

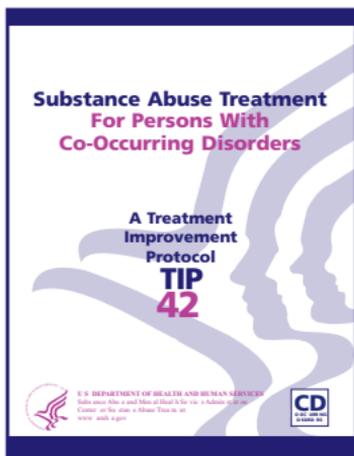
Quick Guide

For Clinicians

Based on TIP 42

Substance Abuse Treatment For Persons With

Co-Occurring Disorders



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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This Quick Guide is based entirely on information contained in TIP 42, published in 2005, and based on information updated through January 2005. No additional research has been conducted to update this topic since publication of the TIP.

WHY A QUICK GUIDE?

This Quick Guide was developed to accompany *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Number 42 in the Treatment Improvement Protocol (TIP) series published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA). This Quick Guide is based entirely on TIP 42 and is designed to meet the needs of the busy clinician for concise, easily accessed “how-to” information.

The Guide is divided into nine sections (see *Contents*) to help readers quickly locate relevant material. For more information on the topics in this Quick Guide, readers are referred to TIP 42.

WHAT IS A TIP?

The TIP series has been in production since 1991. This series provides the substance abuse treatment and related fields with consensus-based, field-reviewed guidelines on substance abuse treatment topics of vital and current interest.

TIP 42, Substance Abuse Treatment for Persons With Co-Occurring Disorders

- Provides information about new developments in the rapidly growing field of co-occurring substance use and mental disorders.
- Focuses on what the substance abuse treatment clinician needs to know and provides that information in an accessible manner.
- 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.

See the inside back cover for information on how to order TIPs and other related products.

INTRODUCTION

The term “co-occurring disorders” refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have co-occurring disorders (abbreviated as COD) have one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs.

By the 1990s, substance abuse treatment programs typically reported that 50 to 75 percent of clients had co-occurring mental disorders, while clinicians in mental health settings reported that between 20 and 50 percent of their clients had a co-occurring substance use disorder.

The objective of TIP 42 and this Quick Guide is to highlight the major developments in the field since the publication of TIP 9, in an effort to help substance abuse and mental health professionals develop a plan for a more integrated treatment community that can better address the needs of clients with COD.

GUIDING PRINCIPLES AND ESSENTIAL ATTITUDES

The following six principles are recommended for use in working with clients with COD.

1. Employ a Recovery Perspective.

The recovery perspective acknowledges that recovery is a long-term process of internal change and that these changes proceed through various stages. This perspective generates at least two main principles for practice:

- Develop a treatment plan that provides for continuity of care over time.
- Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the co-occurring disorder recovery process.

2. Adopt a Multiproblem Viewpoint.

Because people with COD generally have an array of psychiatric, medical, substance abuse, family, and social problems, most are in need of substantial rehabilitation and habilitations. Treatment should address immediate and long-term needs for housing, work, health care, and a support network.

3. Develop a Phased Approach to Treatment.

Many clinicians view clients as progressing through phases. Generally, three to five phases are identified: engagement, stabilization, treatment, and aftercare or continuing care. These phases are consistent with, and parallel to, stages identified in the recovery perspective.

4. Address Specific Real-Life Problems Early in Treatment.

Approaches that address specific life problems early in treatment may incorporate case management and intensive case management to help clients find housing or handle legal and family matters. It also may be helpful to use specialized interventions that target important areas of client need, such as money management and housing-related support services.

Psychosocial rehabilitation, which helps clients develop the specific skills and approaches they need to perform their chosen roles, is also a useful strategy for addressing these specific problems.

Solving such problems is often an important first step toward achieving client engagement in continuing treatment, which is a critical part of substance abuse treatment generally and of treatment for COD specifically.

