



EVIDENCE-BASED
PRACTICES

KIT

Knowledge Informing Transformation

Training Frontline Staff

Integrated Treatment for Co-Occurring Disorders



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



Training Frontline Staff

Integrated Treatment for Co-Occurring Disorders

Acknowledgments

This document was produced for the Substance Abuse and Mental Health Services Administration (SAMHSA) by the New Hampshire-Dartmouth Psychiatric Research Center under contract number 280-00-8049 and Westat under contract number 270-03-6005, with SAMHSA, U.S. Department of Health and Human Services (HHS). Neal Brown, M.P.A., and Crystal Blyler, Ph.D., served as the Government Project Officers.

Disclaimer

The views, opinions, and content of this publication are those of the authors and contributors and do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), SAMHSA, or HHS.

Public Domain Notice

All material appearing in this document is in the public domain and may be reproduced or copied without permission from SAMHSA. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization from the Office of Communications, SAMHSA, HHS.

Electronic Access and Copies of Publication

This publication may be downloaded or ordered at www.samhsa.gov/shin. Or, please call SAMHSA's Health Information Network at **1-877-SAMHSA-7** (1-877-726-4727) (English and Español).

Recommended Citation

Substance Abuse and Mental Health Services Administration. *Integrated Treatment for Co-Occurring Disorders: Training Frontline Staff*. DHHS Pub. No. SMA-08-4366, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.

Originating Office

Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857

DHHS Publication No. SMA-08-4366
Printed 2009



EVIDENCE-BASED
PRACTICES

KIT

Knowledge Informing Transformation

Training Frontline Staff

This five-part workbook, along with the *Training Frontline Staff: Demonstration Video*, will help program leaders teach mental health and substance abuse practitioners about the principles, processes, and skills necessary to deliver effective integrated treatment to consumers with co-occurring disorders. It assumes that mental health practitioners need the following to become integrated treatment specialists:

- An understanding of the basic elements and principles of the evidence-based practice;
- Practical knowledge of common substances and how they affect mental illnesses;
- The ability to assess substance use disorders and consumers' stage of treatment;
- Skills to provide substance abuse counseling to consumers at different stages of treatment; and
- A choice of formats for providing integrated treatment.

Use this workbook to train integrated treatment specialists designated for your Integrated Treatment program. Also, because co-occurring disorders are so common, we believe that all practitioners must learn basic skills to foster recovery from both serious mental illness and substance abuse. Consider using some or all of this workbook to train practitioners throughout your agency.

For references, see the booklet *The Evidence*.

Integrated Treatment for Co-Occurring Disorders

This KIT is part of a series of Evidence-Based Practices KITs created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

This booklet is part of the Integrated Treatment for Co-Occurring Disorders KIT that includes a DVD, CD-ROM, and seven booklets:

How to Use the Evidence-Based Practices KITs

Getting Started with Evidence-Based Practices

Building Your Program

Training Frontline Staff

Evaluating Your Program

The Evidence

Using Multimedia to Introduce Your EBP



EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

What's in this Workbook

How Program Leaders Should Use This Workbook.	A
Prepare program-specific information	B
Prepare agency-specific information	C
Visit an existing team	C
Arrange for didactic training	C
Recruit a consultant.	C
Cross-train	D
Module 1: Basic Elements and Practice Principles.	1
What is Integrated Treatment for Co-Occurring Disorders? . . .	1
Practice principles	2
Program standards	4
How we know that Integrated Treatment for Co-Occurring Disorders is effective	5
Summary	5
Exercise: Explore the Benefits of Integrated Treatment for Co-Occurring Disorders.	7
Exercise: Improve Your Integrated Treatment Program.	9

Integrated Treatment for Co-Occurring Disorders



Module 2: Practical Knowledge of Common Substances	1
Commonly used terms.	1
Alcohol.	5
Cannabis	10
Stimulants.	12
Opiates and opioids	16
Infectious diseases.	19
<i>Exercise: Review the Short- and Long-Term Effects of Substance Use</i>	<i>23</i>
<i>Exercise: Tackle the Issue.</i>	<i>25</i>
Module 3: Stages of Treatment and Core Processes	1
How change occurs	1
Stages of treatment	2
Engagement	4
Screening and assessment	7
Treatment planning	15
<i>Exercise: Identify Consumers with Co-Occurring Disorders</i>	<i>21</i>
<i>Exercise: Review Assessment and Treatment Planning Forms</i>	<i>23</i>
Module 4: Practical Skills for Integrated Treatment	1
Motivational interventions	1
Cognitive behavioral interventions	6
Interventions to prevent relapse	15
<i>Exercise: Practice Motivational Interventions.</i>	<i>21</i>
<i>Exercise: Practice Cognitive Behavioral Interventions.</i>	<i>23</i>
<i>Exercise: Practice Interventions to Prevent Relapses.</i>	<i>25</i>
Module 5: Service Formats	1
Group treatment for co-occurring disorders	1
Self-Help groups	5
Family interventions	9
<i>Exercise: Explore Group Treatment.</i>	<i>15</i>
<i>Exercise: Role-Play: A First Family Meeting.</i>	<i>17</i>

Training Frontline Staff

How Program Leaders Should Use This Workbook

Training Frontline Staff, used along with the *Demonstration Video*, helps mental health practitioners become integrated treatment specialists. It introduces them to the basic principles and skills they need to deliver effective integrated treatment to consumers with both substance abuse and mental illnesses (called *co-occurring disorders*).

This workbook assumes that integrated treatment specialists have already received

training about serious mental illness and are familiar with treating people with serious mental illnesses. For this reason, the workbook focuses on teaching integrated treatment specialists about substance abuse and developing the basic skills needed to help consumers recover from both disorders. For information and resources for implementing this model in substance abuse agencies, see the Treatment Improvement Protocol (TIP) 42 in *The Evidence* in this KIT.



How to Complete this Five-Session Training

- Arrange for integrated treatment specialists to meet at least once a week for 5 weeks. You will cover up to one module each week.
- In this workbook, on the page before each module, you'll find *Notes to the facilitator and program leader*. Review the notes to prepare for the training sessions.
- Copy and distribute the module's reading materials so that integrated treatment specialists can read them before the training session. You'll find this booklet on the KIT's CD-ROM.
- Copy the exercises for each module so that you can distribute them during each training session. You'll find the exercises in this booklet on the KIT's CD-ROM.
- For each session, ask a different group member to facilitate.
- Begin each training session by showing the corresponding segments of the *Training Frontline Staff: Demonstration Video*.
- Discuss the information in the video and workbook.
- Complete the suggested exercises for that module.



To make the content easy to manage, we divided the workbook into five modules.

The Five Modules in *Training Frontline Staff*

1. Basic Elements and Practice Principles
2. Practical Knowledge of Common Substances
3. Stages of Treatment and Core Processes
4. Practical Skills for Integrated Treatment
5. Service Formats

We have found that integrated treatment specialists prefer to read one module at a time and then discuss that module with colleagues as a group. Working through these modules as a group creates an opportunity to discuss and master the practice principles and skills that are essential to effectively providing integrated treatment.

Most modules in this book begin with a vignette that describes someone who has problems that are typical of consumers with co-occurring disorders.

A discussion of the module topic then follows. The discussion comes from experts in the field who have been providing Integrated Treatment for Co-Occurring Disorders for years so integrated treatment specialists can examine their own ideas in relation to the experts.

One effective way to use the workbook is to ask integrated treatment specialists to read the vignettes and discuss them as a group. Exercises are included at the end of each module to stimulate further group discussions.

Prepare program-specific information

In addition to the materials in this workbook, prepare to give integrated treatment specialists information about policies and procedures for your Integrated Treatment program, including the following:

- The Integrated Treatment Fidelity Scale;
- Screening procedures;

- Referral forms;
- Protocols for diagnosing substance use disorders;
- Integrated assessment forms;
- Integrated treatment forms;
- Criteria for assessing the program's fidelity to the evidence-based model; and
- Outcomes that will be monitored.

For sample forms, see *Building Your Program* and *Evaluating Your Program* in this KIT.

Prepare agency-specific information

You should also develop a plan to train integrated treatment specialists about other policies and procedures that may be relevant to the agency in which the Integrated Treatment program operates. These might include the following:

- **Billing procedures:** Integrated treatment specialists must know how to document their activities and bill for services.
- **Safety:** Many agencies with existing community-based programs will have materials about safety. If training in this area is not already available, plan for training about de-escalation techniques. You might also seek a local law-enforcement agency to provide training in personal safety.
- **Mandated reporting:** Integrated treatment specialists must know how to report suspected abuse and neglect. They must also know what to do if they find out about other illegal activity and threats of harm to self or others.
- **Consumers' rights:** Integrated treatment specialists should be aware of the state and federal consumer rights requirements.
- **Other policies and procedures:** Consult your agency's human resource office to learn of other program, agency, or state policies that the staff should know.

Visit an existing team

After your staff completes this workbook, we suggest that new integrated treatment specialists observe an experienced, high-fidelity Integrated Treatment program. If integrated treatment specialists are familiar with the materials in this workbook before their visit, the visit will be more productive. Rather than having to take time to explain the basics, the host program will be able to show the new integrated treatment specialists how to apply the basics in a real-world setting.

Arrange for didactic training

After using this workbook and visiting an experienced Integrated Treatment program, integrated treatment specialists will be ready for a trainer who will help them practice what they have seen and read.

Some program leaders choose to hire an experienced external trainer to help integrated treatment specialists practice evidence-based practice principles, processes, and skills. The initial training should take 2 to 3 days.

Recruit a consultant

Once integrated treatment specialists begin working with consumers, you are responsible for ensuring that they follow the evidence-based model. This task can be challenging.

You must facilitate a staff development process, apply what you have just learned about Integrated Treatment for Co-Occurring Disorders in your own clinical work with consumers, and, at the same time, ensure through clinical supervision that integrated treatment specialists follow the model.



It is very easy to stray from the evidence-based model and do something similar to but not quite the same as Integrated Treatment for Co-Occurring Disorders. Sometimes this happens because integrated treatment specialists believe they are diligently following the evidence-based model, but they miss some of the more subtle aspects of it. In other cases, services for co-occurring disorders start well, but, as more consumers are admitted to the program and pressure mounts, integrated treatment specialists revert to older, more familiar ways of working.

To ensure that your staff follows the evidence-based model, work with an experienced consultant throughout the first year of operation. A consultant can provide ongoing telephone and in-person support to help you with your challenging leadership role.

Cross-train

It is important that staff throughout your agency develop a basic understanding of Integrated Treatment for Co-Occurring Disorders. Cross-training will ensure that other staff members support the work that integrated treatment specialists undertake. Training is also an opportunity for integrated treatment specialists and advisory group members to become familiar with one another. Make sure that the advisory group members and integrated treatment specialists introduce themselves and that they are familiar with one another's roles.

To help you conduct your training, we include these multimedia materials in the Integrated Treatment KIT:

- Introductory PowerPoint presentation;
- Sample brochure; and
- *Introductory Video*.

Once trained, you or your staff will be able to use these materials to present routine, in-service seminars to ensure that all practitioners within the agency are familiar with the Integrated Treatment program.



As discussed in *Building Your Program*, we also recommend that you use these materials to train members of your Integrated Treatment Advisory Committee. The more information that advisory group members have about the evidence-based model, the better they will be able to support the Integrated Treatment program and its mission.

Module 1


Basic Elements and Practice Principles

Notes to the facilitator and program leader

Prepare for Module 1:


- Make copies of Module 1. Your copy is in this workbook; print additional copies from the CD-ROM in the KIT. 
- Distribute the material to those who are participating in your group training. Ask them to read it before meeting as a group.
- Make copies of these exercises:
 - *Explore the Benefits of Integrated Treatment for Co-Occurring Disorders*
 - *Improve Your Integrated Treatment Program*

Do not distribute them until the group training. Your copies are in this workbook; print additional copies from the CD-ROM.

- Make copies of these forms:
 - *Integrated Treatment Fidelity Scale*
 - *General Organizational Index*
 - Outcome measures for your Integrated Treatment program that your agency has developed, if available

Do not distribute them until the group training. Information about these quality assurance instruments is in *Evaluating Your Program* in this KIT. You may also print the *Integrated Treatment Fidelity Scale* and *General Organizational Index* from the CD-ROM.

Conduct your first training session:

- When you convene your group, view the *Introductory Video*. Discuss the video and the content of Module 1. 
- Distribute the following:
 - *Integrated Treatment Fidelity Scale*
 - *General Organizational Index*
 - Outcome measures that your agency will monitor (if available)
 - Exercises for this module
- Review the distributed materials and complete the exercises as a group.

Facilitating the dialogue:

One of the roles of a facilitator and program leader is to facilitate the dialogue during group training sessions. Some people have difficulty speaking in a group, perhaps because they are timid or soft spoken. Others may feel professionally intimidated by those with more experience or higher degrees. Conversely, some integrated treatment specialists will be self-confident and outspoken and will need to learn to listen openly to what others have to say.

As you work together on each module, encourage those who are more withdrawn to express their views and make sure that more vocal group members give others a chance to speak.

Group training also provides the opportunity to assess the anxiety that integrated treatment specialists may feel about providing Integrated Treatment for Co-Occurring Disorders. Use your group training time to explore and address issues openly.

Training Frontline Staff

Module 1: Basics Elements and Practice Principles

Substance use disorders are common and devastating disorders among people with serious mental illnesses. Module 1 presents the basic elements and practice principles of Integrated Treatment for Co-Occurring Disorders. This introduction to the evidence-based model also includes a summary of the research evidence for its effectiveness

What is Integrated Treatment for Co-Occurring Disorders?

Up to 56 percent of people with the most serious mental illnesses have a co-occurring substance use disorder within their lifetime (Regier et al., 1990). Co-occurring disorders are associated with a variety of negative outcomes, including higher rates of relapse, violence, hospitalization, homelessness, and incarceration (Drake et al., 2001).

Integrated Treatment for Co-Occurring Disorders is an evidence-based practice that has been found to be effective in the recovery process for consumers with co-occurring disorders. The goal of this evidence-based practice is to support consumers in their recovery process. Recovery means that consumers are learning to manage both illnesses so that they can pursue personally meaningful life goals.

In Integrated Treatment programs, the same practitioners or treatment team, working in one setting, provide mental health and substance abuse interventions in a coordinated fashion. Consumers receive one consistent message about treatment and recovery. Practitioners trained in the evidence-based model and designated to provide integrated treatment to consumers with co-occurring disorders are called *integrated treatment specialists*.

Practice principles

Integrated Treatment for Co-Occurring Disorders is based on a core set of practice principles. These principles form the foundation of the evidence-based practice and guide integrated treatment specialists in delivering effective treatment to consumers with co-occurring disorders.

Practice Principles of Integrated Treatment for Co-Occurring Disorders

- Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders.
- Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses.
- Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages.
- Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage.
- Substance abuse counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages.
- Multiple formats for services are available, including individual, group, self-help, and family.
- Medication services are integrated and coordinated with psychosocial services.

Principle 1: Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders

Co-occurring disorders are common. Up to 56 percent of people with the most serious mental illnesses have a co-occurring substance use disorder within their lifetime (Regier et al., 1990). Yet most consumers with co-occurring disorders receive treatment from different agencies or for their mental illness or substance use disorder only—if they receive treatment of any kind.

This kind of fragmented treatment often leads to poor outcomes. Consumers with co-occurring disorders have a better chance of recovering from both disorders when they receive mental health and substance abuse treatment in an integrated fashion from the same practitioner (an integrated treatment specialist).

Principle 2: Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses

To effectively assess and treat co-occurring disorders, integrated treatment specialists should be trained in psychopathology, assessment, and treatment strategies for both mental illnesses and substance use disorders. Mental health practitioners, therefore, may need to learn more about the following:

- Substances that are abused by consumers;
- How these substances affect people with co-occurring disorders; and
- The short- and long-term effects of abuse and dependence.

Integrated treatment specialists should understand both mental health terminology and the language used for substance use disorders. They should understand the differences in levels of substance use and abuse and be able to provide integrated services to treat co-occurring disorders.

Principle 3: Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages

Consumers recovering from substance use disorders and serious mental illnesses go through stages, each of which marks readiness for a specific treatment. Integrated treatment specialists must assess consumers' stage of treatment and tailor services accordingly.

The Four Stages of Treatment

- Engagement
- Persuasion
- Active treatment
- Relapse prevention

Principle 4: Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage

Motivational interventions are key to integrated treatment for co-occurring disorders. These interventions help consumers identify personal recovery goals. Typically, consumers reduce or abstain from using substances of abuse as they become motivated to reach their goals. These interventions often stimulate consumers to make a number of changes in their lives.

Motivational interventions include motivational interviewing, motivational counseling, and motivational treatment. When providing the interventions, integrated treatment specialists use specific listening and counseling skills to help consumers who are demoralized or who are not ready to pursue abstinence.

Principle 5: Substance abuse counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages

Consumers may have difficulty managing unpleasant emotions and symptoms that lead to substance use disorders. Integrated treatment specialists with skills in cognitive-behavioral counseling can help consumers stop automatic patterns of thought that lead them to abusing substances. For example, one way to help consumers change their substance use behavior is to help them identify thoughts or feelings that trigger the urge to use and then help them change these thoughts and feelings. Learning to manage negative thoughts and emotions can dramatically help consumers stay away from substances.

Principle 6: Multiple formats for services are available, including individual, group, self-help, and family

Consumers benefit most when multiple formats are available to them at appropriate stages of treatment. For example, consumers in the persuasion stage may benefit from motivational interventions that are provided individually. Including family or other supporters in treatment is recommended because they can be a strong source of support for consumers who often have a restricted, non-substance-using social network. Also, families who receive information are better able to effectively support their relative.

Group treatment can help consumers feel less alone. Whether groups are led by professionals or peers, group treatment allows consumers to develop a peer network. Consumers with similar experiences offer support, empathy, and opportunities to socialize with nonusers, which is especially useful in the relapse prevention stage.

Principle 7: Medication services are integrated and coordinated with psychosocial services

Physicians or nurses who prescribe medications should be trained to effectively treat co-occurring disorders. Medication prescribers should participate in multidisciplinary treatment team meetings. They should work closely with consumers, integrated treatment specialists, and other treatment team members to ensure that treatment for both mental illnesses and substance use disorders is provided in an integrated fashion.

Psychiatric medication should be prescribed despite active substance use. Medication prescribers should avoid prescribing potentially addictive medications to consumers with co-occurring disorders and, when appropriate, they should offer medications that may help reduce addictive behavior.

Many people who take numerous medications at various times throughout their day have difficulties following medication regimes. Providing medication services can help consumers by enhancing their motivation and offering strategies for remembering medication regimes.

Program standards

One of the unique features of Integrated Treatment for Co-Occurring Disorders is that the important characteristics of this evidence-based model have been translated into program standards to help programs replicate effective services. An instrument called the Integrated Treatment Fidelity Scale summarizes these characteristics. The fidelity scale is available to help quality assurance teams assess how closely their program follows the evidence-based model (See *Evaluating Your Program* in this KIT).

Your program leader will distribute this scale to you to review and discuss during training.

Basic Characteristics of Integrated Treatment for Co-Occurring Disorders:

- Multidisciplinary teams
- Integrated treatment specialists
- Stage-wise interventions
- Access to comprehensive services
- Time-unlimited services
- Outreach
- Motivational interventions
- Substance abuse counseling
- Group treatment for co-occurring disorders
- Family interventions for co-occurring disorders
- Alcohol and drug self-help groups
- Pharmacological treatment
- Interventions to promote health
- Secondary interventions for nonresponders

How we know that Integrated Treatment for Co-Occurring Disorders is effective

Researchers began to document the prevalence of co-occurring disorders in the early 1980s. As noted earlier, studies found that up to 56 percent of people with the most serious mental illnesses have a co-occurring substance use disorder within their lifetime (Regier et al., 1990). Furthermore, studies demonstrated that consumers with co-occurring disorders relapsed more frequently and were more likely to be:

- Hospitalized;
- Violent;
- Incarcerated;
- Homeless; and
- Infected with HIV, hepatitis, and other diseases (Drake et al., 2001).

Studies also showed that consumers who received care in systems in which mental health and substance abuse treatment were separated were often excluded from services in one system and told to return when the other problem was under control. Those who received services in nonintegrated systems of care also had difficulty making sense of disparate messages about treatment and recovery. Consequently, the evidence demonstrated that consumers with co-occurring disorders in nonintegrated systems of care have poor outcomes (Drake et al., 2001).

Since the mid 1990s, eight studies support the effectiveness of Integrated Treatment for Co-Occurring Disorders. While the type and array of interventions in these programs vary, they include many of the critical components outlined in the Integrated Treatment Fidelity Scale.

In contrast to nonintegrated treatment, integrated treatment is associated with the following positive outcomes:

- Reduced substance use;
- Improvement in psychiatric symptoms and functioning;
- Decreased hospitalization;
- Increased housing stability;
- Fewer arrests; and
- Improved quality of life (Drake et al., 2001).

Summary

In summary, this module reviewed the basic elements and practice principles of Integrated Treatment for Co-Occurring Disorders. Substantial research has demonstrated its effectiveness.

The next modules provide integrated treatment specialists with specific knowledge and skills to assess and treat consumers with co-occurring disorders.

Exercise: Explore the Benefits of Integrated Treatment for Co-Occurring Disorders

Studies that have explored what makes a difference in whether practitioners adopt a new approach to treatment have found that practitioners are more likely to adopt a practice if it addresses an area that they feel they must improve. Share your experiences about where the traditional service delivery system has been inadequate in treating consumers with co-occurring disorders. Identify aspects of the evidence-based model that address those inadequacies.

Some experiences where the traditional service delivery system has been inadequate:

-
-
-
-
-
-

How Integrated Treatment for Co-Occurring Disorders may address those inadequacies:

-
-
-
-
-

Exercise: **Improve Your Integrated Treatment Program**

Distribute the criteria upon which the Integrated Treatment program will be evaluated (Integrated Treatment Fidelity Scale, General Organizational Index, and your agency's outcome measures).

Review and discuss how the quality improvement instruments will be completed and how the information will be used to improve your program.

Module 2

Practical Knowledge of Common Substances

Notes to the facilitator and program leader

Prepare for Module 2:

- Make copies of Module 2. Your copy is in this workbook; print additional copies from the CD-ROM in the KIT.



- Distribute the material to those who are participating in your group training. Ask them to read it before the group training.

- Make copies of these exercises:

- *Review the Short- and Long-Term Effects of Substance Use*
- *Tackle the Issue*



Do not distribute them until the group training. Your copies are in this workbook; print additional copies from the CD-ROM in the KIT.

Conduct your second training session:

- Discuss the content of Module 2.
- Distribute the exercises for this module.
- Complete the exercises as a group.

Note: This module does not include a video component.

Training Frontline Staff

Module 2: Practical Knowledge of Common Substances

Module 2 introduces you to the definitions for terms commonly used when people talk about substance use disorders. Basic information about alcohol, cannabis, stimulants, opiates, and opioids is presented. Since infectious diseases are a common negative consequence of substance use, this module provides information to you and the consumers you serve about three common but dangerous infectious diseases:

- The hepatitis B virus;
- The hepatitis C virus; and
- The human immunodeficiency virus (HIV).

Commonly used terms

The words and phrases on the following pages are commonly used when people talk about substance use.

Some of the definitions on the next pages are based on information from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV TR).

This manual is used to diagnose mental health and substance-related disorders. For more information on the DSM-IV TR, see www.psych.org.

The words and phrases are presented in alphabetical order. Some words that are commonly used together are grouped together on the next pages.

