The most common side effects of the stimulants are nervousness, sleeplessness, and loss of appetite. Some are expensive, but others are generic and quite inexpensive.

Potential side effects

Stimulants

- Blood disorders (Ritalin and Cylert)
- Change in heart rhythm
- Delayed growth
- Dilated pupils
- Elevated blood pressure
- Euphoria
- Excitability
- Increased pulse rate
- Insomnia
- Irritability
- Liver damage (Cylert)
- Loss of appetite
- Rash
- Seizures (Ritalin and Cylert)
- Tourette's syndrome (Cylert)
- Tremor

Non-stimulants for AD/HD

- Strattera side effects include:
  - High blood pressure
  - Nervousness and the side effects similar to norepinephrine-sparing antidepressants
- Wellbutrin side effects include increased chance of seizure activity.

- Tenex side effects include:
  - Constipation
  - Dizziness
  - Dry mouth
  - Low blood pressure
  - Sleepiness

Note: People taking these medications need to be monitored closely for tolerance and dependence. AD/HD patients generally note increased concentration, focus, and ability to stay on task and behave appropriately when taking the medications.

Potential for abuse or dependence

Prescription stimulant medications may be misused. Recreational or non-medically indicated uses have been reported for performance enhancement and/or weight loss. People with AD/HD or narcolepsy rarely abuse or become dependent on stimulant medications.

Emergency conditions

Psychiatric symptoms including paranoid delusions, thought disorder, and hallucinations have been reported with prolonged use or when taken at high dosages. Overdose with stimulants is a medical emergency. Seek help immediately.

Cautions

- Doctors and pharmacists should be told about all medications being taken (including dosage), including over-the-counter preparations, vitamins, minerals, and herbal supplements (e.g., St. John's wort, echinacea, ginko, ginseng, etc.).
- People taking stimulant drugs should not increase their dose unless this has been ***checked with their physician and a change is ordered***.
- People taking stimulant medications are particularly vulnerable to adverse medical consequences if they concurrently use alcohol and/or illicit drugs.
- With stimulants, there is the potential for development of tolerance and dependence on the medications with accompanying withdrawal. The potential for abuse and misuse is high, as is true with all schedule II drugs.

Special considerations for pregnant women

For women of child-bearing age who may be or think they may be pregnant, the physician should discuss the safety of this medication before starting, continuing, or discontinuing medication treatment. Substance abuse counselors may have a role in encouraging this discussion by suggesting this to their clients.

Narcotic and Opioid Analgesics

Natural opioids

- Opium, morphine, and codeine products

Pure, semi- or totally synthetic derivatives, opioids

- Heroin, Percodan, Demerol, Darvon, oxycodone, and others

Generic and brand names

Generic	Brand
buprenorphine	Buprinex
buprenorphine	Subutex, Suboxone*
butorphanol tartarate	Stadol spray
codeine phosphate	Codeine tablets
codeine sulfate	Codeine tablets

dihydromorphone hydrochloride	Dilaudid-5, Dilaudid HP
fentanyl transdermal	Duragesic patches
fentanyl transmucosal	Fentanyl, Oraley
hydromorphone hydrochloride	Dilaudid
meperidine hydrochloride	Demerol
methadone hydrochloride	Methadone
morphine hydrochloride	Morphine
morphine sulfate	Oramorph, Roxanol, Statex
oxycodone hydrochloride	Roxicodone, OxyContin
oxymorphone hydrochloride	Numorphan
pentazocine hydrochloride	Talwin
propoxyphene hydrochloride	Darvon
propoxyphene napsylate	Darvon-N
tramadol hydrochloride	Ultram

* Combined with naloxone and taken sublingually

The following products use a combination of an opioid or narcotic along with aspirin, Tylenol, or other pain reliever to treat mild to moderate pain.

Anesxia 5/50

Capital with Codeine

Darvocet N 100

Darvocet N 50

E-Lor or Wygesic

Empirin or Phenaphen with Codeine #3

Empirin or Phenaphen with Codeine #4

Endocet, Percocet, or Roxicet

Fioricet with Codeine

Fiorinal with Codeine

Lorcet Plus

Lortab

Percodan

Roxicet

Roxicet oral solution (contains alcohol)

Roxiprin

Talacen

Talwin Compound

Tylenol with Codeine

Tylenol with Codeine syrup (contains alcohol)

Tylox

Vicodin

Vicodin ES

Purpose

Some of these drugs are used to control acute pain that is moderate to severe. They are normally used only for acute pain—and for a short time—because they could become addictive. An exception is using opioids to alleviate the chronic pain associated with cancer, where research has shown that abuse or addiction to these medications rarely occurs. Severe and chronic pain has long been undertreated in the United States. This is partly due to concerns about addiction and partly due to laws that made certain opioids, like heroin, illegal. However, people with addictions still feel pain and, in certain situations, they need pain management just like anyone else. To manage pain, doctors are beginning to prescribe opioids more freely—including methadone and buprenorphine, which are recognized as effective pain medications.

Methadone is a synthetic opioid used in heroin detoxification programs and to maintain sobriety from heroin addiction. Many people who have been addicted to heroin have returned to a productive life because of methadone maintenance programs. Methadone is also occasionally used to provide relief for specific types of pain.

Usual dose and frequency

All drugs have specific doses and frequencies. A doctor will specify the exact amount of medication and when a person should take it. How much medicine and how often to take it are always specified on the prescription bottle. Many medications are taken two or more times a day. Some medications are taken in pill or liquid form. Others are taken in liquid form. A few are taken in a nasal spray or as transdermal patches. Injectable narcotics are not listed here because they are not often used outside a hospital setting. There are many nonaddictive pain medications (medications that pose no risk for addiction) available for pain management that can be used after acute pain is reduced.

Potential side effects

- Constipation
- Decreased ability to see clearly
- Decreased ability to think clearly
- Flushing and sweating
- Pupil constriction
- Respiratory depression
- Stomach upset
- Tolerance

Potential for abuse or dependence

With opioid medications, there is a potential for the development of tolerance and dependence as well as the possibility of abuse and severe withdrawal reactions.

Emergency conditions

- Convulsions and/or cardiac arrest with high dosages
- Overdose may increase pulse rate, and result in convulsions followed by coma or death
- Overdose may depress the breathing centers in the brain leading to lack of ability to breathe

Cautions

- Doctors and pharmacists should be told about all medications being taken (including dosage), including over-the-counter preparations, vitamins, minerals, and herbal supplements (e.g., St. John's wort, echinacea, ginko, ginseng, etc.).
- People taking opioid drugs should not increase their dose unless this has been ***checked with their physician and a change is ordered***.
- Persons taking an opioid medication are particularly vulnerable to adverse medical consequences if they concurrently use alcohol and/or illicit drugs, because alcohol and illicit drugs can increase the sedation effects of the opioids.
- With opioid medications there is a potential for the development of tolerance and dependence as well as the possibility of abuse and severe withdrawal reactions.

Special considerations for pregnant women

For all women of child-bearing age who may be or think they may be pregnant, the physician should discuss the safety of this medication before starting, continuing, or discontinuing medication treatment. Both pregnant women and their unborn infants can become tolerant and physically dependent on opioids and this dependence as well as possible withdrawal syndromes need to be assessed. Substance abuse counselors may have a role in encouraging this discussion by suggesting this to their clients.

Antiparkinsonian Medications

Generic and brand names

Generic	Brand
amantadine hydrochloride	Symmetrel, Symadine
benzotropine maleate	Cogentin
diphenhydramine hydrochloride	Benadryl
trihexyphenidyl hydrochloride	Artane

Purpose

These medications are used to counteract the side effects of the antipsychotic drugs. They are called antiparkinsonian because the neurological side effects of the antipsychotic medications are similar to the symptoms of Parkinson's disease.

Usual dose and frequency

The amount of the medication and the correct times to take it are labeled on the prescription bottle. These medications have very specific doses, and too much can be harmful. As with all medications, a doctor must be consulted in order to safely change the dose in response to side-effect symptoms of the antiparkinsonian medications.

Potential side effects

- Constipation
- Dizziness
- Dry mouth
- Heart failure
- Irritability
- Light-headedness
- Stomach upset
- Tiredness

Emergency conditions

Report any overdose, changes in heart rate or rhythm to the doctor immediately.

Abuse liability of anticholinergic medications

Anticholinergic medications such as benztropine, trihexyophenidyl, and diphenydramine are used as adjuncts to neuroleptics to control extrapyramidal side effects. However, despite their utility, these substances can be abused by some patients with severe mental illness who require neuroleptics. One patient survey found that many abusers of anticholinergics used these agents "to get high, to increase pleasure, to decrease depression, to increase energy and to relax" (Buhrich et al. 2000, p. 929). The survey also found that the misuse of other drugs accompanied the misuse of anticholinergics. Consequently, in the context of COD, providers and consumers need to be aware of the abuse potential of anticholinergics. Open communication between providers and patients is critical to avoid complication from the abuse of these substances.

Cautions

- Doctors and pharmacists should be told about all medications being taken (including dosage), including over-the-counter preparations, vitamins, minerals, and herbal supplements (e.g., St. John's wort, echinacea, ginko, ginseng, etc.).
- People taking antiparkinsonian drugs should not increase their dose unless this has been ***checked with their physician and a change is ordered***.

Special considerations for pregnant women

The risk of malformation associated with benztropine, trihexylphenidyl, and diphenhydramine is not clear, although there is some evidence to suggest that amantadine may be teratogenic (Mortola 1989). For all women of

child-bearing age who may be or think they may be pregnant, the physician should discuss the safety of this medication before starting, continuing, or discontinuing medication treatment. Substance abuse counselors may have a role in encouraging this discussion by suggesting this to their clients.

Hypnotics

Generic and brand names

Generic	Brand
Barbiturates	
secobarbital	Seconal
Benzodiazepines	
estazolam	ProSom
flurazepam	Dalmane
temazepam	Restoril
triazolam	Halcion
Non-benzodiazepine	
zaleplon	Sonata
zolpidem	Ambien
sedating antidepressants	trazedone, mirtazepine, Serzone, tricyclics
anticonvulsants	gabapentin, divalproex, topiramate

Purpose

Hypnotics are used to help a person with sleep disturbances get restful sleep. Lack of sleep is one of the greatest problems faced by people with chemical dependency and psychiatric illness. It can cause the symptoms of these disorders to worsen. For example, mood changes, psychosis, and irritability increase with insomnia. Lack of sleep diminishes a person's ability to think clearly or process information. Sleep–wake cycles and the body's ability to heal itself also suffer when a person is sleep deprived. Older hypnotics cause the body to slow down and "pass out" or sleep. However, they also have a tendency to disturb sleep-staging cycles.

Benzodiazepines enhance the body's natural calming agents, which induces sleep. Ambien and Sonata are non-benzodiazepines that affect one of the body's receptors for the natural calming agent, GABA. These medications induce sleep. They are short acting and do not disturb sleep-staging cycles. Rebound insomnia is a side effect of both Ambien and Sonata. This side effect can be produced if the medications are used for more than 2 weeks and then abruptly stopped.

Antidepressant sleep enhancers work by using their sleep producing side effects to induce sleep. They are nonaddictive but have the capacity to produce all the side effects of their class of antidepressant. Atypical antipsychotics use their calming and sedation side effects to induce sleep. They are non-addictive but have the capacity to produce all the side effects of atypical antipsychotics.

Paradoxically, those with addiction disorders can become rapidly tolerant and dependent on the most commonly used hypnotics, which are the benzodiazepines and zolpidem (barbiturates are now rarely used). Tolerance can lead to decreasing effectiveness, escalating doses, and an even worse sleep disorder when the agent is withdrawn. For this reason, most addiction medicine doctors use anticonvulsants, sedating antidepressants, or sedating antihistamines if the sleep problem continues past acute withdrawal symptoms.

Usual dose and frequency

All drugs have specific doses and frequencies. The physician will specify the exact amount of medication and when it should be taken. How much medicine and how often to take it are

specified on the prescription bottle. All of these medications are generally used for limited periods (3 to 4 days for barbiturates or up to a month for others). For all of these medications, tolerance develops quickly and eventually the usual dose will no longer help the person to sleep.

Potential side effects

- Breathing difficulty (Secobarbital)
- Dizziness
- Drowsiness
- Hangover or daytime sleepiness
- Headache
- Lethargy
- Weakness

Note: There are many drawbacks to long-term use of hypnotics (sleeping pills) such as damaged sleep staging and addiction. Even Ambien and Sonata, if taken for longer than 7 to 14 days, can have a discontinuation rebound insomnia effect. Newer nonaddictive medications are now available to treat insomnia.