5. Plan for the Client's Cognitive and Functional Impairments.

Clients with COD often display cognitive and other functional impairments that affect their ability to comprehend information or complete tasks. Such impairments frequently call for relatively short, highly structured treatment sessions that are focused on practical life problems. Gradual pacing, visual aids, and repetition are often helpful. Even subtle impairments may have a significant impact on treatment success; therefore, careful assessment and treatment planning consistent with the assessment are essential.

6. Use Support Systems To Maintain and Extend Treatment Effectiveness.

The mutual self-help movement, family, and other resources that exist within the client's community can play an invaluable role in recovery. The clinician should help to ensure that the client is aware of available support systems and motivated to use them effectively.

For more information, see chapter 3 of TIP 42.

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
- Recognition of the rights of clients with COD, including the right and need to understand assessment results and the treatment plan

ASSESSMENT

The *screening process* for COD seeks to answer a “yes” or “no” question (e.g., Does the substance abuse treatment client have any significant indication of a possible mental health disorder?), and only indicates whether the possibility of a co-occurring mental health problem warrants further attention at the current time.

Basic assessment, on the other hand, enables the counselor to understand the client’s COD, diagnoses, readiness for change, problem areas, disabilities, and strengths. Intake information consists of

- **Background:** Family; trauma history; marital status; legal involvement; financial situation; health; education; housing status; strengths and resources; employment
- **Substance use:** Age of first use; primary drugs used; patterns of drug use; treatment episodes
- **Psychiatric problems:** Family history of psychiatric problems; client history of psychiatric problems including diagnosis, hospitalization, and other treatment; current symptoms and mental status; medication and medication adherence

If the screening and assessment process establishes a substance abuse or psychiatric disturbance 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 people with COD.

The Assessment Process

The following steps are recommended for assessment of each individual.

Step 1: Engage the client.

Five key concepts that promote the engagement of the client include

- **Universal access (no wrong door):** Recognize that individuals with COD may enter a range of community service sites and that proactive efforts are necessary to welcome them into treatment.
- **Empathic detachment:** Acknowledge that you and the client are working together to make decisions to support the client's best interests and maintain empathic connection even if the client does not fit your expectations, treatment categories, or preferred methods of working.

- **Person-centered assessment:** Focus on the client's perception of the problem, what the client wants to change, and how the client thinks that change will occur.
- **Sensitivity to culture, gender, and sexual orientation:** Recognize your own cultural perspective and inquire how cultural factors influence the client's request for help.
- **Trauma sensitivity:** Consider the possibility of a trauma history before the assessment begins, and try to promote safety in the interview by providing more support and gentleness.

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

Information from collaterals is particularly valuable in evaluating the nature and severity of psychiatric 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 and with the client's permission.

Step 3: Screen and detect co-occurring disorders.

All individuals in need of substance abuse treatment should be screened for co-occurring mental disorders, and all individuals in need of mental health treatment should be screened for the presence of a substance use disorder. In addition, 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. A variety of tools are available for use in safety screening (see appendices G and H of TIP 42).

Mental health screening: A summary of the Mental Health Screening Form-III (MHSF-III) is provided on the following pages. The full form is reprinted in appendix H of TIP 42, and can also be obtained at www.projectreturn.org or www.asap-nys.org/Resources/mhscreen.pdf.

Use of the form is best undertaken after the client and the screener have developed a strong rapport, as some of the questions deal with sensitive matters. Also, screeners must be appropriately trained to administer these items and record the clients' responses.

The MHSF-III is just one of a number of mental health and substance abuse screening instruments available. For more information on other screening and assessment instruments and how to obtain them, see appendices G and H of TIP 42.

The Mental Health Screening Form-III (MHSF-III):

The preferred mode of administration is for staff members to read each item to respondents and get their “yes” and “no” responses. 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?”
- “What was happening in your life at that time?”

The form provides space for this information and for staff member comments.