Words and Phrases Commonly Used About Substance Use

Abstinence, clean, and sober	<p>Abstinence is when a person does not use substances.</p> <p>Clean usually refers to abstaining from substances other than alcohol. When consumers are prescribed a medication such as methadone and they take it as prescribed, they are considered clean.</p> <p>Sober usually refers to abstaining from alcohol.</p> <p>Clean and sober means a consumer is abstinent from both.</p>
Addiction	<p>Addiction refers to physical or psychological dependence on a substance or a practice (such as gambling), so that using the substance is beyond voluntary control.</p>
Detoxification	<p>Detoxification is the process in which a consumer who is physically dependent on a substance stops taking that substance and recovers from its immediate effects. Because withdrawal symptoms can be extremely uncomfortable and dangerous, monitoring, support, and medical and psychiatric treatments during the process can be helpful and even lifesaving. Medications can be used to reduce the severity of symptoms during withdrawal from the substance and to prevent life-threatening illnesses.</p> <p>Detoxification is often used to describe the monitoring, support, and treatments consumers receive to cope with the withdrawal symptoms and craving for substances that emerge when they stop using a substance. Detoxification, however, alone does not treat substance use disorders. Consumers need to be engaged in treatment during and after detoxification.</p>
Intoxication	<p>Intoxication (or inebriation) refers to the experience of being under the influence of a substance that causes a person to feel different than normal. Symptoms of intoxication can be physical, such as slurred speech when intoxicated with alcohol, or psychological, such as feeling relaxed when intoxicated with cannabis. Being intoxicated does not in itself suggest that someone has a substance use disorder.</p>
Polysubstance abuse	<p>Polysubstance abuse refers to abuse of three or more substances (not including tobacco) in the same timeframe and is associated with antisocial personality characteristics, poor functioning, and a strong family history of substance use disorders. Of consumers who also have a substance use disorder, almost half abuse alcohol and other drugs together and about one-fourth abuse multiple drugs.</p> <p>People who use substances often develop a “drug of choice”—the substance that they prefer to use when they have the option. However, people who use one substance usually have tried and used others, and they may develop new addictions or “drugs of choice” over time.</p>
Recovery	<p>Recovery is the process by which a consumer learns new meaning in life beyond the illnesses of substance use and mental illness. To say that a consumer is <i>in recovery</i> implies that he or she is abstinent from substances, but also that he or she is participating in life activities that are meaningful and fulfilling.</p> <p>Recovery also implies that consumers are able to function in meaningful activities despite symptoms of mental illness. Integrated Treatment for Co-Occurring Disorders is designed to help consumers not only to become abstinent, but also to enter a recovery process.</p>

Words and Phrases Commonly Used About Substance Use

Remission	<p>When consumers who once had a substance use disorder have reduced or eliminated substance use so that they no longer experience distress or impairment, they are considered to be <i>in remission</i>. Remission means that consumers no longer meet the DSM-IV TR criteria for Substance Abuse or Dependence. Remission is used in the same way to describe a reduction in symptoms of mental illness.</p> <p>If a consumer is in remission from a substance use disorder, one of the following course specifiers should be added to the consumer's diagnosis:</p> <ul style="list-style-type: none">■ Early full remission refers to remission of 1 to 12 months.■ Early partial remission refers to remission of 1 to 12 months in which one or more criteria for Dependence or Abuse have been met but not the full criteria.■ Sustained full remission refers to remission for 12 months or longer.■ Sustained partial remission refers to remission for 12 months or longer in which one or more criteria for Dependence or Abuse have been met but not the full criteria. <p>These specifiers do not apply to consumers in agonist therapy or in a controlled environment (i.e., substance-free jails, therapeutic communities, or locked hospital units). Diagnoses for such consumers should include the course specifier, "On Agonist Therapy" or "In a Controlled Environment." For more information about agonist therapy, see <i>Opiates and opioids</i> later in this module.</p>
Substance	<p>Substance refers to alcohol, drugs, tobacco, prescribed medications, over-the-counter medications, and other substances, such as glue, that people take for recreational purposes to get high or relaxed.</p>
Substance abuse	<p>According to the DSM-IV TR, Substance abuse is defined as a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by at least one of the following in a 12-month period:</p> <ul style="list-style-type: none">■ A failure to fulfill major role obligations at work, school, or home as a result of recurrent substance use■ Recurrent substance use in hazardous situations (for example, driving while intoxicated)■ Legal problems as a result of recurrent substance use■ Continued substance use despite having recurrent social or interpersonal problems related to substance use (for example, arguments with spouse about consequences of intoxication) <p>Substance abuse is a behavioral disorder in which a person makes poor choices related to substance use, but is still more or less in control of those choices. If the consumer has ever met the criteria for Substance Dependence for that class of substances, then he or she may not be diagnosed with a Substance Abuse disorder for that substance.</p>

Words and Phrases Commonly Used About Substance Use

Substance dependence	<p>Substance dependence is a more severe disorder in which a person loses the ability to control substance use and has powerful impulses to seek intoxication despite past negative consequences. The DSM-IV TR defines Substance Dependence as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three or more of the following, during a 12-month period:</p> <ul style="list-style-type: none">■ Tolerance (see below);■ Withdrawal (see below);■ Taking a substance in larger amounts or over a longer period of time than intended;■ A persistent desire or unsuccessful efforts to cut down or control substance use;■ Spending a great deal of time in activities necessary to obtain the substance, use it, or recover from its effects;■ Giving up or reducing important social, occupational, or recreational activities because of substance use; and■ Continued use of the substance despite knowing that it likely caused or exacerbated a persistent physical or psychological problem.
Substance use disorder	<p>Substance use disorder refers to when consumers use substances in a maladaptive pattern that causes distress or impairment in functioning. Substance abuse and substance dependence are substance use disorders (see above).</p>
Tolerance, physical dependence, and withdrawal	<p>People who repeatedly use a substance often develop a tolerance to it. Tolerance refers to a person's need to use more and more of the substance to get the same pleasurable effect.</p> <p>The concepts of tolerance, physical dependence, and withdrawal are linked. Substance use causes changes in the body and the brain. These changes are probably why tolerance occurs.</p> <p>After regularly using a substance, physical dependence can emerge whereby the body adjusts to the presence of the substance. When people are physically dependent on a substance, they will develop withdrawal symptoms. Withdrawal symptoms cause distress or impairment when people stop or reduce the amount of substance they are using. Withdrawal symptoms are caused by rebound hyperactivity of the biological systems that the substance suppressed. These symptoms are usually quite uncomfortable. People often use substances again to relieve the withdrawal symptoms.</p>

Since people commonly use these terms when they talk about substance use, you will see these terms throughout this workbook. For more co-occurring disorders terminology, see TIP 42 on the CD-ROM in this KIT.

The following sections give you basic information about alcohol, cannabis, stimulants, and opiates

and opioids. Nicotine is clearly an addictive drug and a common problem for consumers. Although this workbook does not cover treatment for nicotine use, treatment programs are available. For a brief history of nicotine dependence and steps for addressing nicotine use in co-occurring disorders, see TIP 42 and other resources on the CD-ROM in this KIT.

Alcohol

Alcohol is a commonly used legal substance that is part of everyday life in our culture. Most people in the U.S. drink alcohol, and about one in five develops problems with alcohol over their lifetime.

Consumers experience problems related to alcohol at a higher rate and with smaller amounts of use than people without mental illnesses. Consumers are especially likely to develop substance use disorders involving alcohol.

It is unclear the extent to which consumers can drink socially over time without running into difficulties. However, consumers who drink are at greater risk of developing problems related to alcohol. Moreover, their alcohol use disorders are strongly associated with a variety of negative outcomes, such as the following:

- Increased symptoms of mental illness;
- Use of illicit drugs;
- Homelessness;
- Violence;
- Victimization;
- Incarceration;
- Suicidal behaviors;
- Hospitalizations; and
- Physical health problems.

For all of these reasons, consumers should avoid alcohol, and integrated treatment specialists should recognize and consistently provide treatment and support to minimize alcohol use.

In the next column you will find Tanya's story. After reading the vignette, consider how you would assess whether Tanya has an alcohol use disorder. Think about the steps that you would take to help Tanya.

Tanya's story

Tanya is a 42-year-old single mother with three children. Tanya became a homemaker at age 26 when she had her first child. After delivery, she had postpartum depression, was hospitalized, and did not drink for an entire year.

Two years later, she continued to experience periods of depression and anxiety and started drinking again to "help her nerves." Tanya drank three to four glasses of wine every night for years and felt that the wine calmed her down and helped her sleep.

Tanya divorced 2 years ago and went back to work part time in an office. Her 16-year-old son lives with his father and her 13-year-old twin daughters live with her.

Tanya reports that over the past several years, she has been drinking more, particularly on the weekend when she stays home and drinks up to a gallon of wine a day. Recently, she has begun to experience blackouts where she can't remember anything she did the previous day. She reported her continuing problems with feelings of sadness and hopelessness, interspersed with feelings of anxiety about her work performance and her children.

Her primary care doctor referred her to the mental health clinic and she went to the appointment accompanied by her sister. Tanya shared her concerns about her mood. She describes having a hard time falling asleep at night and then wakes up often during the night. She feels anxious and irritable most of the day, has no appetite, has lost enjoyment in her life, and has been avoiding family and friends. Though she has felt this way off and on her whole life, it is worse now than it has ever been. Feeling anxious has interfered with her ability to work.

Tanya reports that her daughters have been angry and withdrawn lately. One of them openly uses cigarettes and alcohol. Tanya responds by yelling at her, which she later regrets.

Tanya's sister reports that the children are worried about their mother's drinking. Tanya is surprised but acknowledged that her weekend drinking might be a problem. She is willing to try to cut down on her drinking if she could get some help for her anxiety and depression.

Six months ago, Tanya's primary care doctor prescribed the anti-anxiety medicine, clonazepam, once a day. Some days she takes two or three extra

doses when she needs them to manage her feelings of anxiety.

She agreed to attend an intensive outpatient evening program. She and the practitioner developed a crisis plan before she left the office, which identified the situations that worsened her symptoms and the supports she could turn to if she needed help.

While in the intensive outpatient program, Tanya saw a psychiatrist for a medication evaluation and a therapist for individual counseling. The psychiatrist recommended that she taper off the clonazepam and start fluoxetine, an antidepressant medication. She tried to reduce the clonazepam, but found that her anxiety and depression seemed worse and that she couldn't sleep at all.

Over the next several months she struggled to reduce her use of alcohol and clonazepam. Her depressive symptoms improved only a little when the antidepressant medication dose was increased. At the same time, she worked with her practitioner on her concerns about her daughters.

Recently, her sister called the therapist and said that Tanya had received a ticket for driving while intoxicated last weekend. In the following months, she was ordered by the court to attend self-help groups and counseling. While under court-ordered treatment, she became completely sober, but it took several more months for her depressive symptoms to improve.

Assessing Tanya's alcohol use

Alcohol is a legal substance almost everywhere in Western cultures, and most people in the U.S. drink socially over many years without problems. When does alcohol use become a disorder? According to most definitions, drinking alcoholic beverages constitutes alcohol use disorder (abuse or dependence) when it results in physical, interpersonal, medical, legal, or vocational problems.

The Diagnostic and Statistical Manual (DSM-IV TR) requires recurrent use of alcohol in the face of such problems for a diagnosis of alcohol use disorder. Tanya clearly shows many indicators of alcohol abuse or dependency, such as increased use and unsafe behavior resulting in a ticket for driving while intoxicated.

Understanding the short-term effects of Tanya's alcohol use

A few facts about alcohol are important for every practitioner to know. Alcohol affects every organ in the body, but the brain is particularly sensitive to alcohol. The more alcohol a person consumes, the greater effect it has on the body.

In lower doses (for example, one or two drinks), alcohol often leads to relaxation and increased confidence. However, slightly higher levels of use (or blood levels) typically produce euphoria, giddiness, impaired motor (physical) control, and disinhibition, the combination of which people recognize as being intoxicated or "drunk." Similarly, low doses of alcohol can produce relaxation, while higher amounts cause drowsiness.

Women are affected by alcohol to a greater degree than men because their bodies process alcohol differently, resulting in higher alcohol concentration in their blood. As the dose (or blood-alcohol level) increases, all of the effects of alcohol are often reversed or exaggerated, often dangerously so. For example, euphoria can turn into depression and suicidal behavior, and extreme disinhibition often results in poor judgment (i.e., getting into abusive, high-risk, or dangerous relationships).

Motor dyscontrol can lead to severe lack of coordination and serious accidents. Sedation from alcohol can be so severe that it causes death by suppressing the breathing center in the brain.

For people with serious mental illnesses, many of these negative effects occur at low doses of alcohol. For example, consumers may experience impaired judgment, cognitive problems, or disinhibited behavior even when they are not intoxicated, and alcohol rapidly worsens these problems. Alcohol may also precipitate symptomatic relapses of depression or psychosis and may interact negatively with medications. As Tanya's integrated treatment specialist, assess how her alcohol use affects her in the short term. How does Tanya feel before, during, and after using alcohol?

Alcohol tolerance and withdrawal

People who drink heavily for years often lose control of their drinking and orient their lives more and more around drinking behaviors. In addition, they drink more rapidly, consume larger amounts, drink more often, and experience withdrawal symptoms when they decrease drinking. This set of behaviors, which involves both physiological and psychological dependence on alcohol, is called the *alcohol dependence syndrome*.

The amount of alcohol that Tanya drinks has increased over the past several years, but the effect she feels from alcohol hasn't changed. This shows that she has developed an increased tolerance to alcohol.

With regular drinking, the body breaks down and gets rid of alcohol more quickly; changes occur in the brain so that the person needs to drink more to get the same effect. Tolerance to alcohol generalizes to other drugs and medications, such as benzodiazepines, that affect the brain in similar ways.

Detoxification

People who have developed tolerance to alcohol will have a physiological reaction called *withdrawal* when they reduce the amount they drink or when they stop drinking completely. For Tanya, withdrawal symptoms include anxiety, insomnia, and depression. Other common symptoms include nausea, headache, and tremor.

When alcohol or sedative hypnotics are used over a longer period of time or in larger amounts, withdrawal symptoms worsen and include vomiting, fever, and increased blood pressure. In severe cases, people can experience seizures or *delirium tremens* (DTs), which are acute episodes of delirium, confusion, disorientation, agitation, or intense hallucinations. DTs are also associated with severe, uncontrollable tremors and may be life-threatening, especially if left untreated.

During detoxification, medications and medical monitoring may be used to reduce the severity of symptoms and maintain safety while the person is experiencing withdrawal. For those who have been using large amounts of alcohol or sedative hypnotics, medical supervision during withdrawal is important and can be provided on either an inpatient or outpatient basis. Medications can prevent symptoms, seizures, and DTs.

Considering the long-term effects of alcohol use

Heavy use of alcohol can cause a variety of difficulties over the long term, especially for consumers. Adverse effects of alcohol include medical problems, increased symptoms of mental illness, and functional problems.

Medical problems

Every organ in the body is susceptible to illness from alcohol. Numerous medical problems can result from drinking, including the following:

- Cirrhosis (scarring and inability to function) of the liver;
- Dementia (loss of ability to remember and solve problems);
- Neuropathy (pain and burning in the arms and legs due to nerve damage); and
- Cancer.

Furthermore, alcohol use increases blood pressure, which can worsen hypertension and put stress on the heart, leading to heart disease.

Alcohol affects hormones in men and women, resulting in fertility problems. If a pregnant woman drinks regularly or, on occasion, large amounts of alcohol, the baby may develop fetal alcohol syndrome. Fetal alcohol syndrome causes mental retardation, developmental delays, and physical defects.

Women are more vulnerable to the effects of alcohol than men. As a general rule of use over time, women develop medical problems after having more than one drink a day; for men medical problems develop after having four or more drinks a day.

Another common problem related to alcohol use is insomnia. In the short term, alcohol helps people fall asleep. However, long-term alcohol use disturbs normal sleep and causes awakenings in the night. In the vignette, Tanya began using alcohol to relax and help her sleep. However, her current sleep disturbances may be related to long-term alcohol use.

Increased symptoms of mental illness

Alcohol is a central nervous system depressant. Long-term alcohol use can produce depression or worsen the symptoms of serious mental illness, especially mood problems such as depression and anxiety.

Alcohol use disorders are intertwined with mood in several ways:

- Long-term, regular drinking in moderate to large amounts causes most people to feel depressed, lose their appetite, have body aches and pains, and feel despair. Between 10 and 20 percent of people with alcoholism commit suicide, usually when they are drinking.
- Anxiety problems are common in people with an alcohol use disorder. Alcohol can reduce anxiety in the short term, but as the effect of alcohol wears off, anxiety can worsen as it did for Tanya.

Alcohol itself can cause psychotic symptoms such as hallucinations. People with psychotic disorders often appear more symptomatic over time when they are drinking, probably due to disinhibition and not taking antipsychotic medications.

Functional problems

Alcohol use disorders often lead to other problems that cause stress. People with alcohol use disorders typically experience social and vocational problems. For consumers, alcohol abuse typically leads to the following problems, among others:

- Loss of familial supports;
- Social isolation;
- Behavioral problems;
- Inability to work;
- Inability to make use of treatment;
- Difficulties managing money; and
- Unstable housing.

In the vignette, Tanya's drinking has resulted in social and interpersonal problems, such as difficulties with her husband that led to divorce and interpersonal problems with her daughter. She has engaged in dangerous behavior resulting in legal problems, indicated by a charge for driving while intoxicated. She has also had difficulty working.

Tanya's story is typical of someone with mood and alcohol problems. Alcohol provides a brief escape from feeling bad, but ultimately makes everything worse.

Evaluating the relationship between Tanya's mental illness and alcohol use

It is often difficult to figure out whether alcohol use causes depression and anxiety or whether these symptoms are due to a separate and distinct co-occurring disorder. Are Tanya's depression and anxiety problems truly independent of her drinking or might they just be the consequence of heavy drinking?

If drinking causes the symptoms, they should go away within 1 month of becoming abstinent.

As Tanya's integrated treatment specialist, ask her about periods of abstinence in her life and whether depressive or anxiety symptoms were present during that time. Tanya's year-long period of abstinence is incredibly valuable information. During this period, she experienced a post-partum depression, strongly suggesting that her depressive illness is distinct from her alcohol dependence.

Often the available information is insufficient to tell whether a mental illness is primary or secondary. In this case, we suggest that you assume that both the mental illnesses and substance use disorders are important, and assess and treat both disorders in an integrated fashion. You may learn more information over time that suggests that the symptoms of mental illnesses are caused by substance use; if so, then you can reconsider the diagnoses and treatment.

Assessing Tanya's family history

Both alcoholism and depression have genetic components. That means that these illnesses run in families and that people's genetic makeup contributes to each illness. Alcoholism seems to run in Tanya's family; her father is a recovering alcoholic and her daughter has started to abuse alcohol.

Children of alcoholics are four times more likely to develop alcohol use disorder than are children of non-alcoholics. Children of parents who have depression are also more likely to develop a mood disorder.

Finding out whether family members have experienced substance use or mental disorders is important to help you understand consumers' disorders. If consumers have a strong family history of mood problems, then they are at risk for having mood problems. If consumers have a strong family history of alcohol problems, they are at risk for having alcohol problems.

Some families have both problems in multiple family members. Because of Tanya's family's problems, her integrated treatment specialist should talk with her to help her understand her own vulnerability to these disorders. It is also important for Tanya to learn about her children's vulnerability to substance use and mood disorders and how to prevent these problems.

Should people with alcohol problems take sedative-hypnotic medications?

Medications that are sedating or induce sleep are called *sedative-hypnotics*. Sedative-hypnotic medications are a chemically diverse group of substances, including benzodiazepines such as clonazepam, that are prescribed to reduce anxiety and insomnia. Sedative-hypnotic medications are also prescribed to treat agitation and mania and to reduce some side effects of antipsychotic medications, such as tardive dyskinesia (abnormal movements) and akathesis (restlessness).

Tanya's story raises several interesting issues about medications and alcohol use disorder. Like Tanya, people with alcohol and anxiety problems are often prescribed sedative-hypnotic medications (such as the benzodiazepine, clonazepam) for their anxiety. Using these kinds of medications may worsen the alcohol problem and lead to abuse or dependency because they have a similar effect on the brain as alcohol (they are *cross-reactive*).

In particular, benzodiazepines tend to be overused and abused in the same way as alcohol. Once people take a sedative-hypnotic medication regularly, they may have a hard time stopping because they experience increased anxiety and withdrawal symptoms when they do. This happened to Tanya who had difficulty stopping the clonazepam.

For some consumers with severe anxiety, using benzodiazepines might be necessary. But experts believe that antidepressant medications, which are very effective for treating anxiety and behavior, should be tried first. As Tanya's integrated treatment specialist, speak with Tanya's medication prescriber to explore alternative medications.

Medications for consumers with alcohol use disorders

Disulfiram (Antabuse) is a medication that may reduce addictive behavior for consumers who have alcohol use disorders. Disulfiram causes a very uncomfortable physical reaction if people drink while taking it. Experiencing a disulfiram-alcohol reaction may help consumers avoid drinking in the future.

In addition to the physical reaction, the medication provides a psychological barrier to drinking. However, for consumers to benefit from this effect, they must take the medication for a period of time. During this time, consider offering consumers supports that encourage them to take the medication regularly such as medication monitoring.

Naltrexone (Revia) and Acamprosate are other medications that help consumers reduce alcohol use by lessening alcohol cravings. Like disulfiram, naltrexone and acamprosate do not have abuse potential. Consumers have no symptoms and are not in danger if they use alcohol while taking these medications, so the medications are safe and appropriate for consumers who are still drinking and are not strongly committed to sobriety.

Cannabis

Cannabis (also called *marijuana*, *pot*, *weed*, *herb*, and *hash*) is a commonly used and abused illegal substance throughout the U.S. and other countries. Produced from the leaves, stems, and flowering tops of the plant *Cannabis sativa*, cannabis is widely grown and available in several forms, which vary widely in strength.

The most common form is dried plant parts. Cannabis can be smoked or eaten. Hashish, or hash, is the resin from the female plant flowers, and is usually stronger than the dried plant form. Hashish oil, made by distilling the plant in chemicals, is even more potent. Street marijuana is considerably more potent than in past years because of current growing and harvesting techniques.

This section begins with a vignette of a young man, Corey, who has schizoaffective disorder and uses cannabis. After reading the vignette, think about the effects of cannabis on Corey's mental illness and how you would work with him to promote his recovery.

Corey's story

Corey is a 25-year-old man who has been diagnosed with schizoaffective disorder and cannabis dependence. He began smoking pot at the age of 15 with friends in high school. Corey says that marijuana always made him feel relaxed and comfortable.

At 17, Corey experienced his first manic episode. He felt euphoric, powerful, and brilliant, without any need to sleep or eat. He described plans for a new fighter jet, which he was sure the U.S. Air Force would buy to make him a famous millionaire. Corey was hospitalized during this episode, started on medication, and referred to the local community mental health center for followup treatment. Despite hearing a diagnosis from a case manager and a psychiatrist, Corey wasn't convinced that he had a mental illness and didn't remember the symptoms he experienced while manic.

Since that first episode, Corey accepted prescriptions for anti-psychotic medication, but did not take them regularly. He visited with his case manager every week and told her that he worried about people attempting to steal his plans for a new fighter jet.

He continued to smoke marijuana daily and believed that he needed it to relax. He used to smoke with friends, but because he came to feel that they were out to get him, he smoked in his apartment by himself. Corey had several more hospitalizations for manic and psychotic symptoms. When his case manager suggested that his marijuana use could be associated with not taking medications and ending up in the hospital, he disagreed and stated he would continue to smoke marijuana because, "that is who I am."

Corey's functioning steadily deteriorated. Although he was able to graduate from high school, Corey worked at a series of jobs that never lasted long, which he attributed to poor concentration and difficulty getting along with coworkers. He became isolated from family and friends. He was referred to Integrated Treatment for Co-Occurring Disorders.

At first, his integrated treatment specialist used engagement techniques and motivational interventions to encourage him to attend treatment. Corey soon began working with an employment specialist. Eventually, he chose to take medications regularly. He began holding a steady job at a book publishing company. He stopped using cannabis. He hadn't been hospitalized for more than a year. He stopped bringing up the topic of fighter jets. After 4 years, he is still doing well. He continues to participate in self-help groups and sees a psychiatrist every 3 months.

Understanding the short-term effects of Corey's cannabis use

People who use cannabis report that it makes them feel anxious or paranoid or, conversely, happy, relaxed, and sleepy. Acute cannabis intoxication causes the following:

- Increased appetite;
- Reduced motor performance (as in driving a car);
- Reduced attention, concentration, and memory;
- Visual distortions and decreased recognition of visual stimuli; and
- A sense of time distortion.

High doses of the drug usually lead to paranoia and anxiety. The acute effects last approximately 3 to 4 hours.

People with mental illnesses who are intoxicated with cannabis may appear more paranoid or calm. They are often less able to participate in treatment or other activities due to reduced attention and concentration.

Cannabis use, even in small amounts, can precipitate acute psychotic episodes, which often require hospitalization and sometimes do not resolve quickly or easily. In Corey's case, using cannabis regularly eventually caused him to isolate himself from his family and friends, led to problems at work, and resulted in hospitalization.

Because cannabis users perceive that cannabis is calming and sleep-inducing, they are often unable to recognize its adverse effects. When Corey's case manager first suggested the association between his cannabis use and hospitalization, Corey did not accept that information.

Cannabis tolerance and withdrawal

Some evidence shows that regular, heavy cannabis use produces tolerance, physiological dependence, and withdrawal symptoms. These effects have been somewhat controversial, in part because they can be less severe than those of other drugs and because cannabis is removed from the body slowly.

The active chemical in cannabis, THC, is absorbed into the bloodstream and quickly affects the brain. THC is then absorbed from the blood into fat cells and is slowly released back into the blood. For this reason, it may take days or weeks to remove it from the body. Thus, the typical high ends within hours, but THC remains in the bloodstream at lower levels for a long time.

Detoxification

When someone uses cannabis regularly, the body takes about a month to remove all the cannabis. If people do experience withdrawal symptoms, the symptoms typically include the following:

- Insomnia;
- Anxiety;
- Irritability; and
- Thoughts and dreams about cannabis use.

Destabilization of the mental illness can occur during withdrawal from heavy cannabis use, though symptoms of withdrawal are usually mild and not dangerous. Medical treatment is not necessary, but monitoring mental health symptoms and providing support for avoiding substance use are important.

Considering the long-term effects of cannabis use

Heavy use of cannabis can cause a variety of difficulties over the long term, especially for consumers. Adverse effects of cannabis include medical problems, increased symptoms of mental illness, and functional problems.

Medical problems

Long-term cannabis use has several negative effects on health. Cannabis smoke contains more tar and cancer-causing chemicals than tobacco smoke. Cannabis use is associated with lung damage and cancer. Cannabis is also linked with the following:

- Impaired immune function;
- Heart problems; and
- Changes in reproductive hormones.

Increased symptoms of mental illness

Heavy cannabis use impairs cognition by reducing attention, concentration, and memory. Long-term cannabis use for consumers is associated with these poor outcomes:

- Relapses;
- Hospitalizations;
- Declining functioning; and
- A lack of progress toward life goals.

Corey's story illustrates how his symptoms of mental illness gradually worsened over time as he used cannabis heavily. When he used cannabis regularly, his feelings of paranoia increased.

Functional problems

Similar to alcohol use, heavy cannabis use often leads to other problems that cause stress. People who regularly use cannabis typically experience social and vocational problems. For consumers, cannabis use typically leads to these problems, among others:

- Loss of familial supports and social isolation;
- Behavioral problems;
- Inability to work; and
- Inability to make use of treatment.

