Integrated Services for Substance Use and Mental Health Problems

Overview and Sampler

Developed by faculty from the Dartmouth Medical School
Program Components

About the Authors

Excerpt from Clinical Administrator’s Guidebook

Table of Contents
Program Overview
Chapter 1: Introduction to the Clinical Administrator’s Guidebook
Chapter 2: Overview of Co-occurring Disorders
Chapter 3: Introduction to Dual Diagnosis Capability Program Assessment

Excerpt from Screening and Assessment

Table of Contents
Introduction
Chapter 1: Prevalence of Psychiatric Disorders in Addiction Treatment
Modified Mini Screen (MMS)
Mental Health Screening Form-III (MHSF-III)
CAGE Adapted to Include Drugs (CAGE-AID)
Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)
CD-ROM Read Me File

Excerpt from Integrating Combined Therapies

Table of Contents
How to Build a Patient Workbook
Chapter 1: Introduction to Integrating Combined Therapies
Chapter 2: Evidence-Based Practices for Substance Use Disorders
Chapter 3: Evidence-Based Practices for Substance Use Disorders Adapted for Persons with Co-occurring Psychiatric Disorders
Chapter 4: Stage-Wise Application of MET, CBT, and TSF
Portion of Module 2: Assessing Substance Use and Psychiatric Problems
Handout 2: Mental Health Problems and the Symptoms That Bother Me

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Excerpt from **Cognitive-Behavioral Therapy**

Table of Contents

Introduction

Chapter 1: Core Principles of Cognitive-Behavioral Therapy

Chapter 2: The Effectiveness of CBT for Co-occurring Substance Use and Psychiatric Disorders

Chapter 3: Translating CBT for Co-occurring Disorders into Routine Clinical Practice

Page from chapter 4: Relationship Factors: Therapeutic Alliance and the Therapeutic Frame

Page from chapter 6: Special Issues with CBT and Co-occurring Disorders

Module 4: Patient Education I: Primary Symptoms of Co-occurring Disorders

Handout 5: Goals: Positive Psychology

Excerpt from **Medication Management**

Table of Contents

Introduction to Part 1: Medication Management

Chapter 1: Rationale for Medication Treatment of Co-occurring Disorders

Chapter 2: Co-occurring Disorders and Stages of Change

Portion of Chapter 3: Differentiating Substance-Induced Disorders from Primary Mental Health Disorders

Excerpt from **Family Program**

Table of Contents

Introduction

Chapter 1: Working with Families

Orientation to the Family Psychoeducation Program

Session 1: Psychoeducation about the Psychiatric Disorder

Excerpt from **the Fact Sheets**

Co-occurring Disorders

Bipolar Disorder

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Integrated Services for Substance Use and Mental Health Problems

PROGRAM COMPONENTS

The Co-occurring Disorders Program is made up of a guidebook, five curricula, and a DVD. These components can stand alone, but when used together they provide a comprehensive, evidence-based program for the treatment of persons with co-occurring substance use and psychiatric disorders.

**Clinical Administrator’s Guidebook**
Includes a guidebook and a CD-ROM.

**Curriculum 1 Screening and Assessment**
Includes a three-ring binder, a clinician’s guide, and a CD-ROM.

**Curriculum 2 Integrating Combined Therapies**
Includes a three-ring binder, a clinician’s guide, and a CD-ROM.

**Curriculum 3 Cognitive-Behavioral Therapy**
Includes a three-ring binder, a clinician’s guide, and a CD-ROM.

**Curriculum 4 Medication Management**
Includes a three-ring binder and a CD-ROM.

**Curriculum 5 Family Program**
Includes a three-ring binder, a clinician’s guide, and a CD-ROM.

**A Guide for Living with Co-occurring Disorders: Help and Hope for Clients and Their Families**
Ninety-minute DVD.

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Mark McGovern
Mark McGovern, Ph.D., is an associate professor of Psychiatry and of Community and Family Medicine at Dartmouth Medical School. Dr. McGovern specializes in the treatment of co-occurring substance use and psychiatric disorders and has studied and is published widely in the area of addiction treatment services research. In July 2004, he received a career development award from the National Institute on Drug Abuse. The overarching goal of this award involves developing, testing, and transferring evidence-based treatments to community settings for persons with co-occurring substance use and psychiatric disorders. Dr. McGovern recently received a grant from the Robert Wood Johnson Foundation to form and foster a multistate collaborative among addiction and mental health systems and treatment providers who are striving to improve the chances of recovery for their patients with co-occurring disorders.

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Richard Hendrick
Richard Hendrick, M.Ed., is a television writer, producer, and director and an educator. He has created award-winning productions in the United States for PBS, Turner Broadcasting, and A&E, among others, as well as in Europe. The two series The Voyage of the Mimi and The Second Voyage of the Mimi, which he wrote, directed, and produced, are considered landmark innovations in children’s television. He taught for many years at Dartmouth College—including courses in developmental psychology, educational technology, and television and children—and has also lectured at Harvard Graduate School of Education, Columbia University, Bank Street College, and the University of Siena in Italy. In his production work he is committed to using media to teach, inform, inspire, and enlighten, as well as entertain.
Integrated Services for Substance Use
and Mental Health Problems

Clinical Administrator’s Guidebook

Mark McGovern, Ph.D.,
and other faculty from the Dartmouth Medical School

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## CONTENTS

Acknowledgments ........................................................................................................... ix
Program Overview ........................................................................................................... xi

CHAPTER 1
Introduction to the Clinical Administrator’s Guidebook ................................................. 1

CHAPTER 2
Overview of Co-occurring Disorders ............................................................................. 5

CHAPTER 3
Introduction to Dual Diagnosis Capability Program Assessment ................................... 17

CHAPTER 4
Policy: Evaluating Your Program Structure .................................................................... 23

CHAPTER 5
Policy: Evaluating Your Program Milieu .......................................................................... 35

CHAPTER 6
Clinical Practice: Evaluating Screening and Assessment Procedures ............................. 43

CHAPTER 7
Clinical Practice: Evaluating Treatment Approaches .................................................... 69

CHAPTER 8
Clinical Practice: Evaluating Continuity of Care ........................................................... 105

CHAPTER 9
Workforce: Evaluating Your Staff .................................................................................. 121

CHAPTER 10
Workforce: Evaluating Staff Training ............................................................................ 135

CHAPTER 11
Balancing Organizational Resources with Needs ............................................................ 141

CHAPTER 12
Program Assessment and Change Initiatives ................................................................. 147

CHAPTER 13
Continuous Quality Improvements and Process Improvement Strategies ....................... 153

Conclusion: Letter from the Authors .............................................................................. 161
Resources ......................................................................................................................... 163
Welcome to the **Co-occurring Disorders Program: Integrated Services for Substance Use and Mental Health Problems** developed by faculty from the Dartmouth Psychiatric Research Center, the Department of Psychiatry, and the Department of Community and Family Medicine, Dartmouth Medical School. This program focuses on integrated treatment of persons with concurrent substance use and non-severe mental health disorders, such as mood and anxiety disorders and less severe forms of bipolar disorder. This integrated treatment approach helps people recover by offering both mental health and substance use services at the same time and in one setting.

The Co-occurring Disorders Program is made up of five curricula and two additional components that utilize print, DVD, and Web resources to serve the needs of all the primary stakeholders who treat and are affected by co-occurring disorders. Supervisors, clinicians, and health service workers will find educational materials to guide them in screening, assessing, and treating patients with co-occurring disorders. Worksheets, handouts, and video information are included for patients and their families. The program format is flexible enough to offer a standardized yet customizable treatment experience designed to give patients the maximum knowledge, structure, and support needed to allow them to achieve abstinence from drugs and initiate a long-term program of mental health recovery. Family members, along with patients, are encouraged and guided in the Family Program curriculum, which includes handouts and worksheets for educational purposes, as well as an instructional DVD that offers family members what they need to participate in the recovery of their loved ones.

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**Note:** For the sake of convenience, the word “clinician” refers to any practitioner—counselors, supervisors, therapists, psychologists, facilitators, medical and mental health personnel, administrators, agency directors, and doctors—using these guides and curricula as part of the Co-occurring Disorders Program with patients and family members.
How Will the Co-occurring Disorders Program Help My Organization?

The goal of the Co-occurring Disorders Program is to help addiction treatment programs implement effective services for persons with non-severe co-occurring disorders. However, the program can be used to treat these patients in mental health settings as well. Most addiction treatment providers recognize that patients with non-severe co-occurring disorders are already under their care. The program offers information and tools that will help you develop program policy, practice, and workforce resources in order to deliver the best care possible (in any setting) to all patients with co-occurring disorders.

What Is Included in the Co-occurring Disorders Program?

The Co-occurring Disorders Program includes a guidebook, five curricula, and a DVD that offer everything needed to create an integrated treatment program using the most current, evidence-based tools available.

The components of the Co-occurring Disorders Program are

- **Clinical Administrator's Guidebook**
  This Clinical Administrator's Guidebook contains complete instructions for implementing the Co-occurring Disorders Program. The guidebook is for a mental health or addiction treatment organization’s director, board of directors, CEO, CFO, and other key agency leaders. This guidebook offers all the tools a clinical administrator needs to assess the seven key areas of organizational effectiveness, including the policy, practice, and workforce benchmarks needed to deliver the best possible services to persons with co-occurring disorders. The Clinical Administrator's Guidebook also contains a valuable organizational assessment guide, which outlines the steps needed to assess and improve services offered to patients with co-occurring disorders. Links to resources about co-occurring disorders, a sample charter agreement and Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index implementation plan, and other materials are included on the accompanying CD-ROM.

- **Curriculum 1 Screening and Assessment**
  Screening and Assessment is a must-use tool that helps clinicians evaluate patients with an effective, protocol-driven method so that appropriate treatment options can be addressed with regard to each patient’s symptoms, disorder, and motivation to change. Included are specific measures for screening,
assessment, differential diagnostics, and stage of motivation to address and treat both addiction and psychiatric problems in patients. Screening and Assessment comes with a bound clinician’s guide and a CD-ROM with reproducible patient handouts packaged in a three-ring binder.

**Curriculum 1 Integrating Combined Therapies**

Integrating Combined Therapies utilizes a combination of motivational enhancement therapy (MET), cognitive-behavioral therapy (CBT), and Twelve Step facilitation (TSF) therapy. Each of these therapy approaches has been proven successful when used in community addiction treatment programs. There is a growing consensus that these practices are effective if delivered singularly to patients, but are even more effective if rationally combined based on stage of motivation, problem pattern and severity, and patient preference. Each of these evidence-based practices is described here with appropriate modifications for persons with co-occurring disorders. At the time of this writing, these practices have not been adapted specifically for use in persons with co-occurring disorders, but readily lend themselves to this use with very simple augmentation. This curriculum will enable a clinician to successfully deliver these evidence-based therapies to patients with co-occurring disorders, which results in greater positive outcomes for patients. Integrating Combined Therapies comes with a bound clinician’s guide and a CD-ROM with reproducible patient handouts packaged in a three-ring binder.

**Curriculum 2 Cognitive-Behavioral Therapy**

Cognitive-Behavioral Therapy utilizes cognitive-behavioral therapy (CBT) principles to address the most common psychiatric problems in addiction settings: mood and anxiety disorders and bipolar disorder. CBT is an evidence-based practice for treating substance use disorders and most psychiatric disorders. Research shows that CBT is useful for treating non-severe co-occurring psychiatric disorders in an addiction treatment setting. Psychosocial treatments, particularly CBT, are equally, if not more, effective for the psychiatric disorders that most commonly occur with substance use disorders. Research with CBT for persons with co-occurring disorders has been highly specialized by the specific co-occurring disorder. Providers had no one manual or practice, until now, to implement in real-world settings where patients have a variety of these disorders. Drawing from multiple manuals is burdensome for practitioners.
Cognitive-Behavioral Therapy includes a bound clinician’s guide and a CD-ROM with reproducible patient handouts packaged in a three-ring binder.

Curriculum 4 Medication Management

Medication Management is a valuable resource for medical directors and clinicians. It contains vital, current information about the complex issues of medication management, including medication compliance and other psychological concerns of the patient. Issues of differential diagnosis, timing, indications, monitoring dosage, tolerance and withdrawal, and other issues are considered in this curriculum. Current evidence and consensus-based practices are provided to enable providers to make clinical decisions about medications and their prescription. While many people in peer recovery support groups take psychotropic medication, stigma can still cause some to hide their medication use from others. These issues, and information about the benefits and risks of medications, are also addressed for the patient. Medication Management comes with a CD-ROM and reproducible handouts packaged in a three-ring binder. It offers up-to-date, objective information for health care providers who prescribe medication or for clinicians who care for patients with co-occurring disorders who are using medications.

Curriculum 5 Family Program

This curriculum helps clinicians involve patients with co-occurring disorders and their family members in an integrated treatment approach. First, family members, including the patient, meet to learn about the patient’s specific psychiatric disorder and how it interacts with the substance use disorder. Then, the family joins other families in a twelve-week program of education on such topics as managing cravings, effective communication, using medications, and preventing relapses. The Family Program curriculum includes a clinician’s guide and a CD-ROM with reproducible patient handouts packaged in a three-ring binder. In addition, a 90-minute DVD, A Guide for Living with Co-occurring Disorders: Help and Hope for Clients and Their Families, provides hope and healing for patients with co-occurring disorders and their family members.

A Guide for Living with Co-occurring Disorders: Help and Hope for Clients and Their Families

This 90-minute DVD educates patients and families on the treatment of co-occurring disorders. It provides an educational overview of co-occurring disorders, shows interviews with people who have them, and discusses ways
that patients can participate in treatment to better manage their recovery from both disorders. Included are dramatic vignettes as well as professional narration to show a comprehensive look at all the issues of recovery. Clinicians can use this DVD when implementing all five curricula of the Co-occurring Disorders Program or as a stand-alone with the Family Program.

An additional service available is

Training
Implementation training developed by Hazelden with faculty of Dartmouth Psychiatric Research Center to help addiction treatment and mental health centers develop greater capacity, skills, and processes to treat non-severe mental health patients with substance use disorders is available. Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index assessment training is also available from the faculty of Dartmouth Psychiatric Research Center and designated consultants from across the United States to help addiction treatment and mental health centers develop greater capacity, skills, and processes to treat non-severe mental health patients with substance use disorders.