The MHSF-III also can 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.

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 followup, face-to-face interview is needed for a diagnosis and/or treatment recommendation.

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

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 too 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 nonstop, 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)

Note: Summing the number of "yes" responses can not 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.

Source: J.F.X. Carroll, Ph.D., and John J. McGinley, Ph.D.; Project Return Foundation, Inc., 2000.

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www.asapnys.org/Resources/mhscreen.pdf

Step 4: Determine the severity of symptoms.

To determine the severity of symptoms and disability, consider consulting the American Association of Community Psychiatrists' Level of Care Utilization System (LOCUS, see Step 5 immediately below or go to www.wpic.pitt.edu/aacp/finds/locus.html for more information) or the Dimension 3 subscales in the American Society of Addiction Medicine's Patient Placement Criteria (ASAM PPC-2R) (see Step 5).

Some clients may be eligible for certain mental health programs or benefits. Counselors may need to be aware of how these determinations are made in the State where the client resides.

Step 5: Determine the level of care.

LOCUS may help to determine appropriate placement in "level of care" for individuals presenting for substance use disorder treatment. LOCUS is simple to use and involves consideration of multiple dimensions of assessment:

- Risk of harm (to self or others)
- Functionality (ability to fulfill social responsibilities, interact with others, etc.)
- Comorbidity (level of severity and/or acuity)
- Recovery support and stress (availability of family, social, and community support systems)
- Treatment attitude and engagement (positive about or resistant to change)

- Treatment history (previous periods of sobriety, etc.)

The ASAM PPC-2R is also used for determining level of care and employs six dimensions of assessment:

Dimension 1: Acute Intoxication and/or Withdrawal Potential

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

Dimension 3 is particularly useful in evaluating level of care requirements for individuals with COD and encompasses five areas of risk to be considered:

- Suicide potential
- Interference with addiction recovery efforts
- Social functioning
- Ability for self-care
- Course of illness

Step 6: Determine the diagnosis.

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). Also consider the following three principles:

- **Principle 1:** Diagnosis is established more by history than by current symptom presentation (applies to both mental health and substance use disorders).
- **Principle 2:** Document prior diagnoses and gather information related to current diagnoses, even though you may not be licensed to make a mental health diagnosis.
- **Principle 3:** For diagnostic purposes, it is almost always necessary to tie mental health symptoms to particular periods of time in the client's history, especially times when active substance use disorder was not present.

Step 7: Determine the disability and functional impairment.

Current level of impairment is determined by assessing functional capabilities and deficits in each of the following areas:

- 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 Addiction Severity Index (ASI) and the Global Appraisal of Individual Needs (GAIN) provide some information about level of functioning for individuals with substance use disorders. (The ASI also exists in an expanded version specifically for women [ASI-F]).

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 the use of transportation, budgeting, self-care, and other related skills.

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 focusing exclusively on deficits. 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 integrated treatment relationships.
- Previous mental health 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.

For individuals with psychiatric 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.

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 unsheltered work activities, it is critical to remember that many employers have alcohol- and drug-free workplace policies.

Step 9: Identify cultural and linguistic needs and supports.

- Will the client fit into the treatment culture (either substance abuse or mental health)? Will there be conflicts in treatment (e.g., the client is attached to certain cultural healing practices)?
- Are there cultural or linguistic service barriers (e.g., the client reads or speaks only Spanish, or does not read any language)?

Step 10: Identify problem domains.

Identify problem areas in the client's life (e.g., medical, legal, vocational, family, social). The ASI is helpful in detecting these issues (see appendix G of TIP 42). Clarify how both the mental health and substance use disorder interact with these problem areas, and use this knowledge to identify how a client might better engage in treatment.

Gather information about the client's family, social, and provider networks, and, when appropriate, work out confidentiality issues so communication can occur.

Step 11: Determine the stage of change.