In the vignette, Corey lost interest in pursuing outside activities such as education or work. The loss of interest and motivation may have been due to the cannabis, his mental illness, or, more likely, the combination.

Evaluating the relationship between mental illness and cannabis

Consumers and families often notice that mental illness symptoms start when someone uses substances and they wonder whether substance use caused the mental disorder. Current research suggests that substance use does not cause serious mental illnesses but may precipitate episodes of illness in those who are vulnerable.

The symptoms continue because consumers' biological makeup already predisposed them to having the mental illness. Mental illness symptoms that have been present for months or years rarely resolve without treatment when substance use stops.

Stimulants

Many types of central nervous system stimulants exist including cocaine, amphetamines, and other drugs. Stimulants increase alertness, enhance energy, decrease appetite, and induce a feeling of well-being or euphoria, but can be extremely addicting and lead to negative outcomes.

Cocaine is a frequently abused street drug, especially in urban areas. It comes in various forms that are smoked, inhaled, and injected. Cocaine powder can be snorted or mixed with water and injected. When mixed with water and sodium bicarbonate, it becomes a solid “rock” that is smoked as “crack.” The high is brief, lasting minutes to hours.

A variety of amphetamines (including methamphetamine or “crystal meth”) are also widely available. Amphetamines are usually taken orally or intravenously but can also be snorted or smoked. The amphetamine high lasts from 12 to 24 hours.

MDMA, known as *ecstasy*, *X*, or a variety of other names, has both stimulant and hallucinogenic properties. This substance is available as a tablet, capsule, or powder that is swallowed or snorted and lasts as long as 8 hours.

Other stimulants include prescribed and over-the-counter medications such as the following:

- Methylphenidate, a medication for attention deficit disorder;
- Dexadrine, used for weight loss; and
- Ephedrine, a component in many cold remedies.

When these medications are used in higher amounts than recommended, they can have effects similar to cocaine and amphetamines. Caffeine is also a stimulant and, if used in very large amounts, can have similar effects.

Demographically, cocaine users tend to be young, male, and dependent on multiple substances. Stimulants are commonly used with sedating substances, including alcohol, opioids, cannabis, and sedative-hypnotic medications. People may use the sedating substances to manage agitation or withdrawal symptoms.

This section begins with a vignette of a young man, José, who has been diagnosed with schizoaffective disorder and cocaine dependence. After reading the vignette, consider how stimulant use affected the course of José’s mental illness and treatment. How would you help José?

José’s story

José is a 25-year-old, Puerto Rican-American man who lives at home with his parents, younger sisters, and aunt. He speaks fluent English, but communicates in Spanish with his family and friends. He was diagnosed with schizoaffective disorder, depressed type, and cocaine dependence when he was an 18-year-old high school senior. At that time, after drinking alcohol and smoking crack cocaine, José became extremely depressed and heard voices telling him to kill himself. He was involuntarily hospitalized for a month and, when released, dropped out of school.

José was referred to the local mental health center, where he was assessed and assigned a Caucasian case manager who did not speak Spanish. José was also referred to a substance abuse group, which he did not attend. He thought his case manager was okay “for a white guy,” but made it clear that playing basketball and hanging out with friends in the park were more important than going to the mental health center. He said that cocaine helped with his depression and using it was not a problem.

With his case manager’s help, José obtained disability income. He used his disability checks and also money he borrowed from his family to buy cocaine. His cocaine use created turmoil in the family. José spent most of his time in the park smoking crack with his friends or drinking in a bar down the street from his parents’ apartment.

Constant auditory hallucinations and periodic depressions resulted in several hospitalizations. José's case manager and psychiatrist were so worried about his illness and substance use disorder that they enlisted a translator to engage José's parents in the treatment process.

José's parents wanted him to return home to live with them when he left the hospital. They were sure that if they could stop him from using drugs, everything would be all right. José's father drank heavily, and he argued with José about cocaine use but not about his drinking.

After meeting with José and his parents several times, José's treatment team agreed to pursue a representative payee. The payee made sure his money from the disability checks was spent on appropriate items and was not available for cocaine. José's cocaine use decreased. He wanted more money, however, and began to sell cocaine in the alley next to his favorite bar, which led to an arrest and 3 months in jail.

Understanding the short-term effects of José's stimulant use

In small doses, stimulants increase alertness, enhance energy, suppress appetite, and induce a feeling of well-being or euphoria. At higher doses, stimulants cause the following feelings:

- Euphoria;
- Hyperawareness;
- Hypersexuality;
- Hypervigilance;
- Agitation; and
- Sleeplessness.

Stimulant users typically experience racing thoughts and speech. Anxiety, irritability, and psychosis can also occur. The high of cocaine wears off rapidly, however, and often leads to a cycle of depression and repeated use that goes on for many hours. This same cycle can occur over many days with using methamphetamines.

With MDMA, muscle stiffness, pain, or spasm, as well as elevated body temperature and confusion, are additional effects. With heavy, long-term use of MDMA, cognitive problems can develop that can be permanent.

Confusion and disorientation, as well as seizure, strokes and heart attacks, can occur with very high doses of stimulants. Inhalation and intravenous use are more likely to cause dangerous reactions, such as sudden death due to cardiac arrhythmias.

For consumers, even brief or occasional use of stimulants can induce or worsen psychiatric symptoms or precipitate major relapses. Episodes of mania or psychosis often are initiated by stimulant use. Depression is exacerbated by the cycle of stimulant use.

In José's story, he was hospitalized directly after a time when he was drinking alcohol and smoking crack cocaine. However, José believed that cocaine helped his depression and that his cocaine use was not a problem. As José's integrated treatment specialist, assess how his cocaine use affects him in the short term. How does José feel before, during, and after using cocaine?

Stimulant tolerance and withdrawal

The rapid onset of euphoria, followed quickly by loss of action of stimulants in general and cocaine in particular, makes them highly addictive. People often use the drug repeatedly to sustain the highs and avoid the lows.

Repeated use produces tolerance or diminished effects of the drug and is followed by using larger amounts. This pattern can lead rapidly to addiction. While alcohol use typically transitions into addiction over years, people typically become addicted to cocaine within weeks or months.

When a person stops heavy use of stimulants, withdrawal commonly ensues. Withdrawal from stimulants occurs in three phases:

- The first phase is a “crash” with feelings of depression, agitation, and intense craving.
- Within days, in the second phase, the person experiences fatigue, low energy, and decreased interest.
- Weeks to months later, in the third phase, the person may experience episodic intense craving.

Considering the long-term effects of stimulant use

Heavy use of stimulants can cause a variety of difficulties over the long term, especially for consumers. Adverse effects of stimulant use include medical problems, increased symptoms of mental illness, and functional problems.

Medical problems

People who use stimulants are at high risk for contracting infectious diseases for a number of reasons. Infectious diseases such as hepatitis and AIDs are spread through contact with infected blood and sex fluids. Infection can occur when sharing a straw through which drugs are snorted.

People who use stimulants long term and develop a tolerance are likely to seek out more potent routes of drug administration to satisfy cravings, such as intravenous use (IV or injection). People who share needles are also at high risk for infectious diseases. Furthermore, the euphoria of stimulants often results in unsafe sexual behaviors, which leaves stimulant users vulnerable to infectious diseases.

Increased symptoms of mental illness

For consumers, stimulant use is generally disastrous because it can produce or worsen most psychiatric symptoms. Even intermittent or moderate stimulant use can worsen the symptoms of those with serious mental illnesses.

In José’s story, his paranoia, ideas of reference, depression, and suicidal thoughts had been intertwined since adolescence. Though he is unable to see it, his case manager observed that José’s mental illness symptoms are less severe during periods of sobriety than during periods of active substance use.

Functional problems

By definition, addiction involves increasing preoccupation with drug procurement and use. Long-term addiction often leads to criminal behavior to obtain money for drugs, and potentially, to involvement with the criminal justice system.

Consumers with co-occurring disorders, such as José, are particularly prone to being arrested and incarcerated for drug-related behaviors. Incarceration is almost always a negative experience for consumers, and they often receive inadequate treatment while there.

In the vignette, José used his disability payments to buy cocaine. His case manager and psychiatrist pursued a representative payee. A judge agreed that José was unable to take care of his finances by himself and assigned a payee.

Note that to a large degree this is a legal rather than a clinical issue. The law specifies that people who are unable to manage their disability funds—for example, someone who uses the money for drugs rather than food and housing—cannot receive disability payments directly and the court must decide on an appropriate payee.

José's case manager wanted to support his sobriety by managing his money and reducing his access to cocaine and alcohol. This tactic seemed to help in the short run, but not in the long run. When José's access to money was limited by the payeeship, he reduced his drug use. However, José began to sell drugs and ended up in jail.

Using protective payees and other forms of involuntary interventions is controversial. Most integrated treatment specialists prefer to encourage consumers to use voluntary money management.

As José's integrated treatment specialist, you should develop a relationship with court officers to divert José from incarceration and into treatment. You should also develop a relationship with mental health practitioners in your local prison system to advocate for consumers, like José, who are incarcerated. Efforts to divert consumers from jail include court-ordered participation in treatment, which may improve motivation for treatment and promote behavioral change.

Understanding cultural diversity

Another interesting aspect of this vignette is José's Hispanic background. Many consumers would like to work with a practitioner who is from the same culture as they are. Often, this is simply impossible. It is critical, however, that integrated treatment specialists try to understand the culture in which consumers live and use this information to inform their efforts.

While utilizing bi-lingual staff is preferred, when not available, interpreters may be necessary to communicate with consumers who do not speak English. Consider participating in training to learn how to best use an interpreter. Consumers' culture, race, gender, sexual orientation, age cohort, family, and social network are important parts of their identities. Integrated treatment specialists can be most effective if they understand what these issues mean for each consumer. In José's case, for example, understanding how he experiences his Hispanic heritage, his friendships, and his family are essential to helping him find a path to recovery.

Opiates and opioids

Opiate refers to morphine and codeine (which occur naturally in opium from some types of poppy plants). Similar synthetic drugs are called *opioids*. Doctors prescribe some of these substances, such as morphine, codeine, and oxycontin, to treat pain. Others, such as heroin, are manufactured illegally for nonmedical use.

All of these types of drugs have wide-ranging effects on mood, motivation, pain, stress, breathing, and many other body functions. The human body naturally makes similar substances called *endorphins* which help people tolerate pain, cope with stress, and experience pleasure.

While some of these drugs are prescribed and used for medical reasons with minimal risk of addiction, the risk of addiction is much greater when they are used for nonmedical purposes without medical supervision. The tendency to become addicted is partly genetic and partly related to psychological, social, and environmental factors.

Red flags for the abuse of prescribed opiates and opioids include the following:

- Running out of medication before the prescription should be finished;
- Demanding medications; and
- Obtaining extra prescriptions from other doctors and emergency rooms.

People who are involved in abusing prescription medications may also buy them or sell them illegally.

This section begins with a vignette, Jane's story. Jane has schizophrenia and is addicted to heroin. After reading the vignette, consider the effects of Jane's opiate use. This vignette is followed by a discussion of the short- and long-term effects of opiates on the body as well as the effects on consumers. One specific aspect of treatment, *opioid agonist therapy*, is briefly described.

Jane's story

Jane is a 35-year-old divorced, unemployed woman with schizophrenia and polysubstance abuse. At age 18, Jane entered mental health treatment because she believed that people on the TV were talking to her and commanding her to do things such as shoplift or hurt herself. When she entered treatment, she was abusing alcohol, marijuana, and nicotine.

Jane completed high school and worked as an office cleaner until she was 20. During her first 2 years in treatment, she was hospitalized three times.

She married a man whom she met during her third hospitalization and had her oldest child, Jennifer, with him. Jennifer is now 16 and living in foster care. During and after her pregnancy, Jane was abstinent, attended all her medication evaluations, and became an active member of a relapse prevention group.

Jane's marriage ended in divorce when she was 22. She and her daughter moved back to her parents' house. After a car accident and surgery, Jane was prescribed narcotic pain medications, which she found herself using more and more frequently.

She stopped mental health treatment and resumed smoking marijuana and drinking alcohol with her old friends. A new boyfriend introduced her to heroin, which she began using regularly.

Gradually, her paranoia and delusions returned. She became alternately angry and aggressive or withdrawn and paranoid. Her parents, who regularly participated in an Al-Anon support group, asked her to leave and took custody of her daughter.

Jane moved in with drug-using friends and began shoplifting and trading sex for drugs. Her friends left town, her boyfriend disappeared, and she began staying with strangers and occasionally living on the streets. She was kicked out of the homeless shelter because she threatened staff.

She was later arrested for drug possession and prostitution many times and referred by police back to the clinic for treatment at age 33.

Though Jane said she did not want treatment, she was referred to an Assertive Community Treatment team. For several months, team members met with her and befriended her while she was living on the streets. They helped her get clothes and food.

During this time, Jane became worried that she was pregnant again, so her case manager helped her with a doctor's appointment. When she learned that she was pregnant and had HIV, Jane became very delusional and was hospitalized involuntarily. In the hospital, she began taking medications for the HIV and for her mental illness.

After several weeks in the hospital, Jane became less paranoid and more organized in her thinking. She was concerned about her baby and agreed to move into a transitional housing building that was associated with the mental health center. One of the terms of the housing was to remain substance-free. She agreed to stop using substances to comply with the rules, but also because she did not want to hurt the baby.

Jane worked intensively with the team over the next 2 years. Her mother became involved with her treatment as well.

Jane and her mother decided that the baby should live with Jane's parents while she lived in supported housing. She participated in treatment in the mornings and cared for her baby in the afternoons. Her mother helped her remember her medications at dinnertime. Jane had difficulty with ongoing paranoia but was able to interact with her family appropriately. Her HIV was stable while she continued to take medications.

Understanding the short-term effects of opiate use

Intoxication with an opiate often produces relief from anxiety, a pleasurable sensation such as a “rush” or “thrill,” and a longer lasting relaxed, calm, and soothing state—the “high.” When the drug is injected into the bloodstream, the effect occurs faster than if it is taken by mouth. Some opiates have a slower onset than others and are less likely to cause a “rush.”

When people use opiates, they typically appear calm or sleepy. Their pupils are constricted or small. They can be distracted and unable to participate in regular activities. When they come down from the high, they are often anxious, agitated, and depressed. Sometimes, they experience other withdrawal symptoms.

Due to a combination of several factors, opiates and opioids can be extremely dangerous. The purity of street drugs is highly variable. When these drugs are taken in large amounts or very pure varieties, they suppress the breathing center in the brain.

Most people who use opiates or opioids also abuse other drugs at the same time. Because of these factors, accidental overdoses are common and can result in coma and death. Medications that block the effects of these drugs are used to treat people in emergency rooms to prevent the severe problems associated with overdose.

Opiate tolerance and withdrawal

People who use opiates regularly without medical supervision are highly prone to develop abuse or dependence because of the properties of these substances. Symptoms of withdrawal from opiates and opioids include the following:

- Increased pain sensitivity;
- Dysphoric mood;
- Anxiety;
- Muscle and bone aches;
- Kicking movements caused by spinal reflex;
- Hyperactivity;
- Dilated pupils;
- Stomach cramps;
- Diarrhea;
- Yawning;
- Sweating; and
- Runny eyes.

When consumers use these drugs regularly, they often continue to use them to avoid the uncomfortable symptoms of withdrawal.

Detoxification

Because symptoms of withdrawal are so uncomfortable and craving is severe, detoxification from opiates can be very difficult. Medical treatments are often used to reduce the severity of symptoms during this process. Naltrexone may also be prescribed to block the effect of opiate drugs such as heroin and morphine. It can be used to treat people with opiate abuse or dependence after they complete detoxification.

Opioid agonist therapy

Opioid agonist therapy (previously called *methadone maintenance*) is a standard and well-supported treatment that is unique for chronic addiction to opiates or opioids. In this treatment, medication is prescribed in regular doses that prevent withdrawal symptoms.

Opioid agonist therapy uses medications that attach to the same chemical receptors in the body as heroin, opioid, and opiate pain medications. Methadone has been in use for many years, and two other medications, Buprenorphine and L-Alpha-Acetylmethadol (LAAM), are more recent alternatives to methadone. Buprenorphine may be less likely than Methadone to be abused because of its chemical action. LAAM is longer acting, so consumers only take it three times a week, as opposed to methadone, which is taken daily.

Opioid agonist therapy reduces illegal drug use and dangerous activities to obtain drugs, such as stealing and prostitution, and also reduces the risk of serious medical problems associated with intravenous drug use (HIV and hepatitis). When opioid agonist therapy is used with counseling, case management, or other social services, consumers experience improvements in housing, relationships, and work. Though it has been extensively studied in people with opiate use disorders, opioid agonist therapy has not been studied in people with serious mental illnesses.

All states are developing a process to license and regulate opioid agonist therapy. For more information, go to the SAMHSA Web site at www.dpt.samhsa.gov or contact your state substance abuse authority.

Considering the long-term effects of opiate use

Unlike alcohol, cannabis, and stimulants, opiates do not tend to destabilize mental illness immediately. Opiate use, however, is associated with many long-term risks for consumers, including medical problems, increased symptoms of mental illness, and functional problems.

Similar to stimulant users, consumers who use opiates experience medical problems related to intravenous drug use. Common health problems include infectious diseases, such as HIV and hepatitis, which are discussed in the next section.

Consumers are more vulnerable to having problems when they use substances than people are who do not have a mental illness. Consumers who use opiates over the long term often reduce and abandon usual activities to focus on drug-seeking and drug-using behaviors. For example, consumers who become preoccupied with obtaining opiates may seek prescriptions from doctors, steal, or engage in dangerous sexual activity or illegal activity to obtain drugs.

As the vignette illustrates, consumers need all of their resources to manage their mental illness, meet basic needs, maintain satisfying living conditions, and function in normal adult roles, such as worker, spouse, and parent. Substance use quickly put Jane into catastrophic circumstances. She lost interest in taking care of herself, taking medications, and participating in other therapeutic activities. Thus Jane's substance abuse worsened the recurrence of her mental illness symptoms.

Jane does reasonably well when she is not using substances, but when she uses, she completely loses her ability to take care of herself and her children, manage her illness, function normally, and even avoid life-threatening situations and illnesses.

Infectious diseases

Hepatitis B, hepatitis C, and the Human Immunodeficiency (HIV) viruses are germs that cause illnesses and that can be easily spread from one person to another. Each disease is serious and can harm a person's health and well-being and result in life-threatening illness.

This section describes these three common but dangerous infectious diseases that are caused by viruses. The section explains the following:

- How common infectious diseases are;
- What they are and how the viruses infect people;
- Whether someone should be tested for the diseases;
- The treatment options for the diseases; and
- If someone has a disease, how to avoid spreading it to others.

How common are infectious diseases?

Infectious diseases are more common in some places than others, and in some years compared to others. As of 2001 in the United States, about 1 person in 20 (5 percent) is infected with hepatitis B virus, and about 1 person in 50 (2 percent) has hepatitis C virus. HIV is less common — about 1 person in 200 (.5 percent) is infected with HIV.

Consumers with co-occurring disorders are considerably more likely to have an infectious disease than people who have no disorder or only one disorder. Among people who have both disorders, almost 1 in 4 (25 percent) has hepatitis B virus, about 1 in 5 (20 percent) has hepatitis C virus, and about 1 in 25 (4 percent) has HIV.

What is hepatitis?

Hepatitis is a disease of the liver, which is part of the digestive tract. The liver helps filter out toxic materials, builds proteins for the body, and stores vitamins, minerals, and carbohydrates. People need a functioning liver to stay alive.

Risk Factors for Getting Infectious Diseases

- Sharing injection needles with others
- Sharing a straw for snorting cocaine, amphetamine, or heroin with others
- Having unprotected sex (without a condom) with many partners or people you do not know well
- Having had a blood transfusion, hemodialysis, or organ transplant from an infected source before 1992 (for hepatitis B virus or hepatitis C virus) or before 1985 (for HIV)
- Tattooing or body piercing with improperly sterilized needles
- Sharing personal articles such as a razor, toothbrush, nail file, or nail clippers with others
- Being born to a mother with the infection

Hepatitis B, hepatitis C, and HIV cannot be spread through insect bites, kissing, hugging, or using public toilet seats. To become infected, you must have direct contact with an infected person's body fluids.

When someone has hepatitis, the liver becomes swollen or inflamed because it has been infected with a virus. Though it can take many years to happen, this sickness can cause more serious liver problems and death.

The problems can include the following:

- Cirrhosis (permanent scarring of the liver that reduces blood flow);
- Liver failure (the liver is unable to function); and
- Liver cancer (cancer cells attack the liver).

Many kinds of hepatitis viruses exist, but the most serious ones are hepatitis B and hepatitis C. Preventing infection with hepatitis B and hepatitis C, or taking care of oneself if one has the infection, is important to prevent liver damage and death.

What are HIV and AIDS?

HIV is a virus that attacks and destroys special white blood cells in the body called T-helper or CD4 cells. These T-helper cells are a part of the immune system, which helps the body fight infection and stay healthy. When HIV destroys these cells, the immune system breaks down and is unable to fight infections. Infections that are normally mild can then become serious, causing the person to get very sick and even to die.

Acquired Immunodeficiency Syndrome (AIDS) is the disease someone gets after the HIV virus has destroyed the immune system and the body cannot fight infections.

How do hepatitis viruses and HIV spread?

These viruses pass from one person to another through exposure to infected blood and body fluids. Infection occurs when the blood of an infected person enters the blood stream of an uninfected person. The HIV and hepatitis B viruses can also be passed through the sex fluids (such as semen or vaginal secretions) of infected people when they have unprotected sex with uninfected people.

Hepatitis C is much less likely to be passed to another person through sex fluids, but in some cases, it can happen. Below are some ways that infectious diseases are spread. Review this information with consumers and discuss how they may minimize their risk for contracting an infectious disease.

What about testing for hepatitis B, hepatitis C, and HIV?

Most people who have these viruses do not have noticeable symptoms until long after they contract the virus. Some may not have symptoms at all. Therefore, people must get blood tests to tell if they are infected with hepatitis B, hepatitis C, or HIV.

People should be tested if they have had any of the risk factors listed above. Since consumers with co-occurring disorders are at high risk, they should all be offered blood tests every 6 months to see if they are infected.

How do you prevent and treat these diseases?

Consumers who have not yet been exposed to the hepatitis B virus should be offered the vaccine. Inform consumers that the hepatitis B vaccine is safe and available. The vaccine includes three shots over a period of months.

Most people who get hepatitis B virus recover on their own. However, about 1 in 10 people get a chronic illness years after having the virus. People who have chronic hepatitis B virus may improve from treatment with medicines that boost the body's ability to fight the infection. These medicines are given in a series of inter-muscular injections over a 16-week period and in pills that are taken daily.

People who have chronic hepatitis B illness who get infected with a different virus, hepatitis A, can then get sick with fulminant hepatitis. Fulminant hepatitis is a very serious disease that can cause death. To prevent this, people with hepatitis B virus must get hepatitis A vaccine shots. All children are currently vaccinated against hepatitis A and B.

Unlike hepatitis B, no vaccine protects people from getting hepatitis C virus. Also unlike hepatitis B virus, most people (85 percent) with hepatitis C virus carry the virus for life unless they are treated. This is called *chronic hepatitis C infection* and can cause very serious illness over a period of years.

Several medications help people with hepatitis C. They receive weekly inter-muscular injections and daily oral medications for up to a year. These treatments completely rid many people of hepatitis C virus infection if they finish the treatment. Because the treatments for hepatitis C virus can cause serious side effects, such as flu-like symptoms or depression, doctors decide to treat people with hepatitis C depending on how much the viral illness has affected their liver.

Similar to hepatitis B virus, people with hepatitis C virus who are then infected with the hepatitis A virus can develop fulminant hepatitis, a deadly disease. Taking a vaccine for hepatitis A can prevent this. People who have chronic hepatitis C should get the hepatitis A vaccine.

No vaccine or cure exists for HIV or AIDS. Medications, however, can slow the illness. In addition, new medications that may help more are being developed and tested for HIV and AIDS.

Helping consumers care for themselves

If you are working with consumers who have one of these viruses, encourage them to take care of themselves. Since hepatitis harms the liver and alcohol is toxic to the liver, people who are infected with hepatitis B virus and hepatitis C virus must avoid drinking alcohol.

People with hepatitis B, hepatitis C, and HIV can take other steps to help themselves. First, consumers must get a medical provider who specializes in the care of these conditions and discuss treatment options. They should partner with this professional and learn how to monitor their health, take medication as prescribed, get enough rest, and eat healthy foods.

How to avoid getting or spreading infectious diseases

Encourage consumers to learn how to avoid getting or spreading infectious diseases to others. To avoid getting or spreading infectious diseases, people need to avoid contact with body fluids of people who are infected. See the list for ways in which people can avoid contact with body fluids.

How to Avoid Getting or Spreading Hepatitis and HIV

- Don't use intravenous drugs.
- If you can't stop using drugs, don't share needles with others.
- Don't have sex unless you are sure your partner has been tested and doesn't have any infectious diseases.
- Always use a latex condom when having sexual relations.
- Don't share personal items such as a razor, toothbrush, nail file, or nail clippers with others.

Because most behaviors associated with spreading infectious disease occur in the context of substance use, effective co-occurring disorder treatment will help reduce the spread of these deadly diseases. Offering your consumers testing, immunization, and risk reduction counseling is important in co-occurring disorder treatment.