Potential for abuse or dependence

See *Potential for Abuse or Dependence* for benzodiazepines.

Emergency conditions

- Overdose with any of these medications can be life threatening. Seek help immediately in the event of an overdose.
- Combinations of alcohol and barbiturates or alcohol and benzodiazepines can be deadly.

Cautions

- Doctors and pharmacists should be told about all medications being taken (including dosage), including over-the-counter preparations, vitamins, minerals, and herbal supplements (e.g., St. John's wort, echinacea, ginko, ginseng, etc.).
- People taking hypnotic drugs should not increase their dose unless this has been ***checked with their physician and a change is ordered***.
- People taking hypnotic medications are particularly vulnerable to adverse medical consequences if they concurrently use alcohol and/or illicit drugs.
- With hypnotics, there is the potential for development of tolerance and dependence on the medications with accompanying withdrawal. The potential for abuse and misuse is high.

Special considerations for pregnant women

Barbiturate use during pregnancy has been studied to some extent, but the risk of medication should be discussed with the patient (Robert et al. 2001). There also are reports of a withdrawal syndrome in the neonate (newborn baby) following prenatal exposure to some barbiturates (Kuhnz et al. 1988). For all women of child-bearing age who may be or think they may be pregnant, the physician should discuss the safety of this medication before starting, continuing, or discontinuing medication treatment. Substance abuse counselors may have a role in encouraging this discussion by suggesting this to their clients.

Addiction Treatment Medications

Generic and brand names

Generic	Brand
Antialcoholic	
Disulfram	Antabuse
Opiate blockers and antialcoholic	
Naltrexone hydrochloride	ReVia, Depade

Partial opiate blockers

buprenorphine	Suboxone, Subutex

Opiate maintenance

methadone hydrochloride	Methadone

Other

Acamprosate*

* Works through the GABA system and holds promise for alcohol craving and preventing relapse through a different method than naltrexone. Not reported to be psychoactive.

Purpose

These drugs are used to reduce cravings and the psychological reward from initial use of alcohol or opioids.

Antabuse causes a toxic reaction if alcohol is drunk; that is, it causes an unpleasant physical reaction when the person consumes even a small amount of alcohol. It is used as an aversion therapy for some clients who chronically abuse alcohol to help them remain in a state of enforced sobriety which allows time for supportive and psychotherapeutic treatment to be applied. Antabuse is not psychoactive, although it may make hallucinations worse at high doses (i.e., above 500 mg/day). Patients need to avoid *all* alcohol, even in other sources such as cooking or skin care products, because any alcohol can cause reactions.

Naltrexone completely blocks the pleasurable reinforcement that comes from opioids. It is more commonly used to reduce craving for alcohol and reduce the duration of any relapse to drinking. In research studies it has been shown to moderately decrease alcohol craving and relapse. It is nonpsychoactive, but can interfere with the use of opioids for acute pain.

Buprenorphine is a prescription medication approved in 2002 for treating opioid addiction. It can be used for both opioid withdrawal and as a substitute for opioids in long-term treatment. Buprenorphine is the first medication available to doctors for use in their office-based practice. At low doses, it acts like methadone and satisfies the dependent person's need for an opioid to avoid painful withdrawal. It does not provide the user with the euphoria or rush typically associated with use of other opioids or narcotics. At moderate to high doses, it can precipitate withdrawal. It is, therefore, safer in overdose than methadone.

Methadone has been used in the United States for maintenance treatment of opioid addiction since the 1960s. It is a synthetic, long-acting drug used in heroin detoxification programs to maintain abstinence from heroin addiction. When used in proper doses, methadone stops the cravings but does not create euphoria, sedation, or an analgesic effect. Many people who have been addicted to heroin have returned to a productive life because of methadone maintenance treatment programs. Methadone also is occasionally used to provide relief for specific types of pain.

Usual dose and frequency

All drugs have specific doses and frequencies. The physician will specify the exact amount of medication and when it should be taken. How much medicine and how often to take it are specified on the prescription bottle. Antabuse should never be given to clients without their full knowledge or when they are intoxicated. It should not be given until the client has abstained from alcohol for at least 12 hours. A daily, uninterrupted dose of Antabuse is continued until the client is in full and mature recovery and has reorganized his or her life to maintain recovery. Maintenance therapy may be required for months or even years.

Naltrexone is usually taken once a day but can be taken at a higher dose every second or third day. It is usually started at full dose. Clients should continue to take naltrexone until they

have reached full and mature recovery and have reorganized their life to maintain recovery.

Suboxone is given as a sublingual tablet (it is absorbed under the tongue). It is not absorbed if swallowed or chewed. If injected intravenously, Suboxone will cause opioid withdrawal. Suboxone and Subutex can be given by prescription and do not require daily attendance at a clinic. This is an advantage for persons who do not live near a methadone clinic.

Potential Side Effects

Potential side effects for Antabuse:

- Dark urine
- Drowsiness
- Eye pain
- Fatigue
- Impotence
- Indigestion
- Inflammation of optic nerve
- Jaundice
- Light colored stool
- Liver inflammation
- Loss of vision
- Psychotic reactions
- Skin rashes, itching
- Tingling sensation in arms and legs

Potential side effects for the opioid blockers/opioids are similar to the class of opioid drugs (if buprenorphine is given in high dose, opioid withdrawal symptoms may occur):

- Abdominal cramps
- Body aches lasting 5–7 days
- Diarrhea
- Dizziness
- Fatigue
- Headache
- Insomnia
- Nausea
- Nervousness
- Opioid withdrawal (in some cases)
- Runny eyes and nose
- Severe anxiety
- Vomiting

Emergency Conditions

- Convulsions and/or cardiac arrest with high dosages.
- Overdose may increase pulse rate, result in convulsions followed by coma or death.
- Overdose may depress the breathing centers in the brain leading to inability to breathe.

Cautions

- Doctors and pharmacists should be told about all medications being taken, including over-the-counter preparations.
- Persons taking Antabuse should be warned to avoid even small amounts of alcohol in other food products or "disguised forms" (e.g., vanilla, sauces, vinegars, cold and cough medicines, aftershave lotions, liniments) as this will cause a reaction.
- Persons taking Antabuse should be warned that consuming even small amounts of alcohol will produce flushing, throbbing in head and neck, headache, difficulty breathing, nausea, vomiting, sweating, thirst, chest pain, rapid heart rate, blurred vision, dizziness, and confusion.
- Persons taking opioid medications should not increase their dose unless this has been ***checked with their physician and a change is ordered***.
- People taking opioid medications are particularly vulnerable to adverse medical consequences if they concurrently use alcohol and/or illicit drugs.
- Persons taking Naltrexone should be warned that if they are dependent on opioids, taking Naltrexone will cause opioid withdrawal for up to 3 days and block the effect of any opioids taken for up to 3 days.

Special considerations for pregnant women

While it is not recommended that pregnant women who are maintained on methadone undergo detoxification, if these women require detoxification, the safest time to detoxify them is during the second trimester. For further information, consult the forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT in development *b*). In contrast, it is possible to detoxify women dependent on heroin who are abusing illicit opioids by using a methadone taper. Buprenorphine has been examined in pregnancy and appears to lack teratogenic effects but may be associated with a withdrawal syndrome in the neonate (Jones and Johnson 2001); however, regardless of the efficacy and safety of buprenorphine with pregnant women, it has not yet been approved for use with this population. A National Institutes of Health consensus panel recommended methadone maintenance as the standard of care for pregnant women with opioid dependence.

Pregnant women should be maintained on an adequate (i.e., therapeutic) methadone dose. An effective dose prevents the onset of withdrawal for 24 hours, reduces or eliminates drug craving, and blocks the euphoric effects of other narcotics. An effective dose usually is in the range of 50–150mg (Drozdick et al. 2002). Dosage must be individually determined, and some pregnant women may be able to be successfully maintained on less than 50mg while others may require much higher doses than 150mg. The dose often needs to be increased as a woman progresses through gestation, due to increases in blood volume and metabolic changes specific to pregnancy (Drozdick et al. 2002; Finnegan and Wapner 1988).

Generally, dosing of methadone is for a 24-hour period. However, because of metabolic changes during pregnancy it might not be possible to adequately manage a pregnant woman during a 24-hour period on a single dose. Split dosing, particularly during the third trimester of pregnancy, may stabilize the woman's blood methadone levels and effectively treat withdrawal symptoms and craving.

Breastfeeding is not contraindicated for women who are on methadone. Very little methadone comes through breast milk; the American Academy of Pediatrics (AAP) Committee on Drugs lists methadone as a "maternal medication usually compatible with breastfeeding" (AAP 2001, pp. 780–781).

The Federal government mandates that prenatal care be available for pregnant women on methadone. It is the responsibility of treatment providers to arrange this care. More than ever, there is need for collaboration involving obstetric, pediatric, and substance abuse treatment caregivers. Comprehensive care for the pregnant woman who is opioid dependent must include a combination of methadone maintenance, prenatal care, and substance abuse treatment.

Naloxone should not be given to a pregnant woman as a last resort for severe opioid overdose. Withdrawal can result in spontaneous abortion, premature labor, or stillbirth (Weaver 2003). Propranolol (Inderal), labetalol (Trandate), and metoprolol (Lopressor) are the beta blockers of choice for treating hypertension (high blood pressure) during pregnancy (McElhatton 2001); however the impact of using them for alcohol detoxification during pregnancy is unclear.

For all women of child-bearing age who may be or think they may be pregnant, the physician should discuss the safety of this medication before starting, continuing, or discontinuing medication treatment. Substance abuse counselors may have a role in encouraging this discussion by suggesting this to their clients.

This review is an extensive edit and update of the 5th edition published in 2004; the original version was published in 2000 by the Mid-America Addiction Technology Transfer Center

University of Missouri-Kansas City
5100 Rockhill Road
Kansas City, Missouri 64110
www.mattc.org

Appendix G:

Screening and Assessment Instruments

Addiction Severity Index (ASI)

Purpose: The ASI is most useful as a general intake screening tool. It effectively assesses a client's status in several areas, and the composite score measures how a client's need for treatment changes over time.

Clinical utility: The ASI has been used extensively for treatment planning and outcome evaluation. Outcome evaluation packages for individual programs or for treatment systems are available.

Groups with whom this instrument has been used: Designed for adults of both sexes who are not intoxicated (drugs or alcohol) when interviewed. Also available in Spanish.

Format: Structured interview

Administration time: 50 minutes to 1 hour

Scoring time: 5 minutes for severity rating

Computer scoring? Yes

Administrator training and qualifications: A self-training packet is available as well as onsite training by experienced trainers.

Fee for use: No cost; minimal charges for photocopying and mailing may apply.

Available from:
A. Thomas McLellan, Ph.D.
Building 7
PVAMC
University Avenue
Philadelphia, PA 19104
Phone: (800) 238-2433

Alcohol Use Disorders Identification Test (AUDIT)

Purpose: The purpose of the AUDIT is to identify persons whose alcohol consumption has become hazardous or harmful to their health.

Clinical utility: The AUDIT screening procedure is linked to a decision process that includes brief intervention with heavy drinkers or referral to specialized treatment for patients who show evidence of more serious alcohol involvement.

Groups with whom this instrument has been used: Adults, particularly primary care, emergency room, surgery, and psychiatric patients; DWI offenders; criminals in court, jail, and prison; enlisted men in the armed forces; and workers in employee assistance programs and industrial settings.

Format: A 10-item screening questionnaire with 3 questions on the amount and frequency of drinking, 3 questions on alcohol dependence, and 4 on problems caused by alcohol.

Administration time: 2 minutes

Scoring time: 1 minute

Computer scoring? No

Administrator training and qualifications: The AUDIT is administered by a health professional or paraprofessional. Training is required for administration. A detailed user's manual and a videotape training module explain proper administration, procedures, scoring, interpretation, and clinical management.

Fee for use: No

Available from: Can be downloaded from Project Cork Web site: www.projectcork.org

Beck Depression Inventory–II (BDI–II)

Purpose: Used to screen for the presence and rate the severity of depression symptoms.

Clinical utility: The BDI–II consists of 21 items to assess the intensity of depression. The BDI-II can be used to assess the intensity of a client's depression, and it can also be used as a screening device to determine whether there is any current indication of the need for a referral for further evaluation. Each item is a list of four statements arranged in increasing severity about a particular symptom of depression. These new items bring the BDI–II into alignment with *Diagnostic and Statistical Manual for Mental Disorders, 4th edition* (DSM-IV) criteria.

Items on the new scale replace items that dealt with symptoms of weight loss, changes in body image, and somatic preoccupation. Another item on the original BDI that tapped work difficulty was revised to examine loss of energy. Also, sleep loss and appetite loss items were revised to assess both increases and decreases in sleep and appetite.