Who Are the Authors of the Co-occurring Disorders Program?
The Co-occurring Disorders Program was developed and authored by faculty (listed below) from the Dartmouth Psychiatric Research Center, the Department of Psychiatry, and the Community and Family Medicine Department, Dartmouth Medical School at Dartmouth College. These faculty members are leaders in the field of co-occurring disorders in research, clinical experience, and expertise in addressing the complex issues in treating substance use and mental health disorders. Read the “About the Authors” section on pages iii and iv for a comprehensive description of each author’s credentials and experience.

The Co-occurring Disorders Program authors are
• Mark McGovern, Ph.D., associate professor of Psychiatry and of Community and Family Medicine
• Robert E. Drake, M.D., Ph.D., professor of Psychiatry and of Community and Family Medicine
• Matthew R. Merrens, Ph.D., visiting professor of Psychiatry and codirector of the Dartmouth Evidence-Based Practices Center
• Kim T. Mueser, Ph.D., professor of Psychiatry and of Community and Family Medicine
• Mary F. Brunette, M.D., associate professor of Psychiatry
• Richard Hendrick, M.Ed., award-winning television writer, producer, and director, and an educator

**What Are the Goals of the Co-occurring Disorders Program?**

The Co-occurring Disorders Program is consistent with the goal of the Dartmouth Psychiatric Research Center: To improve the lives of individuals and families affected by co-occurring disorders by creating and promoting evidence-based practices that increase the chances for recovery.

The primary goal of the Co-occurring Disorders Program is to offer current information and proven tools to effectively treat non-severe co-occurring disorders. The program is taken directly from research and best practices in the field.

This program
• helps program directors assess and expand the capabilities of their current organization
• offers clinicians an easy-to-use treatment program with tools that offer clients and their families the services and support needed
• integrates the most current best practices and therapies in the field, such as motivational enhancement therapy, cognitive-behavioral therapy, and Twelve Step facilitation

**Is the Co-occurring Disorders Program Evidence-Based?**

The information provided in this *Clinical Administrator’s Guidebook* of the Co-occurring Disorders Program is based on findings, observations, and studies of more than two hundred addiction treatment programs using the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index. The DDCAT was developed as a benchmark measure to assess the capacity of an addiction treatment program. The benchmarks are based on expert consensus and evidence-based services for persons with co-occurring disorders. Drawing upon the numerous randomized controlled trials testing the Integrated Dual Disorder Treatment (IDDT) model, as well as the rapidly accumulating evidence base for practices with co-occurring substance use and non-severe disorders, the Co-occurring Disorders Program represents the state-of-the-science in treatment approaches for persons in addiction treatment settings. Since the evidence base for co-occurring disorders in addiction treatment exists on a continuum, each component of this series will describe the scientific status of the various treatment approaches, from investigative to promising.
to established practices. In some components—for example, the Family Program—careful adaptations of evidence-based approaches are made in order to be relevant for patients with non-severe psychiatric disorders in addiction treatment programs.

**Who Can Use the Co-occurring Disorders Program?**

The components of the Co-occurring Disorders Program are designed to be used by agency directors, administrators, supervisors, and clinicians. The program is designed for use with adult patients, as well as their family members, who are participating in a residential or outpatient treatment and/or mental health program for substance use and non-severe mental health disorders. These materials have been developed within the context of addiction treatment programs, but are equally useful when applied in a mental health program that would like to offer integrated treatment for co-occurring disorders.

Hard copies of handouts and worksheets for patients are available in each of the clinician’s guides. Reproducible copies of these handouts are also available on the CD-ROM included with each of the guides. The treatment curricula of the Co-occurring Disorders Program (curricula 2, 3, and 4) are suitable for individual or group therapy. Family members, friends, and other loved ones of patients are encouraged to participate in this program. Research shows that when family members are involved in the program, recovery for the patient is more effective.

**How Is the Co-occurring Disorders Program Different from Other Programs?**

The Co-occurring Disorders Program is specifically designed as an effective treatment program for patients with non-severe co-occurring disorders. The interventions in this program are evidence-based and primarily drawn from current research and practice in motivational interviewing, cognitive-behavioral therapy, and Twelve Step facilitation. This program is a comprehensive guide for clinicians, but also includes all the support tools necessary to implement an integrated treatment program to fulfill the needs of patients, family members, team members, and other stakeholders. In addition to four separate clinician’s guides, these support tools include this *Clinical Administrator’s Guidebook* (a program assessment guide), *Medication Management* for clinicians and medical directors, and *A Guide for Living with Co-occurring Disorders* (a 90-minute DVD for clinicians, patients, and family members).
Aside from Integrated Dual Disorder Treatment (IDDT), which is designed for persons with co-occurring disorders with severe mental illness (SMI), no other comprehensive manualized program exists for people with mental health disorders that co-occur with substance use disorders. The Co-occurring Disorders Program is based on the most current, comprehensive, evidence-based practices presently available.

**How Are the Tools in the Co-occurring Disorders Program Different from the Integrated Dual Disorder Treatment (IDDT) Program?**

The IDDT was developed and standardized for use primarily in mental health settings with persons with severe mental illness. The IDDT was not developed for and does not fit in most addiction treatment settings. The Co-occurring Disorders Program was created for use in addiction treatment settings for use with persons with non-severe psychiatric disorders who also suffer from any level (from low to severe) of substance use disorder. Non-severe mental health problems include depression and dysthmic disorders, anxiety disorders including post-traumatic stress disorder (PTSD) and social phobia, and bipolar disorders. For more severe mental illnesses, such as schizophrenia, schizoaffective disorder, severe major depression, and bipolar disorders, IDDT would be the model of choice. People using IDDT may choose to use the Co-occurring Disorders Program to expand their organization’s capabilities to offer integrated treatment for people with non-severe psychiatric disorders.

**Is the Co-occurring Disorders Program Compatible with Twelve Step Recovery?**

To be consistent with principles set forth in Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and other recovery fellowships, the clinician should advocate and support the idea that the patient’s best interest is for abstinence from all mood-altering substances, including alcohol, drugs, and any pharmaceuticals that the patient may be taking without a prescription. Patients are also encouraged to attend other peer recovery support groups, such as Dual Recovery Anonymous (DRA) or Double Trouble in Recovery (DTR). It is recommended that patients in this program purchase or be allowed to borrow copies of AA or NA publications.

**What Special Issues Might Arise When Dealing with Different Cultural Groups?**

The use of the Co-occurring Disorders Program interventions is not limited to certain races, ethnicities, or cultures. The educational information and inspirational
stories included in the clinician’s guides and in the program DVD depict and honor individual and cultural diversity.

This aspect of the Co-occurring Disorders Program makes it very appealing to people in many cultures. The delivery of information can be tailored to a particular population to make it as culturally specific as desired. The use of illustrations that depict diversity helps make the material more acceptable by a wide range of cultures and makes the information more easily understood by patients whose drug use and mental states have resulted in reduced cognitive abilities.

**Is Training Necessary to Implement the Co-occurring Disorders Program?**

Adherence and competence in implementation of the Co-occurring Disorders Program are associated with effective outcomes. It is recommended that you and/or your facility receive additional training and support from Hazelden Publishing and the Dartmouth Psychiatric Research Center to ensure quality implementation of the model. For information on training, customers may contact Hazelden Publishing at (800) 328-9000.

**How Can I Start Using the Co-occurring Disorders Program?**

Each of the components in the Co-occurring Disorders Program can stand alone, but when used together these components provide a comprehensive, evidence-based program for treatment of persons with co-occurring substance use and non-severe psychiatric disorders.

Distribute each component of the Co-occurring Disorders Program to the appropriate audience:

- **Clinical Administrator’s Guidebook**
  This guidebook is appropriate for the program or agency director, board of directors, CEO, CFO, and other key agency leaders.

- **Curriculum 1 Screening and Assessment**
  This curriculum is appropriate for therapists, counselors, or clinicians.

- **Curriculum 2 Integrating Combined Therapies**
  This curriculum is appropriate for therapists, counselors, or clinicians.

- **Curriculum 3 Cognitive-Behavioral Therapy**
  This curriculum is appropriate for therapists, counselors, or clinicians.
• **Curriculum 4 Medication Management**  
The primary audience for this curriculum is medical directors, but it is also appropriate for therapists, counselors, or clinicians.

• **Curriculum 5 Family Program**  
This curriculum is appropriate for therapists, counselors, or clinicians.

• **A Guide for Living with Co-occurring Disorders: Help and Hope for Clients and Their Families**  
This 90-minute DVD is appropriate for therapists, counselors, or clinicians who will use the video to educate patients and their families.

Those seeking to make programmatic change should use all the components that make up the Co-occurring Disorders Program. Your attempts to enhance your program’s services with these materials will be more successful if you form a program-steering committee, designate key individuals to implement and monitor the intended changes, and identify ways to sustain these changes. Some mechanisms to consider in sustaining organizational change include training, clinical supervision, and incorporating these changes into routine protocols (such as in your electronic medical record system).

Please follow the instructions provided at the beginning of each component. The sequence of the material is important to the creation of a treatment dynamic that moves the patient through a systematic recovery process.
The Clinical Administrator's Guidebook is the overall program guide to policy, practice, and the workforce skills necessary to deliver the best possible services to persons with co-occurring disorders. You may choose to use this guide to assess and make positive changes in seven key organizational areas that affect program policy, practice, and staffing.

What Is Included on the Clinical Administrator’s Guidebook CD-ROM?
This Clinical Administrator's Guidebook includes a CD-ROM that contains journal articles, abstracts, and references to the relevant research conducted with co-occurring disorders. These treatment materials have evolved from the application of concepts, described in theoretical and applied research efforts, to the needs of patients with co-occurring disorders who are attempting to recover from drug and alcohol problems and, at the same time, to address their mental health disorders.

The CD-ROM also includes information about the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index, a set of objective policy, practice, and workforce benchmarks to assess your program's capacity to serve persons with co-occurring disorders.

The DDCAT can be used to evaluate your current program by asking questions that fall into seven key dimensions.

► **Dimension 1: Program Structure**
  Do your overall program structure and policies help or inhibit providing services for individuals with co-occurring disorders?

► **Dimension 2: Program Milieu**
  What is the “culture” of your program? Are the staff and physical environment welcoming and receptive to individuals with co-occurring disorders?

► **Dimensions 3 and 4: Clinical Process**
  How do your clinical assessment and treatment procedures and protocols rate in relation to co-occurring disorder assessment and treatment?
Dimension 5: Continuity of Care
How does your program handle continuing care and monitoring for individuals with co-occurring disorders?

Dimension 6: Staffing
Do any staff members have expertise to assess and treat individuals with co-occurring disorders? What are the clinical supervision patterns of your program and hiring practices in regard to expertise in co-occurring disorders?

Dimension 7: Training
Are staff adequately trained and supported for the assessment and treatment of individuals with co-occurring disorders?

How Can I Use the DDCAT Index?
Whether your organization is an addiction treatment center or a mental health center, you may want to use the assessment tools found in chapters 4 to 10 of this Clinical Administrator's Guidebook to measure the ability of your existing program to offer integrated treatment services for co-occurring disorders. For addiction treatment centers, the DDCAT Index will allow you to objectively measure your program at baseline. As your co-occurring treatment program changes and evolves, use the DDCAT as a periodic assessment (yardstick) to evaluate your organization’s progress over time.

A companion, or sister, to the DDCAT, the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT), has been developed by Heather Gotham of the Mid-America Addiction Technology Transfer Center, Jessica Brown and Joseph Comaty of the Louisiana Department of Health and Human Services, and Mark McGovern. The DDCMHT can assess the DDCAT-related benchmarks in mental health settings. Information about the DDCMHT is available from the Dartmouth Psychiatric Research Center and the Mid-America Addiction Technology Transfer Center.

Links to the DDCAT and DDCMHT are on the CD-ROM that accompanies this guidebook.

What Does My DDCAT Score Mean?
The information in chapters 4 to 10 of this guidebook, along with the DDCAT Index or the DDCMHT, will help you categorize your addiction or mental health treatment program into one of four primary categories: addiction-only services (AOS), dual diagnosis capable (DDC), dual diagnosis enhanced (DDE), or mental health–only
services (MHOS). The first three categories are adopted from the *American Society of Addiction Medicine Patient Placement Criteria-2nd edition revised (ASAM PPC-2R)*, published in 2001. The category of MHOS is an adaptation of the DDCAT category (derived from the *ASAM PPC-2R*) of AOS. It is the comparable category for mental health settings as assessed using the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Index. For this guidebook, much as the category of AOS pertains to addiction treatment programs’ co-occurring capability, MHOS pertains to mental health programs’ co-occurring capability.

**Addiction-Only Services (AOS)**
These addiction treatment programs cannot accommodate patients with co-occurring mental health disorders that require ongoing treatment, no matter how stable or functional the patient.

**Mental Health-Only Services (MHOS)**
These psychiatric treatment programs cannot accommodate patients with co-occurring substance use disorders that require ongoing treatment, no matter how stable or functional the patient.

**Dual Diagnosis Capable (DDC)**
Addiction treatment programs at the DDC level have a primary focus on treating substance use disorders. These programs are also capable of treating patients who have relatively stable diagnostic or sub-diagnostic co-occurring mental health disorders related to an emotional, behavioral, or cognitive disorder.

Mental health treatment programs at the DDC level have a primary focus on treating psychiatric disorders. These programs are also capable of treating patients who have relatively stable diagnostic or sub-diagnostic co-occurring substance use disorders.

**Dual Diagnosis Enhanced (DDE)**
These addiction treatment programs are designed to treat patients who have unstable or disabling co-occurring mental health disorders in addition to a substance use disorder.

These mental health treatment programs are designed to treat patients who have unstable or disabling co-occurring substance use disorders in addition to a psychiatric disorder.

Programs at the DDE level are often indistinguishable as either an addiction or mental health treatment program.
Who Should Evaluate Your Treatment Program?
To avoid potential bias, it’s recommended that a person outside of your organization perform the DDCAT evaluation. Studies have consistently shown that self-assessments of program capacity, including using the DDCAT, yield inflated ratings of capability. There are numerous professionals who have been trained in the DDCAT methodology and who are available to perform assessments. Nonetheless, most persons who use the DDCAT have not been formally trained and still find it simple and straightforward to use. You can determine your own approach to doing a program DDCAT assessment and consider all the pros and cons for each possibility.

The DDCAT Index and associated scoring manuals, along with a list of professionals trained to perform the DDCAT evaluation, are available from the Dartmouth Web site at www.dms.dartmouth.edu/prc/dual/atrs.