Exercise: **Review the Short- and Long-Term Effects of Substance Use**

Discuss the short- and long-term effects of using the following substances:

	Short-term Effects	Long-term Effects
Alcohol		
Cannabis		
Stimulants		
Opiates and opioids		

Exercise: **Tackle the Issue**


Review the basic information provided about hepatitis B and C and HIV. Select two members of your training group to play the roles of consumer and integrated treatment specialist. Role play how an integrated treatment specialist would share information about these infectious diseases with consumers.

Module 3

Stages of Treatment and Core Processes

Notes to the facilitator and program leader

Prepare for Module 3:

- Make copies of Module 3. Your copy is in this workbook; print additional copies from the CD-ROM in the KIT. 
- Distribute the material to those who are participating in your group training. Ask them to read it before the group training.

- Make copies of these exercises:

- Identify Consumers with Co-Occurring Disorders*
- Review Assessment and Treatment Planning Forms*



Do not distribute them until the group training. Your copies are in this workbook; print copies from the CD-ROM in the KIT.


- Make copies of your agency's forms for—

- Screening for co-occurring disorders
- Referring consumers to the Integrated Treatment program
- Conducting integrated assessments
- Developing integrated treatment plans
- Any related policies and procedures that your agency has developed (for example, admissions and discharge criteria and assessment, diagnosis of co-occurring disorders, and integrated treatment planning policies and procedures).



Do not distribute them until the group training. For information about developing forms for your Integrated Treatment program, see *Building Your Program* in this KIT. *Note:* If your agency has not yet finished developing these policies and procedures, consider postponing this part of the training until they are developed.

Conduct your third training session:

- When you convene your training, view the following segments of *Training Frontline Staff: Demonstration Video* (approximately 25 minutes): 
 - Overview*
 - Stages of Change and Stages of Treatment*
 - Engagement Stage Interventions*
 - Assessment*
- Discuss the video and the content of Module 3.

One at a time, hand out the exercises and corresponding forms, policies, and procedures and review them as a group.

Training Frontline Staff

Module 3: Stages of Treatment and Core Processes

For many consumers with co-occurring disorders, it takes numerous attempts over time to achieve stable remission or abstinence, but most do attain recovery. This module describes the different stages of change and the types of treatment that are helpful during each stage. Practical skills are presented for engaging consumers at various stages of treatment, conducting integrated assessments, and developing integrated treatment plans.

How change occurs

Change is a process that does not happen quickly or easily. Think about the last big change you made in your own behavior, such as getting on an exercise plan, changing how you interact with others in relationships, or losing weight.

Cigarette smoking is a good example, since smoking is a common addictive habit that many people try to break. If you were a smoker (or have a friend who was), how long did you smoke before you considered that it could be a problem for you?

From that point, how long did it take you to decide that smoking was indeed a problem and that you should stop? This process may have taken years.

From that point, how long did it take to develop a plan? How long before you actually tried to stop? This part of the process may have taken weeks or months.

If you were able to stop, how many times did you have to try before you succeeded completely? Once you stopped, what did you do to try to keep from smoking again?

Most people relapse when they're trying to change their behavior. Did you ever go back to smoking? Did you then go through the same process all over again? Perhaps you can see why people go through several steps and take a long time to give up smoking or other substance use.

As people recover from a substance use disorder, they go through a step-by-step process that can be described in stages.

The Stages of Change

1. Precontemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance

Initially, in the precontemplation stage, people often do not recognize that their substance use is a problem, even when many of their family members and friends do. In this stage, they are not yet considering a need to change.

As people become aware that substance use is a potential problem, they enter the contemplation stage. During this stage they consider their behavior and the possibility of changing.

Once people decide to change, they enter the preparation stage. They become committed to change and develop a plan to cut down or stop using substances.

In the action stage, they try to change by using their plan. They may try many times before they are successful.

Finally, during the maintenance stage, they use strategies to maintain abstinence.

Stages of treatment

The stages of change refer to an internal process. As an integrated treatment specialist, this process is difficult to observe or measure accurately. However, as consumers go through the process of changing, they tend to interact with the treatment system in characteristic ways and should be offered different interventions at different stages. For example, what they find helpful before they consider their behavior a problem is different from what they find helpful when they are actually ready to stop using or after they have stopped.

Stages of treatment refer to the treatments that have been found to help consumers during the different stages of their recovery. The chart shows how the stages of treatment correspond to stages of change.

The Stages of Change		The Stages of Treatment
Precontemplation	➤	Engagement
Contemplation	➤	Persuasion
Preparation	➤	
Action	➤	Active treatment
Maintenance	➤	Relapse prevention

Engagement

Engagement is the stage in which consumers and integrated treatment specialists have no relationship. In this stage, consumers typically do not consider substance use or mental illness symptoms to be problems. During this stage, your job is to help consumers become engaged in integrated treatment for co-occurring disorders.

Engage consumers by providing useful outreach and practical assistance to help them face immediate challenges such as health or financial problems. Integrated treatment specialists develop a working relationship with consumers by using good listening skills and providing motivational interventions such as those described in the next module.

During the engagement stage, integrated treatment specialists conduct an integrated assessment. While the assessment includes gaining an understanding of consumers' substance use, it is important not to confront consumers about their substance use during this stage.

Case example: **Corey's story**

Corey had symptoms of mania and psychosis. He enjoyed smoking cannabis every day, believing it helped him relax. To Corey, smoking pot was an important part of his lifestyle.

Despite being hospitalized, he did not feel he had a mental illness nor did he feel his use of cannabis was a problem in any way. Corey was in the engagement stage.

Persuasion

As the working relationship develops between integrated treatment specialists and consumers, if consumers do not perceive, acknowledge, or understand their substance use or mental illness symptoms, they are in the *persuasion* stage.

During the persuasion stage, help consumers think about the role of substance use in their lives. Active listening, asking exploratory questions about experiences and goals, and educating consumers about substance use and mental illness are common techniques. These techniques, often called *motivational counseling* or *interviewing*, are designed to help consumers think about the following:

- Life goals;
- Substance use;
- Mental illness symptoms; and
- Whether substance use or symptoms deter achieving life goals.

During the persuasion stage, complete a detailed contextual assessment (See *Screening and assessment* later in this module) and use skills for motivational interventions (described in the

next module). During this and later stages, it is often helpful to meet with family members to provide education, get input, and include the family in treatment.

Case example: **Tanya's story**

Tanya presents with concerns about depression and anxiety and problems with her children. With brief counseling, she decides that drinking may be causing problems for her and that she is willing to try cutting back. She comes to treatment in the persuasion stage and moves rapidly into the stage of active treatment.

Active treatment

Once consumers recognize that substance use is a problem and they decide to reduce or stop using altogether, they are in the *active treatment* stage. As their integrated treatment specialist, your task is to provide them with additional skills and supports. For example, consumers may need different kinds of skills:

- **Assertiveness skills**—to avoid substances;
- **Social skills**—to socialize without substances; and
- **Stress management skills**—to manage emotions without substances.

Similarly, consumers in the active treatment stage may need new friends, a better relationship with family, and a self-help group such as Alcoholics Anonymous or Dual Recovery Anonymous. Helping consumers learn skills and find supports is called *active treatment*.

Case example: **Jane's story**

Jane has paranoia and polysubstance dependence on heroin, alcohol, and cannabis. While in treatment 16 years ago, she was clean and sober, but then relapsed into many years of serious mental illness and substance dependence.

When she was hospitalized at age 33, she became clean and sober again. She moved into transitional housing. Currently she is trying to stay away from

substances so she can stay in transitional housing and be involved in parenting her new baby.

After going through all the stages of treatment 16 years ago and then relapsing into the engagement stage where she stayed for many years, she is now back in the active treatment stage.

Relapse prevention

When consumers are abstinent for 6 months or more, they are in the *relapse prevention* stage. The task is to avoid relapsing into problematic substance use. You can help consumers in the relapse prevention stage by working with them to develop a relapse prevention plan.

When developing a relapse prevention plan, work with consumers to identify their triggers to using substances, such as feelings, people, or situations. In partnership with the consumer, outline specific ways they can avoid or handle these triggers or cues.

Another common task during relapse prevention is to facilitate further recovery by developing other healthful behaviors and pleasurable activities.

Case example: **Mark's story**

Mark has schizophrenia and alcohol dependence. After 3½ years of treatment, he is sober. He is attending church, building a new relationship with his sister, and considering getting a different job.

With his integrated treatment specialist, he spends time planning how to remain abstinent by avoiding his old drinking buddies, strengthening new sober relationships, and keeping busy with meaningful activities. He is in the relapse prevention stage.

Progress through stages of treatment

Some consumers move steadily through each stage of treatment and make progress toward recovery. Others move in fits and starts or they move very slowly. Often consumers relapse or move backward and then forward again.

It is important for treatment to correspond to consumers' stage of change. For example, it does little good to work on active treatment skills if consumers do not acknowledge that they have a problem with substance use. It is more effective to engage consumers in a helping relationship and to use motivational interventions to explore their experience.

Engagement

A key to successful assessment and treatment planning is a positive, trusting relationship, which is often called a *working alliance*. *Engagement* is the process of developing a working alliance with consumers.

Engagement is usually based on the following:

- Reaching out to consumers, conveying genuine caring and respect;
- Empathically understanding their situation and goals;
- Offering practical assistance; and
- Eventually helping consumers understand that treatment can help them reach those goals.

Because many consumers with co-occurring disorders who have not yet engaged in treatment are often in crisis, developing a relationship that will foster recovery can be difficult, take time, and require creativity.

This section begins with a vignette, Sheryl's story. After reading the vignette, consider how the integrated treatment specialist engaged Sheryl during different stages of treatment.

Sheryl's story

Sheryl is a 20-year-old woman with a diagnosis of schizophrenia. Her first contact with the mental health center was through a community outreach worker. Someone from the local shelter had called the mental health center because the staff there was concerned about Sheryl's behavior. She often stayed up half the night yelling back at voices that she said called her names. Even more worrisome, she often spent nights on the street prostituting for cocaine.

The outreach worker met Sheryl in the shelter. She was suspicious, fidgety, distracted, and had difficulty talking coherently. The only goal she could think of was to get her own apartment. The outreach worker said that that was something they could work on and asked Sheryl to come to the mental health center to meet with a psychiatrist. Sheryl refused to come to the mental health center, but she did agree to meet with the outreach worker again.

The next day the outreach worker picked Sheryl up and took her out for a cup of coffee and a sandwich. Sheryl reported feeling that she had no one to help her, that she was totally alone. She was angry with her mother, who had hit her and kicked her out when she was 16. Her father refused to talk with her. She didn't know where her siblings were. She said she couldn't trust anyone.

The outreach worker began to meet with Sheryl each morning before she left the shelter and gradually introduced her to other treatment team members. An integrated treatment specialist met daily with Sheryl at the shelter, the soup kitchen, or the local coffee shop. Sheryl continued to insist that an apartment was her only goal. After 2 months, the treatment team agreed to help her find an apartment if she would meet with the psychiatrist.

The psychiatrist diagnosed Sheryl with schizophrenia, alcohol dependence, and cocaine dependence; he prescribed an antipsychotic medication. The outreach worker brought medications to Sheryl, and she agreed to take them knowing that the treatment team would help her get money and an apartment.

Sheryl began to receive Supplemental Security Income benefits and with help from the treatment team, Sheryl got an apartment. Within days, however, it became clear that Sheryl was prostituting and selling drugs in the apartment, and her landlord soon evicted her.

When Sheryl landed back in the shelter, the treatment team offered again to help. Sheryl admitted that she had not been taking the medications, and she rejected suggestions about a payee and a group home. She wanted to control her money and to get another apartment.

For several weeks, Sheryl's behavior worsened with increasing paranoia, less predictable appearances in the shelter, and more frequent signs of physical abuse. At this point, she was arrested for breaking into her mother's home, stealing money, and assaulting her mother.

Because of her psychotic appearance and behavior, she was diverted to a local psychiatric hospital. Treatment

team members visited her regularly and worked with the hospital staff.

As Sheryl took medications, got rest, and had a few weeks away from cocaine, she became clearer and more personable than the team had ever seen her. She expressed regrets about her life of addiction, prostitution, and victimization.

The integrated treatment specialist helped her select a self-help group for women with co-occurring disorders and another group for women with sexual abuse histories; she began to share her fears and anxieties with others. In anticipation of discharge, she agreed to allow the treatment team to become her payee and to live in a supervised apartment. She expressed a strong interest in continuing with the groups.

Having been through the engagement process with several co-occurring disorder consumers such as Sheryl, her integrated treatment specialist knew that she would probably continue to have crises and relapses. But she also knew that she was developing a trusting relationship with her that would encourage Sheryl to continue in treatment and pursue her personal recovery goals.

How does engagement happen?

Not all consumers are demoralized or distrustful, but it is common for consumers who have co-occurring mental illnesses and substance use disorders to have difficulty entering into a treatment relationship. Engaging consumers like Sheryl often takes the following:

- Time;
- Patience;
- An accepting attitude;
- A persistent approach; and
- Being available when an opportunity appears.

Pushing treatment prematurely can interfere with the engagement process. Instead Sheryl's integrated treatment specialist reached out to her to try to develop a relationship based on acceptance, empathy, and helpfulness. Outreach is often necessary, particularly when consumers are overwhelmed and unable to muster the courage and hopefulness that are necessary to pursue recovery.

Sheryl's integrated treatment specialist used reflective listening, a technique of carefully listening to Sheryl's point of view and reflecting understanding back to her to make sure it is correct without trying to interpret the situation, offer advice, or correct any misperceptions. Reflective listening does not mean accepting consumers' views as correct; rather, it ensures that you understand consumers' views, their language, and their attempts to cope. Using this technique is nonthreatening and begins the process of building a trusting relationship. For more information on this and other techniques, see Module 4.

As part of establishing a working alliance, Sheryl's integrated treatment specialist asks about her goals and helps her plan small, realistic steps toward the goals by offering assistance. The treatment team does not support Sheryl's goals when they turn self-destructive such as when Sheryl began selling drugs and prostituting from her apartment. In such a situation, they try to find another goal on which they and Sheryl can agree.

Work with consumers with co-occurring disorders can easily become derailed by consumers' illnesses, crises, or attempts to cope with a bad situation. Remain positive and optimistic, avoid confrontation, and emphasize hope, self-efficacy, and consumers' strengths.

Remember that you should not confront consumers about substance use while establishing a relationship. As you develop a relationship through working together, consumers will discover that substance use and psychiatric symptoms are barriers to accomplishing their goals. At this point, you can suggest treatment possibilities.

Be careful to stay on the consumer's side and to facilitate but not insist that the consumer enters treatment and adheres to treatment recommendations. Over a few months, the relationship and the support will enable most consumers to connect successfully with treatment.

The role of crisis and stabilization

As Sheryl's story illustrates, the opportunity for change often comes with a crisis. Often during forced sobriety, consumers experience a shocking realization that they need to get off the path of self-destruction and do something different. Having an established working alliance with consumers at this point is critically important.

Sheryl's behavior shows that she is severely addicted to crack cocaine, which has worsened her schizophrenia, caused her to lose her supports, and made it difficult for others to maintain a relationship with her. She needed respite, safety, and protection to recover her ability to see her situation rationally and to make good decisions for herself. Hospitalization and protected housing are often critical steps, but they may not be acceptable to consumers.

Despite heroic efforts to help, some consumers, such as Sheryl, will continue to experience wild fluctuations or to spiral downhill. Their lives are so dominated by illness, trauma, addiction, and instability that they do not see the need to master their illnesses or even hope for better lives.

Engagement techniques work

The approach to engagement we have described here is commonly used and is quite effective. In the substance abuse literature it is called *motivational counseling*, and in the mental health literature it is known as *strengths case management*.

The approach has been widely used with homeless consumers and other people who are difficult to engage in treatment. Unlike working with consumers who have a helpful support network and a safe place to live, engaging consumers who are homeless may take more time and skill.

Once consumers are engaged in the relationship and begin to see that treatment might be helpful in reaching their goals, a variety of interventions for substance use and mental health problems can be used, but engagement nearly always precedes involvement in treatment.

We strongly recommend *The Strengths Model* (Rapp, 1998), which describes the engagement process and is extremely helpful for anyone trying to engage consumers with co-occurring disorders in a treatment relationship. For this and other resources, see *The Evidence* in this KIT.

Screening and assessment

A substantial proportion of consumers have a substance use disorder some time in their lives. Assessments of mental illnesses and substance use disorders, however, are often completed separately, at different times, by different practitioners, and in different agencies. Experience and research evidence show that this is a mistake because assessing and treating co-occurring disorders separately is ineffective.

Agencies with effective Integrated Treatment programs routinely screen consumers for both mental health and substance use disorders when consumers enter the agency and periodically after that.

Once consumers are positively screened for substance use and mental health disorders and referred to the Integrated Treatment program, the first step is to provide an in-depth assessment of both disorders. As an integrated treatment specialist, you have to understand both consumers' mental illness and substance use and how they interact before you can provide treatment.

This section begins with a vignette, Marie's story. Marie has bipolar disorder and uses multiple substances. After reading the vignette, consider how to assess Marie's substance use and mental illness.

Marie's story

Marie is a 22-year-old single, unemployed woman with bipolar disorder and polysubstance use disorder. She had brief contacts with the mental health center after being hospitalized twice for mania, but her story begins with a subsequent emergency room visit.

Picked up by the police for disturbing the peace, Marie was brought to the local emergency room for evaluation because she was talking about escaping from demons. On examination, she was dirty, agitated, and yelling as if someone else was in the room. Although she smelled of alcohol, Marie refused to answer questions about alcohol or other drugs. Because she was clearly unable to care for herself, she was admitted to the hospital for further evaluation and treatment of psychosis and possible substance abuse.

The next day in the hospital, Marie was calmer and seemed more oriented to reality, though she continued to focus on her special relationship with God, whom she felt would protect her from demons. An integrated treatment specialist asked Marie again about her substance use and learned that she had been drinking alcohol since she was 13 years old and smoking pot since she was 15.

Her urine screen on admission was positive for alcohol, cannabis, and cocaine. When shown the report of the urine screen, Marie said it must be a mistake. She reported drinking "a few" beers and smoking "a few" joints daily for the past 6 months, but denied using cocaine. She said she liked to get high with her boyfriend after work and then go to the bar and drink beer with him.

She also said she couldn't relax and sleep if she didn't smoke pot, and that she was smoking more than she used to because she didn't get the same effect that she had before. She hadn't tried to cut down on alcohol or cannabis because she felt they hadn't caused her any problems.

Marie said she had been living at home with her parents and working part time at a local record store until she stopped going to work 2 months ago. She hadn't paid her parents for rent and there were disagreements about that. She felt that they had criticized her constantly and said they had threatened to kick her out of the house.

Marie was vague about her activities over the past several months. With Marie's permission, the integrated treatment specialist called her parents, who verified the information Marie had given, and also told the integrated treatment specialist that Marie had had trouble with cocaine in the past and that, in fact, she had moved out of their house 2 months ago. They had feared she had been using drugs, and when they had confronted her about this, Marie had disappeared.

Marie spent 6 weeks in the state hospital. Initially she refused to take medications, wandered the halls at night, and spent all day in bed. She remained preoccupied with God and wanted to end her life to join God in the fight against demons. Eventually she decided to try medication, and after 3 weeks, she became less focused on demons, no longer wished for death, and was getting out of bed for activities during the day.

When her boyfriend came to visit in the middle of Marie's hospitalization, the staff asked him if he had any particular concerns about Marie. He reported that they had both been on a cocaine binge for several weeks before Marie was picked up and that he had just gotten out of a detoxification program himself. Marie became angry and insisted that she had had nothing to do with cocaine.

Principles of screening and assessment

This vignette illustrates four key principles for screening and assessment.

1. Because many consumers have substance use disorders, screen all consumers for both disorders.

Your agency should have a standardized screening instrument and procedures for completing it. Ask your program leader for a copy to review during this training. Screening should be conducted in a matter-of-fact, nonjudgmental way. Don't forget to ask about over-the-counter and prescribed medications because these are also often abused. Remember that co-occurring disorders are illnesses, not bad behavior.

2. In addition to speaking with consumers, gather information from multiple sources.

Like Marie, many consumers are reluctant to talk about behaviors that they believe others

disapprove of, such as drug use or other illegal activities. Marie denied using cocaine, but cocaine was in her urine drug screen, and her parents and boyfriend confirmed that she was a heavy cocaine user. To get accurate information, multiple sources such as family, hospital records, and urine drug screens often help. If consumers refuse to allow a urine drug and alcohol screen, you should probably assume they are using substances.

3. If information does not agree, ask consumers to help resolve the discrepancy in a nonthreatening and matter-of-fact way.

When consumers are worried about being perceived negatively or when they are concerned about legal or other negative consequences as in Marie's case, asking consumers to resolve the discrepancies may not work. Nevertheless, asking them about discrepancies shows that you approach questions about substance use in a straightforward way, without judgment or punishment.

4. It is important to continue the assessment over time.

Screenings and assessments completed soon after meeting consumers or in the context of intoxication, withdrawal, or severe psychiatric symptoms are often inaccurate. To give accurate information, consumers must be mentally stable and feel safe. As you get to know consumers and develop a trusting relationship, more information is often revealed about substance use. Thus, assessment is an ongoing process that continues during treatment.

Integrated Screening and Assessment

- Ask all consumers about substance use in a matter-of-fact way.
- Get information from multiple sources.
- Try to resolve discrepancies in information.
- Continue the assessment over time.

Making the diagnosis

Some consumers who use substances do not have a substance use disorder. While some consumers are able to drink socially or occasionally use a substance without problems for a time, many develop symptoms of a substance use disorder. For this reason, it is important to be familiar with the criteria to diagnose substance use disorders. Take time during this training to review your agency's policies and procedures for diagnosing substance use disorders.

In general, mental health professionals use the *Diagnostic and Statistical Manual (DSM-IV TR)* to diagnose mental health and substance abuse disorders. The Structured Clinical Interview for DSM-IV TR (SCID) is a standardized way of asking questions about symptoms that allow you to form a diagnosis. While some information on the DSM-IV TR criteria for Substance Abuse and Substance Dependence is included in Module 2, for more information on the DSM and SCID, contact the American Psychiatric Association at www.psych.org.

Determining *use without impairment* is also helpful so that consumers can be offered good information and advice before they develop problems. Educate both those consumers who are diagnosed with a co-occurring disorder and those who are using substances without impairment.

Comprehensive longitudinal assessments

Although the integrated treatment specialist in the vignette gathered some information about substance use and mental health history, it was not structured and organized to permit an accurate and complete integrated assessment.

The best model for organizing historical data, called a *comprehensive longitudinal assessment*,

involves collecting information in a timeline on the following:

- Functional status;
- Mental health symptoms, treatment, and response to treatment;
- Substance use, treatment, and response to treatment; and
- Interactions between mental illness, substance use, and treatment.

Use the timeline to move from points in the past to the present in a step-by-step way, choosing the points that seem to make the most sense and describing the information about the consumer.

It may be hard to separate mental health from substance abuse symptoms when individuals are actively using or have relapsed while in treatment. Be sure to ask about times when the consumer functioned well, possibly before substance use started or during a period of sobriety. Periods of good function will help you understand psychiatric symptoms when substance use is stable (and vice versa) and whether treatment has been successful. You may need to fill in this information over time from multiple sources.

In the vignette, Marie's last stable period was a few years ago when she lived with her parents and worked at a record store before her substance use escalated. As Marie's integrated treatment specialist, it would be important to ask her questions such as the following about this period:

- What medications was she taking at that time?
- How well were they helping her symptoms?
- What substances was she using then?
- How did they affect her symptoms and her medication use?
- What treatment was she receiving for each disorder?

Next, move forward in time. Ask her questions to track how her symptoms progressed leading to her ending her job. Closely follow the sequence of events right up to the present admission. Ask questions about her functioning at work, at home, and in relationships to understand her functioning.

Asking these questions provides a longitudinal assessment that emphasizes functional status and begins to help consumers more accurately perceive the effects of substance use. The following is an example of what we might learn from Marie.

Comprehensive Longitudinal Assessment for Marie					
Date	1991–93	Nov–Dec 1993	Jan–March 1994	April–May 1994	May–June 1994
Functional status	Working Abstinent boyfriend	No work Drug-using boyfriend	Homeless Drug-using boyfriend	Living in state hospital	Living in state hospital
Mental illness symptoms and treatment	Moderate depression Not taking meds or attending other treatment	Severe depression Hospitalized twice Not taking meds	No sleep, paranoid, hyperactive Not taking meds	Symptoms improving Not taking meds	Depression, sleep, and hyperactivity improve Taking medication
Substance abuse symptoms and treatment	Weekly cannabis No alcohol or other drugs Attending AA	Daily cannabis and alcohol No treatment	Daily cannabis and cocaine No treatment	No substance use	No substance use Attending persuasion groups
Interactions	Depression-cued cannabis use	Depression-cued greater use Substance use with boyfriend	Severe symptoms and substance use	Structure and sobriety reduce sleep problem and paranoia	Structure, sobriety, and meds reduce symptoms further

Contextual assessments

Another important part of integrated assessments is a detailed description of current substance use patterns, including factors that cause consumers to continue using and consequences for continued use (which may be viewed positively or negatively by consumers). Because this type of assessment addresses the context of substance use and how it interacts with mental illness, we call it the contextual assessment. You may have learned about a similar type of assessment called a functional assessment.

What You Need to Know to Do Contextual Assessment

- **Expectations of use**—for example, relaxation, better social interactions, sleeping better, etc.
- **Immediate reinforcers**—for example, escaping or feeling relaxed or high
- **Positive aspects of use**—for example, make friends, be “cool,” feel good, etc.
- **Negative aspects of use**—for example, expense, hangover, interpersonal problems, etc.
- **Internal triggers for use**—for example, emotions, thoughts, withdrawal, craving, etc.
- **External triggers for use**—for example, people, places, seeing needles, music, etc.