Groups with whom this instrument has been used: All clients age 13 through 80 who can read and understand the instructions, and clients who cannot read (requires reading the statements to them).

Format: Paper-and-pencil self-administered test.

Administration time: 5 minutes, either self-administered or administered verbally by a trained administrator.

Scoring time: N/A

Computer scoring? No. Any staff member can perform the simple scoring.

Administrator training and qualifications: Doctoral-level training or masters-level training with supervision by a doctoral-level clinician are required to interpret test results.

Fee for use: $66 for manual and package of 25 record forms.

Available from: The Psychological Corporation
19500 Bulderve
San Antonio, TX 78259
Phone: (800) 872-1726
www.psychcorp.com

CAGE Questionnaire

Purpose: The purpose of the CAGE Questionnaire is to detect alcoholism.

Clinical utility: The CAGE Questionnaire is a very useful bedside, clinical desk instrument and has become the favorite of many family practice and general internists—also very popular in nursing.

Groups with whom this instrument has been used: Adults and adolescents (over 16 years)

Format: Very brief, relatively nonconfrontational questionnaire for detection of alcoholism, usually directed "have you ever" but may be focused to delineate past or present.

Administration time: Less than 1 minute

Scoring time: Instantaneous

Computer scoring? No

Administrator training and qualifications: No training required for administration; it is easy to learn, easy to remember, and easy to replicate.

Fee for use: No

Available from: May be downloaded from the Project Cork Web site: www.projectcork.org

Circumstances, Motivation, and Readiness Scales (CMR Scales)

Purpose: The instrument is designed to predict retention in treatment and is applicable to both residential and outpatient treatment modalities.

Clinical utility: The instrument consists of four derived scales measuring external pressure to enter treatment, external pressure to leave treatment, motivation to change, and readiness for treatment. Items were developed from focus groups of recovering staff and clients and retain much of the original language. Clients entering substance abuse treatment perceive the items as relevant to their experience.

Groups with whom this instrument has been used: Adults

Format: 18 items at approximately a third-grade reading level. Responses to the items consist of a 5-point Likert scale on which the individual rates each item on a scale from Strongly Disagree to Strongly Agree. Versions are also available in Spanish and Norwegian.

Administration time: 5 to 10 minutes

Scoring time: Can be easily scored by reversing negatively worded items and summing the item values.

Computer scoring? No

Administrator training and qualifications: Self-administered; no training required for administration.

Fee for use: No

Available from: George De Leon, Ph.D., or Gerald Melnick, Ph.D.
National Development and Research Institutes, Inc.
71 West 23rd Street
8th Floor
New York, NY 1001
Phone: (212) 845-4400
Fax: (917) 438-0894
E-mail:
gerry.melnick@ndri.org
www.ndri.org

Clinical Institute Withdrawal Assessment (CIWA-Ar)

Purpose: Converts DSM-III-R items into scores to track severity of withdrawal; measures severity of alcohol withdrawal.

Clinical utility: Aid to adjustment of care related to withdrawal severity.

Groups with whom this instrument has been used: Adults

Format: A 10-item scale for clinical quantification of the severity of the alcohol withdrawal syndrome.

Administration time: 2 minutes

Scoring time: 4 to 5 minutes

Computer scoring? No

Administrator training and qualifications: Training is required and the CIWA is administered by nurses, doctors, and research associates/detoxification unit workers.

Fee for use: No

Available from: Dr. E.M. Sellers
Ventana Clinical Research Corporation
340 College Street
Suite 400
Toronto, Canada
M5T 3A9
Phone: (416) 963-9338
Fax: (416) 963-9732
www.ventana-crc.com

Drug Abuse Screening Test (DAST)

Purpose: The purpose of the DAST is (1) to provide a brief, simple, practical, but valid method for identifying individuals who are abusing psychoactive drugs; and (2) to yield a quantitative index score of the degree of problems related to drug use and misuse.

Clinical utility: Screening and case finding; level of treatment and treatment/goal planning.

Groups with whom this instrument has been used: Individuals with at least a sixth-grade reading level.

Format: A 20-item instrument that may be given in either a self-report or a structured interview format; a "yes" or "no" response is requested from each of 20 questions.

Administration time: 5 minutes

Scoring time: N/A

Computer scoring? No. The DAST is planned to yield only one total or summary score ranging from 0 to 20, which is computed by summing all items that are endorsed in the direction of increased drug problems.

Administrator training and qualifications: For a qualified drug counselor, only a careful reading and adherence to the instructions in the "DAST Guidelines for Administration and Scoring," which is provided, is required. No other training is required.

Fee for use: The DAST form and scoring key are available either without cost or at nominal cost.

Available from: Centre for Addiction and Mental Health
Marketing and Sales Services
33 Russell Street
Toronto, Ontario, Canada M5S 2S1
Phone: (800) 661-1111 (Continental North America)
International and Toronto area: (416) 595-6059

Global Appraisal of Individual Needs (GAIN)

Purpose: The GAIN was developed to implement an integrated biopsychosocial model of treatment assessment, planning, and outcome monitoring that can be used for evaluation, clinical practice, and administrative purposes.

Clinical utility: The GAIN embeds questions for documenting substance use disorder, attention deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, and pathological gambling; dimensional patient placement criteria for intoxication/withdrawal, health distress, mental distress, and environment distress to guide movement among and between levels of care; treatment planning; reporting requirements related to the State client data system; and measures of a core set of clinical status and service utilization outcomes used in the Drug Outcome Monitoring Study.

Groups with whom this instrument has been used: Adults and adolescents

Format: The content of the GAIN is divided into eight areas: background and treatment arrangements, substance use, physical health, risk behaviors, mental health, environment, legal, and vocational. In each area, the questions check for major problem areas and the recency of any problems.

Administration time: 15 to 30 minutes

Scoring time: 20 minutes

Computer scoring? No

Administrator training and qualifications: N/A

Fee for use: The GAIN and its products are tools that are proprietary products owned by Chestnut Health Systems either exclusively or jointly and protected under U.S. copyright laws. The current work is in beta test form, but can be used for evaluation and research under a non-exclusive, non-transferable, limited license at the cost of $1 plus any materials/assistance requested.

Available from: The Lighthouse Institute
Chestnut Health Systems
720 West Chestnut
Bloomington, IL 61701
Phone: (309) 827-6026
www.chestnut.org/li/gain/

Level of Care Utilization System (LOCUS)

Purpose: To assess immediate service needs (e.g., for clients in crisis); to plan resource needs over time, as in assessing service requirements for defined populations; to monitor changes in status or placement at different points in time.

Clinical utility: LOCUS is divided into three sections. The first section defines six evaluation parameters or dimensions: (1) risk of harm; (2) functional status; (3) medical, addictive, and psychiatric co-morbidity; (4) recovery environment; (5) treatment and recovery history; and (6) engagement. A five-point scale is constructed for each dimension and the criteria for assigning a given rating or

score in that dimension are elaborated. In dimension IV, two subscales are defined, while all other dimensions contain only one scale.

Groups with whom this instrument has been used: Adults

Format: A document that is divided into three sections.

Administration time: 15 to 30 minutes

Scoring time: 20 minutes

Computer scoring? No

Administrator training and qualifications: N/A

Fee for use: No

Available from: American Association of Community Psychiatrists www.wpic.pitt.edu/aacp/find.html

Michigan Alcoholism Screening Test (MAST)

Purpose: Used to screen for alcoholism with a variety of populations.

Clinical utility: A 25-item questionnaire designed to provide a rapid and effective screen for lifetime alcohol-related problems and alcoholism.

Groups with whom this instrument has been used: Adults

Format: Consists of 25 questions

Administration time: 10 minutes

Scoring time: 5 minutes

Computer scoring? No

Administrator training and qualifications: No training required.

Fee for use: Fee for a copy but no fee for use.

Available from: Melvin L. Selzer, M.D.
6967 Paseo Laredo
La Jolla, CA 92037-6425

M.I.N.I. Plus

Purpose: Assists in the assessment and tracking of patients with greater efficiency and accuracy.

Clinical utility: The M.I.N.I. is not designed or intended to be used in place of a full medical and psychiatric evaluation by a qualified licensed physician-psychiatrist. It is intended only as a tool to facilitate accurate data collection and processing of symptoms elicited by trained personnel.

Groups with whom this instrument has been used: Adults

Format: An abbreviated psychiatric structured interview that takes approximately 15 to 20 minutes to administer. It uses decision tree logic to assess the major adult Axis I disorders in DSM-IV and ICD-10. It elicits all the symptoms listed in the symptom criteria for DSM-IV and ICD-10 for 15 major Axis I diagnostic categories, one Axis II disorder, and for suicidality. Its diagnostic algorithms are consistent with DSM-IV and ICD-10 diagnostic algorithms.

Administration time: 15 to 20 minutes

Scoring time: N/A

Computer scoring? A computerized version of the M.I.N.I. is available in six languages in the MINI Outcomes program.

Administrator training and qualifications: The M.I.N.I. was designed to be used by trained interviewers who do not have training in psychiatry or psychology.

Fee for use: The M.I.N.I. is made available at no charge on the Internet, mainly for researchers and clinicians who may make single copies of the M.I.N.I. for their own use. When the M.I.N.I. is used in a research study or published paper, appropriate credit should

be given for its use. The proper citation is provided on the last page of the M.I.N.I.

Available from: Medical Outcome Systems, Inc.
medical-outcomes.com

Psychiatric Research Interview for Substance and Mental Disorders (PRISM)

Purpose: The instrument was designed to maximize reliability and validity in community samples, alcohol, drug, and co-occurring disorder treatment samples.

Clinical utility: Although primarily designed as a research instrument, the PRISM provides systematic coverage of alcohol- and drug-related experiences and symptoms that may be useful in identifying areas of focus for treatment. Additionally, the unusually high reliability of the depression diagnoses in individuals with heavy drinking may provide a better basis for treatment decisions than less consistent methods for assessing major depression and dysthymia.

Groups with whom this instrument has been used: Adults

Format: The PRISM is a semistructured clinician-administered interview that measures DSM-III, DSM-III-R, and DSM-IV diagnoses (current and past) of alcohol, drug, and psychiatric disorders and continuous measures of severity, organic, etiology, treatment, and functional impairment.

Administration time: 1 to 3 hours

Scoring time: Immediately

Computer scoring? Yes

Administrator training and qualifications: Interviewer should have at least a master's degree in a clinical field and some clinical experience. Training is required for administration. Training for the administrator involves a self-study manual, ratings of videotapes of interviews, and small group sessions with an experienced trainer.

Fee for use: No

Available from: Dr. Deborah Hasin
New York State
Psychiatric Institute
Box 123 722
West 168th Street
New York, NY 10032
Phone: (212) 960-5518
Cost/source of computerized scoring: Call Dr. Hasin for current information.

Readiness to Change Questionnaire

Purpose: Designed to assist the clinician in determining the stage of readiness for change among problem drinkers or people with alcohol use disorders.

Clinical utility: Assesses drinker's readiness to change drinking behaviors; may be useful in assignment to different types of treatment.

Groups with whom this instrument has been used: Adults and adolescents

Format: A brief 12-item questionnaire consisting of three subscales.

Administration time: 2 to 3 minutes

Scoring time: 1 to 2 minutes

Computer scoring? No

Administrator training and qualifications: No training is required.

Fee for use: No

Available from: Center for Alcohol and Drug Studies
Plummer Court, Carliol Place
Newcastle upon Tyne
NE1 6UR
UNITED KINGDOM
Phone: 44(0)191219 5648
Fax: 44(0)191219 5649

Recovery Attitude and Treatment Evaluator (RAATE)

Purpose: Designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting appropriateness of discharge.

Clinical utility: The RAATE provides objective documentation to assist in making appropriate treatment placement decisions; it strengthens individualized care and facilitates more individualized treatment planning; it measures treatment process; and it assesses the need for continuing care and discharge readiness.

Groups with whom this instrument has been used: Adults

Format: A 35-item structured interview

Administration time: 20 to 30 minutes

Scoring time: Less than 5 minutes

Computer scoring? No

Administrator training and qualifications: Training is required for administration. The RAATE is administered by trained chemical dependency professional (RAATE-CE) or patient (RAATE-QI).

Fee for use: Yes. The RAATE manual is available for $35.00 and the scoring templates are $8.75.

Available from: Evince Clinical Assessments
P.O. Box 17305
Smithfield, RI 02917
Phone: (401) 231-2993
Toll-free in USA:
(800)-755-6299
www.evinceassessment.com

Structured Clinical Interview for DSM-IV Disorders (SCID-IV)

Purpose: Obtains Axis I and II diagnoses using the DSM-IV diagnostic criteria for enabling the interviewer to either rule out or establish a diagnosis of "drug abuse" or "drug dependence" and/or "alcohol abuse" or "alcohol dependence."