Please see the CD-ROM included with this guidebook for more information about the DDCAT Index, including research and methodology, sample DDCAT profiles, and links to DDCAT workbooks and scoring tools.

How Do I Start Using the Clinical Administrator’s Guidebook?
Before you begin the program assessment work found in chapters 4 to 10 of this guidebook, please read the next chapter, “Overview of Co-occurring Disorders,” for a brief history of research findings and information on the evolution and effectiveness of treatment models.
Overview of Co-occurring Disorders

As in any discipline, sound training and experience are often keys to success. Before implementing the Co-occurring Disorders Program, please read this overview of co-occurring disorders. Included are important definitions, a history of the evolution of treatment, and information about key areas and agencies that affect funding and research.

What Are Co-occurring Disorders?
Some people suffer from a psychiatric or mental health disorder, such as depression, anxiety disorders, bipolar disorder, or other mood or adjustment disorders, along with substance use of alcohol or other drugs. Or, a person may have had a substance use disorder at one time in his or her life (e.g., alcohol use in college), but may currently suffer from only one disorder (e.g., major depression). This combination of health disorders is often referred to as a dual diagnosis, dual disorder, or co-occurring disorder. Co-occurring disorders are common in the general population and are even more prevalent among persons seeking treatment in medical, mental health, or addiction treatment settings.

What Is a Substance Use Disorder?
For the purpose of this text, the term “substance use disorders” refers to both substance abuse and substance dependence (as defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* [DSM-IV-TR] published by the American Psychiatric Association) and encompasses the use of both alcohol and other psychoactive substances. Though some see this term as ambiguous, it is used in this text because the lay public, politicians, and many substance use treatment professionals commonly use “substance abuse” to describe any excessive use of any addictive substance. In reality, most people with substance abuse–level disorders are not in addiction treatment. In fact, to be eligible for most addiction treatment settings, a substance dependence–level diagnosis is required.
How Many People Suffer from Co-occurring Disorders?

Researchers estimate that about half of the people treated in mental health settings have had at least one substance use problem in their lifetime, if not within the past year. Approximately 25 percent to 33 percent of the people treated in mental health settings also suffer from past-year or current substance use problems. In addiction treatment settings, these estimates are similar if not higher. As many as 50 percent to 75 percent of people in addiction treatment centers also suffer from a current psychiatric disorder, with an even higher percentage of people having suffered from a psychiatric disorder at some point in their lives.

What Is the Difference between Severe and Non-severe Mental Health Disorders?

Co-occurring substance use disorders occur in people with severe and non-severe mental health disorders. Severe disorders include schizophrenia, bipolar disorder, schizoaffective disorder, and major depressive disorders. Non-severe mental health disorders include mood disorders, anxiety disorders, adjustment disorders, and personality disorders. Of course, severity can vary substantially within any diagnostic condition. For example, depression can be mild, moderate, or severe. PTSD can likewise be well-managed or debilitating. Severity, therefore, is more complex than any specific disorder. However, for the purpose of organizing research, treatments, and policy, these gross categories have been found to be pragmatic and useful, even though they do not capture the inherent complexity and variability of the severity construct (McGovern et al., 2007; McGovern & McLellan, 2008).

Does Having a Co-occurring Disorder Affect Treatment Outcomes for Either Disorder?

Research shows that persons with co-occurring disorders (treated in either mental health or addiction treatment settings) have less favorable outcomes than persons who suffer from only addiction or only a psychiatric disorder. This means that if an alcoholic who is clinically depressed is admitted to an addiction treatment center, it's likely that he or she will receive less adequate treatment for depression than the non-addicted person who seeks depression treatment from a mental health provider. On the other side of the coin, if a depressed alcoholic and an ordinary alcoholic both enter an addiction treatment center, it's likely that the ordinary alcoholic will have a better chance at recovery from alcoholism than the depressed alcoholic.
Not all people with co-occurring disorders report poor treatment outcomes, but most experts agree that having a co-occurring disorder is best viewed as a “risk factor” that can lead to a negative treatment experience. Examples of poor outcomes that have been identified through research include dropping out of treatment early, frequent transfer of the patient between clinicians within treatment settings, recidivism and return to treatment, no decline in substance use, no improvement of psychiatric symptoms, suicide, victimization, increased use of medical services (including hospitals and emergency services), legal problems including incarceration, work and school problems, and less satisfaction with treatment. These negative treatment outcomes have not been lost on policymakers, researchers, treatment providers, or individuals and families who suffer with co-occurring disorders.

Why Is Research on Co-occurring Disorders Challenging?

Researchers have sought to increase our knowledge of the best possible treatments for co-occurring disorders. Because of the complexity and heterogeneity of this field, the research has been cumbersome and slow to progress. One research challenge is in simply defining the term “co-occurring disorder.” For example, a co-occurring disorder may be the co-existence of a diagnosis of schizophrenia and cannabis use, or a diagnosis of alcohol dependence and dysthymia. Further, a person may have had one disorder at one time in his or her life (e.g., alcohol use in college), but not presently, and may suffer at the moment from only one disorder (e.g., major depression). Since experimental rigor is an essential element to research, the need to more precisely define the differences and similarities among co-occurring disorder types has often made the translation of findings to clinical practice exceedingly difficult.

Over the past ten years, both the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) have increased research support for scientists seeking to develop and test treatments for persons with co-occurring disorders in addiction treatment settings. These institutes each have a different focus with respect to substances used by patients. (NIAAA focuses on alcohol use disorders; NIDA focuses on drug use disorders.) With the requirement for diagnostic precision in defining research samples, nationally sponsored research has been highly specific in focus. For example, NIDA has funded studies of cocaine-dependent women with PTSD, but these studies have excluded women with PTSD who also have Axis II personality disorders. The NIAAA has funded studies of alcohol-dependent persons with social phobia, but these studies have excluded persons with other substance use or psychiatric disorders. Precise diagnostic
combinations and strict inclusion criteria such as these may be important for research (i.e., studies have internal validity) but lack the ability to be extrapolated to real-world settings where patients tend to suffer from a complex mixture of mental health problems and addiction to various substances (i.e., studies need more external or ecological validity).

Pragmatic direction from the field of clinical research, both with respect to studies of medications and psychosocial therapies, have also been difficult for addiction treatment settings to come by. Further, research findings on persons without severe mental illnesses, but who suffer from depression, anxiety, or other “less severe” or disabling conditions have also been slow to accumulate.

Meanwhile, persons with non-severe mental health disorders along with substance use disorders still need professional help. They still need services. Addiction treatment providers and health care professionals struggle with old models of care. They try to provide the best possible treatment so that their patients may have at least an average chance (even though historical research suggests they have a less-than-average chance) at recovery.

### Why Is the Assessment and Diagnosis of Co-occurring Disorders Challenging?

Historically, health care professionals who have attempted to treat patients with co-occurring disorders have tried to declare one of the disorders as “primary” and the other as “secondary” based on the order of onset, or some judgment about causality. For instance, if childhood sexual trauma precipitated symptoms of post-traumatic stress disorder (PTSD) and if alcoholism appeared in adulthood, then the perception was that the PTSD must be the primary diagnosis. Patients were treated first for the primary disorder under the assumption that this treatment would naturally leverage change in the secondary disorder. Generally, with the exception of substance-induced disorders, no evidence for therapeutic efficacy exists for this “primary” or “secondary” approach to treatment.

To complicate diagnosis, a person may have co-occurring disorders even though the mental health disorder and the substance use disorder do not occur simultaneously. For example, a patient may have suffered from a childhood behavioral disorder such as oppositional defiant disorder and now may present with cocaine dependence. Unless this person meets the present criteria for another psychiatric disorder (Axis I or Axis II disorders), he or she may not be assessed as having co-occurring disorders.
Many patients suffer from both substance use and psychiatric disorders, which are chronic (versus transient or acute). Current research shows that a past or recent past diagnosis of a psychiatric or substance use disorder (in the presence of its counterpart) may be sufficient to warrant a co-occurring disorder diagnosis.

A patient may have co-occurring disorders, and yet he or she may not presently exhibit enough symptoms (at the traditional diagnostic threshold) to be diagnosed with both disorders. Using traditional assessments tools, this patient would likely be diagnosed with only one disorder and would not receive adequate treatment for both disorders. This example demonstrates that assessment and diagnosis are important skills for both addiction and mental health clinicians. Please refer to curriculum Screening and Assessment for instructions and tools to conduct patient assessments.

What Are the Different Types of Co-occurring Disorders?
The heterogeneity of persons with co-occurring disorders is vast. A man with schizophrenia and cannabis abuse has as much of a co-occurring disorder as a woman with alcohol dependence and social phobia. Yet the potential for differential stigma, access to treatment, lifetime course of the disorder, extent of disability, evidence-based treatments, and peer recovery support groups will be vastly different.

One way of describing this heterogeneity is the quadrant model (also known as the New York model) for dual disorders (see figure 1). This model was featured in SAMHSA’s Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders (published in 2002), and many find it to be of value in simplistically categorizing co-occurring disorder types. Evidence suggests that persons in quadrant III are more likely to present to addiction treatment programs since they suffer from dependence-level disorders. In contrast, persons from quadrant II will likely present to a mental health provider. Persons in quadrant I may not present for any formal addiction or mental health care but instead are more likely found in general health care settings. Persons in quadrant IV often present in crises to emergency rooms, psychiatric hospitals, and detoxification programs. Persons in quadrant IV have had challenges connecting to outpatient services in either addiction or mental health systems. Evidence-based strategies are still being developed for this segment of persons with co-occurring disorders.
The Co-occurring Disorders Program has been specifically developed for persons with non-severe mental health disorders who have any level (from low to high) of substance use disorder.

As figure 1 depicts, persons with co-occurring disorders may be categorized along two axes: psychiatric severity and substance use severity. A person with schizophrenia and cannabis abuse could arguably be placed in quadrant II. This person may be seen to suffer a problem with “high” psychiatric severity and relatively “low” substance severity. In contrast, a woman with social phobia and alcohol dependence could conceivably be placed in quadrant III because she may be seen to suffer from a less severe psychiatric disorder (social phobia versus schizophrenia) and a more severe substance use disorder (dependence versus abuse). Of course, many factors (disability, acuity) may also be associated with a diagnosis and severity. Therefore, many believe that this model is reductionistic and potentially obscuring of similarities and differences among persons with co-occurring disorders.
Meanwhile, professionals continue to use this model for its face validity and practicality. Recent research has validated the model for persons with co-occurring disorders in terms of prevalence and predicted treatment service utilization.

**What Are the Basic Approaches to Treating Persons with Co-occurring Disorders?**

Historically, the treatment of co-occurring disorders could be classified into four models, which are listed here in the order they have evolved. The first model (single model) offers the most basic approach to care, while the integrated model offers the most sophisticated.

The four models of care for co-occurring disorders are:

1. **Single model of care:** The “primary” disease and treatment approach
2. **Sequential model of care:** Treating one disorder at a time
3. **Parallel model of care:** Concurrent treatment of both disorders (i.e., both disorders are treated at the same time but in different places)
4. **Integrated model of care:** Treating both disorders (i.e., both disorders are treated at the same time and at the same place, or by the same provider)

Despite the widespread use of the first three models, current research shows that an integrated approach to co-occurring disorder treatment results in the best possible patient outcomes.

1. **Single Model of Care**

Historically, the general assumption among mental health providers was that if an underlying mental health disorder was addressed, such as depression or anxiety, the patient would no longer need to use alcohol or other drugs to cope. Treatment focused on the underlying mental health disorder, with the belief that substance use would “drop off” or return to normal once the underlying disorder was resolved. This approach has been ineffective for substance use disorders and mental health problems.

   This model of care is commonly termed the “self-medication” model. This model, at least from a mental health perspective, de-emphasizes the primary disease nature of addiction (substantiated in both human and animal studies), including all the biological and neurological changes associated with long-term substance use. The belief that addiction-related brain changes can be altered by addressing an underlying mental health condition alone is erroneous and without scientific foundation.
Conversely, addiction treatment professionals commonly witness profound if not miraculous changes in mood, anxiety, and self-esteem among patients who received only addiction treatment, including peer recovery group support. Addiction treatment providers often attribute treatment failure to those who drop out of services prematurely or who resist attending peer recovery support group meetings such as AA.

Patients who fare well under this treatment model are those who exhibit symptoms of a mental health disorder but do not have a “full-blown” disorder. For example, an alcoholic patient may suffer from symptoms of depression but not a depressive disorder. Recovery for this patient can be relatively straightforward, and the traditional “addiction-only services” approach for alcoholism is adequate. In contrast, an alcoholic who is clinically depressed may not experience relief from the symptoms of depression simply with abstinence from alcohol. This patient may require a more specific and targeted intervention for the equally severe co-occurring disorder of depression.

Although some patients will benefit from the primary disease and treatment approach, it is likely that those who have diagnosable disorders versus symptoms will require interventions directed at both conditions simultaneously.

2. Sequential Model of Care
The sequential treatment model suggests that a primary condition can only be dealt with once the underlying condition is treated so that it becomes less acute or at least less of an interference. For example, an addiction treatment professional may require a patient who is addicted to cocaine to be “stable psychiatically” before addiction treatment can begin. The definition of stable may range from being “not actively suicidal” to being “capable of tolerating twelve hours of group therapy per day.” Alternatively, in a mental health setting, a patient may be required to be “detoxed,” or at least not high or intoxicated in order to be included in group therapy or to be seen by a clinician.

Sequential care does not facilitate the simultaneous utilization of both mental health and addiction treatment services. It may or may not conceptualize one of the disorders as primary, but does acknowledge that services may be necessary for both eventually, but not at the same time.

The sequential model essentially requires the patient to “hold off” on receiving services for one disorder while another disorder is the current focus of treatment. This “holding off” period may range from one week (as in, for example, a stay in an alcohol detoxification service) to six months (in residential treatment) to two
years (as had been recommended for patients with PTSD who were in early recovery from substance use). In some cases, the sequential approach may be clinically reasonable (e.g., through withdrawal periods) and may help in confirming diagnostic impressions. Please refer to curriculum Screening and Assessment for instruction and tools to conduct patient assessments.

3. Parallel Model of Care

In this approach, specialty addiction treatment programs concurrently treat persons for addiction while they are in treatment at a mental health agency for a psychiatric disorder. This is known as parallel care or the concurrent model of care.