Find out what consumers expect from using the substance and how people around them respond when they use. For example, how do they feel after using? Do they believe that substance use helps them feel better or cope with stress?

Explore the positive and negative aspects of use. What do their friends think of their substance use? Their family members? Are there positive or negative consequences to using? Also, examine internal and external triggers for use. Examples of internal triggers are anxiety about leaving the house or boredom. External cues or triggers include external events that lead to substance use such as smelling cigarette smoke or seeing friends smoking pot. During a contextual assessment, gather information from consumers by asking open-ended questions about when, where, and with whom they use substances. Ask about feelings, thoughts, situations, and environments that precede craving or actual use of substances.

Examples of Questions Included in a Contextual Assessment

- When do you usually use alcohol?
- With whom do you usually drink? Where?
- How do you feel before you have a drink?
- What makes you think about wanting to have a drink?
- What is it like when you drink?
How do you feel? What do you do?
- What do you enjoy about drinking?
- What are the down sides to drinking for you?
- What do other people think of your drinking?
- How do you feel after you have a drink?
- Have you ever tried to stop drinking?
- What are your current goals?

Questions included in a contextual assessment allow you to understand consumers' social pattern of use. Does the consumer use substances alone, in a small tight-knit group of friends, or in a large social network? Is the consumer involved with other substance users in high-risk or illegal activity (for example, trading sex for drugs)? This information will help you and consumers tailor a plan to promote their recovery.

Don't be discouraged if you are unable to obtain this information when you first meet consumers. Like Marie, many consumers take weeks or months to trust their integrated treatment specialist enough to tell them about their substance use.

When consumers are in a crisis as Marie was, it is important to get information about their substance use from other sources, such as family and urine drug and alcohol screens. However, to get the detailed information for a contextual assessment, you must spend more time getting to know consumers. Getting this information occurs over time during the engagement and persuasion stages of treatment.

The more information you gather, the more effective and specific the treatment plan can be. For example, in the vignette, Marie said she found cannabis and alcohol relaxing, and she needed to smoke cannabis to fall asleep. She did not mention any negatives to using, though the vignette suggests that her use of cocaine led to interpersonal problems, unemployment, and homelessness.

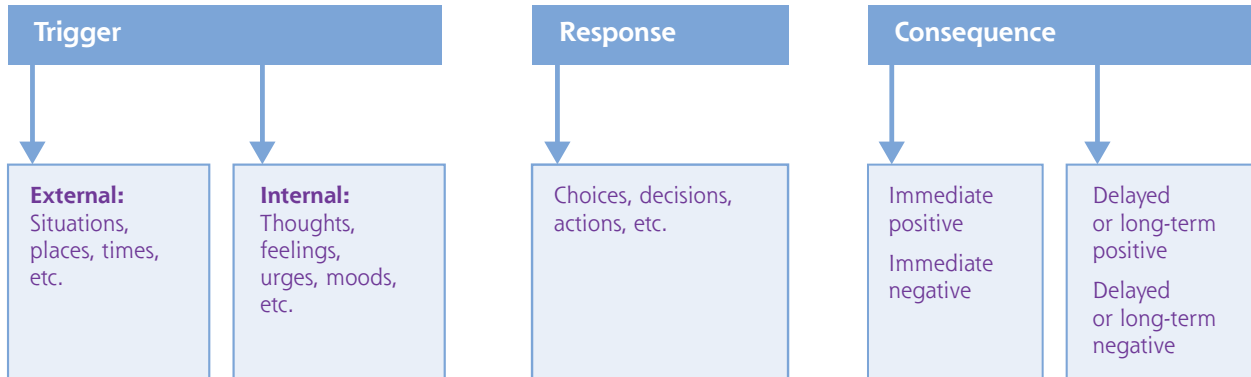
Sometimes it is useful to have consumers like Marie describe a recent day in their life in minute detail, so that you can experience what using substances is like for them and see the pros and cons as they see them. Note that this approach does not imply that we accept consumers' views as totally accurate, since we know that substance abuse and psychiatric symptoms can lead to misperceptions and rationalizations, but rather that we believe it is critical to understand consumers' view of the world.

Diagram your contextual assessment

Use the information you gather through the contextual assessment to diagram the factors

related to consumers' substance use. Below is an example of the relationship between triggers, responses, and consequences.

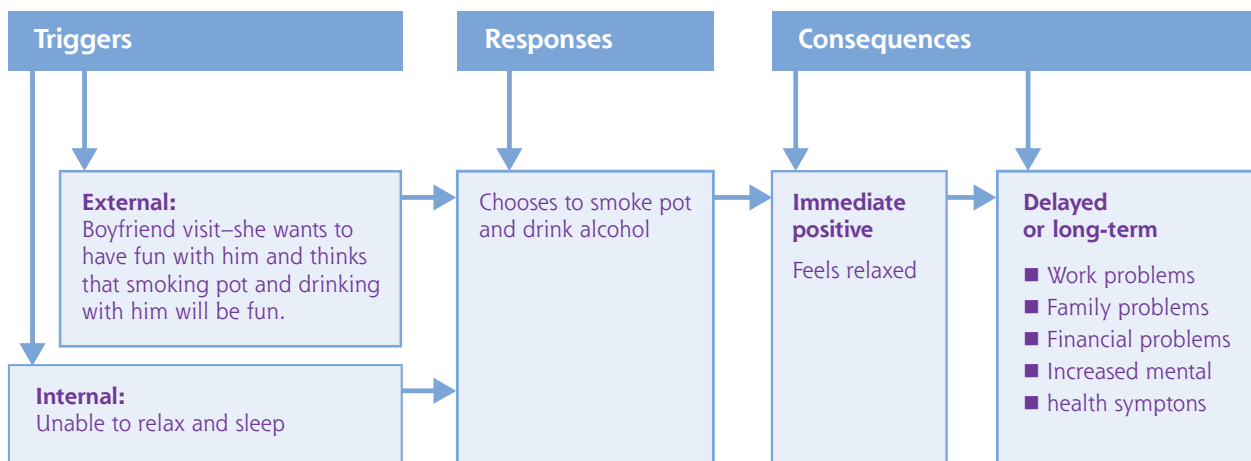
General Contextual



Diagrams help you understand consumers' substance use. Information gathered through the diagram can help you to talk with consumers about their substance use and plan behavioral interventions that will help them to meet their goals.

The diagram below is based on the vignette, Marie's story. It illustrates how Marie's depressed feelings led her to think that smoking pot would cheer her up (*expectancy*). She smokes pot and then feels relaxed (*immediate reinforcer*) but the next day she is upset to realize that she spent all her money on the pot (*long-term consequence*).

Contextual Analysis Model for Marie



Assess consumers' stage of change

Stages of change are a way of describing consumers' readiness for reducing or stopping substance use and their involvement in treatment. To develop an effective treatment plan, it is important to assess consumers' stage of change and identify the associated stage of treatment.

Because consumers often say what they think their integrated treatment specialist wants to hear, many

report being more motivated to quit than they really feel. To avoid this problem, use information collected during your contextual assessment and your comprehensive longitudinal assessment to assess consumers' stage of change. Observe their behavior to understand the role that substances play in their lives.

Rate consumer's stage of change and the associated stage of treatment according to the Stage of Treatment Assessment Form on the next page.

Stage of Treatment Assessment Form

Use this form to record consumers' stage of treatment over the last 3 months. If the consumer is receiving inpatient treatment, base your assessment on the time period before being hospitalized.

		1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
1. Pre-engagement	The consumer meets the criteria for a substance use disorder but does not have contact with the integrated treatment specialist.				
2. Engagement	The consumer meets DSM criteria for Substance Abuse or Dependence but has little or irregular contact with an integrated treatment specialist.				
3. Persuasion	The consumer meets DSM criteria for Substance Abuse or Dependence and has regular contact with an integrated treatment specialist, but continues to use the same amount of substances or has reduced substance use (fewer substances, smaller quantities or both) for less than 1 month.				
4. Active Treatment	The consumer is engaged in treatment and has reduced or abstained from substance use for 1–6 months.				
5. Relapse Prevention	The consumer is engaged in treatment and abstained from substance use for 6 months or more.				
6. In Remission or Recovery	The consumer is in Sustained Full Remission (has not met DSM criteria for Substance Abuse or Dependence for one year or more).				

Effective treatments are different at each stage. What helps in the early engagement phase is very different from what helps in the active treatment phase.

In the vignette, Marie's story, more information is needed to assess Marie's stage of treatment, but it appears that she is still in the engagement stage.

By identifying Marie's stage of treatment, her integrated treatment specialist can match treatments to the problem that Marie is interested in working on, her individualized goals, and her current readiness to consider change.

For more information on conducting integrated assessments, see TIP 42 and other resources on the CD-ROM in this KIT.

Treatment planning

Treatment planning is a collaborative process that guides treatment. It involves working with consumers and their family members (or other supporters) to consider the assessment information, establish personal recovery goals, and specify the means by which treatment can help consumers reach those goals.

Initial treatment planning typically occurs over weeks or months during the assessment and engagement processes. For consumers with co-occurring disorders, the treatment plan will address both mental health and substance use and will involve building both skills and supports for recovery goals. We assume that you are already familiar with the general approach to treatment planning. This section focuses on integrated treatment planning for both substance use and mental health treatment.

This section begins with a vignette, Ferdinand's story. Ferdinand has schizophrenia and abuses alcohol. After reading the vignette, review how Ferdinand and his integrated treatment specialist followed a six-step process to develop goals and an integrated treatment plan to support attaining those goals.

Ferdinand's story

Ferdinand is a 59-year-old, widowed, unemployed man with schizophrenia, alcohol abuse, and diabetes. He recently moved to New York from North Carolina to live with his daughter, who wants to help care for him.

According to his daughter and medical records from North Carolina, Ferdinand spent the last 30 years living in a small apartment with his wife, until her death 5 years ago. He drank heavily in his early 20s but had no further history of alcohol problems.

While his wife was alive, he took an antipsychotic medication and was able to take care of his basic needs. After her death, however, he became quite isolated in his apartment and his health rapidly deteriorated.

According to his daughter, over the last year Ferdinand developed trouble with urinary incontinence and also

appeared to be losing his memory. He was frequently angry and confused, and often talked to himself.

The restaurant owners across the street where he ate most meals kicked him out and refused to serve him, and he lost weight rapidly. Soon after, he was involuntarily hospitalized.

When he was admitted to the hospital, his blood alcohol level was above the state limit for intoxication, and his medication level was undetectable. His blood sugar was higher than normal, which led to a diagnosis of diabetes. He was started on intramuscular insulin, as well as an antipsychotic medication.

When his daughter brought him in to the mental health center in New York for treatment, he appeared disheveled, irritable, and distracted. He did not talk to himself, but admitted that he heard voices. His memory was poor.

He was angry about the insulin shots, which he did not believe he needed. He was willing to take medication for his "nerves." He said he was grateful to his daughter for caring about him, but upset about moving.

He denied drinking any alcohol and said that drinking had never been a problem for him. He said that the urine test in the hospital must have been a mistake.

When the integrated treatment specialist asked him what his goals for himself were, he said he "just wanted things to get back to normal," and wasn't able to articulate any more specific goals.

Ferdinand's daughter was concerned about his drinking. She had found numerous empty vodka bottles in his apartment in North Carolina, but she didn't think he was drinking now that he was living with her. When asked about the bottles, Ferdinand became upset and said he didn't remember any vodka bottles.

His daughter was also concerned about his physical health and his incontinence, which was better than before but still an occasional problem at home.

At the end of two meetings and after reviewing records from his previous treatment in North Carolina, Ferdinand, his daughter, his psychiatrist, and his integrated treatment specialist agreed on five treatment goals:

- First, Ferdinand wanted to be able to take care of himself at the house while his daughter was at work.
- Second, he wanted to stay physically healthy and find out more about his diabetes by seeing a doctor.

- Third, he wanted to work with the mental health team to “keep his nerves in check.”
- Fourth, he agreed to make his daughter happy by avoiding alcohol.

- Fifth, Ferdinand acknowledged that he was lonely without his wife and needed to meet some people in his new town.

These goals led to specific goals and targets outlined in the treatment plan below.

Integrated Treatment Plan		Consumer name: Ferdinand	Initial plan date: 1/1/07
		Mental illness diagnosis: Schizophrenia	Plan updated on:
		Substance use diagnosis: Probable alcohol abuse	
		Stage of treatment: Persuasion	
Problem 1	Hasn't been taking care of himself		
Goal	Take care of himself while daughter is working		
Targets	Get up, shower, eat breakfast, and get dressed in clean clothes every day by 9:30; make himself a sandwich or soup for lunch every day.		
Intervention	Outreach to home by case manager; practice skills with case manager; set up cues in room to complete tasks. Make chart to check off meals.		
Responsible practitioner	Joe (case manager)		
Review date and evaluation measure	Weekly progress reports from consumer and case manager; review of meal chart		
Problem 2	Physical health including diabetes, incontinence, and memory problems		
Goal	Stay physically healthy		
Targets	Make and keep medical appointments; take meds prescribed by doctor		
Intervention	Nursing assistance in setting up pill box, coordination with internist		
Responsible practitioner	Patricia (nurse)		
Review date and evaluation measure	Biweekly progress report from consumer, nurse and internist		
Problem 3	"Nerves," auditory hallucinations, irritability		
Goal	Keep nerves in check, for example, reduce frequency of hallucinations, irritability		
Targets	Meet with psychiatrist; take prescribed medications; meet weekly with integrated treatment specialist		
Responsible practitioner	Pam (integrated treatment specialist), Phil (psychiatrist)		
Review date and evaluation measure	Biweekly progress report from consumer, psychiatrist and integrated treatment specialist		
Problem 4	Possible abuse of alcohol		
Goal	Avoid alcohol use		
Intervention	Meet weekly with integrated treatment specialist to learn about and discuss alcohol use; meet with integrated treatment specialist and daughter monthly for family support		
Responsible practitioner	Pam (integrated treatment specialist)		
Review date and evaluation measure	Weekly progress report from consumer, daughter, and integrated treatment specialist		
Problem 5	Social isolation, loss of wife, and move to new community		
Goal	Establish social contacts		
Intervention	Attend senior center 3 days a week, talk with members		
Responsible practitioner	Joe (case manager)		
Review date and evaluation measure	Monthly progress report from consumer and case manager.		

Develop an integrated treatment plan with Ferdinand

For Ferdinand, multiple areas of concern exist. In addition to his mental health and his drinking, Ferdinand had these issues:

- Physical health concerns;
- Memory problems;
- Grief issues;
- Social isolation; and
- Issues related to transitioning to a new community.

Ferdinand's integrated treatment specialist followed this six-step process to develop an integrated treatment plan:

1. Evaluate pressing needs;
2. Determine consumers' stage of treatment;
3. Select target behaviors for change;
4. Determine interventions for achieving desired goals;
5. Choose measures to evaluate the effects of your interventions; and
6. Select followup times to review the plan.

Step 1 Evaluate pressing needs

When consumers are in crisis, such as in danger of hurting themselves or others, you need to address these issues first. Helping consumers develop safety and stability is usually a precondition to helping them move toward sobriety.

In many cases, such as Ferdinand's, the crisis situation cannot be resolved without addressing substance use, and the integrated treatment specialist must address both the pressing needs and the substance use. Common pressing needs include the following:

- Dangerous behaviors;
- Homelessness;

- Victimization;
- Violence;
- Severe symptoms;
- Medical problems;
- Legal problems; and
- Acute intoxication.

For Ferdinand, his medical problems, weight loss, and confusion were pressing issues that endangered his life. His inability to take care of himself has been a serious problem, but he may be able to do much better with supports, medical attention, and medications. Taking medications and avoiding alcohol may resolve his confusion. When faced with multiple needs, it is important to collaborate with consumers and choose goals in which they are interested in working.

Step 2 Determine consumer's stage of treatment

As discussed above, your assessment of consumers' stage of change will determine their stage of treatment and allow you to select the most appropriate interventions. In the vignette, Ferdinand's report, his daughter's report, the clinical records, and the staff observations suggested that he was in the persuasion stage of treatment. Therefore, choose appropriate interventions for this stage.

Step 3 Select target behaviors for change

Factors that affect ongoing substance use or increase the risk of relapse should be the targets for change. To identify suitable targets, ask, "What changes are necessary to decrease substance use or to minimize the chances of a relapse?"

In the vignette, Ferdinand is in the persuasion stage of treatment. Appropriate interventions for this stage

include helping Ferdinand learn how substance use interferes with personally valued goals, such as controlling diabetes and improving his memory. The vignette suggests that Ferdinand began drinking after losing his wife and that loneliness and isolation may have been precipitants. As Ferdinand's integrated treatment specialist, talk with Ferdinand about the likely relationship between his moods and his drinking. Monitor his symptoms of grief and depression and work with him to increase his social support and daily activity.

Step 4 Determine interventions for achieving desired goals.

Different interventions are helpful at different stages of treatment. In early stages of treatment, do not focus on abstinence because consumers are not yet interested and motivated to abstain. Attempts to push consumers to stop using a substance before they are ready are usually ineffective. However, once

consumers are interested in giving up a substance, target interventions at helping them do so.

In the vignette, Ferdinand is willing to discuss alcohol use, but has not admitted that alcohol is a problem or even that he is using. Demanding that he attend A.A. at this point would not make sense. Perhaps his drinking is situational and he will be able to stop with supports.

As Ferdinand's integrated treatment specialist, you could monitor his substance use and educate him about the effects of alcohol on aspects of his life that matter to him. As your working relationship with Ferdinand strengthens, develop a more specific treatment plan that supports his goals.

See the chart below for a list of common problems, target behaviors, and appropriate interventions for each stage of treatment.

Examples of Common Problems, Target Behaviors, and Interventions			
Stage of treatment	Problem	Target behavior	Intervention
Engagement	Lack of regular contact with integrated treatment specialist	Regular contact with integrated treatment specialist	<ul style="list-style-type: none"> ■ Assertive outreach ■ Practical assistance (housing, entitlements, other) ■ Introduction to individual, family, self-help, and group treatment formats
Persuasion	Substance use interferes with personally valued goals	Efforts to reduce substance use to make progress toward personal goals	<ul style="list-style-type: none"> ■ Motivational counseling ■ Persuasion groups ■ Basic social skills training ■ Vocational supports
Active treatment	Achieving abstinence; managing substance use cravings and mental illness symptoms	Teaching and practicing coping skills such as imagery, self-talk, and distraction or replacement activities	<ul style="list-style-type: none"> ■ Cognitive-behavioral counseling
Relapse prevention	Isolation or loneliness due to mental health symptoms or distance from substance-using friends	Improved skills for making friends	<ul style="list-style-type: none"> ■ Social skills training ■ Self-help group referral

Step 5 Choose measures to evaluate the effects of your interventions

Once specific interventions are selected, determine how you will measure consumers' progress. Your measures should be simple, objective, easy to use, and clearly related to the target behavior. For example, if the target for Ferdinand is to avoid alcohol, his daughter and integrated treatment specialist can help monitor his appearance, behavior, and house closely for 2 weeks. There should be no signs of alcohol use.

Step 6 Select followup times to review the plan

Treatment plans are only useful if you follow through with the proposed interventions. Measuring consumers' progress will help you to be aware of any problems with the planned interventions early on, so that they can be resolved and interventions can be delivered. Sometimes planned interventions do not have the desired effects on the target behavior. For example, Ferdinand may relapse to drinking when he is alone at night. If this occurs, a new treatment plan would need to address that reality. Remember that integrated treatment planning must focus on consumers' goals, which must be measurable and meaningful.

Treatment planning is continuous

Though Ferdinand's story describes the process of developing an initial treatment plan, treatment planning is an ongoing process. As you get to know Ferdinand and determine which interventions are effective, work with him to adjust the treatment plan accordingly. As Ferdinand moves through the different stages of treatment, update his treatment plan to ensure that he receives appropriate and effective interventions.

Assess and treat cognitive problems

Cognitive problems such as confusion or memory loss can be due to a variety of difficulties, such as the following:

- Old age;
- Stroke;
- Schizophrenia;
- Antipsychotic medications;
- Diabetes;
- Alcohol use; or
- Change in environment or routine.

In Ferdinand's case, he faces several of these difficulties. The most important point is that confusion and memory loss are often reversible and should be assessed thoroughly by a psychiatrist and an internist.

Intoxication with or withdrawal from alcohol and other substances cause reversible changes in memory and concentration during the time of use or withdrawal. Cognitive problems can persist for weeks or months and gradually clear up once a person stops using.

Unfortunately, alcohol can also cause permanent changes in memory and other cognitive functions. The only way to know if these memory problems will get better is to observe consumers carefully during prolonged abstinence. In Ferdinand's case, the recent history of alcohol abuse, medication non-adherence, uncontrolled medical problems, and situational stress may account for his cognitive problems. All of these factors should improve with good care, and Ferdinand should be able to function at a much higher level if he recovers his cognitive functioning.

When consumers with co-occurring disorders have problems with memory and concentration, the first step is to measure the problems by using simple tests, such as the Folstein Mini Mental Status Exam. Ask your program leader for a copy of the assessment tool used in your agency.

If your agency uses the Folstein Mini Mental Status Exam, you may follow these guidelines. If the problems are *severe* (score less than 20) or *moderate* (score less than 25) and do not improve within a month of sobriety or improvement in physical illness, refer the consumer for a medical evaluation to assess other medical problems that could be causing the impairment. If another assessment is used, ask for specific procedures.

In summary, this module discusses how change typically occurs for consumers with co-occurring disorders. Information and skills were presented for engaging consumers at different stages of change, conducting integrated assessments and developing integrated treatment plans. The next module provides specific techniques that you may use to treat consumers with co-occurring disorders.

Exercise: Identify Consumers with Co-Occurring Disorders

Answer the following questions to help reinforce your understanding of your agency's policies and procedures.

1. What is your agency's policy for screening consumers for co-occurring disorders?

As a group review your agency's screening instrument.

■

■

■

2. How will consumers be referred to your Integrated Treatment program?

(Review your agency's Referral Form.)

3. Under what circumstances would consumers be discharged from your Integrated Treatment program?

■

■

■

Exercise: Review Assessment and Treatment Planning Forms

Answer the following questions to help reinforce your understanding of your agency's policies and procedures.

1. What are your agency's policies and procedures for assessing consumers with co-occurring disorders?

As a group, review your program's form for conducting the following:

- Comprehensive longitudinal assessments;
- Contextual assessments;
- Assessments of consumers' stage of treatment; and
- Assessments of cognitive impairment.

Discuss how these assessments gather information needed to evaluate and treat both serious mental illnesses and substance use disorders.

2. What are your agency's procedures for diagnosing substance use disorders?

3. What are your agency's policies and procedures for developing integrated treatment plans?



As a group, review your program's treatment plan form and procedures for updating it.

Module 4


Practical Skills for Integrated Treatment

Notes to the facilitator and program leader

Prepare for Module 4:

- Make copies of Module 4. Your copy is in this workbook; print additional copies from the CD-ROM in the KIT. 
- Distribute the material to those who are participating in your group training. Ask them to read it before the group training.
- Make copies of these exercises: 
 - *Practice Motivational Interventions*
 - *Practice Cognitive Behavioral Interventions*
 - *Practice Interventions to Prevent Relapses*Do not distribute them until the group training. Your copies are in this workbook; print copies from the CD-ROM in the KIT.

Conduct your fourth training session:

- When you convene your training, view the following segments of *Training Frontline Staff: Demonstration Video* (approximately 30 minutes): 
 - *Motivational Counseling*
 - *Active Treatment Stage*
 - *Substance Abuse Counseling*
 - *Relapse Prevention Stage*
 - *Relapse Prevention Counseling*
- Discuss the video and the content of Module 4.
- One at a time, distribute the exercises and complete them as a group.

Training Frontline Staff

Module 4: Practical Skills for Integrated Treatment

Module 4 outlines skills that may be used at various stages of treatment when working with consumers who have co-occurring disorders. Skills include motivational interventions, cognitive-behavioral techniques, and strategies for reducing relapse.

Motivational interventions

Motivation refers to a state of readiness to change. Consumers in the engagement and persuasion stages of treatment are not yet ready or motivated to change their substance use, even though others may think that they could benefit from change.

In the early stages of treatment, integrated treatment specialists can help increase consumers' readiness to reduce substance use by using the skills described in this section.

This section begins with a vignette, Kevin's story. Kevin has post-traumatic stress disorder and uses alcohol. The vignette introduces five basic principles of motivational interviewing and how to use them to help consumers become interested in reducing substance use.

Kevin's Story

Kevin is a 57-year-old, Irish-American, unemployed, divorced father of five grown children. He was diagnosed with post-traumatic stress disorder, psychotic disorder not otherwise specified, alcohol dependence, and probably mild dementia due to head trauma. He has been living at the homeless shelter and receiving outreach services from a mental health center.

He has used alcohol and marijuana since adolescence. Since his discharge from the Marines 20 years ago, he has experienced symptoms of racing thoughts, flashbacks, anxiety, and social avoidance.

Kevin worked as a heavy-equipment operator until 5 years ago when he was in an automobile accident and sustained a brain injury. He was charged with driving while intoxicated, lost his driver's license, and lost his job. Since then, he has not had stable housing, has not worked, and has experienced poor memory and concentration in addition to his other symptoms.

As his use of alcohol and marijuana increased over time, he has become more and more paranoid. Kevin has been arrested a number of times for criminal threatening and assault.