Questionnaires such as SOCRATES and URICA (both reproduced in appendix B in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment*, pages 220–229) can facilitate the stage of change assessment, or it can be clinically determined by interviewing the client and evaluating the client's responses in terms of stages of change:

- 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)

Step 12: Plan treatment.

In integrated treatment settings, staff clinicians provide interventions for mental health and substance use disorders. In nonintegrated treatment settings, staff clinicians must develop relationships with mental health providers to coordinate client treatment planning.

Integrated treatment planning involves helping the client to make the best possible choices of treatment 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.

For more information on assessment issues, see chapter 4 of TIP 42.

TECHNIQUES FOR WORKING WITH CLIENTS WITH COD

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

Follow the guiding principles of motivational interviewing: (1) express empathy; (2) develop discrepancy; (3) roll with resistance; (4) support self-efficacy.

- Respond to any expression of desire to change with interest, and encourage the client to elaborate on the statement.
- Explore the costs and benefits of substance use with the client with the aim of tipping the balance toward change.
- Match motivational strategies to the client's stage of change.

Design Contingency Management Techniques To Address Specific Target Behaviors.

- Provide refreshments in groups and at social activities.
- Monitor urine specimens.
- Check medication adherence.
- Reward clients for obtaining particular goals in their treatment plan.
- Reinforce appropriate verbal and social behavior.

Use Cognitive–Behavioral Therapeutic Techniques.

- 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 and tapes.

Use Relapse Prevention Techniques.

- Provide relapse prevention education on both mental disorders and substance abuse and their interrelations.
- Teach skills to increase medication adherence, and help the client handle pressure from others to discontinue psychotropic medication.
- 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.

Use Repetition and Skills-Building To Address Deficits In Functioning.

- Be concrete in communicating ideas, using simple concepts, having brief discussions, and repeating the core concepts several times.
- Present information in multiple formats (verbally, visually, or affectively through stories, music, and experiential activities).
- Try role-playing real-life situations.

Facilitate Client Participation In Mutual Self-Help Groups.

- Help the client locate an appropriate group.
- Help the client find a sponsor, ideally one who also has COD and is at a late stage of recovery.
- Help the client prepare to participate appropriately in the group.
- Help overcome barriers to group participation.
- After the client attends a group, talk with the client about how he felt and how the meeting went; then discuss with the client any thoughts, feelings, or obstacles to attending another meeting again soon.

For more information, see chapter 5 of TIP 42.

SPECIFIC POPULATIONS

The awareness of COD in subpopulations and concern about its implications has been growing. TIP 42 focuses on three of these subgroups: women, the homeless, and those in criminal justice settings.

Women With COD

- Identify and build on each woman's strengths.
- Avoid confrontational approaches.
- Teach coping strategies based on a woman's experiences, with a willingness to explore the woman's individual appraisals of stressful situations.
- Arrange for daily needs such as childcare and transportation.
- Have a strong female presence on staff.
- Promote bonding among women in the program.
- 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 health support networks with shared family goals.
- Make prevention and emotional support available for children.

Pregnancy and co-occurring disorders

Pregnancy can aggravate or diminish the symptoms of co-occurring mental illness. Women with co-occurring disorders sometimes avoid early prenatal care, have difficulty complying with health-care providers' instructions, and are unable to plan for their babies or care for them when they arrive. Many pregnant women with co-occurring disorders are distrustful of substance abuse and mental health treatment providers, yet they are in need of multiple services.

Issues to address with co-occurring mental illness

- Make careful treatment plans during pregnancy for women with mental health problems that include planning for childbirth and infant care.
- Work to maintain medical and psychological stability during the client's pregnancy, and collaborate with other healthcare providers to ensure that treatment is coordinated.
- When women are parenting, it often retriggers their own childhood traumas. Therefore, balance growth and healing with coping and safety.
- Focus on the woman's interest in and desire to be a good mother.

- 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.
- Allow for evaluation over time for women with COD. Reassessments should occur as mothers progress through treatment.
- Be aware of the signs and symptoms of postpartum depression.