Parallel care happens in addiction treatment programs when addiction treatment services are provided while the patient is also being treated (pharmacologically or in individual psychotherapy) in a mental health setting for a psychiatric disorder. An addiction treatment program may recognize the need for mental health services—including, but not limited to, psychotropic medication—and may refer the patient for concurrent psychiatric evaluation and medication management. Likewise, a mental health professional may refer a psychiatric patient to an addiction treatment center for concurrent treatment for substance use.

Parallel services intend to provide care for both mental health and substance use disorders at the same time, but are typically offered in different settings and by different providers. Parallel care can be delivered in consultative, collaborative, or coordinated fashion (see the section entitled “How Do Treatment/Provider Relationships Vary within Models of Care?” beginning on page 14 for definitions of these terms). Parallel services often require the patient to navigate from provider to provider, or from program to program. Sometimes the communication between mental health and addiction providers is poor, and care is fragmented or duplicative or even conflictual. In other instances, parallel models are fairly well organized. Providers work in concert and as a team, even though they are from different programs in different locations. Services offered at the parallel level can approach integration if they are particularly well coordinated and the patient’s experience can be relatively seamless.

4. Integrated Model of Care

Integrated treatment may take place at the individual clinician level, the program level, the agency level, or the system of care level.

An integrated clinician is one with developed expertise in both mental health and addictive disorders. Such professionals may have advanced certification in their discipline or mastery in specific treatment approaches.
Integration at the program level happens when members of a treatment team address both mental health and substance use disorders within a single treatment location, episode, record, and experience.

Integration at the agency level may share some, but not all, of the characteristics of programmatic integration, but more navigation by the patient and between clinicians is required. In this instance, an agency may provide both addiction and mental health services but in separate programs or departments. The patient may be asked to meet with two sets of providers, who may vary in clear lines of communication about the treatment plan or the patient’s response to treatment.

Integration may also exist at the system level, such as within a geographical region, where clear guidelines and linkages are seamless and formalized. In this instance, two separate agencies may have a well-developed protocol for simultaneously managing patient care. Agencies may share as many as 25 percent of the same patients and have worked out ways to develop a common treatment plan and to monitor patient progress.

Integration requires the active collaboration of both addiction and mental health services providers in the development of a single treatment plan to address both disorders. It also requires the continuing formal interaction and cooperation of these providers in the ongoing reassessment and treatment of the client.

How Do Treatment/Provider Relationships Vary within Models of Care?
Models of care may vary by the nature and type of relationship that exists between the addiction and mental health services professionals.

The following terms are used to describe these relationships:
1. Minimal coordination
2. Consultation
3. Collaboration
4. Integration

These terms represent the nature and quality of the relational contact and coordination between service providers. They do not refer to the program structure or location. “Minimal coordination” is the lowest benchmark while “integration” is the highest.

1. Minimal Coordination
A program could be functioning at the level of minimal coordination even though mental health and addiction treatment services are being provided by two people...
working at the same agency in the same building; whereas, another program
could be at the integration level even if services are provided by two people
working for different agencies in different programs. In other words, “co-location”
guarantees nothing. The relationship may be integrated or minimal regardless of
shared space.

Programs at the level of minimal coordination may acknowledge a co-occurring
condition; however, there is no effort made to handle the condition. On the rare
occasion that a referral is made, the follow-up is typically inadequate.

2. Consultation
Programs at the level of consultation may have informal and limited interactions
with outside service providers. This may involve transferring medical/dinical
information or giving updates on a patient’s progress. The key to this level is that
the program attempts to maintain a connection after the initial referral to ensure
the referred person enters the recommended treatment service.

3. Collaboration
Programs at the level of collaboration formally and systematically involve multiple
service providers in the sharing of responsibility for treating a person with
coocurring disorders. This includes regular and planned communication, sharing
of progress reports, or memoranda of agreement. The key to this level is that all
parties involved are aware of their responsibilities and expectations.

4. Integration
Programs at the level of integration involve members of a treatment team working
together to cover both mental health and substance use disorders within a single
treatment location, episode, record, and experience. Parallel models can approach
integration contingent upon the degree of coordination. Some sequential models
can also approach integration if the process of linkage is seamless from the clinical
and patient perspective. This manual will describe how services can be delivered
to support integration, even in parallel or sequential frameworks.

How Is the Treatment of Co-occurring Disorders Improving?
Historically, health care organizations have often failed to approach and treat
psychiatric disorders and addiction as concurrent disorders requiring concurrent
treatment. In fact, about 50 percent of persons with co-occurring disorders never
receive concurrent treatment for both disorders. In cases where concurrent treat-
ment is offered, 75 percent to 85 percent of the time those services are not offered
in an integrated manner. This probably leaves less than 15 percent of persons with co-occurring disorders receiving adequate treatment.

Over the past twenty years, increasing efforts have been underway to make positive changes in systems of care. These changes include how, what, and where treatment is delivered, as well as how these services are paid for by third parties such as Medicaid, Medicare, federal block grants, and private insurance companies. Parallel efforts have been occurring even more recently to address workforce issues. In the meantime, current research demonstrates that integrated treatment, which treats both disorders concurrently, offers the best possible outcomes for patients and patients’ families. The Co-occurring Disorders Program offers a guidebook, five curricula, and a DVD that create a comprehensive program of evidence-based, integrated treatment for co-occurring disorders.
Introduction to Dual Diagnosis Capability Program Assessment

Chapters 4 through 10 of this *Clinical Administrator’s Guidebook* cover the policy, clinical practice, and workforce resources that organizations must evaluate when assessing their capability to serve persons with co-occurring disorders. This guidebook includes all the tools needed to evaluate, improve, and track your organization’s capabilities.

As with the DDCAT treatment program assessment tool, the chapters in the *Clinical Administrator’s Guidebook* are organized by seven dimensions that fall under one of three categories: policy, clinical practice, and workforce.

<table>
<thead>
<tr>
<th>POLICY</th>
<th>CLINICAL PRACTICE</th>
<th>WORKFORCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Program milieu</td>
<td>4. Treatment</td>
<td>7. Training</td>
</tr>
<tr>
<td></td>
<td>5. Continuity of care</td>
<td></td>
</tr>
</tbody>
</table>

Chapters 4 through 10 offer specific instruction on how to evaluate your organization within each of the seven organizational dimensions and offer examples of why each dimension is important.

Before you proceed into the detailed analysis beginning in chapter 4, read this brief overview of the seven dimensions. This overview identifies the key people who affect each dimension. It also lists the key questions that staff should ask themselves to evaluate their organization’s capabilities within each dimension.
POLICY

1. Program Structure

Who Are the Key People Who Establish a Program’s Policy?
Key people include an agency director, board of directors, key agency administrative and clinical leadership, the CEO, the CFO, and sometimes—through a consumer advisory board or committee—former patients and patients’ families.

What Are the Key Questions for Your Organization?
- What kind of agency do we have?
- What is our mission statement and what is involved in changing it?
- What are our present financial and licensing arrangements for mental health services, or for persons with mental health diagnoses?
- What kind of relationship do we have with the local mental health service providers who we refer patients to most frequently?

2. Program Milieu

Who Are the Key People Who Create the Physical or Social Environment in Which Treatment Occurs?
Key people include an agency director, board of directors, key agency administrative and clinical leadership, the CEO, the CFO, and patients and patients’ families.

What Are the Key Questions for Your Organization?
- What kind of social and physical environment do we have?
- What does our environment, including the decor, posters, artwork, and brochures, say about our receptivity to persons with psychiatric problems?
- Is there a stigma to having a psychiatric problem?
- Do we welcome everyone?
- Are there patient and family education materials about co-occurring disorders that are available in the waiting areas and on the walls, or incorporated into group or individual sessions?
CLINICAL PRACTICE

3. Assessment

Who Are the Key People Who Affect Patient Assessment?
Key people include agency administrative and clinical leadership, clinical supervisors, and clinicians.

What Are the Key Questions for Your Organization?
- What is our current protocol to screen, assess, and diagnose psychiatric disorders?
- How do we make distinctions between symptoms, substance-induced disorders, or actual psychiatric disorders that may need treatment?
- Is our assessment protocol systematic or does it vary, depending on the particular clinician who performs the assessment?
- Do we have exclusion criteria based on psychiatric issues?
- Who reviews and enforces these criteria and what are his or her qualifications?
- Do we think about, talk about, or document patient motivation and preferences for treatments during our initial encounter?

4. Treatment

Who Are the Key People Who Affect Patient Treatment?
Key people include agency administrative and clinical leadership, clinical supervisors, and clinicians.

What Are the Key Questions for Your Organization?
- What do we do about our patients’ psychiatric problems?
- What kind of access to medications do our patients have?
- Do we have therapy groups, educational sessions, or family sessions that discuss psychiatric issues?
- Do we consider the special challenges a person with co-occurring disorders may face when attending community peer recovery support group meetings?
- Do we think about, talk about, or document patient motivation and preferences for treatments and adapt what we offer them based on these considerations?
5. Continuity of Care

Who Are the Key People Who Affect Continuity of Care?
Key people include agency administrative and clinical leadership and clinicians.

What Are the Key Questions for Your Organization?

- What happens if a patient under our care is suicidal, homicidal, unable to care for herself or himself, unable to sit for a full day in our group program, unable to get out of bed, unable to talk in groups, and/or unable to stop thinking about troubling memories?
- Does our treatment with a patient have an endpoint?
- Do we encourage patients who have successful recovery to come back and share their stories with current patients?
- When we discharge or transfer patients do we consider psychiatric needs?

WORKFORCE

6. Staffing

Who Are the Key People Who Have Direct Contact with Patients?
Key people include agency administrative and clinical leadership, administrative support staff, clinical supervisors, clinicians, and peer recovery support persons. Also, personnel such as residential aides or other paraprofessionals may play an influential role.

What Are the Key Questions for Your Organization?

- Do our patients have ready access to medications that are evidence-based (i.e., FDA-approved) for psychiatric problems?
- What role does the person who prescribes this medicine play in our program?
- Do we have staff members who are capable and supported in assessing and offering treatment to persons with co-occurring psychiatric problems?
- What mechanisms do we have to supervise and review care for persons with psychiatric problems?
- How open are we to persons in recovery from co-occurring disorders being a part of our service delivery team?
7. Training

Who Are the Key People Who Have Patient Contact and How Are They Trained?
Key people include agency administrative and clinical leadership, administrative support staff, clinical supervisors, clinicians, and peer recovery support persons. Also, personnel such as residential aides or other paraprofessionals may play an influential role.

What Are the Key Questions for Your Organization?

- Are all agency personnel, patients, and families accepting and open about psychiatric problems?
- Do the majority of our clinical staff know which psychiatric disorders are most likely present in persons under their care, how to identify them, and what to do about them?
- How many clinical staff members are competent in delivering an evidence-based treatment to persons with co-occurring disorders?
- Do we keep track of the money and time we spend on training, and do we dedicate a portion of training to co-occurring disorders?

In chapters 4 to 13 of this Clinical Administrator’s Guidebook, you will find specific recommendations and practical tools to address each of the seven organizational dimensions that organizations must consider when developing or improving services for persons with co-occurring disorders.

Keep in mind the role of all key people who may be interested in or charged with implementing these best practices. Change can be challenging and takes time, but with strong leadership, patience, and a team united toward the same goal, you can be very successful in creating or expanding your organization’s capabilities to offer integrated treatment for people with co-occurring disorders.
# CONTENTS

Acknowledgments ......................................................................................... ix
Introduction ........................................................................................................ 1

CHAPTER 1
Prevalence of Psychiatric Disorders in Addiction Treatment ...................... 7

CHAPTER 2
Complexities of Assessment ......................................................................... 17

CHAPTER 3
The Initial Clinical Process .......................................................................... 25

CHAPTER 4
The Screening Process .................................................................................. 31

CHAPTER 5
The Assessment and Diagnostic Process .................................................... 45

CHAPTER 6
Assessing Motivation ................................................................................... 51

CHAPTER 7
Developing a Recovery Plan ........................................................................ 59

CHAPTER 8
Shared Decision Making .............................................................................. 65

CHAPTER 9
Using Screening Measures to Monitor Symptom Change and
Guide Shared Decision Making .................................................................. 71

CHAPTER 10
Continuous Quality Improvement and Process Improvement Strategies .... 75

CHAPTER 11
Conclusions .................................................................................................. 81

References ...................................................................................................... 83

Contact Information for Screening and Assessment Materials ................. 87
What Is This Guide About?

The order of components in the Co-occurring Disorders Program corresponds to the sequence of events in a clinician’s relationship with a patient: (1) screening and assessment; (2) negotiating a treatment plan; (3) delivering and monitoring a treatment and assessing patient response; and (4) connecting the patient to supports—naturally occurring, professional, and peer support—that will augment the recovery process. Without the first step, it will be virtually impossible for a patient (or provider) to progress through the subsequent stages. Co-occurring disorders must be seen and identified. This guide, Screening and Assessment, is intended to assist the frontline clinician in detecting, identifying, classifying, and monitoring changes in co-occurring substance use and psychiatric disorders. Being able to do this is the essential first step in the treatment process.

For the sake of convenience, the word “clinician” refers to any practitioner—counselors, supervisors, therapists, psychologists, facilitators, medical and mental health personnel, administrators, agency directors, and doctors—using these guides and curricula as part of the Co-occurring Disorders Program with patients and family members.

If My Primary Focus Is on Addictive Disorders, How Does This Guide Fit with My Work?

Historically, in addiction treatment settings, psychiatric “symptoms” were considered to be secondary to substance use. These symptoms were believed to be primarily associated with the effects of substances. From depression to anxiety to hallucinations, most symptoms were understood to be a result of intoxication, withdrawal, or cravings. Treatment, therefore, was directly focused on supporting patients through the period of intoxication and withdrawal by keeping them medically and socially safe. The initiation of abstinence officially started once the more acute symptoms of withdrawal had passed. During this phase, treatment planning and some actual treatment began. Psychiatric symptoms were still understood within the context of “Life on life’s terms,” and the patient’s sometimes overwhelming
experiences of emotion were seen as normal processes consistent with being newly sober.

Patients in traditional Twelve Step programs learned that some of these problems, particularly those that were long-standing, might be associated with character defects. These character defects would be the subject of analysis in Step Four of the Twelve Steps, and processing with a trusted other in Step Five. Continuing work on these defects would take place in Steps Six and Seven. Many of these issues were believed to be related to the core disease of alcoholism or addiction, and by working a solid and continuing program of recovery, the rough edges of these issues would be sanded down. Or at least they would become less central in the recovering patient’s day-to-day life and relationships.