He refused treatment at the local Veterans Administration Hospital and at the local mental health center, but was willing to meet with mental health practitioners at the homeless shelter.

Kevin's behavior at the shelter has been paranoid and aggressive. During his last court hearing, the judge ruled, "This man needs mental health treatment. See that he gets treatment and is not a threat to the community." The judge wrote a court order requiring Kevin to participate in treatment at the mental health center.

Kevin's integrated treatment specialist began meeting with him at the homeless shelter every day. They usually went for a walk and had coffee. Over the next month, they had many conversations. The integrated treatment specialist started by asking Kevin what he thought about the judge's order. Kevin thought, "He has it in for me," and refused to go to the mental health center.

The integrated treatment specialist continued to meet with him at the shelter or a coffee shop, and Kevin agreed. Asked about the good things in his life right now, Kevin identified having a warm, dry place to sleep, his five children, his drinking buddies, and a good disability income check from the VA.

The integrated treatment specialist then asked Kevin what was "not so good" in his life right now. Kevin listed the judge's order requiring him to be in treatment, living with the "crazy" people in the shelter, and running out of money during the month.

The integrated treatment specialist asked Kevin to tell him more about his concern about living with the "crazy" people and running out of money during

the month. He learned that Kevin wanted to have his own place, but that his confidence in being able to keep housing was low. With his integrated treatment specialist's help, Kevin listed the following pros and cons of having his own apartment.

Pros	Cons
Privacy	Trouble managing his money
Nothing gets stolen	Isolation and loneliness
Control of when to sleep, eat, etc.	Drinks more
Something that is his	Friends want to move in
	No money for furnishings
	Not eligible for housing supplement

After looking over the list, Kevin began to talk more about his use of substances and how much he had lost because of drinking. When he was taking medication, he was able to concentrate better and felt more hopeful about life.

Kevin's integrated treatment specialist said that Kevin was presenting an interesting picture and wondered if Kevin would like feedback on his impressions, noting that the feedback could be taken or thrown out. Kevin agreed to hear the feedback. The integrated treatment specialist suggested that there could be a connection between Kevin's use of substances, taking medication, and his capacity to live on his own. The case manager also wondered if Kevin's desire to be in control has actually left him out of control in most areas of his life. He then asked for Kevin's reaction to the feedback. Kevin agreed he wanted control of his life and that until recently he believed he was in control.

Kevin's integrated treatment specialist asked him what he wanted to do next. Kevin decided to begin working on a plan that included reducing his drinking to every other day, attending a money management group once, and thinking about opening a bank account to work on saving money for housing.

After 4 months, Kevin was taking medication. After two more months, he decided to apply for and got into a residential treatment setting where he was able to stop substance use, take some classes, and become involved in Alcoholics Anonymous. He stayed there for 2 years and then transitioned into his own apartment. He had reconnected with one of his children and was proud to be involved with her family.

What is motivational interviewing?

Motivational interviewing is an approach to counseling that helps consumers enhance their motivation to reduce substance use or to become abstinent in order to reach their personal goals. These techniques can also be used to help consumers become motivated for mental health treatment or make other changes in their lives.

This consumer-centered counseling approach aims to help consumers who aren't yet ready to change. In the past, these consumers were seen as "resistant" or "in denial" of their substance use or mental health problems. Motivational interviewing, on the other hand, assumes that practitioners can help consumers increase their readiness to change behavior by helping them focus on their own goals.

Using stage-wise integrated treatment that includes the techniques described in this section results in remission of substance use disorders for the majority of consumers who receive the treatment. Even consumers like Kevin who are often seen as difficult to treat because of severe symptoms, threatening behavior, or difficulties processing information tend to respond well to this approach.

Stage of treatment

Motivational interviewing techniques are important to use when working with consumers in the engagement and persuasion stages of treatment. For example, initially Kevin is in the engagement stage of treatment. Therefore, his integrated treatment specialist concentrates on developing trust and building motivation.

The integrated treatment specialist explores Kevin's mixed feelings about his substance use and about treatment for his mental illness without passing judgment, giving advice, or being coercive in any sense. He helps Kevin set goals and recognize that using substances gets in the way of reaching his goals.

Principles of motivational interviewing

Motivational interviewing uses these five principles or strategies:

- Express empathy.
- Develop discrepancy.
- Avoid argumentation.
- Roll with resistance.
- Instill self-efficacy and hope.

Integrated treatment specialists should keep these principles in mind while interacting with consumers during the persuasion stage.

Express empathy

To express empathy, the integrated treatment specialist begins by actively listening to consumers without offering judgment, criticism, or advice. The goal is to fully understand consumers' situations and perspectives.

During active listening, use body language to show consumers you are interested. Face consumers and make frequent eye contact. Repeat what they say and ask for more information and more details to clarify their view of the world.

Do not give advice, reframe consumers' views, make interpretations, or attempt to persuade them of anything. The goals of reflective listening are to understand the world through consumers' eyes and to build trust by being a good listener and demonstrating that understanding.

Early in treatment, consumers are often not interested in treatment. Pushing for change at this time only turns consumers off and increases resistance to change. Thus, initially the focus is on building trust and supporting consumers instead of suggesting change. For example, in Kevin's vignette, the integrated treatment specialist wisely tries to form a relationship, listen carefully, and assure Kevin that change is up to him.

Set goals and develop discrepancy

One way that consumers can become more motivated to change is if they start to see that their current behavior interferes with their own goals. To help consumers in this way, first, help them clarify what their goals are. This is usually done as a part of the treatment planning process described in Module 3. It is critical to identify *their* goals, not the family's, yours, or anyone else's. Help consumers focus on goals that are feasible and healthy. Together look carefully at steps needed to reach the goals.

After collaboratively developing goals and targets with consumers during the treatment planning process, integrated treatment specialists and consumers may choose one goal from the integrated treatment plan that they want to pursue. Choosing one goal allows consumers and integrated treatment specialists to outline concrete steps that consumers can take to achieve the goal. Recording these decisions in an *action plan* will help guide and monitor progress. For an example of how an integrated treatment plan and action plan can help set goals, see the vignette.

Second, when the topic of substance use arises, help consumers explore the pros and cons of continued use, including how the substance use affects the steps they want to take to reach their goals. When consumers list pros and cons of substance use and consider them in depth, they often make their own argument for changing. You can then highlight the discrepancy between the goal and the substance use by repeating to consumers their recognition of how substance use interferes with their goals.

This approach assumes that almost everyone with a substance use disorder is ambivalent about continuing to use. In this process, consumers often express concern about their own substance use or a desire to change. When this happens, reflect the statement back and support the change process as it unfolds. For example, in Kevin's case, the integrated treatment specialist helped him

with what is called a *decision balance exercise*.

This exercise is often useful for consumers with co-occurring disorders. The exercise can be done on a simple, structured worksheet that can be used to guide the discussion. The worksheet also serves as a visual prompt to focus attention.

In doing this exercise, Kevin identified the "good things" in his life as well as the "not so good" things. The integrated treatment specialist learned that Kevin wished to have his own home rather than live in the shelter and that he strongly wished to reconnect with his children. In the decision balance he explored some of the steps necessary to get housing.

It might be helpful to point out, using Kevin's own words, the discrepancy between Kevin's current behavior and his goals. As Kevin's integrated treatment specialist, emphasize the ways in which his use of alcohol and marijuana may prevent him from living the way he desires.

In addition to discussing housing, ask Kevin if his use of substances has affected his relationship with his children. Repairing relationships with family can be an important motivator to reduce substance use. However, take care not to overwhelm consumers with early discussions of too many areas of behavior change.

When integrated treatment specialists work with consumers with co-occurring disorders, the multitude of problems may seem overwhelming. Some prefer to focus on the area in which consumers are most ready to change; others begin by targeting behaviors that pose the greatest threat to consumers' well-being.

In either case, remember that the consumer is ambivalent. Decisional balance statements should reflect that genuine ambivalence, for example, "I hear you saying that you really enjoy drinking, but that it also keeps you broke and apart from your children."

Avoid argumentation

Many consumers reject being labeled with the diagnosis of a mental illness or substance use disorder. Motivational interviewing differs from other approaches to treating substance use disorders in that it avoids confrontation, especially around diagnostic labels. The principle is to avoid arguments in general, with the assumption that arguments simply strengthen consumers' beliefs rather than help them change their beliefs.

While making a diagnosis is necessary to help you target treatment, it may not be helpful to consumers. As a general rule, discussing with consumers the advantages and disadvantages of their substance use is more helpful than emphasizing a diagnosis.

In motivational interviewing, whenever you sense disagreement, it is time to change strategies rather than argue. Focus on using discrepancy or ambivalence in consumers' thinking, not on discrepancy between you and the consumer. This is an important principle behind the success of these techniques. Most consumers will not want to change if they feel they have to defend themselves and that their integrated treatment specialist is unsupportive.

In Kevin's story, the integrated treatment specialist appropriately focused on Kevin's life context (homelessness) and behavior (drinking) rather than labeling Kevin as alcoholic or mentally ill. Also of note, Kevin's integrated treatment specialist did not argue with him about the judge's pronouncement. Instead he offered an empathetic ear to his concerns and an acceptable way for them to meet on Kevin's own turf.

Roll with resistance

If consumers don't want to go in a certain direction (*resistance*), it is important to let them express their opinions or to "roll with it," instead of trying to fight it. It is helpful to encourage consumers to explore all the possible answers to their own questions and concerns. By doing this, consumers become the source of answers, do not feel defeated

in sharing their concerns, and are able to risk expressing true feelings. For example, helping Kevin develop a pros-and-cons list about having his own place to live helped him think about the impact of his drinking on housing.

Be ready to roll with unusual behavior, such as consumers' restlessness, disorganized behavior, and inappropriate speech. Handle this behavior in a matter-of-fact way, rather than interpreting it as a sign that consumers are unmotivated or too ill to participate. Since Kevin refused to go to the mental health center, the integrated treatment specialist initially met with him at the homeless shelter. This is a good example of "rolling with resistance." As Kevin developed further trust, they were able to explore Kevin's concerns about going to the mental health center.

The principle of rolling with resistance was also applied when developing an integrated treatment plan with Kevin. In Kevin's case, he and his integrated treatment specialist could work on several potential areas. Rather than getting into a struggle, Kevin's integrated treatment specialist found an area where Kevin was ready to do some work.

Support self-efficacy

The final principle in motivational interviewing is to support consumers' self-efficacy. *Self-efficacy* is the belief that one can succeed at change. This is particularly critical for consumers who are demoralized, depressed, or hopeless.

Consumers with co-occurring disorders are often reluctant to attempt to change because they have a long history of failing to achieve their goals. For this reason, it is important to demonstrate optimism and belief in consumers' ability to change by interest, attitude, comments, and behavior.

Self-efficacy can be enhanced by achieving success on small, realistic goals, and undermined if consumers focus on unrealistic goals.

For consumers with co-occurring disorders, reducing dangerous behavior or substance use

may be a more realistic early goal than complete abstinence. Remember that success breeds greater self-efficacy and further success.

One strategy for increasing self-efficacy is to discuss examples of positive changes that consumers accomplished in the past. In Kevin's case, his former job as a heavy-equipment operator seemed to be a particular source of pride. As Kevin's integrated treatment specialist, raising the issue of this past success and exploring a time in his life when things went well for him is a way of rekindling optimism, self-efficacy, and remembrance of important goals.

Homelessness and treatment of co-occurring disorders

Many consumers with co-occurring disorders become homeless over the course of their lives because substance use disorders worsen the symptoms of mental illness. In addition, when consumers use substances, they often behave in ways that cause problems with relationships, finances, housing, and self-care. They often lose their housing as a result of those problems.

Consequently, many consumers with co-occurring disorders end up in homeless shelters. For consumers in these settings, offering treatment that includes motivational interviewing is critical to helping them attain stable housing as well as sobriety.

Recovery: Getting back to life

Consumers with co-occurring disorders are usually motivated by a desire to pursue recovery, which means attaining personally satisfying and meaningful life goals. They have often become discouraged, lost hope, and given up on their goals. The crux of motivational interviewing is to help consumers identify those goals, break them down into realistic steps, and figure out that managing one's illnesses is part of achieving one's goals.

Consumers with co-occurring disorders have the same goals as everyone else. They want to have meaningful activities, friendships, and family members in their lives. For example, many consumers with co-occurring disorders are parents. Many have had problems in their role as parents and they may have lost custody of their children, but still strongly wish to be good parents and have contact with their children. Similarly, most consumers with co-occurring disorders—even those who are homeless and unemployed for many years—want to work. These normal wishes for normal adult roles can be strong motivators to become engaged in treatment to attain sobriety and control of mental illness symptoms.

Integrated treatment specialists can instill new hope that life will get better by providing practical and intensive supports, by helping consumers recognize the costs they are incurring through their substance use, and by helping identify small steps toward large goals. This support can help consumers achieve some success and find optimism, confidence, and meaning in their lives. This is what recovery is all about.

Cognitive behavioral interventions

For consumers who are ready to stop using substances, counseling helps them develop the skills and supports they need to live a satisfying life without substances. Using cognitive techniques in counseling sessions, especially during the active stage of treatment, helps consumers identify thoughts, emotions, behaviors, and situations that lead to substance use. Using behavioral techniques to change these patterns helps consumers avoid further substance use.

This section begins with Susan's story. Susan is a young woman with polysubstance abuse and an acute anxiety disorder. After reading the vignette, consider the cognitive behavioral interventions you would use to counsel Susan.

Susan's story

Susan is an attractive 18-year-old single student. A week before her mother brought her in for treatment at the mental health center, Susan was admitted to the local emergency room for intoxication. The integrated treatment specialist met with Susan alone first and then was joined by her mother.

During the intake, Susan appeared disheveled, tremulous, and distracted. Her eye contact was poor. She described increasing substance use, depression, and anxiety over several months with the following symptoms:

- Insomnia;
- Rapid changes in mood;
- Difficulty concentrating in class and doing homework; and
- Feeling tense and worried most of the time.

She gave the following history of substance use: she first drank alcohol at age 14 and for the past 6 months has been drinking up to six drinks a night on weekends (with friends and at parties).

She first used ecstasy at age 17 and now uses it once or twice per month. She first used cocaine 6 months ago and now uses it every weekend at parties, and she tried heroin last week at a party before going to the emergency room. She said that when she starts drinking at parties, she drinks more mixed drinks or wine than she plans to, but that all her friends "get wasted" like that.

Susan reported several problems. She had been struggling to do her work in high school. She recently quit working on the school paper. She also revealed that she often "hooks up" with guys at parties and doesn't use any birth control or other protection. She is concerned about the possibility of being pregnant.

The integrated treatment specialist asked her if she had ever been sexually touched when she didn't want to be. After a lengthy pause, Susan revealed that she had been raped 6 months earlier after an all-night party, a "Rave." She had been afraid to tell her parents or anyone.

Susan was tearful and tremulous talking about the rape. The integrated treatment specialist asked her about post-traumatic stress disorder symptoms. She reported intrusive memories, occasional nightmares, and that she always felt "on the edge" and extremely alert. She felt nervous and cried when she thought about what happened. The memories bothered her all the time. She avoided situations that reminded her of what happened, including the young man. When she saw him, she experienced feelings of panic. Sometimes she wished she were dead, but she had not made plans to harm herself because she wouldn't shame her family that way.

The integrated treatment specialist asked her whether these feelings led her to want to drink or use drugs. Susan said that when she experienced intrusive memories of her assault and when she had trouble sleeping at night, she thought about drinking, but that she only drank when she went out with friends. Whenever she was on a date or at a party, she couldn't wait to have a drink. She always used drugs at parties when she was offered, but she didn't think she had the urge to use in other situations. She couldn't remember actually saying, "No," when offered a substance and didn't know if she could.

Susan's mother reported a strong family history of anxiety, depression, and substance abuse in several family members. She was shocked and angry with Susan for using substances, but wanted to help her address her problems.

The integrated treatment specialist empathized with the symptoms and problems that Susan was experiencing. She suggested that the problems might be made worse by using substances. She asked for Susan's input about the effect of using substances on her current situation. Susan wasn't sure, but thought if she felt better she might not feel like using substances so much.

The integrated treatment specialist suggested that they try an experiment. Susan was to keep a journal for a week. She would write down every time she used substances, what was happening, what she was thinking and feeling before using, and also what she experienced during and after using. The integrated treatment specialist gave her a worksheet to use for this assignment.

At the end of the evaluation, Susan agreed she wanted to work on feeling better, even if it meant changing her substance use. She agreed to come weekly to therapy, but she did not want to see a doctor for a psychiatric or physical evaluation. Her mother agreed to keep an eye on Susan and to restrict her from dates and parties until they met again and developed a plan of action.

When Susan and her integrated treatment specialist met the next week, they looked at the journal and worksheets together and talked more. Susan had not used any substances because her mother, “barely let me out of the house!” Susan was able to identify thoughts, feelings, and situations in the past that led to using drugs and alcohol that allowed them to complete a contextual assessment of her use of alcohol, cocaine, and ecstasy.

Key triggers for wanting to use alcohol were memories of being raped and the anxiety she felt around boys, dating, and parties. Key situations leading to other substance use were being at a party where others were using and offering substances to her. She and her integrated treatment specialist began to look at other ways to handle these situations without using substances.

During this meeting, the integrated treatment specialist talked with Susan about alcohol and other substances, giving her information about how they affected her body and her mood. She also gave her information about post-traumatic stress disorder, which helped Susan to understand most of her symptoms. They agreed to talk more about what to do next the following week. She agreed to continue to write in her journal and to stay at home.

At the next meeting, after updating Susan’s integrated treatment plan, Susan chose a goal she particularly wanted to pursue. Susan and her integrated treatment specialist developed an action plan to help her to work on that goal (see Susan’s action plan on the next page).

They also met with Susan’s mother, and Susan revealed more about her problems with substances and shared the plan with her. Susan asked her mother to help by doing one fun thing with her on Saturdays. Her mother agreed. They also agreed on a 10 P.M. curfew and a 1-week grounding if it was broken.

Action Plan		Name:	Susan	Consumer I.D.:	1234
		Integrated Treatment Specialist:	Jane	Date:	1/1/01
Goal	Avoid using all street drugs and reduce alcohol to no more than two drinks in 1 week				
Detox plan:	None				
Cues or triggers:	<ul style="list-style-type: none"> ■ Peer pressure ■ Anxiety around boys 	<ul style="list-style-type: none"> ■ Feeling anxious and overwhelmed by memories of rape ■ Being at a party or other place where substances are being used 			
Consequences or reinforcers:	<ul style="list-style-type: none"> ■ Perceived peer acceptance 	<ul style="list-style-type: none"> ■ Perceived reduction in anxiety 			
Early warning signs for anxiety and depression:	Anticipation of social events				
Action steps:					
1.	Susan will learn how to refuse substances and to avoid social situations (including parties) where there is potential for substance use:				
	Practice saying, "No," and suggesting other activities with practitioner	Target date:	January 15		
	Say, "No," and suggest another activity if close friend suggests attending party (for example, go to a movie, take a walk, go shopping or to mall, get ice cream, etc.)	Target date:	February 1		
2.	Susan will make friends who don't use substances:				
	Practice conversation skills with integrated treatment specialist	Target date:	February 1		
	Try out conversation skills with one person at school	Target date:	Every day in February		
	Invite one person who does not do drugs to an activity	Target date:	March 1		
3.	Susan will learn how to cope with depression and anxiety better:				
	Participate in relaxation training with practitioner	Target date:	February 1		
	Practice relaxation exercise or other relaxation activity	Target date:	Daily, on-going		
	Learn other ways to cope with anxiety on dates and in other social situations	Target date:	March 1		
	Practice positive self-talk for dates and other social situations	Target date:	March 1		
	Learn and practice conversation and assertiveness skills: how to say, "No," to agree, and to disagree with someone	Target date:	March 15		
	Consider meeting with doctor to discuss medication	Target date:	April 1		
4.	Susan will fill her time with healthy and fun activities:				
	Attend school and homework club	Target date:	Daily, ongoing		
	Attend karate class (chosen by Susan as new "fun" activity)	Target date:	Weekly, ongoing		
	Do one enjoyable activity (from list of 15 things generated by Susan) alone, with mother, or with a friend	Target date:	Daily, ongoing		
5.	Susan will learn about rape, how to avoid being a victim, and how to cope with the symptoms related to rape:				
	Read handout	Target date:	January 15		
	Consider attending group for rape survivors by listing pros and cons	Target date:	February 1		

Susan and her integrated treatment specialist met weekly for a year. In the first 4 months, they focused mostly on helping Susan learn and practice relaxation skills and the social and assertiveness skills to stay away from parties and to say, "No," when substances were offered.

Susan's mother and her integrated treatment specialist also encouraged her to engage in other fun activities, which helped Susan's mood. After a few months, she agreed to see a psychiatrist for a medication evaluation and decided to try an antidepressant medication. She also agreed to get a medical evaluation and testing for infectious diseases.

Susan stopped using substances but then had three different one-night lapses of heavy alcohol use, which she reported were related to going on a date and being offered alcohol. By the third month of treatment, the memories of the rape and anxiety related to them were less bothersome, but her social anxiety was not.

Susan, her mother, and the integrated treatment specialist reviewed her integrated treatment plan at this point. In the next 6 months, she and her integrated treatment specialist worked on reducing her social anxiety and developing more positive self-esteem by improving her conversation and assertiveness skills.

In this context, she talked in more detail about how she was raped and her shame around this event. Her integrated treatment specialist suggested an A.A. group for young people and a rape survivors group to give her a place to make new friends and get further support, but Susan adamantly stated she would have nothing to do with groups.

She did make a new friend at the afternoon homework club and started dating a boy from her karate class. Neither one used drugs. She remained substance-free for 6 months and stopped seeing the integrated treatment specialist when she entered college.

This vignette illustrates that to do effective substance abuse counseling integrated treatment specialists should do the following:

- Clarify the psychiatric diagnosis;
- Determine the extent of substance abuse problems;
- Determine consumers' stage of treatment; and
- Complete comprehensive longitudinal and contextual assessments.

In the vignette, Susan's diagnoses were post-traumatic stress disorder (PTSD) and polysubstance abuse (not dependence). Once she became aware that substance use worsened her problems in many ways, Susan quickly became committed to giving up substance abuse. By the third meeting with her integrated treatment specialist, Susan was fully in the active treatment stage.

Once consumers reach the active treatment stage, it is appropriate to provide substance abuse counseling to help them recover from co-occurring disorders.

Techniques used in counseling sessions depend on consumers' stage of treatment. During the engagement stage, the integrated treatment specialist focuses on establishing a trusting relationship in which substance use and other personal issues can be discussed openly.

During the persuasion stage, practitioners focus on helping consumers develop motivation to change substance-using behaviors. Once consumers are actively trying to reduce or eliminate substance use in the active treatment stage or when they are abstinent and attempting to maintain abstinence in the relapse prevention stage, cognitive behavioral counseling skills are particularly important.

Integrated treatment and action plans

Substance abuse counseling is based on consumers' integrated treatment plans. As discussed in Module 3, treatment planning is a collaborative process that guides treatment. Following a six-step process, integrated treatment specialists work with consumers to develop personal recovery goals and an integrated treatment plan to support attaining those goals.

As illustrated in the vignette, once the integrated treatment plan is developed, an *action plan* can also be a useful tool for working in depth with consumers on one specific goal. The plan is based on a detailed analysis of the emotions, thoughts, behaviors, and circumstances before, during, and after substance use. This information is gathered throughout the assessment process as the integrated treatment specialist gets to know consumers' world through their eyes, learns about the details of their substance use, and helps them develop motivation for pursuing life goals. Individual targets of the plan can include biological, psychological, cognitive, interpersonal, and environmental antecedents or consequences to substance use.

Integrated treatment and action plans are always developed with consumers. If consumers are part of the process of developing the plans, they are more likely to understand and accept them fully. It also makes it clear that consumers are responsible participants in carrying out these plans. Action plans include the specific strategies, timelines, and responsibility for addressing each target. In the vignette, cognitive behavioral interventions were used to help Susan learn to avoid or cope with internal cues and external situations that lead to substance use. Before a plan could be specified, however, the integrated treatment specialist needed to know about withdrawal, craving, triggers to use, expectations of use, and what reinforces use for Susan.

Cues that lead to substance use

As discussed in the last section, consumers face many situations, emotions, and thoughts that lead to substance use. Situations may be external cues to use substances. For example, for Susan, being offered substances at a party was an external cue to use.

Integrated treatment specialists can help consumers consider ways to avoid or cope with external cues. Although this help is provided both during the active treatment and the relapse prevention stages, specific techniques are discussed below under *Interventions for preventing relapse*.

Many consumers have difficulty managing emotions, which then leads to substance use. Common emotions that precede substance use are anger, anxiety, depression, and loneliness, though consumers who have substance use disorders report that almost any uncomfortable emotion can lead them to use substances. Helping consumers identify and manage these emotions or internal cues is a central part of substance abuse counseling.

Unpleasant emotions are often accompanied by negative or self-defeating thoughts, which can also be internal cues that lead to substance use. For example, anger at a spouse might lead to these thoughts: "I hate him. I'm miserable in my marriage. It's all hopeless. I might as well drink." Or in Susan's case, anxiety in social situations led to two scenarios in her head: "I'm not popular enough. No guy will ever really love me for who I am. I just need a drink to get rid of how bad I feel." Or "I'm so anxious I can't stand it. People are noticing how stupid I look. I need to drink to relax and fit in."

Thoughts, emotions, and behaviors directly affect and change one another. By changing one of these three, usually the other two will change, too.