Clinical utility: A psychiatric interview.

Groups with whom this instrument has been used: Psychiatric, medical, or community-based normal adults.

Format: A psychiatric interview form in which diagnosis can be made by the examiner asking a series of approximately 10 questions of a client.

Administration time: Administration of Axis I and Axis II batteries may require more than 2 hours each for patients with multiple diagnoses. The Psychoactive Substance Use Disorders module may be administered by itself in 30 to 60 minutes.

Scoring time: Approximately 10 minutes

Computer scoring? No. Diagnosis can be made by the examiner asking a series of questions of a client.

Administrator training and qualifications: Designed for use by a trained clinical evaluator at the master's or doctoral level, although in research settings it has been used by bachelor's-level technicians with extensive training.

Fee for use: Yes

Available from: American Psychiatric Publishing, Inc.
1400 K Street, N.W.
Washington, DC 20005
www.appi.org

Substance Abuse Treatment Scale (SATS)

Purpose: To assess and monitor the progress that people with severe mental illness make toward recovery from substance use disorder.

Clinical utility: This scale is for assessing a person's stage of substance abuse treatment, not for determining diagnosis.

Groups with whom this instrument has been used: Adults, adolescents (over 16 years)

Format: Very brief, relatively nonconfrontational questionnaire for detection of alcoholism, usually directed by saying "have you ever" but may be focused to delineate past or present.

Administration time: Less than 1 minute

Scoring time: Instantaneous

Computer scoring? No

Administrator training and qualifications: No training required for administration; it is easy to learn, easy to remember, and easy to replicate.

Fee for use: No

Available from: Can be downloaded from the Center for Mental Health Services Web site, www.mentalhealth.org/cmhs/CommunitySupport/research/toolkits/pn6toc.asp

University of Rhode Island Change Assessment (URICA)

Purpose: The URICA operationally defines four theoretical stages of change—precontemplation, contemplation, action, and maintenance—each assessed by eight items.

Clinical utility: Assessment of stages of change/readiness construct can be used as a predictor, treatment matching, and outcome variables.

Groups with whom this instrument has been used: Both inpatient and outpatient adults

Format: The URICA is a 32-item inventory designed to assess an individual's stage of change located along a theorized continuum of change.

Administration time: 5 to 10 minutes to complete

Scoring time: 4 to 5 minutes

Computer scoring? Yes, computer-scannable forms.

Administrator training and qualifications: N/A

Fee for use: No; instrument is in the public domain. Available from author.

Available from: Carlo C. DiClemente
University of Maryland
Psychology Department
1000 Hilltop Circle
Baltimore, MD 21250
Phone: (410) 455-2415

Appendix H: Screening Instruments

This appendix reproduces two screening instruments available for unrestricted use:

- Mental Health Screening Form-III (MHSF-III)
- Simple Screening Instrument for Substance Abuse (SSI-SA)

One of the difficult decisions facing the consensus panel related to the inclusion of specific screening and assessment instruments. The consensus panel decided to include an instrument for the substance abuse field to screen for mental health issues and an instrument for mental health settings to use to screen for substance abuse issues.

Recognizing time, cost, and effort as severe initial barriers to implementing anything new into a treatment service system, the consensus panel selected two screening instruments that can be reproduced for free and have instructions that can also be reproduced for free. Information about other screening instruments and assessment tools is given in appendix G.

There is clear face validity as well as supportive psychometric findings to the two screening instruments in this appendix. Neither the questions nor the formats of the MHSF-III and the SSI-SA are likely to cause difficulty for staff or clients. These two screening techniques require minimal staff training for their use, and their simplicity makes their incorporation into treatment services relatively easy. Both instruments were specifically designed for use within a clinical setting for clients receiving or seeking treatment and for administration and use under the standard conditions found in most substance abuse and/or mental health clinics. The consensus panel cautions against other uses of these instruments, unless the professionals deciding on such use have given full consideration to the limitations of these two specialized screens.

The Mental Health Screening Form-III

With the permission of Project Return Foundation, Inc., the consensus panel has taken the opportunity to present the Mental Health Screening Form-III in its entirety (see also www.projectreturn.org).

Guidelines for Using the Mental Health Screening Form-III

The Mental Health Screening Form-III was initially designed as a rough screening device for clients seeking admission to substance abuse treatment programs.

Each MHSF-III question is answered either "yes" or "no." All questions reflect the respondent's entire life history; therefore all questions begin with the phrase "Have you ever…"

The preferred mode of administration is for staff members to read each item to respondents and get their "yes" and "no" responses. Then, after completing all 18 questions (question 6 has two parts), the staff member should inquire about any "yes" response by asking "When did this problem first develop?"; "How long did it last?"; "Did the problem develop before, during, or after you started using substances?"; and, "What was happening in your life at that time?" This information can be written below each item in the space provided. There is additional space for staff member comments at the bottom of the form.

The MHSF-III can also be given directly to clients to complete, providing they have sufficient reading skills. If there is any doubt about someone's reading ability, have the client read the MHSF-III instructions and question number one to the staff member monitoring this process. If the client cannot read and/or comprehend the questions, the questions must be read and/or explained to him or her.

Whether the MHSF-III is read to a client or he reads the questions and responds on his own, the completed MHSF-III should be carefully reviewed by a staff member to determine how best to use the information. It is strongly recommended that a qualified mental health specialist be consulted about any "yes" response to questions 3 through 17. The mental health specialist will determine if a follow-up, face-to-face interview is needed for a diagnosis and/or treatment recommendation.

The MHSF-III features a "Total Score" line to reflect the total number of "yes" responses. The maximum score on the MHSF-III is 18 (question 6 has two parts). This feature will permit programs to do research and program evaluation on the mental health-chemical dependence interface for their clients.[1]

The first four questions on the MHSF-III are not unique to any particular diagnosis; however, questions 5 through 17 reflect symptoms associated with the following diagnoses/diagnostic categories: Q5, Schizophrenia; Q6, Depressive Disorders; Q7, Posttraumatic Stress Disorder; Q8, Phobias; Q9, Intermittent Explosive Disorder; Q10, Delusional Disorder; Q11, Sexual and Gender Identity Disorders; Q12, Eating Disorders (Anorexia, Bulimia); Q13, Manic Episode; Q14, Panic Disorder; Q15, Obsessive-Compulsive Disorder; Q16, Pathological Gambling; and Q17, Learning Disorder and Mental Retardation.

The relationship between the diagnoses/diagnostic categories and the above-cited questions

[1]Note: The "Total Score" cannot be used with any individual client. Summing the number of "yes" responses cannot be taken to be indicative of more or less of any "trait" or "dimension." Even the use of a "Total Score" for research and program evaluation purposes requires careful understanding of and attention to the fact that fundamentally each item is an independent and separate screening device/question on its own. That is, every "yes" item is a positive screen suggesting the need for further evaluation, and most items are screens for a particular mental disorder. Anyone using "Total Scores" for an appropriate narrow set of possibilities related to program evaluation and/or research should take care that such use does not create confusion.

was investigated by having four mental health specialists independently select the one MHSF-III question that best matched a list of diagnoses/diagnostic categories. All of the mental health specialists matched the questions and diagnoses/diagnostic categories in the same manner, that is, as noted in the preceding paragraph.

A "yes" response to any of questions 5 through 17 does not, by itself, ensure that a mental health problem exists at this time. A "yes" response raises only the possibility of a current problem, which is why a consult with a mental health specialist is strongly recommended.

Simple Screening Instrument for Substance Abuse

The Simple Screening Instrument for Substance Abuse (SSI-SA) was developed by the consensus panel of TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (Center for Substance Abuse Treatment 1994*c*). The SSI-SA has previously been called the Simple Screening Instrument for Outreach for Alcohol and Other Drug Abuse; the Simple Screening Instrument (SSI); and the Simple Screening Instrument for AOD (SSI-AOD). To avoid confusion, the consensus panel suggests using "SSI-SA" (Simple Screening Instrument for Substance Abuse) when referring to this screening instrument.

As a government-supported document, the SSI-SA is in the public domain, can be used without charge or permission and can be reproduced without limit, including the instructions. It is a 16-item scale, although only 14 items are scored so that scores can range from 0 to 14. These 14 items were selected by the TIP 11 consensus panelists from existing alcohol and drug abuse screening tools. A score of 4 or greater has become the established cut-off point for warranting a referral for a full assessment.

Since its publication in 1994 the SSI-SA has been widely used and its reliability and validity investigated. Peters and colleagues (2004) reported on a national survey of correctional treatment for COD. Reviewing 20 COD treatment programs in correctional settings from 13 States, the SSI-SA was identified as among the most common screening instruments used. Peters et al. (2000) found the SSI-SA to be effective in identifying substance-dependent inmates, and the SSI-SA demonstrated high sensitivity (92.6 percent for alcohol or drug dependence disorder, 87.0 percent for alcohol or drug abuse or dependence disorder) and excellent test-retest reliability (.97). Knight et al. (2000) also found the SSI-SA a reliable substance abuse screening instrument among adolescent medical patients.

Peters and Peyton (1998) evaluated a number of screening instruments for use by drug courts and found the Alcohol Dependence Scale/Addiction Severity Index – Drug Use section combined, the Texas Christian University Drug Dependence Screen (TCUDS), and the SSI-SA "to hold considerable promise for use with participants in drug court programs" (p. 17).

The Urban Institute (Moore and Mears 2003) interviewed practitioners within correction-based drug treatment programs in 13 States selected to include a diversity of regions and sizes. Again, the TCUDS and the SSI-SA were widely used, as was the Michigan Alcohol Screening Test (MAST). The TCUDS was deemed to produce fewer false positives than the SSI-SA. Winters (1995), in a small study of 95 clients from a drug evaluation program, found a sensitivity of 97.0 percent and specificity of 55.2 percent. "Overall classification accuracy or 'hit rate' was 84.2 percent .... [Thus] false classifications occurred in 15.8 percent of the sample, yet the majority of the errors are of the 'false positive' type ... which is the preferred type of error for a screening test" (p. 3). For program administrators or clinicians considering the SSI-SA for their own screening purposes, the false–positive rate will produce more referrals than other screening instruments, such as the TCUDS, might pro-

Mental Health Screening Form-III

Instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation, this is why each question begins - "Have you ever ...."

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?

   YES NO

2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?

   YES NO

3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?

   YES NO

4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?

   YES NO

5. Have you ever heard voices no one else could hear or seen objects or things which others could not see?

   YES NO

6. (a) Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself?

   YES NO

   (b) Did you ever attempt to kill yourself?

   YES NO

7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed?

   YES NO

8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?

   YES NO

9. Have you ever given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property?

   YES NO

10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior?

    YES NO

Mental Health Screening Form-III (continued)

11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?

    YES NO

12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?

    YES NO

13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?

    YES NO

14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?

    YES NO

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate.

    YES NO

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?

    YES NO

17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?

    YES NO

Print client's name: _____ Program to which client will be assigned: _____

Name of admissions counselor: _____ Date: _____

Reviewer's comments: _____

_____

_____

_____

Total Score: _____(each yes = 1 point)

Source: J.F.X. Carroll, Ph.D., and John J. McGinley, Ph.D.; Project Return Foundation, Inc., 2000.
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duce. On the other hand, the SSI-SA is likely to correctly identify a high percentage of cooperative clients and to miss (false negatives) only a few—that is, only a few people who warrant a full evaluation and are likely to have a substance use disorder will be deemed by this screening instrument not to warrant a full assessment. Choosing a screening instrument and designing a screening and assessment treatment process are complex challenges that typically require expert input.

Lastly, the National Health Care for the Homeless Council recently developed general recommendations for the care of homeless patients (Bonin et al. 2004). Within these guidelines are recommendations to consider the SSI-SA to screen for substance use problems (and the MHSF-III to screen for mental disorders).

The following sections are reprinted from TIP 11.

Development of the SSI-SA

Routine screening for substance abuse can be used to initiate the process of assessment by identifying a client's possible problems and determining whether he or she needs a comprehensive assessment. Ideally, a screening instrument for substance abuse should have a high degree of sensitivity: It should be broad in its detection of individuals who have a potential substance abuse problem, regardless of the specific drug or drugs being abused.

The substance abuse screening instrument presented in this section was designed to encompass a broad spectrum of signs and symptoms for substance use disorders. These conditions are characterized by substance use that leads to negative physical, social, and/or emotional consequences and loss of control over one's pattern and amount of consumption of the substance(s) of abuse.