Pharmacologic considerations

- Before giving any medications to pregnant women, make sure they understand the risks and benefits of taking these medications and sign informed consent forms.
- Certain psychiatric medications may be associated with birth defects, especially in the first trimester of pregnancy, and weighing potential risk/benefit is important. In most cases, safe and appropriate medications can be found; however, this requires expert advice and consideration by a physician and pharmacist who have experience working with pregnant women with psychiatric disorders.
- Since pregnant women often present to treatment in mid- to late-second trimester, and poly-drug use is the norm rather than the exception, it is important first to screen these women for dependence on substances that can produce a

life-threatening withdrawal for the mother: alcohol, benzodiazepines, and barbiturates.

For more on pharmacologic considerations for pregnant women, see appendix F of TIP 42.

Homeless Clients With COD

- Address housing needs.
- Teach clients skills for maintaining housing.
- Work closely with shelter workers and other providers for the homeless.
- Address real-life issues (e.g., legal and pending criminal justice issues, Supplemental Security Insurance/entitlement applications, issues related to children, health care needs, etc.).

Criminal Justice 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 directions.
- Design highly structured activities.
- Provide ongoing monitoring of symptoms.

For more information on special populations, see chapter 7 of TIP 42.

OVERVIEW OF SPECIFIC MENTAL DISORDERS

This section provides a brief overview for working with clients who exhibit the most commonly seen mental disorders in the substance abuse treatment population. For more detailed information on these and other mental disorders, see chapter 8 and appendix D of TIP 42.

Each disorder is concisely defined, followed by recommendations for treatment. One recommendation made throughout is to closely monitor the medication needs of the client. The clinician can do this by

- Referring the client to a psychiatrist or other prescriber for determination of psychotropic medication needs and dosage.
- Familiarizing him- or herself with common psychotropic medications and their side effects (see appendix F of TIP 42).
- Instructing the client on the importance and role of medication in the recovery process.
- Observing and reporting symptoms and behaviors to the prescribing psychiatrist. This will assist in identifying medication needs and adjusting medications as needed.

- Encouraging medication adherence and assisting the client with medication monitoring.
- Using peers or peer groups to help monitor medication and to support the client in the proper use of medication.

Suicidality

Suicidality is a measure or estimate of a person's likelihood of committing suicide. Suicide is not a mental disorder in and of itself, but it is a high-risk behavior associated with COD, especially (though not limited to) serious mood disorders.

What to know:

- Abuse of alcohol and other drugs is a major risk factor in suicide.
- 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 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 may also relate to alcohol's ability to remove inhibitions, leading to poor judgment, mood instability, and impulsiveness.

- Substance intoxication is associated with increased violence toward others and self.

What to do:

- Take all suicide threats seriously.
- Assess the client's risk of self-harm and harm to others.
- Develop a safety and risk management process with the client.
- Provide availability of contact 24 hours a day until psychiatric referral can be realized. Refer high-risk clients for psychiatric intervention.
- Monitor and develop strategies to ensure medication adherence.
- Develop long-term recovery plans to treat substance abuse.

Personality Disorders

Two personality disorders are discussed in TIP 42: borderline personality disorder and antisocial personality disorder.

Borderline Personality Disorder

The essential feature of borderline personality disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and emotions, along with marked impulsivity that begins by early adulthood and is present in a variety of contexts.

What to know:

- 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 borderline personality disorder may use the same drugs of choice, route of administration, and frequency as the individuals with whom they are interacting.
- People with borderline personality disorder may use substances in a variety of ways and settings, in idiosyncratic and unpredictable patterns.
- Polydrug use is common (e.g., alcohol and other sedative-hypnotics taken for self-medication).
- Individuals with borderline personality disorder are often skilled in seeking multiple sources of favorite medications, such as benzodiazepines.