Indeed, many patients with co-occurring disorders probably benefit from and make great strides with this approach. Patients with mild depression, perhaps in the absence of the effects of alcohol, gain a more positive outlook and self-esteem, and become less isolating by using cognitive strategies (practicing acceptance, decreasing unrealistic self-blame and guilt) and positive coping skills (asking for help, spirituality). Patients with social phobia, perhaps in the absence of the effects of benzodiazepines, make dramatic gains in social avoidance and terror about public speaking, meeting new people, or being assertive by gradually developing trust, decreasing negative expectations, and becoming more comfortable in group situations. On the other hand, research has shown that not everyone benefits from traditional treatments. Many drop out early; many do not respond even after multiple treatment episodes or several cycles in and out of peer support groups. Some deteriorate and die, or become incarcerated or institutionalized (McLellan et al. 2000). Most commonly, patients with these disorders never even get treatment or exposure to peer support groups (Grant et al. 2004).

With this evidence in mind, it is now widely accepted that patients with co-occurring disorders may have a less-than-average chance of benefiting from traditional treatments. There is little evidence that addressing the substance use problem by itself will directly and positively affect the mental health problem, especially if the problem is of at least moderate severity and persistence and meets criteria for a psychiatric disorder.

Being able to accurately identify who has a co-occurring disorder, and the severity and type, is certainly the first step in understanding a patient at risk for being a nonresponder to treatment, and perhaps at risk for premature departure (i.e., dropout) and relapse. Once patients with these disorders have been identified,
a treatment plan to address their problems can be developed, which will increase
the chances for treatment completion, positive benefit, and a successful recovery.

If My Primary Focus Is on Psychiatric Disorders,
How Does This Guide Fit with My Work?

For several reasons, most patient substance use problems are not detected in
mental health settings. Professionals may not be adequately trained; patients them-
selves may believe that substance use is not the purview or business of mental
health practitioners; and few practices may be in place to screen, assess, or diagnose
substance-related conditions. Mental health providers have historically assumed
that patients with alcohol or drug problems will seek treatment at specialized
treatment programs, staffed by specialized treatment providers. In fact, most
patients with substance use disorders will never seek or get treatment. Most of
those who do will present in primary care and mental health settings rather than
specialized addiction treatment programs. Mental health providers have been
able to identify the more obvious cases of substance-related problems, such as when
a patient presents for appointments in obvious intoxicated states. Detection is also
possible when the patient chooses to reveal substance use as a chief complaint. In
studies of detection of substance-related problems in mental health settings, the
findings reveal that only 5 percent to 10 percent of persons with substance use
problems, co-morbid with mental health problems, are correctly identified (Harris
and Edlund 2005). Interestingly, substance-related disorders are much less likely to
be detected or diagnosed to the degree to which patients are female, white, profes-
sional, and insured.

Patients in mental health settings with undiagnosed substance-related problems
have been found to have less favorable outcomes than patients with mental health
problems only (Drake, O’Neal, and Wallach 2008). Their psychiatric symptoms and
substance use are not treated, and patients more often drop out of treatment or miss
appointments. One study (Margules and Zweben 1998) even found that patients
with substance use and co-occurring disorders on mental health providers’ case-
loads were more likely to be transferred to other practitioners within the clinic.
In addition, therapists or doctors were more likely to cancel their appointments.
Ironically, these results applied to cases with undetected substance use problems!

Even when substance-related problems were detected, many mental health
providers conceptualized these problems as “symptoms” of underlying conditions.
This treatment approach targeted the primary problem, such as depression, inter-
personal problems, low self-esteem, or anxiety, and assumed substance use as a
maladaptive coping or “self-medication” strategy. Even today, this approach to co-morbid disorders likely persists among mental health providers as the most common technique or model in routine practice settings. A recent review of medication studies of co-occurring depression and substance use disorders found that antidepressant medications had no effect on either substance use or depression if taken in isolation (i.e., without integrated or concurrent treatment focused on the substance use disorder) (Nunes and Levin 2004).

There is no evidence that addressing the mental health problem by itself will directly and positively affect the substance use problem, if the substance use problem is at the level of substance-related disorder.

**Are the Primary Addiction and Primary Mental Health Approaches Still the Most Common?**

As outlined in the *Clinical Administrator’s Guidebook*, researchers in mental health and addiction treatment services continue to find that the prevailing approach to psychiatric problems in addiction treatment settings is “addiction-only services,” and the approach to substance-related problems in mental health settings is “mental-health-only services.” Although the number of providers and practitioners offering dual diagnosis capable (DDC) or integrated services is growing, the majority (60 percent to 70 percent) of mental health and addiction providers still have primarily single disease approaches (McGovern, Matzkin, and Giard 2007).

By using the tools provided in this guide, practitioners will take the first step toward improving services for their patients with co-occurring disorders. This step, as with other steps in processes of change, may be the hardest one to initiate. But, once taken, this first step, screening and assessment, will turn out to be the most important and transformational in enhancing co-occurring treatment services.

**How Can I Use This Guide Successfully?**

*Screening and Assessment* is intended to be a practical clinical guide to screening and assessment of mental health problems in the context of substance use disorders. Since we will also address the presence of substance use problems co-existing with psychiatric disorders, the guide may also be useful in mental health settings.

This guide addresses the complexities involved in distinguishing between psychiatric disorders and substance-induced disorders. Clinical skill is necessary to apply this information to patient care. We advise clinical supervision, specifically by an appropriately trained, certified, licensed, and/or competent professional.
Screening measures for the most common psychiatric disorders are provided on pages 5–19 of the three-ring binder as reproducible hard copies that can be duplicated using a copy machine and on the accompanying CD-ROM as PDFs that can be printed using a computer. These materials are in the public domain and ready for immediate implementation.

Following the discussion of screening measures, we describe the framework for a good clinical assessment for co-occurring disorders. Although standardized assessment tools exist, they are not included in this guide, as several of the best validated ones are proprietary. If the program or practitioner decides to utilize proprietary measures, information is included on how to order them. We do provide our own clinical assessment forms for various psychiatric disorders on pages 23–35 of the three-ring binder and on the CD-ROM.

We present information about the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* differential diagnoses of substance-induced versus independent psychiatric disorders. This review should also help the clinician distinguish between substance use and psychiatric disorders and begin to plan treatment accordingly.

Treatment planning, especially planning that incorporates patient motivation and treatment preferences, is a key theme of this guide. An index for assessing a patient’s motivation to address co-occurring problems and treatments, the Stage of Motivation and Treatment Readiness for Co-occurring Disorders (SOMTR-COD), is included on page 41 of the three-ring binder and on the CD-ROM. It can be immediately implemented in practice settings. This form will help guide conversations with patients on how they want to focus their change efforts. Obviously, the clinician may have other ideas about these efforts and choose to negotiate treatment, suggest more careful monitoring, and begin to deliver motivational enhancement therapy for co-occurring disorders (see *Integrating Combined Therapies*).

After a treatment plan has been negotiated, the clinician can record it on the Comprehensive Recovery Plan template, included on page 43 of the three-ring binder and on the CD-ROM. This form can be used as a document of understanding between the patient and the clinician regarding the path for working together to achieve treatment goals.

In aggregate, quality assurance or process improvements at the program or clinic level can address recurrent treatment problems. Concrete suggestions on how to collect and study these data are also provided.
We hope these materials help you to more accurately and reliably identify the types of problems from which your patients suffer. Identifying and discussing these issues with your patients is likely to improve their chances for successful recovery and eventually improve outcomes.
Prudence suggests that people should plan for high-probability events. An 80 percent chance of rain may warrant grabbing an umbrella upon leaving for work. On the other hand, when you buy a ticket for a $20 million lottery, you usually do not make preparations for winning because there is such a remote chance that will happen.

A higher prevalence or occurrence of certain psychiatric problems in addiction treatment settings may suggest that clinicians develop a plan for response. Higher rates of one disorder versus another may help you to decide the kind of treatments you want to offer, the materials you want to obtain for patient and family education, or even the way you want to organize relationships with other treatment providers. Prevalence rates should certainly suggest the likelihood of the presentation of disorders, and perhaps the thoroughness with which you might try to identify and/or assess these problems.

In contrast, disorders that are less common or even rare in the population may not require as much attention in your treatments, community provider relationships, or screening and assessment.

Deciding what disorders to focus on can be determined by the rates these disorders occur at your center or clinic.

**Population-based Studies**

Epidemiological, or population-based, studies are normally based on interviews. Essentially, a representative sample is selected, and trained personnel conduct structured diagnostic interviews in community settings. Persons must agree to these interviews, and they are compensated for their participation.

Regier and colleagues published the best-known study addressing the issue of co-occurring disorders in 1990 (see figure 1 on the next page). Among a sample
of close to 10,000 adults across the United States, of those with alcohol use disorders, about one-third (36 percent) had a psychiatric disorder. And of those with a drug use disorder, over half (53.1 percent) had a psychiatric disorder. The odds of having a psychiatric disorder, if the person had an alcohol use disorder or drug use disorder, escalated two- and fourfold, respectively. In other words, if you have a patient with an alcohol use disorder, it is a good bet that the patient will also have a psychiatric disorder; and if you have a patient with a drug use disorder, there is an even greater chance.

**FIGURE 1**

**Co-morbidity of Substance Use and Psychiatric Disorders**

Among a sample of about 10,000 adults:
- 13.5% had an alcohol use disorder. Of those, 36.6% also had a psychiatric disorder.
- 6.1% had a drug use disorder. Of those, 53.1% also had a psychiatric disorder.
- 22.5% had a psychiatric disorder. Of those, 28.9% also had an alcohol or drug use disorder.

<table>
<thead>
<tr>
<th></th>
<th>%</th>
<th>ODDS RATIO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Use</td>
<td>13.5</td>
<td></td>
</tr>
<tr>
<td>Psychiatric Disorder</td>
<td>36.6</td>
<td>2.3</td>
</tr>
<tr>
<td>Drug Use</td>
<td>6.1</td>
<td></td>
</tr>
<tr>
<td>Psychiatric Disorder</td>
<td>53.1</td>
<td>4.5</td>
</tr>
<tr>
<td>Psychiatric Disorder</td>
<td>22.5</td>
<td></td>
</tr>
<tr>
<td>Alcohol or Drug Disorder</td>
<td>28.9</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Source: Regier et al. 1990

These investigators also examined the rates of substance use disorders among those with specific psychiatric disorders. Of those with a psychiatric disorder, 25 percent to 33 percent also had a substance use disorder (alcohol or drug). Figure 2 displays the lifetime rates of these co-occurring disorders. The table shows that for patients with bipolar disorders and schizophrenia, substance use disorders are of considerable prevalence. Patients with other mood disorders (depression, dysthymia) and anxiety disorders (phobias, obsessive compulsive disorder, panic disorder) are also at great risk.
Several population-based studies have focused on the prevalence of co-occurring substance use disorders, and there is remarkable convergence in findings, even though the methods for these studies varied (Clark et al. 2008).

**FIGURE 2**  
**Lifetime Prevalence of Substance Use Disorders for Psychiatric Disorders**

<table>
<thead>
<tr>
<th>PSYCHIATRIC DISORDER</th>
<th>% ANY SUBSTANCE ABUSE/DEPENDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Population</td>
<td>16.7</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>47.0</td>
</tr>
<tr>
<td>Any Affective Disorder</td>
<td>32.0</td>
</tr>
<tr>
<td>Any Bipolar Disorder</td>
<td>56.1</td>
</tr>
<tr>
<td>Major Depression</td>
<td>27.2</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>31.4</td>
</tr>
<tr>
<td>Any Anxiety Disorder</td>
<td>23.7</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>32.8</td>
</tr>
<tr>
<td>Phobia</td>
<td>22.9</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>35.8</td>
</tr>
</tbody>
</table>

Source: Regier et al. 1990

One of the more recent studies (Grant et al. 2004) had substantially improved methods, and, in particular, was careful to distinguish between substance-induced disorders and independent psychiatric disorders. This study also focused on the most common disorders in the population: mood, substance use, and anxiety disorders. These disorders, taken together, probably affect as many as sixty million persons in the United States alone.

Art to come.
As figure 3 shows, the overlap in disorders is consistent with the studies by Regier and colleagues. About one in five persons with a substance use disorder had either an anxiety disorder or a mood disorder. Persons with drug use disorders were more likely than those with alcohol use disorders to have a psychiatric problem. Persons with mood disorders were slightly more likely than those with anxiety disorders to have a co-occurring substance use disorder.

Prevalence of Psychiatric Disorders among Patients in Treatment

Much like any medical condition, there is probably a difference between people who have a problem and do not seek treatment and those who do seek treatment. Among other factors, one may assume that those who seek treatment are suffering greater degrees of severity or impairment. Of course, it may also be the case that any individual with a disease may not seek care because of geographic, financial, cultural, informational, or other matters of access.

Nevertheless, when the Grant study examined the rates of co-occurring disorders among those seeking treatment (versus those who did not), the degree of overlap skyrocketed, particularly among those with substance use disorders (see figure 4). This does suggest that among patients seeking treatment, co-occurring disorders are found two or three times the rate expected in the general population.

---

### FIGURE 3

**Twelve-Month Prevalence of Index Substance Use and Co-occurring Mood and Anxiety Disorders**

<table>
<thead>
<tr>
<th>INDEX DIAGNOSIS</th>
<th>% CO-MORBID MOOD</th>
<th>% CO-MORBID ANXIETY</th>
<th>% CO-MORBID SUBSTANCE USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Substance Use Disorder</td>
<td>19.67</td>
<td>17.71</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>18.85</td>
<td>17.05</td>
<td></td>
</tr>
<tr>
<td>Drug</td>
<td>31.80</td>
<td>25.36</td>
<td></td>
</tr>
<tr>
<td>Mood Disorder</td>
<td></td>
<td>19.97</td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td></td>
<td></td>
<td>14.96</td>
</tr>
</tbody>
</table>

Source: Grant et al. 2004
In 2001, Cacciola and colleagues from the University of Pennsylvania reviewed the literature on prevalence rates of psychiatric disorders in addiction treatment settings. To date, this has been the best and most comprehensive review of prevalence rates in addiction treatment settings. Similarly, the most thorough single study has been by Ross, Glaser, and Germanson (1988). (See figure 5.)