The view of substance abuse problems and disorders presented in this section and reflected in the screening instrument is consistent with that adopted by the World Health Organization and the American Psychiatric Association. Briefly stated, this view holds that substance abuse disorders are biopsychosocial disorders, causing impairment and dysfunction in physical, emotional, and social domains. Certain cognitive and behavioral signs and symptoms are also associated with substance abuse (see the observation checklist at the end of the screening instrument for substance abuse). Although many of these latter signs and symptoms can be the result of various medical, psychiatric, and social problems, individuals with a substance abuse disorder generally exhibit several of them.

The screening instrument for substance abuse was developed by first identifying five primary content domains, which are described in the sections that follow. The screening questions then devised were assigned to one or more of these categories. These screening questions were adapted from existing tools found in the published literature. Because most of these existing tools were designed to screen for alcohol abuse, many items needed to be revised to address other drugs. The sources for the screening items included in the instrument are shown in Figure H-1.

Domains Measured by the Instrument

Substance consumption

A person's consumption pattern—the frequency, length, and amount of use—of substances is an important marker for evaluating whether he or she has a substance abuse problem. Questions 1, 10, and 11 in the substance abuse screening instrument were formulated in order to help delineate an individual's consumption pattern.

Patterns of substance consumption can vary widely among individuals or even for the same individual. Although substance use disorders often consist of frequent, long-term use of substances, addiction problems may also be characterized by periodic binges over shorter periods.

Figure H-1
Sources for Items Included in the Simple Screening Instrument for Substance Abuse

Question No.	Source Instrument
1	Revised Health Screening Survey (RHSS)
2	Michigan Alcohol Screening Test (MAST)
3	CAGE
4	MAST, CAGE
5	History of Trauma Scale, MAST, CAGE
6	MAST, Drug Abuse Screening Test (DAST)
7	MAST, Problem-Oriented Screening Instrument for Teenagers (POSIT)
8	MAST, DAST
9	MAST, DSM-II-R
10	POSIT, DSM-III-R
11	POSIT
12	POSIT
13	MAST, POSIT, CAGE, RHSS, Alcohol Use Disorders Identification Test (AUDIT), Addiction Severity Index (ASI)

Note: References for these sources appear at the end of this section.

Preoccupation and loss of control

The symptoms of preoccupation and loss of control are common in people with substance use disorders. Preoccupation refers to an individual spending inordinate amounts of time concerned with matters pertaining to substance use. Loss of control is a symptom usually typified by loss of control over one's use of substances or over one's behavior while using substances. These symptoms are measured by screening test questions 2, 3, 9, 11, and 12.

The symptom of preoccupation is marked by an individual's tendency to spend a considerable amount of time thinking about, consuming, and recovering from the effects of the substance(s) of abuse. In some cases, the individual's behavior may be noticeably altered by his or her preoccupation with these matters. Such an individual may, for example, lose interest in personal relationships or may become less productive at work as a result of constant preoccupation with obtaining more of the substance of abuse.

Loss of control over substance use is typified by the consumption of more of the substance(s) of abuse than originally intended. Many persons with a substance abuse problem feel that they have no direct, conscious control over how much and how often they use substances. Such an individual may, for example, initially intend to have only one drink but then be unable to keep from drinking more. He or she may find it difficult or impossible to stop drinking once he or she has started. In other instances, a person who originally plans to use a drug for a short period of time may find that he or she is increasingly using it over longer periods than originally intended.

Loss of behavioral control, on the other hand, is typified by loss of inhibitions and by behaviors that are often destructive to oneself or others. In many cases, these behaviors do not occur when the individual is not using substances. A person with a substance use problem may begin taking unnecessary risks and may

act in an impulsive, dangerous manner. Individuals who are intoxicated from substance abuse may, for example, have sex with someone in whom they ordinarily would not have a sexual interest, or they may start an argument or fight.

Adverse consequences

Addiction invariably involves adverse consequences in numerous areas of an individual's life, including physical, psychological, and social domains. In the screening instrument for substance abuse, questions 5–9, 12, and 13 are designed to elicit adverse consequences of substance abuse.

Examples of adverse physical consequences resulting from substance abuse include experiencing blackouts, injury and trauma, or withdrawal symptoms or contracting an infectious disease associated with high-risk sexual behaviors. One of the most serious health threats to people with substance use disorders, particularly those who inject drugs intravenously, is infection with HIV, the causative agent of AIDS.

Adverse psychological consequences arising from substance abuse include depression, anxiety, mood changes, delusions, paranoia, and psychosis. Negative social consequences include involvement in arguments and fights; loss of employment, intimate relationships, and friends; and legal problems such as civil lawsuits or arrests for abuse, possession, or selling of illicit drugs.

As an individual's use continues over time and addiction takes hold, adverse consequences tend to worsen. Thus, people in the very early stages of addiction may have fewer adverse consequences than those in the later stages. Individuals in the early stages of addiction may therefore not make the connection between their substance abuse and the onset of negative consequences. For this reason, some of the items directed at identifying substance-related adverse consequences in the screening instrument attempt to obtain this information without making an overt association with substance abuse.

Problem recognition

Making a mental link between one's use of substances and the problems that result from it—such as difficulties in personal relationships or at work—is an important step in recognizing one's substance abuse problem. Questions 2–4 and 13–16 in the substance abuse screening instrument are problem recognition items. Some of these items ask about past contacts with intervention and treatment services, because both research and clinical experience indicate that a history of such contacts can be a valid indicator of substance abuse problems.

Some individuals who have experienced negative consequences resulting from their substance abuse will report these problems during a screening assessment. Clients who show insight about the relationship between these negative consequences and their use of substances should be encouraged to seek help.

Many, if not most, people who abuse substances, however, do not consciously recognize that they have a problem. Other reasons why a person may not disclose a substance abuse problem include denial, lack of insight, and mistrust of the interviewer. These individuals cannot be expected to respond affirmatively to "transparent" problem recognition items—those in the form of direct questions, such as "Do you have a substance problem?"—during a screening interview. For these individuals, questions must be worded indirectly in order to ascertain whether negative experiences have ensued from the use of substances.

Tolerance and withdrawal

Substance abuse, particularly prolonged abuse, can cause a variety of physiological problems that are related to the development of tolerance and withdrawal. Questions 5 and 10 are aimed at determining whether an individual has experienced any of the signs of tolerance and withdrawal.

Tolerance is defined as the need to use increasing amounts of a substance in order to create the same effect. If tolerance has developed and the individual stops using the substance of abuse, it is common for withdrawal effects to emerge.

Withdrawal from stimulants and related drugs often includes symptoms of depression, agitation, and lethargy; withdrawal from depressants (including alcohol) often includes symptoms of anxiety, agitation, insomnia, and panic attacks; and withdrawal from opioids produces agitation, anxiety, and physical symptoms such as abdominal pain, increased heart rate, and sweating.

Administration of the Simple Screening Instrument

Two versions of the simple screening instrument are presented in this section. They have been designed to be administered in the form of either an interview (Figure H-2, p. 506) or a self-administered test (Figure H-3, p. 509) to individuals who may be at risk of having a substance abuse problem.

Use of the screening instrument should be accompanied by a careful discussion about confidentiality[2] issues. The interviewer should also be clear about the instrument's purpose and should make it understood that the information elicited from the instrument will be used to benefit, not to punish, the individual being screened.

Ideally, the screening test should be administered in its entirety. Situations may arise, however, in which there is inadequate time to administer the entire test. Street outreach community workers, for example, may have very limited time with an individual.

In such situations, a subset of the screening instrument can be administered. The four boldfaced questions—1, 2, 3, and 16—constitute the short form of the screening instrument. These items were selected because they represent the prominent signs and symptoms covered by the full screening instrument. Although this abbreviated version of the instrument will not identify the variety of dimensions tapped by the full instrument and is more prone to error, it may serve as a starting point for the screening process.

Notes on the screening questions

The screening instrument begins with a question about the individual's consumption of substances (question 1). This question is intended to help the interviewer decide whether to continue with the interview—if the response to this first question is no, continued questioning may be unnecessary.

Questions 2–4 are problem recognition items intended to elicit an individual's assessment of whether too much of a substance is being used, whether attempts have been made to stop or control substance use, and whether previous treatment has been sought. Answers to these questions may help the service provider understand how the individual thinks and feels about his or her use of substances. People who later report negative consequences as the result of their substance use but who nevertheless answer "no" to these problem recognition questions may have poor insight about their substance abuse or may be denying the severity of their substance problem.

Questions 5–12 were designed to determine whether an individual has experienced any adverse consequences of substance abuse. These include medical, psychological, social, and legal problems that often are caused by substance abuse and addiction. Some questions are intended to elicit symptoms of aggression

[2]Confidentiality is governed by the Federal "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations (42 C.F.R. Part 2) and the Federal "Standards for Privacy of Individually Identifiable Health Information" (45 C.F.R. Parts 160 and 164).

Figure H-2
Simple Screening Instrument for Substance Abuse Interview Form

Note: **Boldfaced** questions constitute a short version of the screening instrument that can be administered in situations that are not conducive to administering the entire test. Such situations may occur because of time limitations or other conditions.

Introductory statement:

"I'm going to ask you a few questions about your use of alcohol and other drugs during the past 6 months. Your answers will be kept private. Based on your answers to these questions, we may advise you to get a more complete assessment. This would be voluntary—it would be your choice whether to have an additional assessment or not."

During the past 6 months…

1. **Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opioids, uppers, downers, hallucinogens, or inhalants.)** (yes/no)
2. **Have you felt that you use too much alcohol or other drugs?** (yes/no)
3. **Have you tried to cut down or quit drinking or using drugs?** (yes/no)
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.) (yes/no)
5. Have you had any of the following?
   - Blackouts or other periods of memory loss
   - Injury to your head after drinking or using drugs
   - Convulsions, or delirium tremens ("DTs")
   - Hepatitis or other liver problems
   - Feeling sick, shaky, or depressed when you stopped drinking or using drugs
   - Feeling "coke bugs," or a crawling feeling under the skin, after you stopped using drugs
   - Injury after drinking or using drugs
   - Using needles to shoot drugs
6. Has drinking or other drug use caused problems between you and your family or friends? (yes/no)
7. Has your drinking or other drug use caused problems at school or at work? (yes/no)
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.) (yes/no)
9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? (yes/no)
10. Are you needing to drink or use drugs more and more to get the effect you want? (yes/no)
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? (yes/no)
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? (yes/no)

Figure H-2 (continued)
Simple Screening Instrument for Substance Abuse Interview Form

13. Do you feel bad or guilty about your drinking or drug use? (yes/no)

    Now I have some questions that are not limited to the past 6 months.

14. Have you ever had a drinking or other drug problem? (yes/no)
15. Have any of your family members ever had a drinking or drug problem? (yes/no)
16. **Do you feel that you have a drinking or drug problem now?** (yes/no)
    - Thanks for answering these questions.
    - Do you have any questions for me?
    - Is there something I can do to help you?

Notes: _____

_____

_____

_____

_____

_____

Observation Checklist

The following signs and symptoms may indicate a substance abuse problem in the individual being screened:

- Needle track marks
- Skin abscesses, cigarette burns, or nicotine stains
- Tremors (shaking and twitching of hands and eyelids)
- Unclear speech: slurred, incoherent, or too rapid
- Unsteady gait: staggering, off balance
- Dilated (enlarged) or constricted (pinpoint) pupils
- Scratching
- Swollen hands or feet
- Smell of alcohol or marijuana on breath
- Drug paraphernalia such as pipes, paper, needles, or roach clips
- "Nodding out" (dozing or falling asleep)
- Agitation
- Inability to focus
- Burns on the inside of the lips (from freebasing cocaine)

(question 9), physical tolerance (question 10), preoccupation (question 11), and loss of control (question 12). Question 13 is designed to tap feelings of guilt, which may indicate that the individual has some awareness or recognition of a substance problem; questions 14 and 16 are intended to measure the respondent's awareness of a past or present problem; and question 15 elicits the individual's family history of substance abuse problems.

Parenthetical words or phrases that accompany some of the screening questions are intended to provide the interviewer with specific examples of what is being looked for or to help the respondent understand the question. For instance, question 1 asks whether an individual has used substances, and the wording in parentheses prompts the administrator to ask about specific substances of abuse.

Scoring and interpretation

A preliminary scoring mechanism for the screening instrument is provided in Figure H-4, p. 511.

Questions 1 and 15 are not scored, because affirmative responses to these questions may provide important background information about the respondent but are too general for use in scoring. The observational items are also not intended to be scored, but the presence of most of these signs and symptoms may indicate a substance abuse problem.