What to do:

- Anticipate that client progress will be slow and uneven.
- Assess the risk of self-harm by asking what is wrong, why this is a problem now, whether the client has specific plans for suicide, past attempts, current feelings, and protective factors (see the discussion of suicidality in appendix D of TIP 42 for a risk assessment protocol).

- Maintain a positive but neutral professional relationship, avoid overinvolvement, and monitor the counseling process frequently with supervisors and colleagues.
- Set clear boundaries and expectations regarding roles and behavior.
- When appropriate, assist the client in developing skills to manage negative memories and emotions (e.g., deep breathing, meditation, cognitive restructuring), or refer the client for such assistance.

Antisocial Personality Disorder

The two essential features of antisocial personality disorder 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.

What to know:

- The prevalence of co-occurring antisocial personality disorder and substance abuse is high.
- Most people diagnosed as having antisocial personality disorder 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 antisocial personality disorder use substances in a polydrug pattern involving alcohol, marijuana, heroin, cocaine, and methamphetamine.
- People with antisocial personality disorder 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. Some may limit themselves to exploitative or manipulative behaviors that do not make them so vulnerable to spending time in jail.

What to do:

- Confront dishonest and antisocial behavior directly and firmly, and stress immediate learning experiences that teach corrective responses.
- Hold clients responsible for their behavior and its consequences.
- Use peer communities to confront behavior and foster change.
- Assess and correct antisocial and criminal thinking.
- Foster longer-term individual value change and the establishment of new peer reference groups as the key to recovery.

Mood Disorders and Anxiety Disorders

Mood disorders include the depressive disorders, bipolar disorders, and two disorders based on etiology—mood disorder due to a general medical condition and substance-induced mood disorder.

The essential features of anxiety disorder are excessive anxiety and worry accompanied by fatigue, irritability, muscle tension, disturbed sleep, and/or difficulty concentrating. An individual with anxiety disorder finds it difficult to control the worry.

Although mood disorders are distinct from anxiety disorders, many similarities exist between the two in terms of what to know and what to do when counseling clients with these disorders.

What to know:

- Among women with a substance use disorder, mood disorders may be prevalent.
- Women are more likely than men to be clinically depressed.
- Certain populations are at risk for anxiety and mood disorders, such as 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.

What to do:

- Differentiate among the following: anxiety and mood 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.
- Maintain a calm demeanor and a reassuring presence.
- 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 symptoms that intensify.
- 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.

Schizophrenia and Other Psychotic Disorders

Clients with acute symptoms of schizophrenia are typically seen in mental health settings, whereas clients seen in substance abuse settings are almost always in a “residual” stage of schizophrenia. The residual phase is usually characterized by hallucinations, disorganized speech, and severely disorganized or catatonic behavior.

What to know:

- There is evidence of increasing use of alcohol and drugs among people with schizophrenia (from 14 to 22 percent in the 1960s and 1970s to 25 to 50 percent in the 1990s).
- 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 most typically used.
- 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 illness requires a multiple-contact, longitudinal assessment.
- Clients with COD involving psychosis have a higher risk for self-destructive and violent behaviors, 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.

What to do:

- 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 to facilitate stabilization (i.e., crisis intervention, psychiatric consultation).
- Assist the client to obtain entitlements and other social services.
- 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.
- Help the client obtain needed housing and vocational services.

- Monitor clients for signs of substance abuse relapse and a return of psychotic symptoms.

Attention-Deficit/Hyperactivity Disorder (AD/HD)

The essential feature of AD/HD is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more serious than is observed typically in individuals at a comparable level of development.

What to know:

- Recent studies of the adult substance abuse treatment population have found AD/HD in 5 to 25 percent of people.
- 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. Marijuana is 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 improve substantially with each month of sobriety.
- The presence of AD/HD complicates the treatment of substance abuse, since these clients may have more difficulty engaging in treatment and learning abstinence skills, be at greater risk for relapse, and have poorer substance use treatment outcomes.