**FIGURE 4**

Twelve-Month Prevalence of Index Substance Use and Co-occurring Mood and Anxiety Disorders of Treated Persons

<table>
<thead>
<tr>
<th>INDEX DIAGNOSIS</th>
<th>% CO-MORBID MOOD</th>
<th>% CO-MORBID ANXIETY</th>
<th>% CO-MORBID SUBSTANCE USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Substance Use Disorder</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>40.69</td>
<td>33.98</td>
<td></td>
</tr>
<tr>
<td>Drug</td>
<td>60.31</td>
<td>42.63</td>
<td></td>
</tr>
<tr>
<td>Mood Disorder</td>
<td></td>
<td></td>
<td>20.78</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td></td>
<td></td>
<td>16.51</td>
</tr>
</tbody>
</table>

Source: Grant et al. 2004

**FIGURE 5**

Psychiatric Disorders in Addiction Treatment

Two studies of prevalence rates in addiction treatment settings had similar findings. Persons with substance use disorders are also likely to have mood and anxiety disorders.

<table>
<thead>
<tr>
<th>DISORDER</th>
<th>CACCIOLE</th>
<th>ROSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood Disorder</td>
<td>10–45%</td>
<td>31.4%</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>10–46%</td>
<td>45.4%</td>
</tr>
<tr>
<td>Post-traumatic Stress Disorder</td>
<td>15–45%</td>
<td>NA</td>
</tr>
<tr>
<td>Antisocial Personality Disorder</td>
<td>25–50%</td>
<td>36.5%</td>
</tr>
<tr>
<td>Borderline Personality Disorder</td>
<td>10–30%</td>
<td>NA</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>&lt; 5%</td>
<td>4.3%</td>
</tr>
</tbody>
</table>

Source: Cacciola et al. 2001; Ross, Glaser, and Germanson 1988
The Cacciola review notes the wide “bands” of variability in prevalence rates across a number of studies. The variability found by Cacciola is initially quite striking and results from the different measures, methods, settings, populations, and diagnostic criteria used across studies. Nonetheless, a consistent pattern begins to emerge. Much like with the population-based studies, persons with substance use disorders, and even more so among those seeking treatment, are likely to suffer from mood and anxiety disorders.

Cacciola also observed relatively high, though perhaps less than expected, rates of Axis II personality disorders. Next to mood and anxiety disorders, patients with antisocial personality disorders compose the largest group of patients with psychiatric disorders in addiction treatment. Some researchers have argued that Axis II disorders, in particular antisocial personality disorder, cannot be reliably diagnosed because of the considerable overlap with drug use behaviors. These behaviors may include larceny, robbery, and burglary to obtain money for drugs, disregard of laws to support drug use, and violation of social norms and relationship commitments as a consequence of addiction.

A more recent study (McGovern et al. 2006, which is included on the CD-ROM) surveyed frontline addiction treatment providers as to the prevalence of specific psychiatric disorders in program settings. Over 450 providers were surveyed, and remarkably, the estimates were consistent with the research studies. As figure 6 shows, mood disorders (including dysthymia and major depression), anxiety disorders (including generalized anxiety disorder, panic disorder, social phobia, 

![FIGURE 6](image)

**Addiction Treatment Provider Estimates by Psychiatric Disorder**

Mood disorders, anxiety disorders, and post-traumatic stress disorder were cited most often among patients seeking treatment.
### Axis I: Clinical Disorders

Axis I disorders include various disorders and conditions related to symptoms and impairments in functioning. An Axis I diagnosis is typically related to the current presentation, but an Axis I diagnosis can also be reviewed for its presence over a person's lifetime. The table below lists the primary Axis I disorders according to *DSM-IV*.

- Disorders usually first diagnosed in infancy, childhood, or adolescence (excluding mental retardation, which is diagnosed on Axis II)
- Delirium, dementia, and amnestic and other cognitive disorders
- Mental disorders due to a general medical condition
- Substance-related disorders
- Schizophrenia and other psychotic disorders
- Mood disorders
- Anxiety disorders
- Somatoform disorders
- Factitious disorders
- Dissociative disorders
- Sexual and gender identity disorders
- Eating disorders
- Sleep disorders
- Impulse-control disorders not elsewhere classified
- Adjustment disorders
- Other conditions that may be a focus of clinical attention

### Axis II: Personality Disorders

Axis II disorders include various personality disorders related to long-standing maladaptive functioning, particularly in relation to self and others. Axis II disorders can usually be traced to childhood or adolescence and are constellations of maladaptive behaviors, interpersonal relationships, and self-regulatory patterns. The table below lists the primary Axis II disorders according to *DSM-IV*.

- Paranoid personality disorder
- Schizoid personality disorder
- Schizotypal personality disorder
- Antisocial personality disorder
- Borderline personality disorder
- Histrionic personality disorder
- Narcissistic personality disorder
- Avoidant personality disorder
- Dependent personality disorder
- Obsessive-compulsive personality disorder
- Personality disorder not otherwise specified
- Mental retardation
and obsessive compulsive disorder), and post-traumatic stress disorder (PTSD) were cited the most often as co-morbidities among patients presenting for services. Borderline personality (BP) and antisocial personality (AP) disorders were also common, and patients with severe mental illnesses (such as schizophrenia, bipolar disorder, or schizoaffective disorder) were rare. Patients with bipolar disorder accounted for most of the estimates in the severe mental illness (SMI) category.

Barlow (2002) reviewed the relative chronology of onset of mental health and substance use disorders and found that among anxiety disorders, both generalized anxiety and panic disorders are more likely to occur during or develop secondarily to substance use. In contrast, two other anxiety disorders, PTSD and social phobia, have been found by researchers to predate the onset of the substance use disorder. As such, PTSD and social phobia are most likely to be independent psychiatric disorders. Longitudinal studies (those following a large group of people over an extended period of time) are still needed to tease out the patterns of order of other co-occurring disorders.

Several disorders have been reported to be common but have been less carefully researched for prevalence as co-occurring disorders. Among these are attention deficit and hyperactivity disorder, personality disorders other than antisocial or borderline, sleep disorders, and sexual and gender identity disorders. Therefore, these disorders are currently less understood from an evidence-based perspective (SAMHSA 2002; McGovern and McLellan 2008).

Based on the review of prevalence in the general population and clinical settings, prudence suggests that patients with substance use disorders, and those who care for them, may need a plan for the following Axis I disorders, in order of relative likelihood:

1. Mood disorders (including dysthymia and major depression)
2. Anxiety disorders (including generalized anxiety, panic disorder, obsessive compulsive disorder, agoraphobia, and simple phobias)
3. Post-traumatic stress disorder (although a DSM-IV anxiety disorder, the presence of trauma and unique symptoms—such as re-experiencing—warrant special consideration)
4. Social phobia (a DSM-IV anxiety disorder, its likely independence from substance use disorder may also warrant special consideration. In addition, the fact that persons with social phobia may avoid treatment because of primarily group formats should be considered.)
5. Bipolar disorder
Patients with substance use disorders need to learn about these disorders, and practitioners need to be able to accurately detect and potentially treat them. Given their common overlap with substance use disorders, neglecting these disorders in practice will likely result in less favorable outcomes.

Although prevalent, personality disorders may require even more developed assessment protocols and more time for observation and assessment for accurate diagnostics. This is true not only for patients with Axis II disorders without substance use disorders but also especially true for those with co-occurring disorders. Refer to Crouse, Drake, and McGovern (2007) for information on the prevalence, assessment, and treatment for co-occurring personality and substance use disorders.

### Key Points Addressed in Chapter 1

1. Psychiatric disorders co-exist in 20 percent to 30 percent of persons with substance use disorders, and these rates double (40 percent to 60 percent) in treatment settings.
2. Substance use disorders co-exist in 20 percent to 50 percent of persons with psychiatric disorders, and these rates also increase, depending on the disorder, in treatment settings.
3. Depression, anxiety, PTSD, social phobia, and bipolar disorder are the most common co-occurring conditions among patients with substance use disorders in addiction treatment.
4. Either alcohol or drug problems are common among patients with psychiatric disorders.
Section A – Please circle “yes” or “no” for each question.

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks? Yes No

2. In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time? Yes No

3. Have you felt sad, low, or depressed most of the time for the last two years? Yes No

4. In the past month, did you think that you would be better off dead or wish you were dead? Yes No

5. Have you ever had a period of time when you were feeling up, hyper, or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.) Yes No

6. Have you ever been so irritable, grouchy, or annoyed for several days, that you had arguments, had verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way? Yes No

Section B – Please circle “yes” or “no” for each question.

7. Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable, or uneasy, even when most people would not feel that way? Did these intense feelings get to be their worst within ten minutes? (If the answer to both questions is “yes”, circle “yes”; otherwise circle “no.”) Yes No

8. Do you feel anxious or uneasy in places or situations where you might have the panic-like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult? Examples: o being in a crowd, o standing in a line, o being alone away from home or alone at home, o crossing a bridge, o traveling in a bus, train, or car? Yes No

9. Have you worried excessively or been anxious about several things over the past six months? (If you answer “no” to this question, answer “no” to Question 10 and proceed to Question 11.) Yes No

10. Are these worries present most days? Yes No

11. In the past month, were you afraid or embarrassed when others were watching you or when you were the focus of attention? Were you afraid of being humiliated? Examples: o speaking in public, o eating in public or with others, o writing while someone watches, o being in social situations. Yes No
12. In the past month, have you been bothered by thoughts, impulses, or images that you couldn’t get rid of that were unwanted, distasteful, inappropriate, intrusive, or distressing? Examples:
   ○ being afraid that you would act on some impulse that would be really shocking,
   ○ worrying a lot about being dirty, contaminated, or having germs,
   ○ worrying a lot about contaminating others, or that you would harm someone even though you didn’t want to,
   ○ having fears or superstitions that you would be responsible for things going wrong,
   ○ being obsessed with sexual thoughts, images, or impulses,
   ○ hoarding or collecting lots of things,
   ○ having religious obsessions.

   Yes  No

13. In the past month, did you do something repeatedly without being able to resist doing it?
   Examples:
   ○ washing or cleaning excessively,
   ○ counting or checking things over and over,
   ○ repeating, collecting, or arranging things,
   ○ other superstitious rituals.

   Yes  No

14. Have you ever experienced, witnessed, or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples:
   ○ serious accidents,
   ○ sexual or physical assault,
   ○ terrorist attack,
   ○ being held hostage,
   ○ kidnapping,
   ○ fire,
   ○ discovering a body,
   ○ sudden death of someone close to you,
   ○ war,
   ○ natural disaster.

   Yes  No

15. Have you re-experienced the awful event in a distressing way in the past month? Examples:
   ○ dreams,
   ○ intense recollections,
   ○ flashbacks,
   ○ physical reactions.

   Yes  No

Section C – Please circle “yes” or “no” for each question.

16. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?

   Yes  No

17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?

   Yes  No

18. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or, have you ever felt that you were possessed?

   Yes  No

19. Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you?

   Yes  No

20. Have your relatives or friends ever considered any of your beliefs strange or unusual?

   Yes  No

21. Have you ever heard things other people couldn’t hear, such as voices?

   Yes  No

22. Have you ever had visions when you were awake or have you ever seen things other people couldn’t see?

   Yes  No
**Instructions:** In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation. This is why each question begins, “Have you ever . . . ”

Please circle “yes” or “no” for each question.

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? ................................................................. Yes No

2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? ......................................................... Yes No

3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? ................................................................. Yes No

4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? ........................................................................................................... Yes No

5. Have you ever heard voices no one else could hear or seen objects or things which others could not see? ........................................................................................................... Yes No

6. (a) Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? ...... Yes No (b) Did you ever attempt to kill yourself? ........................................................................................................... Yes No

7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? ........................................................................................................... Yes No

8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? ........................................................................................................... Yes No

9. Have you ever given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property? ................................................................. Yes No

10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? ...... Yes No

11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? ........................................................................................................... Yes No

12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? ........................................................................................................... Yes No

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13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly nonstop, when you moved quickly from one activity to another, when you needed little sleep, and when you believed you could do almost anything? … Yes No

14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, or uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, or you felt dizzy or unsteady, as if you would faint? … Yes No

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. … Yes No

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, or with your family and friends as a result of your gambling? … Yes No

17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem? … Yes No
Please circle “yes” or “no” for each question.

Have you felt you ought to cut down on your drinking or drug use? ................................................. Yes  No

Have people annoyed you by criticizing your drinking or drug use? ......................................................... Yes  No

Have you felt bad or guilty about your drinking or drug use? ................................................................. Yes  No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? ................................................................. Yes  No
Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)

During the past 6 months:

1. Have you used alcohol or other drugs? (such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants) ......................................................... Yes No

2. Have you felt that you use too much alcohol or other drugs? ................................................................. Yes No

3. Have you tried to cut down or quit drinking or using drugs? ................................................................. Yes No

4. Have you gone to anyone for help because of your drinking or drug use? (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program) ......................................... Yes No

5. Have you had any of the following? Put a check mark next to any problems you have experienced.
   ○ Blackouts or other periods of memory loss?
   ○ Injury to your head after drinking or using drugs?
   ○ Convulsions or delirium tremens (DTs)?
   ○ Hepatitis or other liver problems?
   ○ Felt sick, shaky, or depressed when you stopped drinking or using drugs?
   ○ Felt “coke bugs” or a crawling feeling under the skin after you stopped using drugs?
   ○ Injury after drinking or using?
   ○ Used needles to shoot drugs?

   Circle “yes” if at least one of the eight items above is checked ................................................................. Yes No

6. Has drinking or other drug use caused problems between you and your family or friends? .................. Yes No

7. Has your drinking or other drug use caused problems at school or at work? ................................. Yes No

8. Have you been arrested or had other legal problems? (such as bouncing bad checks, driving while intoxicated, theft, or drug possession) ................................................................. Yes No

9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? .......... Yes No

10. Do you need to drink or use drugs more and more to get the effect you want? ................................. Yes No

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? ................................. Yes No

12. When drinking or using drugs, are you more likely to do something you wouldn’t normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? ................................................................. Yes No

13. Do you feel bad or guilty about your drinking or drug use? ................................................................. Yes No

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The next questions are about lifetime experiences.