Cognitive techniques

When you examine how consumers come to use substances, particular thoughts and feelings usually come before the urge to use, which is then followed by the substance use behavior.

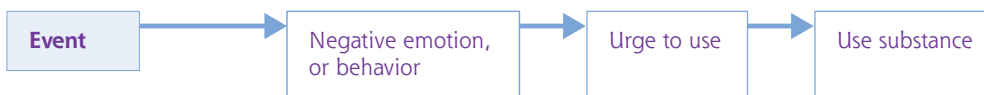
One way to help consumers change their substance use behavior is to help them identify the thought or feeling, stop, and then change the preceding thought or feeling.

The figure below illustrates the process of identifying the negative thought, emotion, or behavior that leads to urges to use substances. It shows how consumers can stop the thought and replace the old response of using a substance with a positive thought or a coping behavior.

Being able to manage negative thoughts and negative feelings can dramatically improve consumers' ability to stay away from substances.

Using positive thoughts, emotions, or coping behavior to stop substance use

Old pattern



New pattern



OR



Cognitive Skills

- Identify negative thoughts.
- Categorize negative thoughts.
- Stop negative thoughts.
- Replace negative thoughts with positive thoughts.

In Susan's case, the integrated treatment specialist helped her understand how her thoughts were linked to her feelings and behavior by having Susan keep a journal of thoughts, feelings, and behaviors and talk about situations in detail with her integrated treatment specialist. First, they looked at how social situations brought on anxiety. When in a dating or group situation, Susan worried about what others thought of her. The integrated treatment specialist taught her about different kinds of negative thoughts such as the ones described below.

Categorizing Negative Thoughts

Unrealistic goals (perfectionism)	"I must do everything right" or "Other people should always be friendly."
Imagining catastrophe	"If things don't work out exactly the way I expect, then it's useless, terrible, the end of the world."
Overgeneralization	"I am never on time" or "I will always feel this bad."
Expecting the worst	"Nobody will ever like me" or "My marriage is doomed."
Putting herself down	"My mother always said I was stupid" or "I'm weak."
Black-and-white thinking	"If that person doesn't like me, they must hate me" or "If I'm not perfect, I must be a complete failure."

The integrated treatment specialist helped her identify the thoughts she had in these situations, such as making an assumption and then leaping to an overgeneralization, such as, "He doesn't like me; he thinks I'm ugly. Everyone must hate me," which

led to negative self-statements, such as, "I'm pathetic." These thoughts always made Susan feel anxious or depressed and led her to want to drink to avoid her feelings and forget her memories.

The integrated treatment specialist helped Susan come up with different thoughts to use when she found her mind going in this direction. What worked for Susan was to repeat a positive slogan she learned in karate. Other consumers may want to develop their own personal affirmation statement, such as, "I can do it without alcohol." or "I have faith in myself." Some consumers find A.A. slogans helpful and use them to replace negative thoughts that lead to drinking.

Below are other examples of ways to reduce negative thinking.

Ways to Reduce Negative Thinking

- Recall the good things in life and about yourself.
- Challenge and refute irrational beliefs.
- Avoid assuming catastrophe.
- Re-label the distress.
- Make a hopeful statement about yourself.
- Blame the event, not yourself.
- Remind yourself to stay on task.
- Pat yourself on the back.

Behavioral techniques

Behavioral techniques to reduce or stop using substances include helping consumers:

- Improve conversation skills;
- Learn assertiveness and relaxation skills;
- Replace substance use activities with other pleasant activities; and
- Manage mood problems.

In the vignette, Susan experienced anxiety related to PTSD symptoms and social situations, which led her to crave alcohol. Therefore, the integrated treatment specialist worked with her on skills to manage the anxiety without alcohol. She focused on relaxation training, which included helping Susan develop awareness of her body's cues for anxiety and training her how to breathe and relax her body. The integrated treatment specialist also helped Susan practice using a quick, deep breath and a relaxing thought when she was in social situations that bring on anxiety.

Many consumers with co-occurring disorders lack social skills, including conversation skills and assertiveness skills. Since interpersonal problems often lead to substance use, many consumers benefit from improving their ability to interact socially with others.

Skills that help consumers cope with interpersonal issues include how to do the following:

- Start and continue a conversation;
- Listen;
- Assert an opinion;
- Make a request;
- Refuse a request;
- Give and receive criticism; and
- Refuse an offer to use a substance.

In the vignette, Susan had problems with both conversation skills and assertiveness skills. She used alcohol to help relax in social situations. Even though she didn't want to use drugs, she had no idea how to refuse.

Another important behavioral intervention is to help consumers start new enjoyable activities that reduce anxiety and depression, increase enjoyment, and replace the substance-using activities. Engaging family members to help reinforce the new activities can be helpful, as it was with Susan.

Learning these skills continues in the relapse prevention stage of treatment. For this reason, more information about these and other behavioral techniques is discussed in the next section, Interventions to prevent relapse.

Reviewing and updating integrated treatment plans

One key aspect of an integrated treatment plan is that it should be reviewed at a specified time or earlier if something unexpected occurs. Reviewing the plan helps the integrated treatment specialist and consumers see how they are doing and whether they are on track with learning new skills and attaining sobriety.

Regular review also allows for changing the plan if it is ineffective. When Susan relapsed on dates with boys, she and her integrated treatment specialist looked at the events and saw that early on she was unable to get her worries about the boy out of her mind and became overwhelmed by anxiety. She then went to a party and drank.

The integrated treatment specialist refocused their work by doing the following:

- Helping her understand that parties where alcohol and drugs were present were a bad idea;
- Practicing skills for saying, "No," to going to parties; and
- Using affirmation and assertiveness skills to say, "No," to boys whom she thought were probably not going to be respectful to her.

Co-occurring diagnoses and trauma

The majority of consumers with co-occurring disorders have experienced traumatic events during their lives, and many have post-traumatic stress disorder. It is important to ask consumers about trauma and to screen for PTSD.

Effective interventions for consumers who have experienced trauma include the following:

- Education;
- Support groups; and
- Cognitive-behavioral therapy designed to directly address symptoms of PTSD.

Working with teenagers

Many teenagers who will develop co-occurring disorders present for treatment in emergency rooms. Unlike Susan, they usually do not show up for followup appointments.

Teens need close followup and assertive outreach to engage them in treatment early in their illness. They need to be offered information and a menu of treatment options. When engaged in treatment early, consumers with co-occurring disorders have a good chance of greatly reducing or preventing problems. It is essential to involve family members in treating teenagers. Family therapy may be appropriate as the main form of treatment for teenagers with co-occurring disorders.

Since Susan's drinking was triggered by anxiety problems, her integrated treatment specialist chose individual treatment, but also engaged Susan's mother by providing education, encouraging her to provide structure and limits that reduced Susan's access to substances, and asking her to engage her daughter in other enjoyable activities.

Interventions to prevent relapse

Once consumers have attained and sustained sobriety for 6 months, they are considered to be in stable remission and in the relapse prevention stage of treatment. During this time they are still vulnerable to using substances. Common goals

for consumers in this stage of treatment include the following:

- Avoiding substance use;
- Reducing the impact of relapse from both disorders;
- Returning to work;
- Improving social relationships; and
- Getting more involved in recreational activities.

Relapse prevention fosters developing skills and activities to meet the common goals described above. This section begins with a vignette, Mark's story. Mark has stopped using substances and works with his integrated treatment specialist to stay abstinent. After reading the vignette, consider how you would support Mark in the relapse prevention stage of treatment.

Mark's story

Mark is a 35-year-old, single man diagnosed with schizophrenia and alcohol dependence who lives alone in an apartment. He occasionally sees his brother, who is a drug dealer, and his sister, who is a secretary and doesn't use substances.

Mark has been working with an integrated treatment specialist for 3 years. After progressing through the stages of treatment, he has been sober for the last 6 months.

Mark and his integrated treatment specialist identified internal and external cues for his alcohol use in his integrated treatment plan. They also identified early warning signs for his schizophrenia.

Once these were identified, Mark and his integrated treatment specialist developed a relapse prevention plan that specified steps to take if he experienced any of these cues or high-risk situations. The plan also addressed what to do if he did relapse in order to minimize the length and severity of relapse. In Mark's case, the plan included immediate calls to his sister and to his integrated treatment specialist.

Since it was clear that spending time with old drinking buddies wasn't a good idea, Mark wanted to find new friends. He first renewed relationships with family. Mark enjoyed being around his sister again,

went fishing with his brother-in law, and had weekly dinners with his sister's family.

Mark's integrated treatment specialist helped him work on social skills to use in making new sober friends. He attended one meeting of Alcoholics Anonymous, but felt uncomfortable and didn't return. He did, however, join a local church and met several people by attending regularly.

In addition, Mark began to expand his recovery to other areas of his life. Although he had been working part-time as a janitor for the mental health center, he was dissatisfied with this job. An employment specialist helped him find a new job working in the stock room of a local retail store, a job that he really enjoyed.

Two years later, Mark was still not drinking, though he had experienced one brief relapse after running into an old drinking buddy at the grocery store. He was able to call his sister the next day, and she helped him get back on track by calling his integrated treatment specialist, and thus renewing his goal to be sober and developing a plan for what to do if the old friend called him. He was still working part-time, enjoying a positive relationship with his sister, and attending church.

Mark said, "Some days I still wish I could drink, but I know I just can't go back." Despite encouragement and support, he did not return to Alcoholics Anonymous. He did continue to regularly meet with his integrated treatment specialist to review his relapse prevention plan.

Helping consumers who are in the relapse prevention stage of treatment

In the vignette, Mark is in the relapse prevention stage of treatment where the main goal is to maintain his sobriety and expand his recovery to other areas of his life. His treatment team, including his integrated treatment specialist, has taken five important steps to help him remain stable and sober, but also to help him expand his recovery.

- The first step is to make a relapse prevention plan that will enable Mark to prevent or stop a relapse at the earliest possible point if it occurs.
- Second, Mark's integrated treatment specialist helped him develop better social skills to establish

friendships with sober friends as well as to get along with family, roommates, and coworkers.

- Third, Mark and his integrated treatment specialist developed social and leisure activities as alternative outlets to using alcohol and drugs.
- Fourth, Mark worked with an employment specialist to explore new job possibilities. Mark was able to obtain and sustain a job that he found interesting.
- Finally, although Mark was uncomfortable with participating in a self-help group, he developed and sustained new relationships by attending church that provided some social support for sustaining his sobriety.

These steps do not need to be accomplished in any particular order. Some consumers will focus on a few but not all of the steps. Many consumers will begin working on some of these steps during earlier stages of treatment. Consumers' preferences and choices are important.

Relapse Prevention Interventions

- Make a relapse prevention plan.
- Support and reinforce previously learned skills for sobriety.
- Facilitate social skills to make sober friends.
- Facilitate social and leisure activities.
- Explore job opportunities.
- Encourage and facilitate participating in self-help groups.

Maintaining awareness

Many skills and techniques learned and practiced in the active treatment stage are still relevant in the relapse prevention stage of treatment. It is important to remember consumers' specific cues or triggers for substance use. Though high-risk

situations will be unique to each consumer, some external cues are common. Some common external clues include the following:

- Being with people or being in situations where consumers previously used substances;
- Experiencing interpersonal stress (such as a disagreeing with a family member or breaking up with a girlfriend);
- Experiencing loss (losing a job or a case manager); and
- Experiencing a relapse of mental illness symptoms.

When faced with an external cue, consumers need to learn strategies to avoid substance use. They may work with their integrated treatment specialist, treatment team, or self-help group to learn strategies such as refusing substance use, leaving a stressful situation, and using distractions or other alternative behaviors, such as listening to relaxing music, instead of using the substance. Finally, identifying a supportive contact person consumers can call for direction and support when they feel they are at risk for using substances is vital.

Social skills

Three types of skills are commonly used to communicate with others:

- Social perception;
- Problem-solving; and
- Behavioral skills.

Consumers must be able to accurately perceive relevant social information in the situation, such as the other person's affect and whether the situation is public or private. After sizing up a situation, consumers must be able to decide on a communication goal, identify options for achieving the goal, and select one with a high chance of success. This involves solving problems.

Once consumers have selected a response, they need the skills to put it in action. These skills include nonverbal behaviors, such as how close to stand to another person, and verbal behaviors, such as loudness and choice of words.

Symptoms of mental illness often interfere with consumers' ability to communicate effectively. Consequently, consumers may have trouble forming or sustaining relationships. Some consumers use substances as a way of joining a social group and finding acceptance from others. Consumers with co-occurring disorders may rely on substance use for social contact.

In the vignette, Mark's main cues to drink were being around people who drank or in places where drinking occurred. To address the cue of people who drink, Mark's integrated treatment specialist helped him devise a relapse prevention plan.

Common social skills that integrated specialists work on with consumers include the following:

- Finding ways to avoid old friends who use substances;
- Finding different friends;
- Refusing substances if offered;
- Calling a support person before using substances; and
- Staying busy with a particular activity or job to avoid old drinking friends.

Group or individual counseling can be used to teach social skills. Integrated treatment specialists can explain the skills and their specific components, show consumers the specific skills, and help consumers practice the skills. Consumers need feedback and practice to be able to use social skills in real life.

Developing good social skills is key to maintaining sobriety. Work with consumers to gain these skills. For more information about social skills training programs that are available in user-friendly manuals, see *The Evidence* in this KIT.

Basic Social Skills

Listening to others

- Maintain eye contact.
- Nod your head.
- Say, "Okay," or "Uh-huh."
- Repeat what the other person said.

Making requests

- Look at the person.
- Say exactly what you would like the person to do.
- Tell the person how it would make you feel.

Expressing positive feelings

- Look at the person.
- Tell them exactly what it was that pleased you.
- Tell the person how it made you feel.

Expressing negative feelings

- Look at the person. Speak calmly and firmly.
- Say exactly what the person did to upset you.
- Tell the person how it made you feel.

Refusing an unreasonable request

- Look at the person. Speak calmly and firmly.
- Tell the person that you are sorry but you are unable to do what they asked.

Recreation, work, and friends

When consumers have a substance use disorder, using substances typically becomes a preoccupation so that they give up other enjoyable activities and relationships. Often consumers with co-occurring disorders can't remember how they had fun before they began using substances. If the only rewarding activity in consumers' lives is using substances, it is unlikely that they will give up the activity unless they learn other ways to have fun.

Consumers with co-occurring disorders often need to re-learn ways to relax and pursue enjoyment. Integrated treatment specialists should ask consumers what they enjoy doing. Sometimes you will have to help them remember what they did as children so they can recall what they liked to do for fun. Ask about all kinds of recreation including the following:

- Hobbies;
- Crafts;
- Sports;
- Social activities;
- Clubs;
- Classes;
- Art;
- Household activities;
- Yard work; and
- Volunteer work.

In some cases, it is helpful to give consumers a list of fun activities and ask them what they used to do for fun and what they'd like to do now for fun. Lists such as the one below remind consumers which activities can be fun.

After reviewing the list with consumers and identifying enjoyable activities, help them set a goal. Specify the type of activities they would like to complete in the next week and the steps they can take to fulfill the goal.

Fun Activities

Listening to music	Playing the piano	Playing the guitar	Reading a magazine
Reading a newspaper	Watching a sports game	Playing tennis	Playing basketball
Riding a bike	Taking a walk	Watching a sunset	Swimming in a pool
Going to a beach	Eating an ice cream cone	Eating a piece of pizza	Going out for coffee
Doing a crossword puzzle	Playing cards	Volunteering at a hospital	Writing a letter
Mowing the lawn	Raking the leaves	Planting flowers	Watering plants
Organizing your closet	Buying a new shirt or dress	Window shopping	Giving a gift to a friend
Calling a friend	Calling a family member	Taking care of a pet	Writing a story
Taking a class	Learning a new sport	Doing your hair in a new way	Painting your fingernails
Making a shelf	Sewing a tablecloth	Knitting a scarf	Painting your room
Collecting stamps	Baking a cake	Learning a new hobby	Writing a letter to the editor of the paper

Vocational goals

Work is a critical part of recovery for many consumers. Having a daily activity such as work is a major predictor of staying sober. Aside from the financial rewards, work is reinforcing in many ways that help consumers stay sober. Going to work helps consumers feel like everyone else. It gives them a sense of purpose in life and helps them feel that they are contributing to the world. Work also provides structure in the day and is a place to make friends with other sober people.

Research and experience show that consumers with co-occurring disorders can keep jobs as well as consumers who do not have substance use problems. Furthermore, many report that working was a key step in the recovery process. Consequently, you should encourage consumers to work. The employment services described in the *Supported Employment KIT* are effective for consumers with co-occurring disorders. For more information, visit www.samhsa.gov.

Symptoms of mental illness

Episodes of mental illness can lead to relapses in substance use. Therefore, it's important to help consumers minimize symptoms of mental illness as well as to avoid using substances by doing the following:

- Using psychiatric medications;
- Managing stress;
- Getting adequate sleep;
- Using social support;
- Engaging in enjoyable activities; and
- Using recovery strategies.

Rather than badgering consumers to take medication, help them develop an overall plan for achieving and maintaining wellness. This plan usually involves learning how to use medications effectively as well as many other strategies.

Exercise: **Practice Motivational Interventions**

Review the vignette, *Kevin's story*, and the five basic principles of motivational interviewing. Discuss how you, as Kevin's integrated treatment specialist, would use motivational interventions to help Kevin.

Exercise: **Practice Cognitive Behavioral Interventions**

Review the vignette, *Susan's story*. Discuss how you, as Susan's integrated treatment specialist, would use cognitive and behavioral techniques to help Susan.

Exercise: **Practice Interventions to Prevent Relapses**


Review the vignette, *Mark's story*. Discuss the types of interventions that you would use to support Mark's efforts to stay sober.

Module 5

Service Formats

Notes to the facilitator and program leader

Prepare for Module 5:

- Make copies of Module 5. Your copy is in this workbook; print additional copies from the CD-ROM in the KIT. 
- Distribute the material to those who are participating in your group training. Ask them to read it before the group training.


- Make copies of these exercises:

- Explore Group Treatment*
- Role-Play: A First Family Meeting*

Do not distribute them until the group training. Your copies are in this workbook; print additional copies from the CD-ROM in the KIT.



Conduct your fifth training session:

- When you convene your group, view the following segments of *Training Frontline Staff: Demonstration Video* (approximately 10 minutes): 
 - Groups for Clients with Co-Occurring Disorders*
- Discuss the video and the content of Module 5.
- One at a time, distribute the exercises and complete them as a group.

Training Frontline Staff

Module 5: Service Formats

Integrated Treatment programs are most effective when consumers are able to access services in a variety of formats. This module describes different types of group treatment, self-help groups, and family interventions that are effective for consumers with co-occurring disorders.

Group treatment for co-occurring disorders

Group treatment can be a powerful way for consumers with co-occurring disorders to learn about themselves, discover new skills, find models of recovery, develop new values, cultivate social supports, and have the experience of helping others.

Feedback from peers is often more valued than the opinions of treatment providers. Groups are also a cost-effective way of providing education and treatment to several people (usually 6 to 12) at the same time.

Many types of groups are used for consumers with co-occurring disorders. The following are some examples:

- Stage-wise treatment groups;
- Self-help groups such as Alcoholics Anonymous and Narcotics Anonymous;
- Skills training groups; and
- Educational groups.

High-fidelity, co-occurring disorder programs are able to engage about two-thirds of consumers with co-occurring disorders in group interventions.

This module begins with a vignette, Vicky's story. Vicky has bipolar disorder and uses alcohol. After reading the vignette, consider the ways that group treatment was an effective way to help Vicky.

Vicky's story

Vicky is a 23-year-old African American woman who has been diagnosed with bipolar disorder and alcohol dependence.

Vicky has shown symptoms of bipolar disorder since she was 17 years old and reports that she started drinking alcohol around the same time. She had a manic episode at age 21, when she stayed awake for several days studying for courses she was taking in college. She became convinced she was teaching the courses and acted this way in class, resulting in her dismissal. After 2 months of hospitalization and medication, she did not return to college.

Vicky worked at a series of jobs. She started drinking alcohol daily, however, and her moods became unpredictable with dramatic highs and lows. She was often unable to work and lost several jobs. She experienced another manic episode and was hospitalized again. When she was able to think clearly, she realized that her landlord had given her an eviction notice because she hadn't paid her rent. She had no way to pay the hospital either. The hospital social worker referred her to the mental health center.

For the next 12 months, the treatment team worked with Vicky to engage her into treatment, stabilize her living situation, and help her stay on medication. After they developed a good relationship with her, they began talking with her about how alcohol seemed to be interfering with her personal goal of holding down a steady job and returning to college some day.

Vicky was in the persuasion stage. Her integrated treatment specialist suggested that she attend a co-occurring disorders group to meet people struggling with issues similar to hers.

At first Vicky was reluctant to attend the group. She wasn't sure she would fit in and she didn't want strangers knowing about her troubles. She was afraid she would be the only African American in the group. She agreed to give the group a try for a month because she was already at the mental health center and could meet with her integrated treatment specialist after the group.

Vicky was surprised to see other people of color in the group, and that one of the leaders was African American. At first when people were talking about their substance use, she felt nervous and passed when it was her turn. She was shocked at how bad some of the other people's problems were.

The group leader let Vicky's integrated treatment specialist know that she wasn't talking in the group. Vicky's integrated treatment specialist talked with her about her fears of "people knowing my business." The group members reviewed the policy of confidentiality. After the third week, she began to talk about how much she enjoyed drinking alcohol. She also talked some about how much her father used to drink and how badly he acted when he was "really bad drunk."

She heard about how other people had parents who abused substances and how substance use disorders are biological diseases that can run in families. She was impressed when another group member announced that she was planning to start attending an Alcoholics Anonymous group with her brother, who had stopped drinking a year ago, and that that group member was going to stop drinking. She told her integrated treatment specialist that she felt she might have something in common with some of the people in the group. She really liked one of the group leaders and would stay after the group to talk with her.

During the group many discussions occurred about how substance use interacted with mental illness. Another person in the group had bipolar disorder. Vicky learned from the discussions about how she and the others were more sensitive to the effects of alcohol than someone without a mental illness and how drinking can worsen mania or depression.

As people talked about their substance use, the group facilitators would start a discussion about the similarities for group members and help people examine some of the negative consequences of their use. Vicky talked about how alcohol helped her feel better when she was feeling like a failure in her life. This led to a discussion with her doctor about depression and whether alcohol prevented her medications from helping as much as they could.

Over time Vicky began to see that her daily alcohol use was interfering with her ability to keep a job. With the help of the group, she decided to try a period of drinking only on nights when she didn't have to work the next day.

Group members helped her come up with ideas about what to do on the nights she didn't drink. A few of them offered to get together with her to watch TV or play cards. Vicky stuck with this plan for several months and remained in her job for over a year. She eventually chose to stop drinking completely.

Stage-wise treatment groups

Stage-wise treatment groups focus on helping consumers in the same stage of treatment move toward recovery. It is recommended that programs offer two types of stage-wise treatment groups:

- Groups for consumers in the persuasion stage of treatment; and
- Groups for consumers in the active treatment and relapse prevention stage.

Persuasion groups

Persuasion groups are for consumers who do not yet see that their substance use is a problem; they are in the engagement and persuasion stages of treatment. Persuasion groups offer support and education. Participants are encouraged to explore how their substance use affects their lives, with the goal of helping them see how substance use interferes with reaching their own goals.

Like Vicky, most consumers are anxious about attending a group for the first time. Explain that the purpose of the group is NOT for consumers to give up using substances, but is just to learn about substances in a supportive environment with other people like themselves.

Help consumers try a group by asking them just to attend for a short time to see what it is like. Group leaders must be in contact with consumers' treatment team members so that individual and group treatment can be coordinated.

Persuasion groups are long term and have group members coming and going all the time. They may be led by an integrated treatment specialist or co- led by a consumer in recovery.

Persuasion groups meet weekly and last 45 minutes to an hour. They often have a break in the middle for snacks and socializing to keep consumers' attention.

Characteristics of Persuasion Groups

- Are supportive
- Are nonjudgmental
- Facilitate peer interaction
- Educate
- Use motivational interviewing techniques
- Are long term
- Support attendance

Leaders of persuasion groups expect that group members are currently using substances. They offer an open, nonjudgmental opportunity for consumers to talk about how they use substances and how their lives are going.

Each group begins with members sharing how their week went and what their substance use was like. The leaders use this information to begin a discussion about common problems that group members are having and to encourage peer-to-peer interaction. Motivational interviewing techniques are also used to point out how consumers' substance use interferes with taking steps toward their goals.

In the vignette, Vicky was able to learn from others in the group and to get help from them when she was ready to consider cutting back on her alcohol use. Like many consumers, she trusted her peers' opinions because she believed they knew what living with co-occurring disorders was really like.

Many consumers initially resist participating in groups but subsequently become very attached to the group. Group leaders try to maintain attendance by making the group low-key, supportive, and fun. They make sure that every consumer feels valued by checking in with each group member. Leaders do not confront consumers about their substance use, and they keep the group safe and positive for everyone.

Refreshments are usually served. Some groups have weekly drawings for prizes, such as tickets to the movies. Sometimes groups have structured activities or group outings to help keep consumers interested in attending the group.

Helping consumers initially connect with a persuasion group is the most difficult step. Once they become regular members and feel part of the group, almost everyone benefits.

Active treatment groups

Consumers who participate in active treatment groups are either in the active treatment or the relapse prevention stage of treatment. The goal of active treatment groups is to help consumers stop using substances and learn new skills to maintain abstinence.

Active treatment groups are for consumers who have decided that substance use is a problem they want to change. When consumers decide to reduce their substance use or try a period of abstinence, they are ready for active treatment groups. For example, at the end of the vignette, Vicky was ready for an active treatment group.