What to do:

- 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 (e.g., noise, desktop items) from the environment.
- Use visual aids to convey information.
- Reduce the length of meetings and verbal exchanges.
- Encourage the client to use tools 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)

The essential feature of PTSD is the development of characteristic symptoms following exposure to a traumatic stressor.

PTSD is classified in DSM-IV-TR as a type of anxiety disorder, but is treated separately in TIP 42 because of its special relationship to substance abuse and the growing literature on PTSD and its treatment.

What to know:

- 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.
- From 55 to 99 percent of women with substance abuse problems report a lifetime history of physical and/or sexual abuse.
- Most women with this COD have experienced childhood physical and/or sexual abuse; men with both disorders typically experienced crime victimization or war trauma.
- People with PTSD and substance abuse are more likely to experience further trauma than people with substance abuse alone.
- Repeated trauma is common in domestic violence, child abuse, and some substance-using lifestyles (e.g., the drug trade).

- 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.
- 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 are also common.
- As a counselor, it is important to help clients understand that becoming abstinent from substances does not resolve PTSD; both disorders must be addressed in treatment.

What to do:

- 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.
- Develop a plan for increased safety.
- Establish both perceived and real trust.
- Attend to behavior even more than words.
- Limit questioning about the details of the 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 severe trauma.
- Refer to trauma experts for trauma exploratory work.

Eating Disorders

Two eating disorders are discussed in TIP 42: anorexia nervosa and bulimia nervosa.

Anorexia nervosa is a disorder in which the individual fails to maintain a minimally healthy 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.

Individuals with bulimia nervosa are subject to binge eating and use inappropriate methods to prevent weight gain. The self-esteem of individuals

with bulimia nervosa is excessively influenced by body shape and weight.

What to know:

- The prevalence of bulimia nervosa is elevated in women presenting for substance abuse treatment.
- Approximately 15 percent of women and 1 percent of men in inpatient substance abuse treatment centers have had an eating disorder (primarily bulimia nervosa) in their lifetime.
- 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 substance abuse treatment clients without 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 purposes of weight loss, appetite suppression, and purging. These include 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.
- Individuals with eating disorders experience urges (or cravings) for binge-foods similar to urges for drugs.

What to do:

- 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 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.

Pathological Gambling

The essential feature of pathological gambling is persistent and recurrent maladaptive gambling behavior that disrupts personal, family, or vocational pursuits.

What to know:

- 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.
- At a minimum, the rate of problem gambling among people with substance use disorders is four to five times that found in the general population.
- Among pathological gamblers, alcohol has been found to be the most common substance of abuse.
- Even though pathological gambling is often 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 is often essential to identify specific triggers for each addiction. It is also helpful to identify ways in which the use of addictive substances or activities act as mutual triggers.

It is particularly important to evaluate patterns of substance use and gambling:

- 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 may 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 (e.g., someone who has had a history of alcohol dependence also develops a gambling problem).

What to do:

- Carefully assess the frequency of gambling: 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 gambling.
- Understand the similarities and differences of substance use disorders and pathological gambling.
- As with any COD, recognize that a client's motivation level may be at different points for dealing with each disorder.
- Employ 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.

RESOURCES FOR PROFESSIONAL DEVELOPMENT

Counselors and clinicians can check with their State certification bodies to determine whether training leading to formal credentials in counseling clients with COD disorders is available.

This list of resources is not exhaustive, and does not necessarily signify endorsement by CSAT, SAMHSA, or the U.S. Department of Health and Human Services (DHHS).