14. Have you ever had a drinking or other drug problem? ..........................  Yes  No
15. Have any of your family members ever had a drinking or drug problem? ..........................  Yes  No
16. Do you feel that you have a drinking or drug problem now? ..........................  Yes  No
Welcome to the *Screening and Assessment* CD-ROM

This CD-ROM contains supplemental and research materials for *Screening and Assessment: Clinician’s Guide* of the Co-occurring Disorders Program.

Screening and assessment is the essential first step in the treatment process. This manual helps the practitioner detect and identify co-occurring disorders, determine a recovery plan, and monitor changes in patients.

This CD-ROM includes the following files:

- **Screening Measures**
  These measures test for the likely presence of a mental health disorder. Copies of the screening measures are also available in the three-ring binder.
  
  — **Modified Mini Screen (MMS)**: A self-report measure that rapidly assesses for present mood, anxiety, and psychotic spectrum disorders.

  — **Mental Health Screening Form–III (MHSF–III)**: A self-report measure that covers a range of disorders.

  — **CAGE Adapted to Include Drugs (CAGE-AID)**: A screen for alcohol and drug problems.

  — **Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)**: A longer screen for alcohol and drug problems.

  — **Center for Epidemiologic Studies Depression Scale (CES-D Scale)**: A commonly used measure for depression.

  — **Life Events Checklist**: A brief screen for post-traumatic stress disorder.

  — **PTSD Checklist (PCL)**: Used to screen for post-traumatic stress disorder.

  — **Social Interaction Anxiety Scale (SIAS)**: A self-report measure used to detect social anxiety and social phobia.
Clinical Assessment Forms

These forms add structure to the assessment process. They outline the process of assessment for the most common psychiatric disorder in addiction treatment, as well as the potential for suicide. The forms feature filters to rule out substance-induced disorders. Copies of the clinical assessment forms are also available in the three-ring binder.

- Clinical Assessment Form for Anxiety Disorders
- Clinical Assessment Form for Dysthymia
- Clinical Assessment Form for Major Depression
- Clinical Assessment Form for Manic/Hypomaniac/Bipolar Disorder
- Clinical Assessment Form for PTSD
- Clinical Assessment Form for Social Phobia
- Clinical Assessment Form for Suicidality

Additional Materials

These handouts and forms, in addition to the screening and assessment measures, assist the clinician in the treatment and diagnosis of co-occurring disorders. Copies of these additional materials are also available in the three-ring binder.

- Feelings from A to Z: This handout illustrating emotions and facial expressions can help facilitate the clinical interaction and the development of affect management skills.

- Substance Abuse Treatment Scale (SATS): This scale measures a patient’s motivation for change based on behavior, rather than cognition.

- Stage of Motivation and Treatment Readiness for Co-occurring Disorders (SOMTR-COD): This form asks clinicians to provide global ratings on both substance use and mental health problems, and to re-assess patient motivation over the course of treatment.

- Comprehensive Recovery Plan for Patient with Co-occurring Disorder: This form provides an opportunity to map a course and target a treatment toward a patient’s specific problems, and provides the practitioner and patient with a document or living contract about the goals of their relationship.
— **Summary Scoring Sheet**: This form provides the clinician with a tool to plot patient scores on the CES-D Scale, PCL, and SIAS.

► **Journal Articles**

These three articles describe some of the research on which the Co-occurring Disorders Program was developed.


► **Hazelden Products on Co-occurring Disorders**

A complete list of the items available in the Co-occurring Disorders Series, along with products for general audiences and others specifically for adolescents.

► **Co-occurring Disorders Program Abstracts**

This file contains a list of twenty-five research articles related to the treatment of co-occurring disorders.
Integrated Services for Substance Use
and Mental Health Problems

Integrating Combined Therapies
Clinician’s Guide

Mark McGovern
and other faculty from the Dartmouth Medical School
# TABLE OF CONTENTS

How to Build a Workbook ................................................................. ix

**PART I**

Chapter 1: Introduction ................................................................. 1
Chapter 2: Evidence-Based Practices for Substance Use Disorders ................. 7
Chapter 3: Evidence-Based Practices for Substance Use Disorders Adapted for Persons with Co-occurring Psychiatric Disorders .......... 13
Chapter 4: Stage-Wise Application of MET, CBT, and TSF ......................... 17
Chapter 5: Therapeutic Alliance, Therapeutic Frame, and Relationship Factors .......... 21
Chapter 6: How to Use This Guide .................................................. 25
Appendix A .................................................................................. 35
Appendix B .................................................................................. 36
Appendix C .................................................................................. 38
References .................................................................................. 39

**PART II**

Module 1: Introduction to Integrating Combined Therapies (ICT) ...................... 45

**Phase I: Motivational Enhancement Therapy (MET): Enhancing and Securing Motivation**
Module 2: Assessing Substance Use and Psychiatric Problems ......................... 49
Module 3: Goals ........................................................................... 57
Module 4: Connecting Problems with Goals: Developing Discrepancy and Establishing Motivation .................................................... 63
Module 5: How to Change? Developing an Action Plan .................................. 73
Treatment Decision Point I ................................................................ 87

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# TABLE OF CONTENTS

## Phase II: Cognitive-Behavioral Therapy (CBT): Assisting with Change

<table>
<thead>
<tr>
<th>Module</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Antecedents, Behaviors, and Consequences (ABCs) of Relapse Prevention</td>
<td>91</td>
</tr>
<tr>
<td>7</td>
<td>Patient Education: Primary Symptoms of the Disorder and Relapse Potentials</td>
<td>101</td>
</tr>
<tr>
<td>8</td>
<td>Coping with Urges and Cravings</td>
<td>107</td>
</tr>
<tr>
<td>9</td>
<td>Refusal Skills and Social Pressures</td>
<td>117</td>
</tr>
<tr>
<td>10</td>
<td>Managing Negative Emotions</td>
<td>127</td>
</tr>
<tr>
<td>11</td>
<td>Recreation and Leisure Time</td>
<td>143</td>
</tr>
<tr>
<td>12</td>
<td>Social Support for Recovery</td>
<td>149</td>
</tr>
<tr>
<td></td>
<td>Treatment Decision Point II</td>
<td>155</td>
</tr>
</tbody>
</table>

## Phase III: Twelve Step Facilitation (TSF): Sustaining and Enjoying Life

<table>
<thead>
<tr>
<th>Module</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Introduction and Prior Experience</td>
<td>159</td>
</tr>
<tr>
<td>14</td>
<td>How Do Twelve Step Meetings Work? Social Support, Alternative Activities, and Relapse Prevention</td>
<td>171</td>
</tr>
<tr>
<td>15</td>
<td>Twelve Step Programs and Persons with Co-occurring Disorders</td>
<td>181</td>
</tr>
<tr>
<td>16</td>
<td>Steps One, Two, and Three</td>
<td>189</td>
</tr>
<tr>
<td>17</td>
<td>Getting Active: Attendance, Participation, Working the Steps, Sponsorship, and Service Work</td>
<td>201</td>
</tr>
<tr>
<td>18</td>
<td>What Is Recovery?</td>
<td>209</td>
</tr>
</tbody>
</table>

## Phase IV: Transition

<table>
<thead>
<tr>
<th>Module</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Generalization, Review, and Closure</td>
<td>215</td>
</tr>
<tr>
<td>20</td>
<td>Recovery Checkups</td>
<td>219</td>
</tr>
</tbody>
</table>

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How to Build a Patient Workbook

The patient workbook is a critical component for providing structure within the Co-occurring Disorders Program. Without it, treatment and management of the educational materials, handouts, and worksheets for the patients can become disorganized and thus less effective. People in recovery with co-occurring disorders need structure. Organization is crucial in achieving coherence and usefulness of these patient materials. In order to effectively implement the Co-occurring Disorders Program, you will need to do the following:

- Photocopy the reproducible handouts from the sessions or modules in each curriculum. (A CD-ROM containing PDFs of these reproducible pages is packaged with each curriculum.) Make extra copies of the handouts to have on hand during sessions, especially when using curriculum 2 Integrating Combined Therapies, curriculum 3 Cognitive-Behavioral Therapy, and curriculum 5 Family Program.

- Compile the handouts in a three-ring binder or a folder for each patient.

- Customize your patients’ workbooks by using the sample cover found in the three-ring binder, as well as on the CD-ROM, of each of the three curricula mentioned above.

- Give each patient a workbook upon admission to your program.

- Decide whether the workbook will be kept by the clinician at your center/clinic or taken home with the patient. This decision can be jointly made with the patient.

- Include extra handouts whenever necessary.
The Integrating Combined Therapies (ICT) curriculum is one of seven components in the comprehensive Co-occurring Disorders Program: Integrated Services for Substance Use and Mental Health Problems. Like the other four curricula in the program, ICT can be used either as a stand-alone curriculum or systematically integrated into the entire Co-occurring Disorders Program. For the sake of convenience, the word “clinician” refers to any practitioner—counselors, supervisors, therapists, psychologists, facilitators, medical and mental health personnel, administrators, agency directors, and doctors—using these guides and curricula as part of the Co-occurring Disorders Program with patients and family members.

This clinician’s guide describes the integrating combined therapies (ICT) approach to persons with co-occurring substance use and psychiatric disorders. Integrating these therapies combines three evidence-based psychosocial treatments for substance use disorders that have been adapted for the co-occurring disorder patient. The three evidence-based psychosocial treatments are motivational enhancement therapy (MET), cognitive-behavioral therapy (CBT), and Twelve Step facilitation (TSF).

Specific and generic versions of the three approaches have been consistently found effective for persons with alcohol and drug use disorders. Effectiveness has been found across a variety of settings and with a wide range of patient populations, varying by substance severity, substance type, age, gender, culture, and socioeconomic factors. Further, these approaches have been rated as the top three evidence-based practices that community addiction treatment providers describe in terms of “readiness to adopt” in their clinical work.

McLellan et al. (2000) noted that in routine health care, combinations of treatments are common, particularly in chronic disease management. For example, instead of using a single treatment for hypertension, medications are often combined for the most beneficial effects. Therefore, combining historically separate, if not “competitive,” interventions such as MET, CBT, and TSF is consistent with maximizing potential patient benefits. Clinical researchers

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and practitioners have already embraced the rationale for combining these three approaches. Treatment researchers have further evolved the application of these therapies by organizing a practical combination of MET, CBT, and TSF that is relevant for each patient (with regard to his or her own readiness to change) that clinicians will encounter.

MET is focused on ascertaining and eliciting a patient’s motivation to change and perhaps utilizing professional help to do so. It is focused on making the decision to change and taking the first steps toward change. CBT catches a patient at the next step of this process by providing the patient with the tools and/or skills that will enable him or her to change successfully. This may involve the initiation of abstinence, the prevention of relapse, or the development of new ways to cope with negative thoughts.

Notable efforts combining MET and CBT have been researched (Sampl and Kadden 2001, 2002 and Carroll et al. 2006). Most recently, Miller (2004), in a large multisite study funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), developed and tested the combined behavioral intervention (CBI) model for persons with alcohol use and dependence disorders. The CBI approach was found to be effective, and it added the TSF model to MET and CBT. This addition was a logical capstone to the other two interventions, since MET focused on the “initiation of change,” CBT on “making change,” and TSF on “maintaining change.” Adding the TSF therapy to this combined model is consistent with other chronic disease and recovery models that rely on Twelve Step facilitation to help patients maintain change. TSF considers not only symptom reduction, but also quality of life issues ranging from personal goals to spirituality.

Since MET and CBT are generic practices also used to treat a variety of mental health disorders, adapting them for persons with co-occurring disorders is a logical extension of their foci. TSF and related evidence-based treatments have historically focused on the connection with traditional peer recovery supports, such as Alcoholics Anonymous and Narcotics Anonymous, and have not been routinely used or studied among persons with psychiatric disorders. Nonetheless, persons with co-occurring disorders can enjoy the benefits of peer recovery support groups, but they often face certain barriers in their initial attempts to engage.

Integrating combined therapies (ICT) is the adapted integration of MET, CBT, and TSF evidence-based manual-guided treatments. It is intended to enhance the
applicability of each to persons with co-occurring substance use and psychiatric disorders. The ICT curriculum is primarily designed for delivery in the context of an addiction treatment program. The addiction treatment program may be drug free, abstinence based, or methadone maintenance or medication-assisted recovery based. It is important to understand that co-occurring substance use and psychiatric disorders require intensive and adequate treatment of addiction, especially if the person suffers a substance dependence disorder. Integrated or augmented psychiatric or psychosocial treatments may only be effective under these circumstances.

This guide may also be used in an office-based or mental health practice, either alone or in tandem with other services. It is important to ascertain the severity of the substance use problem to determine if this treatment can be effective under these circumstances. For example, in the context of active substance use, it may be clinically necessary for the patient to be placed in a more intense level of care to stabilize the substance-related problem. If, however, the patient is stable, or in a period of early or advanced recovery, then this treatment may be delivered within the context of an office-based or mental health practice.

A mental health practitioner or clinic may find this guide particularly useful for the intentional focus on substance use issues. Most mental health providers may be more comfortable with approaching the psychiatric or cognitive targets in their MET and CBT interventions. These materials, both in the clinician’s guide and patient workbook, will help the provider focus equally on the patient’s relationship with substances. Further, the mental health practitioner unfamiliar with Twelve Step recovery groups and programs may find the TSF component invaluable in helping patients overcome their fears and reluctance to utilize this powerful, effective, readily available, lifelong, and free community resource.
The treatments outlined in this guide consist of several important clinical practices.

1. **Substance use**: Clinicians must ask about substance use initially and throughout the course of treatment. These persons are at high risk for relapse to substance use. Multiple factors will make it challenging for them to sustain abstinence or to discontinue the use of substances as a primary coping strategy to manage psychiatric symptoms.

2. **Psychiatric symptoms**: Clinicians must ask about psychiatric symptoms initially and throughout the course of treatment. Patients may be relying less on substances to cope with their psychiatric symptoms, such as anxiety, depression, or other symptoms related to their disorder. As a result, they will be in a position to learn new coping skills. In the meantime, until they develop new coping skills through ICT, they may be unsure, at least temporarily, of how to manage their psychiatric symptoms.

3. **Shared decision making**: The initial set or phase of modules involves MET practices. The purpose of these modules is to help clinicians elicit and examine patient problems and goals, and consider interest and strategies for change. The patient and clinician are collaborators in this process. The clinician collects and presents evidence, offers an expert opinion, and reviews the pros and cons of decisions. The patient discloses important information to add to the evidence base, is candid about the monitoring change, and makes the best decision based on his or her preferences and hoped-for outcome. This is a *shared and nonhierarchical* process.