These weekly groups are also led by an integrated treatment specialist or co-led by a consumer in recovery. They last 60 to 90 minutes and include a break in the middle.

Active treatment groups are offered on a long-term basis, with consumers participating for as long as they feel they need support. Because consumers

in this stage are motivated to stop all substance use, the expectation is that consumers will attend regularly without group leaders needing to use engagement activities.

Consumers further along in recovery act as role models for those who are still trying to achieve abstinence. When a group member relapses, other members help them get back on track. If consumers are unable to stop using substances within a few weeks after relapse, encourage them to return to a persuasion group. In this way, group leaders help members use the relapse as a learning experience.

In active treatment groups, leaders educate consumers about how to reduce and stop using substances. They provide training for skills that will help consumers achieve their goals for recovery. These skills include the following:

- Recognizing high-risk situations;
- Identifying and managing internal and external cues that lead to substance use;
- Practicing communication skills for assertiveness and for refusing substances;
- Exploring new ways of coping with stress; and
- Using stress management skills such as relaxation techniques or imagery to deal with cravings.

Active treatment groups usually start with consumers taking turns describing how their week went and any challenges they faced in staying sober. Leaders decide which problems may be relevant to focus on that week. Leaders encourage group members to become involved in offering concrete suggestions and participating in role plays that permit practicing a particular skill or confronting a particular situation. Self-help materials are often used. Consumers give feedback and support to those who do a role-play.

When consumers are ready to graduate from active treatment groups, leaders encourage them to join a self-help group to continue to get social support for sobriety.

Characteristics of Active Treatment Groups

- Are supportive
- Are educational
- Teach social skills
- Promote coping skills
- Teach self-care skills
- Are available long term
- Expect sobriety

Combined groups

In many treatment settings, consumers in the persuasion and active treatment stages are invited to participate in a combined treatment group. Mental health centers may choose to run a single group for co-occurring disorders when they feel there are not enough consumers to attend two separate groups.

The challenge in running a combined group is meeting the varied needs of all group members. Consumers in the persuasion stage of treatment need to explore the effects of substance use on their lives, while those in the active treatment stage need to learn new skills to stop using substances, to remain abstinent, and to go on with their lives.

The advantage of a combined group is the opportunity for consumers in the engagement stage to have peer role models who are abstinent. The disadvantage of combined groups is that issues that are relevant for consumers in the persuasion stage may not be relevant for those in active treatment, so some active treatment consumers may lose interest and drop out. Ideally, groups for both stages should be offered.

Self-Help groups

The term *self-help* refers to a process of working toward recovery from mental illnesses or substance use disorders with a group of people who share the same problem. In self-help groups, people share their experiences, strengths, and hopes to help others overcome a variety of illnesses and behaviors.

The most widely used form of self-help for drinking problems—Alcoholics Anonymous (A.A.)—is an organization of people who use mutual support groups, sponsorship, the 12 Steps, and the 12 Traditions to recover from alcohol abuse or dependency. A.A. was founded in 1935 and has millions of active members in more than 100 countries. A.A. is an invaluable and free resource that enables many people to attain and sustain recovery. Though A.A. is often referred to as a support system or an adjunct to treatment, it is actually a remarkable organization that offers people with substance use disorders virtually everything known to be helpful in recovery. A.A. offers the following:

- Regular activity;
- A new way of seeing the world;
- Sober friends and supports;
- Hope;
- Role models;
- Spirituality;
- Cognitive-behavioral strategies for change;
- Emergency help;
- A way of making amends for past mistakes; and
- An opportunity to help other people.

Many other successful approaches to self-help have been modeled on A.A.

Self-Help and the 12 Steps

A.A. is based on the 12 Steps to Recovery, the 12 Traditions, and mutual responsibility. The 12 Steps are guidelines for recovery (see below).

The founders of A.A. believed that people went through a process to achieve sobriety. They wrote this process down in a step-by-step way for others to follow.

The 12 Steps of Alcoholics Anonymous

Step 1:	We admitted we were powerless over alcohol, that our lives have become unmanageable.
Step 2:	We came to believe that a Power greater than ourselves could restore us to sanity.
Step 3:	We made a decision to turn our will and lives over to the care of God, as we understood him.
Step 4:	We made a searching and fearless moral inventory of ourselves.
Step 5:	We admitted to God, to ourselves, and another human being the exact nature of our wrongs.
Step 6:	We were entirely ready to have God remove all these defects of character.
Step 7:	We humbly asked Him to remove our shortcomings.
Step 8:	We made a list of all people we harmed, and became willing to make amends to them all.
Step 9:	We made direct amends to such people wherever possible, except when to do so would injure them or others.
Step 10:	We continued to take personal inventory and when we were wrong, promptly admitted it.
Step 11:	We sought through prayer and meditation to improve our conscious contact with God, as we understood him, praying only for knowledge of His will for us and the power to carry that out.
Step 12:	Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

The Twelve Steps are reprinted with permission of Alcoholics Anonymous World Services, Inc. ("AAWS"). Permission to reprint The Twelve Steps does not mean that AAWS has reviewed or approved the contents of this publication, or that AAWS necessarily agrees with the views expressed herein. A.A. is a program of recovery from alcoholism **only**—use of The Twelve Steps in connection with programs and activities which are patterned after A.A., but which address other problems, or in any other non-A.A. context, does not imply otherwise.

The process of working on the 12 Steps in a peer-group setting with a sponsor helps consumers stop using alcohol and stay sober by offering skills and supports. Consumers learn by reading from self-help literature, observing the unsuccessful and successful coping strategies of others in groups, and being coached by their sponsor and peers in the groups.

The A.A. model of self-help works in many ways, and numerous books have been written about recovery through 12-step programs. For example, psychologists have pointed out that 12-step programs help people learn to manage their feelings, reduce their use of avoidant and destructive coping strategies, and increase their use of healthy cognitive and behavioral coping strategies.

A.A. meetings are self-help groups run by non-professional people who are themselves working on recovering from addictive disorders. A.A. is the model upon which many other self-help groups are based, including the following, among others:

- Cocaine Anonymous;
- Narcotics Anonymous;
- Rational Recovery;
- Double Trouble (specifically for people with co-occurring disorders);
- Dual Recovery Anonymous (specifically for people with co-occurring disorders).

A.A. is not a religious organization, but it does have a spiritual component. The Steps talk about a Higher Power. In 12-Step meetings, people are encouraged to believe that a Higher Power can be anything outside of themselves that can help them change their addictive behavior, though many people do think of a Higher Power as God.

To participate in A.A., it is not necessary to believe in a Higher Power, but it does play a role in many meetings. Some meetings open or close with the Serenity Prayer or the Lord's Prayer. Rational Recovery is a self-help organization that uses principles of A.A. without the emphasis on religion or a Higher Power.

Before referring consumers to a 12-Step meeting, visit some open meetings to see what they are like. You should be familiar with local self-help groups, including which groups understand and accept people who are taking medicine because these groups will be most accepting of consumers with co-occurring disorders.

On the next page is a vignette, Joanne's story. Joanne has bipolar disorder and is dependent on alcohol and cocaine. After reading this vignette, reflect on how the self-help group helped Joanne and at which point group treatment was most effective.

Joanne's story

Joanne is a 30-year-old woman with bipolar disorder, alcohol dependence, and cocaine dependence. She has been going to the local mental health center for treatment for 10 years. For the past 2 years, Joanne has attended treatment groups without making much progress.

About a year ago, she had a manic episode during which she was charged with driving while intoxicated. She felt unjustly charged and discussed the issue with her integrated treatment specialist and peers in the group. After some months of discussion, she accepted that she would have to follow the judge's recommendation to do something about her substance use.

Over a 6-month period, Joanne tried to avoid drugs, but whenever she went out with friends, she couldn't resist the temptation to get high with cocaine. After using substances, Joanne became depressed for several days.

Joanne became discouraged about quitting because she didn't want to stay away from her friends who were using. Joanne's integrated treatment specialist asked her if she had ever tried a self-help group such as Alcoholics Anonymous to stay sober and as a way to meet sober people. Joanne replied she had gone to one meeting several years ago, but she didn't like it. She didn't feel as if she fit in and she didn't want to have to talk in front of a big group of people that she didn't know.

Joanne's integrated treatment specialist explained that many different self-help meetings exist and encouraged Joanne to try several, suggesting that maybe she could find a group where she felt more comfortable. They got a meeting list and picked out a few meetings that were nearby and at times that were good for Joanne.

Joanne's integrated treatment specialist offered to attend a few meetings with her so she wouldn't have to go by herself. They picked open-speaker meetings in which Joanne would not have to speak. The two attended the meetings and then talked about how it felt on the drive home. Joanne said she felt nervous, but also relieved that she was not alone in her attempt to get sober.

With Joanne's consent, her integrated treatment specialist approached another recovering consumer about helping Joanne find meetings that she liked. The integrated treatment specialist introduced Joanne to this person and Joanne agreed to attend more meetings with her.

Joanne finally found two women's meetings in which she felt comfortable and began attending them regularly on her own. After a few months of attending, she met a woman she liked and trusted and asked the woman to be her sponsor. She and Joanne began talking and attending meetings regularly.

The integrated treatment specialist took these steps to encourage Joanne to try a self-help group:

- Talked with Joanne about the pros and the cons of self-help groups;
- Once Joanne was interested in trying a meeting, helped her pick an appropriate meeting;
- Talked about what to expect, what to do, and how to act at the meeting;
- Went to the meeting with Joanne;
- After the meeting, asked Joanne how it went and gave feedback on her perspective of how it went;
- Told Joanne at least one positive behavior she used during the meeting;
- Chose another meeting, accompanied Joanne, and discussed how it went; and
- Linked Joanne with another recovering person who went to meetings with her.

Choosing a 12-Step meeting

In the vignette, the integrated treatment specialist attended an open-speaker meeting with Joanne. The difference between open and closed meetings is that anyone who is interested may attend an open meeting. Closed meetings are just for people who admit to having a problem.

A.A. has many types of meetings:

- In **speaker meetings**, people tell the story of their illness and recovery.
- In **discussion meetings**, group members may bring up problems they are having with their addiction.
- In **step meetings**, one of the steps is read aloud and discussed.
- In **Big Book meetings**, a chapter in the *Big Book of Alcoholics Anonymous* is read and people discuss it.

As an integrated treatment specialist, you should be prepared to refer consumers to 12-Step meetings. In the vignette, the integrated treatment specialist had a meeting list, so it was easy to sit down with Joanne and choose some meetings. If you don't have a meeting list, you can always find 12-Step meetings in the yellow pages or online. For more information see, www.alcoholics-anonymous.org.

Encourage consumers to try different meetings and support them in finding one with which they are comfortable. A discussion meeting, for example, is not a good place to start for someone who feels uncomfortable speaking in a group. Let consumers know that they never have to speak at a meeting other than to say that they pass.

Sponsorship

In the vignette, Joanne finds a sponsor. A sponsor is someone with stable sobriety (usually 4 or more years). Sponsors often talk daily to people they sponsor, go to meetings with them, and socialize with them. Sponsors guide a person through the steps of the program and help when a person has an urge to use substances. Many sponsors make themselves available day or night.

Group members are encouraged to work with sponsors of the same sex. People who are willing to be sponsors usually raise their hands at meetings.

When consumers look for a sponsor, they need to pick someone they like and trust because this is important to developing close relationships. Often groups will have a list of temporary sponsors who agree to take phone calls or give rides to meetings to support someone until they find the “right” sponsor for them.

Who should go to self-help groups?

Self-help groups can be effective for the following:

- Any consumer who wants to go;
- Consumers who have no sober support network; and
- Consumers who like the idea of peer support rather than or in addition to professional supports.

Since self-help groups are so widely available and affordable (free) and offer so many different tools and supports for recovery, everyone should be encouraged to try them. Participating in self-help groups can be a positive experience for consumers with co-occurring disorders even if they do not embrace the 12 Steps and Traditions. When consumers find a “home” group, they often experience a sense of acceptance and community that they didn't have before.

Many 12-Step meetings rely on the concept of accepting that you are an “addict” and using this self-identification to accept help from others and avoid substance use. Some consumers have difficulty tolerating this type of self-concept, which is experienced as a threat to self-esteem. Do not push consumers who are clear that they do not want to attend or those who are very angry. Instead reintroduce the idea of attending a 12-Step group at a later stage. If a consumer has difficulty accepting the concepts of powerlessness and character defects, suggest other readings that may better appeal to them.

Some consumers need more help than Joanne did to use 12-Step groups. They may need an introduction to the ideas used in these groups. They may need explicit coaching about what to wear, how to act, and what to say. Instruct consumers about some of the unwritten “etiquette” expected at self-help meetings. For example, explain that since the program is anonymous, who they see and what they hear at the meeting is confidential. Remind them that when someone is talking they should remain in their seat. Let them know if coffee or food are provided, they should only take one helping and, if possible, they should leave a donation. Finally, it may be helpful to remind consumers that some meetings are nonsmoking. In these meetings, consumers are usually allowed to smoke outside the meeting. For consumers with co-occurring disorders, this type of orientation will help them to be accepted by the group.

Some consumers will need social-skills training to learn the skills to interact appropriately at 12-Step meetings before they are ready to attend. While at meetings, integrated treatment specialists can greet people and shake hands to model social skills. An integrated treatment specialist may need to go to meetings with some consumers for a longer period of time.

It often helps to discuss the meeting afterward to clear up any misunderstandings. If meetings for consumers with co-occurring disorders, such as Double Trouble or Dual Recovery Anonymous, are available, many of these difficulties are eliminated.

Other options

Many self-help options are available. In the vignette, Joanne was able to successfully use A.A. as a support system. Initially, she had some ambivalence because she had tried it once and didn’t feel as if she fit in. Many consumers with co-occurring disorders feel this way. These feelings arise for different reasons. Some consumers are uncomfortable with the spiritual aspect of the program. An alternative might be Rational Recovery where spirituality is not a part of the program.

Another reason consumers feel uncomfortable is that their mental illness makes them feel as if they don’t belong. A Dual Recovery Anonymous group might help solve that problem. If Joanne had not succeeded in A.A., her integrated treatment specialist might have encouraged her to try Narcotics Anonymous or Cocaine Anonymous, which directly address addiction to substances other than alcohol. If consumers try and really dislike 12-Step programs, look for alternative ways to support recovery.

For more information on self-help groups, see TIP 42 and other resources on the CD-ROM in this KIT.

Family interventions

Working with the families of consumers with co-occurring disorders is extremely important. Consumers often have few friends, small social networks, or drug-abusing friends who encourage self-destructive behaviors. Family members can be their most important social supports.

Consumers and their families often experience serious tension and conflict around substance use, difficult behavior, and symptoms of mental illness. Families may not understand the interactions among substance use, mental illness, and behavior. They need practical information about co-occurring disorders and help in developing strategies to meet family goals.

Family interventions can reduce stress in the family, increase the family's ability to offer positive supports, and focus everyone on the same goals. Because families can be such a strong source of support for consumers with co-occurring disorders, it is important to include them in treatment.

This section begins with a vignette, Jack's story. Jack has schizophrenia and abuses alcohol. After reading the vignette, consider how Jack's family played a critical role in his recovery. How did Jack's treatment team involve Jack's family in different stages of treatment?

Jack's story

Jack is a 26-year-old, unemployed man diagnosed with schizophrenia and alcohol abuse. Jack was hospitalized three times and had not worked in several years.

When Jack drank, his symptoms of schizophrenia worsened, including delusions of reference, poor attention, and disorganization. He argued frequently with his mother and stepfather, with whom he lived. Though he wanted friends, he had difficulty meeting people.

One day Jack's mother called his integrated treatment specialist, furious because she had found a bag of marijuana in his bedroom. She demanded to meet with Jack's treatment team. When Jack's integrated treatment specialist mentioned this to Jack, he agreed that his substance use was causing problems with his parents and that they should all meet.

In a long family meeting, the treatment team members tried to understand each person's view of the current situation and what each was hoping could happen. They offered Jack and his family several options:

- First, they told them of a monthly educational group at the mental health center.
- Second, they explained that the National Alliance on Mental Illness (NAMI) also held a monthly meeting of families who were trying to help a relative with mental illness.
- Third, they suggested family therapy as an option.

After explaining each option, they agreed that Jack's parents would attend a NAMI meeting and that the family members would discuss the options and call the integrated treatment specialist about what they would like to do next.

Two weeks later, Jack's parents called again with the news that Jack had come in "stumbling drunk" and that a huge fight had ensued. They all returned to the mental health center and quickly decided to try family therapy.

The therapist met with each family member to understand his or her view of the problem and the situation. Jack expressed an interest in making some friends and in having a girlfriend. He recognized that his drinking was a problem and said that he wanted to cut down.

Jack's mother expressed extreme anxiety over Jack's mental illness and the effects of alcohol. She felt that Jack was unable to take care of himself and that she needed to monitor him daily. Jack's mother wanted to spend less time managing Jack's illness and more on herself and with her husband.

Jack resented what he perceived to be his mother's over-involvement in his life, which led to conflict between them. Despite these problems, they both enjoyed being together.

Jack's stepfather was supportive of his wife's concern for Jack, but he tended to be highly critical, which often inflamed difficult situations. He didn't understand schizophrenia, but was interested in learning more. He wanted Jack to live more independently so that he and his wife could travel more.

The family treatment began with weekly educational sessions. Jack talked openly about his symptoms and his stepfather began to see what the experience was like for Jack.

During the educational sessions on substance use, Jack gained a better understanding of how he used substances to escape from feelings of failure but how using them actually made things much worse.

Jack's mother contacted the local NAMI group and began to attend a group, which she found quite helpful.

In several months, the family was introduced to problem-solving exercises. They worked on several problems in succession over the next 8 months.

- First was getting Jack involved in activities and meeting potential friends. He enrolled in a course at a local community college within a few months. Social skills training with his integrated treatment specialist helped him to make a friend at the college, and he met several sober friends in a co-occurring disorders group.

- The second goal was to increase Jack's independence. After several discussions, Jack moved into supervised housing, and several months later he got his own apartment. Jack and his parents agreed on how much support the treatment team would provide and what role his mother would play in supporting his recovery process.
- The third issue was Jack's drinking, which the family chose not to address until Jack relapsed after a few months of sobriety. After several sessions, Jack's family began to accept Jack's need to learn to control his own behavior and Jack again became committed to reducing his drinking.

Jack's family members were involved in developing his treatment plan and learned how to encourage sobriety without reacting strongly to Jack's drinking.

Jack joined a co-occurring disorders treatment group, reduced his drinking dramatically, and began to actively work on his recovery. After 1 year, Jack's parents were extremely proud of the progress that he made and were able to understand brief setbacks as part of recovery. The family sessions ended.

Jack and his parents continued to regularly participate at the monthly multiple-family group meetings. Jack's parents appreciated the support from other families and continued to learn more about co-occurring disorders from other families. They were also helpful to other families who were feeling helpless about their relatives' drinking.

Jack now has found a couple of nondrinking friends and a part-time job. He has succeeded in dramatically decreasing his drinking; he currently drinks one or two beers on occasion and has long periods of abstinence. He has been abstinent from marijuana use since beginning the family sessions.

Jack's mental illness has been stable for almost 2 years, and he has not been hospitalized since the beginning of family work. His current goals are to find a better job and a girlfriend. Jack's parents have achieved their goal of having more time for themselves and have taken several vacations on their own.

Stages of treatment for families

The concept of stages of treatment can also be useful for working with families. At the beginning of treatment, during the engagement stage, integrated treatment specialists should reach out to families, provide them with practical assistance, and give them information about mental illnesses and substance use disorders to establish a working relationship. In the vignette, this does not appear to have happened with Jack's family. Instead the family initiated contact with Jack's treatment team.

As the family enters the persuasion stage, integrated treatment specialists should educate them about the effects of substances on the course of mental illness and about treatment. Education helps families become interested in supporting and encouraging their relatives to address the substance use. If needed, integrated treatment specialists can use motivational interviewing techniques to help family members recognize the impact of the substance use disorder. Families need to see substance use as a barrier to their relative's goals. In the vignette, the integrated treatment specialist helped the family focus on Jack's goals as well as their own.

When family members are committed to the same goals of reducing substance use, they enter the active treatment stage. You can use many different methods to help consumers learn to manage their illnesses and pursue goals, depending on their motivation to change, the circumstances of their substance use, and their family's communication and problem-solving skills. When consumers have reduced substance use, family work in the relapse prevention stage aims at minimizing vulnerability to relapses of substance use and expanding recovery to other areas of functioning. Jack's family was able to make progress in many different areas.

Family interventions

Family interventions for consumers with co-occurring disorders can include the following:

- Education;
- Family therapy;
- Family support groups; and
- Family organizations.

Education

The primary goal of education is to help families understand the nature of the mental illness and its interactions with substance use. Most families know little about mental illnesses and even less about substance use disorders. Though they want to help their relatives, they may not understand the recovery process or know how to nurture recovery. Helping families understand the situation from consumers' perspectives is a powerful way to enlist their support. Their new understanding helps them learn to work together on shared goals.

Education can be provided orally; with pamphlets, books, and videos; and in support groups with speakers. Education alone is helpful for many families, but by itself is not a treatment for consumers with co-occurring disorders.

Family education typically covers eight topics:

- Psychiatric diagnoses;
- Medications;
- Stress-Vulnerability Model;
- The role of the family;
- Basic facts about alcohol and drugs;
- Cues or triggers for and consequences of substance use;
- Treatment of co-occurring disorders; and
- Good communication.

Other topics of interest to families include the following:

- Dealing with cravings;
- Managing stress;
- Dealing with high-risk situations;
- Coping with depression;
- Finding self-help groups;
- Finding and improving relationships;
- Resolving conflicts;
- Participating in recreational and leisure activities;
- Working;
- Planning for the future;
- Learning new advances in medication treatment; and
- Managing money.

Family therapy

Family therapy involves the following:

- Outreach and engagement of the family;
- Education about mental illnesses and substance use disorders; and
- Training in problem-solving techniques for addressing the co-occurring disorders and their impact on the family.

An immediate goal of family therapy is to maintain family involvement and reduce the stress of substance use on them. Long-term goals are to decrease consumers' substance use and help everyone make progress toward personal and shared goals.

The focus of problem-solving training is to teach families how to address problems on their own. Family members are taught the following sequence for solving problems:

1. Define the problem to everyone's satisfaction.
2. Generate possible solutions.
3. Evaluate advantages and disadvantages of solutions.
4. Select the best solution.
5. Plan to implement the selected solution.
6. Meet at a later time to review progress.

When families are still in the persuasion stage, problem-solving is aimed at developing motivation to address substance use or reduce its effects on the family. Integrated treatment specialists look for ways to prompt family members to consider whether consumers' substance use interferes with achieving the goal.

Developing a discrepancy between substance use and a desired goal can help a family become motivated to address the substance use disorder. For example, consumers who want to work but do not view their alcohol use as a problem may experience problems on the job on the day after they drink. Family problem-solving that is focused on improving consumers' job performance or getting a better job may lead to a decision to reduce drinking on certain days or to stop drinking altogether.

When families are in the active treatment stage, problem-solving focuses directly on reducing substance use. This may include anticipating high-risk situations for continued abuse or relapse as well as developing skills and supports for getting needs met without using substances (for example, finding places to meet people who are not substance users).

In relapse prevention, the focus of problem-solving often shifts to other areas that further recovery, such as working, living independently, taking care of health, and developing close relationships.

Family support groups

Ongoing, multiple-family support groups can be useful for families. Groups may be led by integrated treatment specialists who bring in speakers or facilitate family participation. The meetings focus on providing ongoing education to families about co-occurring disorders, facilitating a free exchange that validates others' experiences, motivating families to address the co-occurring disorders, and sharing successful coping strategies.

Potential speakers include the following:

- A psychiatrist to talk about new medications;
- A representative from the Social Security Administration to discuss rules about benefits;
- An integrated treatment specialist to discuss various aspects of addiction; or
- A mental health consumer to discuss the concept of recovery.

Family organizations

Al-Anon is a self-help group for family members and other supporters of people who have substance use disorders. Families can get information, support, and skills for coping with their relative's substance use problems by attending Al-Anon.

The National Alliance on Mental Illness (NAMI) is a grassroots organization of consumers and their families. NAMI provides support and education to consumers and families and advocates for nondiscriminatory and equitable funding and policies for people with serious mental illnesses. The organization supports research into the causes, symptoms, and treatments of mental illnesses, and public education to eliminate stigma.

In many areas, state and local NAMI chapters sponsor monthly family support meetings to provide an opportunity for consumers and their families to learn from one another's experience. NAMI chapters also offer regular educational meetings.

Selecting family interventions

Families can participate in any of these options. Combining treatment and support groups can be especially helpful. When working with families to decide which intervention will be most helpful to them, assess the family members' areas of interest and motivation for being involved. Encourage families to get involved in at least one of the interventions because any interaction with family is better than none.

As with consumers, it is critical to treat families with dignity and respect. They have a wealth of knowledge and experience with consumers that is invaluable.

Exercise: **Explore Group Treatment**

Review the vignette, *Vicky's story*. What steps did Vicky and her integrated treatment specialist take to help Vicky consider group treatment? How was group treatment an effective way to help Vicky?

Exercise: **Role-Play: A First Family Meeting**

Select three members of your training group to play the roles of consumer, the consumer's mother, and the integrated treatment specialist. Practice how you would facilitate a first family meeting. Remember to provide some information about mental illnesses and substance use disorders. Explore consumer and family goals, initiate family involvement, and provide information on options of available family interventions.