Discipline-Specific Education

Although there have been improvements in the past decade, there are still very few university-based programs that offer a formal curriculum on COD. However, many professional organizations are promoting the development of competencies and practice standards for intervening with substance abuse problems, including

- The American Society of Addiction Medicine (ASAM)
- The American Psychological Association
- 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
- The International Nurses Society on Addictions

The disciplines of medicine and psychology have recognized subspecialties in COD with a defined process for achieving a certificate in this area. Professionals can check with the following organizations for current information on certification by discipline:

- ASAM at www.asam.org
- The American Academy of Addiction Psychiatry (AAAP) at www.aaap.org
- The American Psychological Association's College of Professional Psychology at www.apa.org/college/
- The National Association of Social Workers (NASW) at www.naswdc.org

Listservs and Discussion Groups

There are a number of e-mail listservs and Internet 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 are generally geared more toward professionals and are more closely monitored. Discussion groups are usually open to anyone, and may not be closely monitored. See appendix I of TIP 42 for a more detailed description.

National Mental Health Association

www.nmha.org

(800) 969-NMHA (6642)

The National Mental Health Association (NMHA) has expanded its mission to encompass COD. NMHA has a formal committee made up of board members, NMHA staff, and experts in the field. The committee reviews issues and provides recommendations for policy development and information materials. The organization continues to develop resources, documents, publications, and a designated section on its Web site (www.nmha.org). In addition, the NMHA has conducted coalition-building programs for substance abuse and mental health service providers, clients, and family members.

**Consumer Organization and Networking
Technical Assistance Center (CONTAC)**

www.contac.org

(888) 825-TECH (8324)

CONTAC has developed and offers a listing of names and contacts for resources and information on substance use disorders, COD, services, and mutual self-help support. CONTAC also offers the Leadership Academy, a training program that is designed to help clients learn how to engage in and develop consumer services. Recently, a training component focusing on substance abuse and dependence has been developed and incorporated into the program.

National Empowerment Center

www.power2u.org

(800) power2u (769-3728)

The National Empowerment Center has prepared an information packet that 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, COD, services, and mutual self-help support.

SAMHSA's Co-Occurring Center for Excellence (COCE)

www.coce.samhsa.gov

(301) 951-3369

SAMHSA established the Co-Occurring Center for Excellence (COCE) in 2003 in order to provide the field with key resources needed to disseminate knowledge and increase adoption of evidence-based practices.

COCE's mission is to (1) *receive* and *transmit* advances in substance abuse and mental treatment that address all levels of mental disorder severity and can be adapted to the unique needs of each client, (2) *guide* enhancements in the infrastructure and clinical capacities of the substance abuse and mental health service systems, and (3) *foster* the infusion and adoption of evidence-based treatment and program innovation into clinical practice.

SAMHSA's National Mental Health Information Center

www.mentalhealth.samhsa.gov

(800) 789-2647

SAMHSA's National Mental Health Information Center was developed for users of mental health services and their families, the general public, policymakers, providers, and the media.

Information Center staff members are skilled at listening and responding to questions from the public and professionals. The staff quickly directs callers to Federal, State, and local organizations dedicated to treating and preventing mental illness. The Information Center also has information on Federal grants, conferences, and other events.

Ordering Information

TIP 42

Substance Abuse Treatment for Persons With Co-Occurring Disorders

TIP 42 – Related Products

KAP Keys for Clinicians

Quick Guide for Administrators

Quick Guide for Mental Health Professionals

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Three Ways To Obtain FREE Copies of All TIPs Products:

1. Call SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at **800-729-6686**, TDD (hearing impaired) **800-487-4889**.
2. Visit NCADI's Web site at **www.ncadi.samhsa.gov**.
3. You can also access TIPs online at:
www.kap.samhsa.gov.



Other Treatment Improvement Protocols that are relevant to this Quick Guide:

- **TIP 27:** *Comprehensive Case Management for Substance Abuse Treatment* (1998) **BKD251**
- **TIP 36:** *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (2000) **BKD343**
- **TIP 44:** *Substance Abuse Treatment for Adults in the Criminal Justice System* (2005) **BKD526**
- *Substance Abuse and Trauma* (Expected publication date 2006)
- *Substance Abuse Treatment: Addressing the Specific Needs of Women* (Expected publication date 2006)

See the inside back cover for ordering information for all TIPs and related products.