It is expected that people with a substance abuse problem will probably score 4 or more on the screening instrument. A score of less than 4, however, does not necessarily indicate the absence of a substance abuse problem. A low score may reflect a high degree of denial or lack of truthfulness in the subject's responses. The scoring rules have not yet been validated, and thus the substance abuse screening instrument needs to be used in conjunction with other established screening tools when making referrals.

Referral Issues

The substance abuse screening instrument, as a first step in the process of assessment for substance abuse problems, can help service providers determine whether an individual should be referred for a more thorough assessment. When an individual with a potential substance abuse problem is identified through the instrument, the interviewer has the further responsibility of linking the individual to resources for further assessment and treatment.

Agencies and providers using the substance abuse screening instrument should be prepared to make an appropriate referral when the screening identifies a person with a possible substance abuse problem. A phone number written on a piece of paper is not likely to be effective in linking the individual to the appropriate resource for assessment and treatment. Rather, a thorough familiarity with local community resources is needed on the part of the service provider. The referring provider should take a proactive role in learning about the availability of appointments or treatment slots, costs, transportation needs, and the names of contact people at the agencies to which referrals are made.

Because many individuals identified as having possible substance abuse problems receive services from more than one agency, it is essential that one agency assume primary responsibility for the client. The ideal model is a case management system. Through personal contacts, case managers can help patients progress through various programs and systems, cut red tape, and remove barriers to access to services.

Providing effective services for substance abuse requires close cooperation among agencies. Community linkages can help increase the quality of treatment for patients, whereas interagency competition decreases the quality of comprehensive care.

Substance abuse problems should be seen within the larger context of other problems, both current and past, confronted by the individual. Current problems such as instability in housing

Figure H-3

Simple Screening Instrument for Substance Abuse Self-Administered Form

Directions: The questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months.

During the last 6 months…

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opioids, uppers, downers, hallucinogens, or inhalants)

   ___Yes ___No

2. Have you felt that you use too much alcohol or other drugs?

   ___Yes ___No

3. Have you tried to cut down or quit drinking or using alcohol or other drugs?

   ___Yes ___No

4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)

   ___Yes ___No

5. Have you had any health problems? For example, have you:

   ___Had blackouts or other periods of memory loss?

   ___Injured your head after drinking or using drugs?

   ___Had convulsions, delirium tremens ("DTs")?

   ___Had hepatitis or other liver problems?

   ___Felt sick, shaky, or depressed when you stopped?

   ___Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?

   ___Been injured after drinking or using?

   ___Used needles to shoot drugs?

6. Has drinking or other drug use caused problems between you and your family or friends?

   ___Yes ___No

7. Has your drinking or other drug use caused problems at school or at work?

   ___Yes ___No

Figure H-3 (continued)

Simple Screening Instrument for Substance Abuse Self-Administered Form

8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)

   ___Yes ___No

9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?

   ___Yes ___No

10. Are you needing to drink or use drugs more and more to get the effect you want?

    ___Yes ___No

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?

    ___Yes ___No

12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?

    ___Yes ___No

13. Do you feel bad or guilty about your drinking or drug use?

    ___Yes ___No

The next questions are about your lifetime experiences.

14. Have you ever had a drinking or other drug problem?

    ___Yes ___No

15. Have any of your family members ever had a drinking or drug problem?

    ___Yes ___No

16. Do you feel that you have a drinking or drug problem now?

    ___Yes ___No

Thanks for filling out this questionnaire.

and employment, homelessness, and hunger often represent immediate needs that are more pressing for the individual than treatment for his or her substance abuse. Past crises, such as incest, rape, and sexual abuse, can also affect how an individual responds to the screening questions.

Some of the items in the screening instrument may trigger emotional distress or a crisis. Reactions may sometimes include anxiety or depression, which may be accompanied by suicidal thoughts and behaviors. Agencies should therefore develop specific protocols to manage such crises. These protocols should include

Figure H-4
Scoring for the Simple Screening Instrument for Substance Abuse

Name/ID No.: _____ Date: _____

Place/Location: _____

Items 1 and 15 are not scored. The following items are scored as 1 (yes) or 0 (no):

___ 2	___ 7	___ 12
___ 3	___ 8	___ 13
___ 4	___ 9	___ 14
___ 5 (any items listed)	___ 10	___ 16
___ 6	___ 11	

Total score: ____ Score range: 0-14

Preliminary interpretation of responses:

Score	Degree of Risk for Substance Abuse
0-1	None to low
2-3	Minimal
>4	Moderate to high: possible need for further assessment

inhouse management and appropriate referrals and followup.

See appendix C, Glossary, for substance abuse screening terms.

Sources for the Substance Screening Questions

Addiction Severity Index: McLellan, A.T., Luborsky, L., Woody, G.E., and O'Brien, C.P. An improved diagnostic evaluation instrument for substance abuse patients: The Addiction Severity Index. *Journal of Nervous and Mental Disease* 186:26–33, 1980.

AUDIT: Babor, T.F., De La Fuente, J.R., and Saunders, J. *AUDIT: Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Health Care*. Geneva: World Health Organization, 1989.

CAGE: Mayfield, D., McLeod, G., and Hall, P. The CAGE questionnaire: Validation of a new alcoholism screening instrument. *American Journal of Psychiatry* 131:1121–1123, 1974.

DAST: Skinner, H.A. Drug Abuse Screening Test. *Addictive Behavior* 7:363–371, 1982.

DSM-III-R: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 3d Edition, Revised. Washington, DC: American Psychiatric Association, 1987.

History of Trauma Scale: Skinner, H.A., Holt, S., Schuller, R., Roy, J., and Israel, Y. Identification of alcohol abuse using laboratory tests and a history of trauma. *Annals of Internal Medicine* 101:847–851, 1984.

MAST: Selzer, M.L. The Michigan Alcohol Screening Test: The quest for a new diagnostic instrument. *American Journal of Psychiatry* 127:1653–1658, 1971.

POSIT: Rahdert, E.R. *The Adolescent Assessment and Referral System Manual.* DHHS Pub. No. (ADM) 91-1735. Rockville, MD: National Institute on Drug Abuse, 1991.

RHSS: Fleming, M.F., and Barry, K.L. A three-sample test of a masked alcohol screening questionnaire. *Alcohol* 26:81–91, 1991.

Appendix I: Selected Sources of Training

Sources of Training on Addiction Disorders

Addiction Technology Transfer Centers (ATTCs)

Check with your local ATTC. Course offerings vary.

- www.nattc.org
- For curricula, lectures, videos, and printed training materials available through ATTCs, see www.nattc.org/resPubs.html
- For information on distance training offered by ATTCs and other providers, see www.addictionED.org

Hazelden Institute

Hazelden offers training opportunities at many levels and locations.

The Graduate School of Addiction Studies offers both a Master of Arts in Addiction Studies and individualized programs. A Chemical Dependency Counselor Certificate program is available for those with less formal training. Contact the Graduate School at (888) 257-7800, ext. 4175 for more information.

- www.hazeldon.org

The Hazelden Distance Learning Center for Addiction Studies provides opportunities for home-based study. Courses may be taken via the Web or using traditional print materials. Contact the Distance Learning Center at (800) 328-9000 for more information.

- www.dlcas.com

National Association for Alcohol and Drug Abuse Counselors (NAADAC)

The NAADAC Web site includes lists of approved education providers, distance learning opportunities, and post-secondary programs. Home study materials are also available through NAADAC. Contact: (800) 548-0497.

- www.naadac.org

National Clearinghouse for Alcohol and Drug Information (NCADI)

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) NCADI distributes materials developed by SAMHSA's Center for Substance Abuse Prevention and Center for Substance Abuse Treatment, along with several other agencies. Contact NCADI at (800) 729-6686 for more information.

- http://store.samhsa.gov

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

Project Matching Alcoholism Treatment to Client Heterogenity (MATCH) manuals are the result of the collaborative efforts of the Project MATCH investigators and are used as guides by the therapists in the trial. They are presented to the alcohol research community as standardized, well-documented intervention tools for alcoholism treatment research. The manuals address 12-Step facilitation, motivational enhancement, and cognitive–behavioral treatments.

- To access Project MATCH materials, see http://pubs.niaaa.nih.gov/publications/match.htm for an order form or write to:

  National Institute on Alcohol Abuse and Alcoholism
  Publications Distribution Center
  P.O. Box 10686
  Rockville, MD 20849-0686

National Institute on Drug Abuse (NIDA)

NIDA publishes a wide variety of treatment-related materials, including a three-volume set of therapy manuals for cocaine addiction. Contact: (301) 443-1124.

- www.nida.nih.gov

National Development and Research Institutes, Inc. (NDRI)

NDRI offers an extensive training program of 75 courses in substance abuse and HIV/AIDS, consultation, and technical assistance for program development and implementation. Contact: (212) 846-4566.

- www.ndri.org

Other University-Based Training

A number of universities offer training. For example, the Division on Addictions at Harvard Medical School offers a fellowship in addictions and other training for counselors, MSWs, and other clinicians.

Rutgers Center for Alcohol Studies

The Center for Alcohol Studies offers two types of programs through its Education and Training Division. Both the School of Alcohol and Drug Studies and the Institute of Alcohol and Drug Studies offer weeklong programs throughout the summer months for interested professionals and laypersons. During the academic year, professionals may choose 1-day courses from the Continuing Professional Education Seminars. Contact the Center's Education and Training Division at (732) 445-4317 for more information.

- http://alcoholstudies.rutgers.edu

State Certifying Boards for Chemical Dependency Counseling

A list of individual State boards is available through NAADAC. Contact: (800) 548-0497 or visit www.naadac.org. Another list is available through the International Certification and Reciprocity Consortium. Contact: (919) 572-6823.

- http://internationalcredentialing.org/

Sources of Training on Mental Health

American Counseling Association

Home study courses, learning institutes, and onsite training. Contact: (703) 823-9800.

- www.counseling.org

American Psychological Association

Office of Continuing Professional Education. Home study and other approved courses, including some co-occurring disorder specific offerings. Contact: (202) 336-5991.

- www.apa.org/ce/

American Psychiatric Association

Office of Continuing Medical Education. Gives CME credits for review and exam based on the Association's annual meeting. Ask for a listing of other conferences and courses available for CME credits. Contact: (202) 682-6179.

- www.psych.org

National Mental Health Information Center (NMHIC)

This is a service of SAMHSA's Center for Mental Health Services. NMHIC distributes materials developed by the Center for Mental Health Services and other agencies. Several training manuals are among the publications offered. Contact NMHIC at (800) 789-2647 for more information.

- www.mentalhealth.samhsa.gov

National Institute of Mental Health (NIMH)

NIMH provides a variety of manuals and research reports, including texts on anxiety disorders and depression. Contact: (301) 443-4513.

- www.nimh.nih.gov

Sources of Training on Co-Occurring Disorders

Addiction Technology Transfer Centers (ATTCs)

Check with your local ATTC. Course offerings vary.

- www.nattc.org/regCenters.html
- For distance training offered by ATTCs and other providers, see www.addictionED.org
- For curricula, lectures, videos, and printed training materials: www.nattc.org/resPubs.html (search for co-occurring disorders)

Formal Continuing Education COD Curricula

Several examples follow:

Dual Recovery Project

Houston Community College, University of Houston, Harris County MHMRA, Houston, Texas. Contact: (713) 970-7000.

- trustin@pol.net

Integrated Program Development and Clinical Interventions

Foundations Associates and the Dual Diagnosis Recovery Network in Nashville, TN provide specialized training on implementation and financing of integrated program models and integrated clinical interventions. Contact: (888) 869-9230.

- www.dualdiagnosis.org; mcartwright@dual-diagnosis.org

MISA Curriculum

Seven modules, Behavioral Healthcare Resource Program, University of North Carolina, School of Social Work. Contact: (919) 962-1225.

- ssw@unc.edu

National Development and Research Institutes

NDRI has a COD Curriculum with 10 modules targeting the generalist. Contact: (646) 638-2497.

- www.ndri.org

Washington State Institute for Mental Health Research and Training

The institute has extensive training materials as well as training videotapes on COD. Contact: (253) 756-2741.

Miscellaneous Training

A variety of training opportunities are listed by Kathleen Sciacca at

- users.erols.com/ksciacca/upcom.htm

State-Sponsored Training

Many States have developed model curricula.

Listservs and Discussion Groups on Co-Occurring Disorders

The following is a selection of listservs and discussion groups dealing specifically with the topic of co-occurring disorders. These online communication networks offer members the opportunity to post suggestions or questions to a large number of people at the same time. Listservs differ in that they are generally geared more toward professionals and are more closely monitored. Discussion groups are usually open to anyone, and may not be closely monitored. Submissions to listservs are distributed to all members, so before submitting a query or a comment to an entire listserv group, you may wish to monitor the discussions.

CataList—The Official Catalog of Listserv Lists

CataList, a general resource, is a catalog of more than 55,000 listserv lists. It allows users to browse listserv lists, search by keyword for mailing lists of interest, and obtain information about listserv host Web sites. CataList contains information only about public lists; confidential lists and lists of purely local interest are not in the searchable database.

- www.lsoft.com/lists/listref.html

Co-Occurring Dialogues

As an expansion of services to the CSAT Treatment Improvement Exchange on the Web (www.treatment.org), the Division of State and Community Assistance has established *Co-Occurring Dialogues*, a listserv focusing on issues related to dual diagnosis. Subscription to the *Co-Occurring Dialogues* discussion list (dualdx@treatment.org) is free and unrestricted. Just send an e-mail to dualdx@treatment.org stating a desire to subscribe. A description of membership, purpose, and utilization will follow your subscription.

This discussion list belongs to the field. Membership is open, but the list is moderated, and CSAT reserves the right to remove any member who the agency feels is not interacting in a professional manner. Co-Occurring Dialogues is offered as a means of communication, idea sharing, brainstorming, sharing of exciting publications and opportunities, etc. It is an open vehicle for communication between and among researchers, educators, treatment agencies, the recovery community, treatment providers, and all levels of government.

- www.treatment.org/Topics/DualDialogues.html

Dual Diagnosis Bulletin Board

This subdivision of the Dual Diagnosis Listserv is a more general discussion area. Visitors can review postings on the bulletin board by clicking on headings of interest, and/or submit information for posting to the bulletin board. This area is open to anyone, consumers as well as professionals, and is not moderated.

- http://users.erols.com/ksciacca/#board

Dual Diagnosis Listserv

This listserv is operated by Dr. Kathleen Sciacca, Founding Executive Director of Sciacca Comprehensive Service Development for Mental Illness, Drug Addiction and Alcoholism (MIDAA), located in New York City. The listserv is an extension of the Dual Diagnosis Web site (users.erols.com/ksciacca), and is reserved for persons who are credentialed in the mental health and substance abuse fields and have an interest in the theory, practice, treatment, systemic change, and program implementation for dual/multiple disorders in various combinations. A resume or curriculum vitae must be submitted in order to subscribe. Membership is determined at the discretion of the list manager. Once credential information is received, members will receive a welcome message informing them of acceptance to the list and instructions on how to post to the forum.

- users.erols.com/ksciacca/ddl.htm

Dual Diagnosis Pages: Colleagues List

The Colleagues List is a division of The Dual Diagnosis Pages, a general resource Web site for co-occurring addiction and personality disorders. The Colleagues List allows professionals to act as mutually supporting resources. Mental health and substance abuse treatment professionals can post a description of themselves and their qualifications/background so that practitioners with common interests, issues, or questions can get in touch with each other.

MIDAS: Discussion Group

MIDAS is a member of the Dual Disorder Web Ring, and offers a Discussion Group through Yahoo.com. MIDAS is an Australian site provided by the South Western Sydney Area Health Service, but it offers links to programs and resources around the world. There are no special conditions for joining the Discussion Group, and new members are joining all the time. However, the description given on the home page freely acknowledges that the group gets active only from time to time, sometimes slowing down for months.

Appendix J: Dual Recovery Mutual Self-Help Programs and Other Resources for Consumers and Providers

Dual Recovery 12-Step Fellowships

Double Trouble in Recovery

The organization provides 12 steps that are based on a traditional adaptation of the original 12 steps. For example, the identified problem in step one is changed to co-occurring disorders, and the population to be assisted is changed in step 12 accordingly. The organization provides a format for meetings that are chaired by members of the fellowship.

Contact information

Double Trouble in Recovery
c/o Mental Health Empowerment Project
271 Central Avenue
Albany, NY 12209
(518) 434-1393
www.doubletroubleinrecovery.org

Dual Diagnosis Anonymous

The organization provides a hybrid approach that developed 5 steps in conjunction with the traditional 12 steps. The five steps differ from those of other dual recovery groups in underscoring the potential need for medical management, clinical interventions, and therapies. The organization provides a meeting format that is used by fellow members who chair the meetings.

Contact information

Dual Diagnosis Anonymous
320 North E. Street, Suite 207
San Bernardino, CA 92401
(909) 888-9282

Dual Disorders Anonymous

The organization provides 12 steps that are based on a traditional adaptation of the original 12 steps. For example, the identified problem in step one is changed to co-occurring disorders, and the population to be assisted is changed in step 12 accordingly. The organization provides a format for meetings that are chaired by members of the fellowship.

Contact information

Dual Disorders Anonymous
P.O. Box 681264
Schaumburg, IL 60168
(847) 781-1553

Dual Recovery Anonymous

The organization provides 12 steps that are an adapted and expanded version of the traditional 12 steps. The expanded approach changes the identified problem to co-occurring disorders, and the population to be assisted is changed accordingly. It also retains most of the traditional language while modifying certain terms in an effort to meet the needs of mental health consumers. In addition, it incorporates affirmations into three of the 12 steps. The organization provides a meeting format that is used by fellow members who chair the meetings.

Contact information

Dual Recovery Anonymous World Services, Inc.
P.O. Box 8107
Prairie Village, KS 66208
(877) 883-2332 (toll free)
E-mail: draws@draonline.org
www.draonline.org

Dual Recovery Empowerment Foundation

This organization offers the program Dual Recovery Self-Help, which encompasses information on dual recovery 12-Step fellowships; 12-Step principles for personal recovery, coping, and life skills; and forming dual recovery 12-Step groups and meetings.

Contact information

Dual Recovery Empowerment Foundation
P.O. Box 8708
Prairie Village, KS 66208
(615) 504-9797
rwth@kc.rr.com

Supported Mutual Help for Dual Recovery

Dual Diagnosis Recovery Network (DDRN)

The DDRN is a program of Foundations Associates that derives part of its funding from the Tennessee Department of Mental Health and Developmental Disabilities, as well as the Tennessee Department of Health, Bureau of Alcohol and Drug Abuse Services. DDRN provides dual recovery mutual help information in all areas of the services that are offered; education and training through community programs, inservice training, workshops, State, regional, and national conferences; advocacy and coalition building through networking and coordinating a statewide task force that engages chemical dependency and mental health professionals, consumers, and family members; provides information through the Dual Network quarterly journal and the resource and information clearinghouse.

Contact information

Dual Diagnosis Recovery Network (DDRN)
220 Venture Circle
Nashville, TN 37228
(888) 869-9230
www.dualdiagnosis.org

Support Together for Emotional/Mental Serenity and Sobriety (STEMSS)

STEMSS is a psychoeducational group intervention. The model has been developed to train facilitators to initiate, implement, and maintain support groups for consumers. The six steps of the program and the support groups are intended to complement participation in traditional 12-Step programs.

Contact information

Michael G. Bricker, Executive Director
STEMSS Institute and Bricker Clinic
140 E. Dekora Street
Saukville, WI 53080
(414) 268-0899

Other Resources for Consumers and Providers

Consumer Organization and Networking Technical Assistance Center (CONTAC)

CONTAC distributes a list of names and contacts for resources and information on substance addictions, co-occurring disorders, services, and mutual help support. CONTAC also offers the Leadership Academy, a training program that is designed to help consumers learn how to engage in and develop consumer services. Recently, a training component focusing on substance abuse/dependence was developed and incorporated into the program.

Contact information

Consumer Organization and Networking
Technical Assistance Center (CONTAC)
1036 Quarrier Street, Suite 208A
Charleston, WV 25891
(304) 346-9992 or (888) 825-8324

National Council on Alcoholism and Drug Dependence (NCADD)

NCADD has a nationwide network of nearly 100 affiliates. These affiliates provide information and referrals to local services, including counseling and treatment. NCADD also offers a variety of publications and resources.

Contact information

NCADD National Office
20 Exchange Place, Suite 2902
New York, NY 10005
(212) 269-7797
Fax: (212) 269-7510
E-mail: national@ncadd.org
www.ncadd.org

National Empowerment Center

The National Empowerment Center has prepared an information packet, which includes a series of published articles, newspaper articles, and a listing of organizations and Federal agencies that provide information, resources, and technical assistance related to substance abuse and dependence, co-occurring disorders, services, and mutual help support.

Contact information

National Empowerment Center
599 Canal Street
Lawrence, MA 01840
(800) 769-3728
www.power2u.org

National Mental Health Association

The National Mental Health Association has expanded its mission to encompass substance abuse/addictions and co-occurring disorders. The organization continues to develop resources, documents, and publications. A designated section on the organization's Web site is dedicated to co-occurring disorders.

Contact information

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
(800) 969-6642
TTY: (800) 433-5959
www.nmha.org

National Mental Health Consumers' Mutual Help Clearinghouse

The organization has developed and offers a resource kit, which provides the names and contacts for resources and information on substance addictions, co-occurring disorders, services, and mutual help support.

Contact information

National Mental Health Consumers' Self-Help Clearinghouse
1211 Chestnut Street, Suite 1207
Philadelphia, PA 19107
(800) 553-4KEY
www.mhselfhelp.org

Appendix K: Confidentiality

Federal Laws and the Right to Confidentiality

In the early 1970s, Congress recognized that the stigma associated with substance abuse and fear of prosecution deterred people from entering treatment. As a result, it enacted legislation that gave clients in a substance abuse treatment program a right to confidentiality (42 USC §290dd-2). For the 3 decades since the Federal confidentiality regulations (42 C.F.R. Part 2, or Part 2) were issued in response to the Federal mandate, confidentiality has been a cornerstone practice for substance abuse treatment programs across the country.

In December 2000, the Department of Health and Human Services (DHHS) issued the "Standards for Privacy of Individually Identifiable Health Information" final rule (Privacy Rule), pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, Subparts A and E. Substance abuse treatment programs that are subject to HIPAA must comply with the Privacy Rule. The Privacy Rule and other guidance regarding its requirements may be accessed through the DHHS Office for Civil Rights (OCR) Web site at www.hhs.gov/ocr/hipaa/. In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA) has issued guidance titled "The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs," which can be accessed through its Web site at http://www.samhsa.gov/healthprivacy/.

How the Two Federal Laws Relate to Each Other and to State Law

Substance abuse treatment programs need to understand how both Federal laws—the older substance abuse-specific Part 2 regulations and the Privacy Rule—apply to their programs.

Applicability

Part 2

Part 2 applies to all programs (individuals or organizations) specializing, in whole or in part, in providing treatment, counseling, or assessment and referral services for substance use disorders (§§2.11, 2.12(e)). (Any citations in this appendix that begin with §2 refer to sections of 42 C.F.R. Part 2.) Part 2 applies only to programs that receive Federal assistance, including indirect forms of Federal aid, such as tax-exempt status or State or local government funding that is from (in whole or in part) the Federal government or any form of Medicaid or Medicare funding for any purpose.

Privacy Rule

The Privacy Rule applies to healthcare providers (persons or organizations that furnish, bill, or are paid for health care in the normal course of business) who transmit health information

- In electronic form (generally, via computer-based technology) and
- In connection with transactions for which DHHS has adopted a HIPAA standard, such as submitting healthcare claims to Medicaid or private payors.

Drug and alcohol programs are healthcare providers because they furnish health care in the normal course of business. However, only those programs that transmit health information in electronic form and in connection with a HIPAA transaction, such as a healthcare claim, are subject to the Privacy Rule (such programs, along with health plans and healthcare clearinghouses, are HIPAA "covered entities"). (For a list of the HIPAA transactions for which standards have been adopted, see 45 C.F.R. Part 162. Note that *once a program is subject to HIPAA, all "protected health information" [see below] that the program transmits or maintains about individuals is covered by the Privacy Rule—whether the information is in oral, written, or electronic form.*)

Information protected

Part 2 requirements

The Part 2 requirements

- Apply to information about any individual who has applied for or received any substance-abuse–related assessment, treatment, or referral services and prohibit all disclosures of information about that person that are not specifically permitted by nine limited exceptions.
- Are more restrictive of communications in many instances than either the doctor–patient or the attorney–client privilege.
- Apply to information about current and former clients from the time they make an appointment and apply to any information that would identify them as individuals who use substances either directly or by implication.
- Apply to information about clients who are mandated into treatment as well as to information about those who enter treatment voluntarily.
- Apply whether the person seeking information already has that information, has other ways of getting it, has some form of official status, is authorized by State law, or comes armed with a subpoena or search warrant.
- Violating Part 2 is punishable by a fine of up to $500 for a first offense and up to $5,000 for each subsequent offense (§2.4).

Privacy Rule requirements

Under the Privacy Rule, a program may not use or disclose protected health information except as permitted or required by the Rule. See 45 C.F.R. §164.502(a). Protected health information is defined as individually identifiable health information held or transmitted by a covered entity or its "business associate," with limited exceptions. See 45 C.F.R. §160.103. It does not include such information in employment records or in certain educational records. The Privacy Rule permits disclosures in many circumstances in which Part 2 would not. Most importantly, the Privacy Rule

does not require that the client consent to disclosures made for "treatment, payment or health care operations" (§§164.502(a)(1)(ii); 164.506(c)). (Citations in the form §164. . . refer to sections in 45 C.F.R. Part 164.) Part 2 requires client consent for almost all such disclosures. There are civil and criminal penalties for violations of the Privacy Rule.

State laws and regulations

Covered entities will usually be able to comply with both Privacy Rule and applicable State law provisions. However, there may be situations in which the provisions of the Privacy Rule and State law are contrary, which generally means the covered entity would find it impossible to comply with both. If contrary, the Privacy Rule overrides State law, unless the State law is more stringent; that is, unless the State law provides greater privacy protection for the individual who is the subject of the protected health information. If the State law is more stringent, programs must comply with the State law. A Privacy Rule provision would also not prevail over a contrary State law provision where DHHS had granted an exception.

Working with both sets of regulations

Substance abuse treatment programs that are already complying with Part 2 should not have a difficult time complying with the Privacy Rule, as it parallels the requirements of Part 2 in many areas. Programs subject to both sets of rules must comply with both, unless there is a conflict between them. Generally, this will mean that substance abuse treatment programs should continue to follow Part 2. In some instances, programs will have to establish new policies and procedures or alter existing policies and procedures.

Security of records

Part 2 requires programs to maintain written records in a secure room, a locked file cabinet, a safe, or other similar container. It requires programs to adopt written procedures to regulate access to and use of clients' records. Either the program director or a single staff person should be designated to process inquiries and requests for information (§2.16).

Section 164.530(c) of the Privacy Rule requires programs that are covered entities to maintain reasonable and appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information. The issue of security is addressed in more detail through a separate Security Rule issued by DHHS on February 20, 2003, that establishes the administrative, physical, and technical safeguards required to guard the integrity, confidentiality, and availability of protected health information that is electronically stored, maintained, or transmitted. See 45 C.F.R. §164.306. Alcohol and substance abuse programs that are covered entities must be in compliance with the Security Rule by April 20, 2005. The Security Rule can be accessed through the Centers for Medicare and Medicaid Services Web site at www.cms.hhs.gov.

More information can be obtained from the technical assistance publication "The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs," which can be found at
http://www.samhsa.gov/healthprivacy/.
For printed copies, contact SAMHSA's Health Information Network at (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired) (800) 487-4889.

Appendix L: Resource Panel

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Notes: Because the entire volume is about substance abuse treatment and co-occurring disorders (COD), the use of these terms as entry points has been minimized in this index. Tools and instruments are listed by their commonly known acronyms. Reference locators for information contained in figures appear in *italics*.

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CSAT TIPs and Publications Based on TIPs

What Is a TIP?

Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under CSAT's Knowledge Application Program to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

What Is a Quick Guide?

A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

What Are KAP Keys?

Also based on TIPs, KAP Keys are handy, durable tools. Keys may include assessment or screening instruments, checklists, and summaries of treatment phases. Printed on coated paper, each KAP Keys set is fastened together with a key ring and can be kept within a treatment provider's reach and consulted frequently. The Keys allow you—the busy clinician or program administrator—to locate information easily and to use this information to enhance treatment services.

Ordering Information

Publications may be ordered for free at http://store.samhsa.gov. To order over the phone, please call 1-877-SAMHSA-7 (1-877-726-4727)(English and Español). Most publications can also be downloaded at http://www.kap.samhsa.gov.

TIP 1 **State Methadone Treatment Guidelines**—Replaced by TIP 43

TIP 2* **Pregnant, Substance-Using Women**—*BKD107*
Quick Guide for Clinicians *QGCT02*
KAP Keys for Clinicians *KAPT02*

TIP 3 **Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents**—Replaced by TIP 31

TIP 4 **Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents**—Replaced by TIP 32

TIP 5 **Improving Treatment for Drug-Exposed Infants**—*BKD110*

TIP 6* **Screening for Infectious Diseases Among Substance Abusers**—*BKD131*
Quick Guide for Clinicians *QGCT06*
KAP Keys for Clinicians *KAPT06*

TIP 7 **Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System**—Replaced by TIP 44

TIP 8 **Intensive Outpatient Treatment for Alcohol and Other Drug Abuse**—Replaced by TIPs 46 and 47

TIP 9 **Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse**—Replaced by TIP 42

TIP 10 **Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients**—Replaced by TIP 43

TIP 11* **Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases**— *BKD143*
Quick Guide for Clinicians *QGCT11*
KAP Keys for Clinicians *KAPT11*

TIP 12 **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**—Replaced by TIP 44

TIP 13 **Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders**—*BKD161*
Quick Guide for Clinicians *QGCT13*
Quick Guide for Administrators *QGAT13*
KAP Keys for Clinicians *KAPT13*

TIP 14 **Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment**—*BKD162*

TIP 15 **Treatment for HIV-Infected Alcohol and Other Drug Abusers**—Replaced by TIP 37

TIP 16 **Alcohol and Other Drug Screening of Hospitalized Trauma Patients**—*BKD164*
Quick Guide for Clinicians *QGCT16*
KAP Keys for Clinicians *KAPT16*

TIP 17 **Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System**—Replaced by TIP 44

**Under revision*

TIP 18 **The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers**—*BKD173*

Quick Guide for Clinicians *QGCT18*

KAP Keys for Clinicians *KAPT18*

TIP 19 **Detoxification From Alcohol and Other Drugs**—Replaced by TIP 45

TIP 20 **Matching Treatment to Patient Needs in Opioid Substitution Therapy**—Replaced by TIP 43

TIP 21 **Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System**—*(SMA) 08-4073*

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TIP 22 **LAAM in the Treatment of Opiate Addiction**—Replaced by TIP 43

TIP 23 **Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing**—*(SMA) 08-3917*

Quick Guide for Administrators *QGAT23*

TIP 24 **A Guide to Substance Abuse Services for Primary Care Clinicians**—*(SMA) 08-4075*

Concise Desk Reference Guide *BKD123*

Quick Guide for Clinicians *QGCT24*

KAP Keys for Clinicians *KAPT24*

TIP 25 **Substance Abuse Treatment and Domestic Violence**—*(SMA) 08-4076*

Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Treatment Providers *MS668*

Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Administrators *MS667*

Quick Guide for Clinicians *QGCT25*

KAP Keys for Clinicians *KAPT25*

TIP 26 **Substance Abuse Among Older Adults**—*(SMA) 08-3918*

Substance Abuse Among Older Adults: A Guide for Treatment Providers *MS669*

Substance Abuse Among Older Adults: A Guide for Social Service Providers *MS670*

Substance Abuse Among Older Adults: Physician's Guide *MS671*

Quick Guide for Clinicians *QGCT26*

KAP Keys for Clinicians *KAPT26*

TIP 27 **Comprehensive Case Management for Substance Abuse Treatment**—*(SMA) 08-4215*

Case Management for Substance Abuse Treatment: A Guide for Treatment Providers *MS673*

Case Management for Substance Abuse Treatment: A Guide for Administrators *MS672*

Quick Guide for Clinicians *QGCT27*

Quick Guide for Administrators *QGAT27*

TIP 28* **Naltrexone and Alcoholism Treatment**—*(SMA) 05-4077*

Naltrexone and Alcoholism Treatment: Physician's Guide *MS674*

Quick Guide for Clinicians *QGCT28*

KAP Keys for Clinicians *KAPT28*

TIP 29 **Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities**—*(SMA) 08-4078*

Quick Guide for Clinicians *QGCT29*

Quick Guide for Administrators *(SMA) 08-3592*

KAP Keys for Clinicians *KAPT29*

TIP 30 **Continuity of Offender Treatment for Substance Use Disorders From Institution to Community**—*(SMA) 08-3920*
Quick Guide for Clinicians *QGCT30*
KAP Keys for Clinicians *KAPT30*

TIP 31 **Screening and Assessing Adolescents for Substance Use Disorders**—*(SMA) 08-4079*
See companion products for TIP 32.

TIP 32 **Treatment of Adolescents With Substance Use Disorders**—*(SMA) 08-4080*

Quick Guide for Clinicians *QGC312*

KAP Keys for Clinicians *KAP312*

TIP 33 **Treatment for Stimulant Use Disorders**—*(SMA) 06-4209*

Quick Guide for Clinicians *QGCT33*

KAP Keys for Clinicians *KAPT33*

TIP 34 **Brief Interventions and Brief Therapies for Substance Abuse**—*(SMA) 07-3952*

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KAP Keys for Clinicians *KAPT34*

TIP 35 **Enhancing Motivation for Change in Substance Abuse Treatment**—*(SMA) 08-4212*

Quick Guide for Clinicians *QGCT35*

KAP Keys for Clinicians *KAPT35*

**Under revision*

TIP 36 **Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues**—*(SMA) 08-3923*

Quick Guide for Clinicians *QGCT36*

KAP Keys for Clinicians *KAPT36*

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TIP 37 **Substance Abuse Treatment for Persons With HIV/AIDS**—*(SMA) 08-4137*

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Drugs, Alcohol, and HIV/AIDS: A Consumer Guide—*(SMA) 08-4127*

Drugs, Alcohol, and HIV/AIDS: A Consumer Guide for African Americans—*(SMA) 07-4248*

TIP 38 **Integrating Substance Abuse Treatment and Vocational Services**—*(SMA) 06-4216*

Quick Guide for Clinicians *QGCT38*

Quick Guide for Administrators *QGAT38*

KAP Keys for Clinicians *KAPT38*

TIP 39 **Substance Abuse Treatment and Family Therapy**—*(SMA) 08-4219*

Quick Guide for Clinicians *QGCT39*

Quick Guide for Administrators *QGAT39*

TIP 40 **Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction**—*(SMA) 07-3939*

Quick Guide for Physicians *QGPT40*

KAP Keys for Physicians *KAPT40*

TIP 41 **Substance Abuse Treatment: Group Therapy**—*(SMA) 05-3991*

Quick Guide for Clinicians *QGCT41*

TIP 42 **Substance Abuse Treatment for Persons With Co-Occurring Disorders**—*(SMA) 08-3992*

Quick Guide for Clinicians *(SMA) 07-4034*

Quick Guide for Administrators *QGAT42*

KAP Keys for Clinicians *(SMA) 08-4036*

TIP 43 **Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs**—*(SMA) 08-4214*

Quick Guide for Clinicians *QGCT43*

KAP Keys for Clinicians *(SMA) 07-4108*

TIP 44 **Substance Abuse Treatment for Adults in the Criminal Justice System**—*(SMA) 05-4056*

Quick Guide for Clinicians *QGCT44*

KAP Keys for Clinicians *(SMA) 07-4150*

TIP 45 **Detoxification and Substance Abuse Treatment**—*(SMA) 08-4131*

Quick Guide for Clinicians *(SMA) 06-4225*

KAP Keys for Clinicians *(SMA) 06-4224*

Quick Guide for Administrators *(SMA) 06-4226*

TIP 46 **Substance Abuse: Administrative Issues in Outpatient Treatment**—*(SMA) 06-4157*

Quick Guide for Administrators—*(SMA) 07-4232*

TIP 47 **Substance Abuse: Clinical Issues in Outpatient Treatment**—*(SMA) 06-4182*

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TIP 49 **Incorporating Alcohol Pharmacotherapies Into Medical Practice**—*(SMA) 09-4380*

TIP 50 **Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment**—*(SMA) 09-4381*

TIP 52 **Clinical Supervision and Professional Development of the Substance Abuse Counselor**—*(SMA) 09-4435*

Substance Abuse Treatment For Persons With Co-Occurring Disorders

This TIP, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, revises TIP 9, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*. The revised TIP provides information about new developments in the rapidly growing field of co-occurring substance use and mental disorders and captures the state-of-the-art in the treatment of people with co-occurring disorders. The TIP focuses on what the substance abuse treatment clinician needs to know and provides that information in an accessible manner. The TIP synthesizes knowledge and grounds it in the practical realities of clinical cases and real situations so the reader will come away with increased knowledge, encouragement, and resourcefulness in working with clients with co-occurring disorders.

Collateral Products Based on TIP 42

Quick Guide For Clinicians
KAP Keys For Clinicians
Quick Guide for Administrators
Quick Guide for Mental Health Providers

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