4. **Patient education**: The second set or phase of modules and Fact Sheets involves CBT practices. By using the fact sheets as handouts for each major psychiatric disorder, clinicians will provide patients with basic information about their disorder and related problems. In addition, patients will be provided with information and other handouts about treatments. These same Fact Sheets will also be used in curricula 4 *Cognitive-Behavioral Therapy* and 6 *Family Program*.

5. **Cognitive-behavioral coping skills development**: Also consistent with CBT practices, patients will learn alternative coping strategies to minimize their compulsion to use substances, reduce their reliance on substances for self-regulation, manage negative affect, and strengthen their relationships and recreational lives.
6. **Developing peer recovery supports:** The third set or phase of modules involves TSF practices. TSF emphasizes the potency of the Twelve Step recovery program, both in terms of the suggested Steps as outlined in the literature, but also in terms of the opportunity for peer recovery support and fellowship. This adapted TSF approach focuses on the particular challenges persons with psychiatric problems may encounter in their initial entrée into peer support groups and provides them with knowledge and skills to overcome these anticipated and actual barriers.

7. **Recovery checkups:** Clinicians should discuss with the patients what types of services they will continue to receive once the formal work with ICT is concluded. Since addiction and psychiatric disorders are typically chronic, with a vulnerability to relapse, the patient will need to consider both as requiring ongoing monitoring for the foreseeable future, if not for life. A final module is provided on how clinicians can conduct a recovery checkup either onsite or by phone.
Evidence-Based Practices for Substance Use Disorders

In a recent review of documented treatments for substance use disorders, a list of evidence-based practices was developed (McGovern and Carroll 2003). This list included both pharmacological and psychosocial interventions. The pharmacological intervention list is updated by the FDA-approval process and is described in curriculum Medication Management, one component of the Co-occurring Disorders Program. The list of psychosocial interventions has not been substantially changed, although some interventions, such as the Matrix Model, are promising in the evidence base.

Evidence-based psychosocial treatments for addiction are numerous, and most fit into one of these four therapy categories: cognitive and behavioral psychology, motivational psychology, family systems, and group psychology. Most psychosocial treatments for mental health disorders can also be placed into these categories, with the primary treatment falling into the category of cognitive and behavioral psychology, more so than motivational approaches and group psychology.

In the largest multisite trial ever conducted by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), MET, CBT, and TSF were the primary interventions. The overall outcomes among the treatments were comparable. In the largest multisite trial ever conducted by the National Institute on Drug Abuse (NIDA), four manual-guided treatments were compared: CBT, supportive-expressive psychotherapy (SEP), individual drug counseling (IDC), and group drug counseling (GDC). Both IDC and GDC were designed to be “treatments-as-usual,” but they performed at least as well as the CBT and SEP approaches. Overall, all four treatment were similar in effectiveness.

**Motivational Enhancement Therapy (MET)**

MET includes motivational approaches that include motivational interviewing (MI), motivational enhancement therapy (MET), brief interventions, and brief motivational interventions. MET, in its many “name brand” covers, is a treatment that is generically effective to engage patients in a process of change. These approaches share several common principles:
1. Express empathy: Work with the patient respectfully, supportively, collaboratively, and as equals. Patient choice is paramount.

2. Develop discrepancy: Raise awareness as the patient considers his or her goals and examines how substances (or mental health problems) interfere with these goals.

3. Avoid argumentation: Do not allow abuses of power, the use of force, or the use of pejorative labels in dialogues between patients or between clinician and patient. Encourage patients to think critically when articulating arguments both for and against change.

4. Deflect defensiveness: Ask questions, practice reflective listening, and ask patients for options or other ways of thinking or reacting.

5. Support self-efficacy: Help each patient restore his or her morale, encourage hope, and be optimistic about each patient’s potential for success.

**Cognitive-Behavioral Therapy (CBT)**

Cognitive-behavioral therapy, in its many “name brand” covers, is also a treatment that is generically effective to assist patients in a process of change.

CBT includes relapse prevention therapy (RPT) (Marlatt and Gordon 1985, Gorski 1985, and Daley et al. 2002), cognitive-behavioral coping skills therapy (Kadden et al. 1992), cognitive-behavioral therapy (Project MATCH Research Group 2002), and more behavioral-oriented treatments, such as behavioral couples therapy (O’Farrell and Fals-Stewart 2002) and contingency management (CM) approaches (Higgins et al. 2000 and Petry et al. 2000).

CBT approaches share basic principles, but they may vary based on emphasis of these principles:

1. reducing exposure to substances
2. fostering motivation for abstinence, including setting reinforcement or reward schedules
3. using self-monitoring or objective monitoring
4. recognizing and coping with urges, cravings, and negative affect
5. identifying cognitive and behavioral processes with relapse potential
6. developing a clear action plan for urges and cravings, use and relapse

Like MET, CBT is a generic evidence-based practice for the treatment of substance use disorders.
Twelve Step Facilitation (TSF) Therapy

If MET was developed to engage change (how well are you?), and CBT to assist change (how do you get well?), then TSF was developed to sustain change (how do you stay well?) and elaborate upon it. Since both MET and CBT are fundamentally symptom-focused (i.e., dealing with remission), TSF includes not just the absence of something negative (e.g., symptoms) but also the transformation of the quality of one’s overall life.

TSF and the two similar approaches in the NIDA Cocaine Collaborative studies, individual drug counseling (IDC) and group drug counseling (GDC), are manual-guided treatments that were developed as proxies for “addiction treatment as usual.” Surprising to some, these approaches were equally effective as the more research- and scientific-theory-driven approaches, such as MET, CBT, or SEP.

TSF, IDC, and GDC share basic principles:

1. introducing Twelve Step recovery principles, such as the limits of personal will in controlling addiction, considering a relationship with a power greater than oneself, taking personal responsibility for recovery tasks and relationship problems, and developing an interest in working with others
2. providing guided exposure to and processing experiences with peer support groups in the community
3. raising awareness of the lifelong nature of the recovery process

TSF is focused on guiding patients through the process of affiliating and connecting with peer recovery support groups in the community. An average person may have major apprehensions about attending these kinds of Twelve Step meetings, because peer recovery support groups are not professionally led, occur in groups or individual formats, have a vernacular and organization that appears religious or cult-like to some, and can suffer from media images and historical stereotypes.

The TSF phase in this guide introduces the concepts of these peer support group meetings, from meeting types to the Twelve Steps to sponsorship and appropriate participation. Patients are well prepared for meetings, attend them between sessions, and report back about their experiences. This makes the initial peer group connection easier for the patient to navigate. Asking a patient to routinely review his or her experiences in attending these groups is likely to reinforce attendance.

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This manual-guided approach offers a protocol for treatment that may or may not be similar to a center’s “addiction treatment as usual.” It can vary depending on the approach of the individual clinician. In fact, because the sessions in this guide are so purposeful, deliberate, and targeted, it is hypothesized that this treatment will be more effective than traditional treatment, or at least it represents addiction treatment “as it should be.”

Although some recent research (Timko and DeBenedetti 2007) has found that intensive referral and checking is associated with increased Twelve Step group meeting attendance, the advantage to TSF is that it has a demonstrated effectiveness with attendance and positive outcomes.

**Combined Behavioral Intervention (CBI)**

Combined Behavioral Intervention (Miller 2004) is the first combination of evidence-based treatments to include TSF. Other approaches combine versions of MET and CBT. They are MET/CBT-5 and -7 (Sampl and Kadden 2001, 2002), MET + CBT (McKee et al. 2007), and MET and CBT coping skills training (Rohsenow et al. 2004), as well as early work by Kadden et al. (1992), Monti et al. (1989), and Miller and Heather (1998). A programmatic combination of MET and CBT can also be found in the Matrix Model, which has been studied with methamphetamine-use-disordered persons in intensive outpatient program settings (Rawson et al. 1995).

The addition of TSF to MET and CBT is important. First, it recognizes the limitations of both motivational and cognitive-behavioral approaches. Second, it capitalizes on the opportunity to build social support for recovery through peer community groups. Third, it appreciates the findings of the multisite studies (NIAAA and NIDA) that found TSF (or IDC and GDC) to be possibly the most effective over time. The therapeutic benefits of connecting patients with peer recovery support groups are extensive.
In addition, we accept that, like addiction and most psychiatric disorders, co-occurring disorders should be treated as chronic (vs. acute) medical conditions (McLellan et al 2000); therefore, considering treatment supports that extend indefinitely is essential. Peer support groups in the community afford precisely this support for persons in recovery with co-occurring disorders.

CBI was developed in manual format and is designed for delivery by trained clinicians in specialized addiction treatment programs. CBI is a state-of-the-art individual outpatient psychotherapy for alcohol dependence disorders that merges MET, CBT, and TSF. Essentially, CBI includes four phases: (1) enhancing motivation for change; (2) functional analyses of substance use behavior; (3) CBT training modules; and (4) maintaining change. The first phase is derived from MET, the second and third from CBT, and the last from TSF approaches found in the NIAAA Project MATCH manuals (Nowinski, Baker, and Carroll 1995).

A recent large NIAAA multisite study of CBI (in conjunction with alcohol medications such as naltrexone and acamprosate) found that across 1,383 patients and eleven outpatient clinics, having received CBI was associated with significantly positive clinical response post-treatment, compared with not having received CBI (Donovan et al. 2008).

CBI is an example of a rational compound of psychosocial treatments that have an evidence base. An amalgam of evidence-based treatments should be studied to determine their overall effectiveness (e.g., Donovan et al. 2008), but since the efficacy of each has already been established, the question pertains more to the mechanisms of change, dose effects, and the ability to generalize the interventions to other settings, disorders, age cohorts, and cultural groups.

Integrating combined therapies (ICT) for co-occurring disorders extends the use of combined treatments such as CBI to persons with co-occurring substance use and psychiatric disorders. Much like CBI, ICT is an amalgam of previously established evidence-based practices (MET, CBT, and TSF) adjusted for combination and adapted for the specific application.
Research on treatments for persons with co-occurring substance use and psychiatric disorders is rapidly developing and expanding (McGovern and McLellan 2008). Although some basic principles have been established—for example, that integrated treatment approaches are most effective—the exact details of the mechanisms of these treatments and for whom they are most effective still requires further study.

As described in the *Clinical Administrator’s Guidebook*, one component of the Co-occurring Disorders Program, Integrated Dual Disorder Treatment (IDDT) (Mueser et al. 2003) has the best evidence for effectiveness for persons with severe and persistent mental illnesses with substance abuse-level disorders. IDDT is in the dissemination stage and is widely regarded as an evidence-based practice. For the significantly larger group of persons with relatively non-severe psychiatric disorders (such as depression, anxiety, PTSD, and adjustment disorders) and substance dependence-level disorders, evidence-based practices and combinations of these practices as offered in this Co-occurring Disorders Program offer the best evidence base.

The table on the next page outlines these practices for both substance use and psychiatric disorders.

Although the specific treatments may vary by disorder, a common denominator is the use of FDA-approved medications for the psychiatric or substance use disorders. Using appropriate medication treatment can often complement the use of MET or CBT for some patients with co-occurring disorders. Refer to *Medication Management* for indications, administration, side effects, and drug interactions for each specific medication used to treat co-occurring mental health disorders. Interestingly, Illness Management and Recovery (IMR), a SAMHSA evidence-based practice for persons with severe mental illnesses (not necessarily co-occurring), shares many principles in common with TSF.

Psychosocial treatments such as psychotherapy, counseling, and patient education are the most common vehicles for services in addiction and mental
health treatment. Most, if not all, addiction treatment programs offer psychosocial services; this included addiction treatment programs that rely primarily on medication-assisted recovery, which use medications such as methadone or buprenorphine.

Clinicians can use Integrating Combined Therapies: Clinician’s Guide to improve their specialized interventions. This clinician’s guide provides specialized interventions for psychiatric problems common in people suffering from substance use disorders.

Generally, these treatments involve a component of ascertaining and developing a therapeutic alliance about the motivation to change and to use professional help to assist in the change process. Patient assessment and awareness raising through education is often an important piece to this motivation-building and shared decision-making process. The treatments, particularly behavioral or cognitive-behavioral therapies, include a functional analysis of the antecedents, behaviors, and consequences of the target behavior (e.g., alcohol use, cannabis use, panic attacks, or social anxiety). They monitor behavior, establish learning alternatives, work to decrease anxiety by increasing exposure to feared stimuli, utilize reinforcement contingencies, and work to increase a sense of self-efficacy. Lastly, trying to improve relationships, communication, peer support, and alternative replacement activities are also common results of effective treatment.
Blending together these common elements from addiction treatment and psychiatric treatment is a relatively straightforward process that many practitioners have already established in their programs and offices. Some practitioners have taken handouts and materials from addiction and mental health treatment manuals, photocopied them, and used them in an organized manner with patients who suffer with both a substance use and mental health disorder. Other practitioners have used more specific addiction treatment manuals (e.g., for MET or MI) and modified them informally to fit with patients in group sessions.

Treatment models, each with some research-based evidence accrued or accruing, have been specifically developed for persons with co-occurring substance use and psychiatric disorders. Figure 1 on page 16, describes the appropriate treatment approach for patients with specific combinations of substance use and psychiatric disorders.

Most addiction treatment providers offer psychosocial treatments in residential, intensive outpatient, and outpatient programs over the course of multiple hours of services. Residential programs may offer up to forty or more hours per week of psychosocial services in the form of groups, meetings, and individual sessions. Intensive outpatient programs offer a minimum of twelve hours per week of services, and outpatient programs may offer as few as one hour per week and as many as eleven hours per week. This means that there are plenty of available hours to integrate psychosocial services for patients with co-occurring psychiatric disorders, especially since about 50 percent of addiction treatment program patients will have these disorders.

Many addiction treatment programs offer only addiction-focused psychosocial interventions with some being evidence-based, some being idiosyncratic, and others being more traditional. Other addiction programs offer some services that begin to address some co-occurring psychiatric disorder issues. These generic services can be individual sessions where psychiatric disorders are addressed along with a variety of other concerns. They may also be addressed in the context of groups, known as feelings, anger management, affect management, or communication skills groups. Many addiction treatment groups of this nature introduce the fact that many patients will have co-occurring disorders, and the group will help the patients manage the disorders through increased awareness (this may or may not include education about the psychiatric disorder) and some new coping skills.

Many mental health providers have tried to supplement existing CBT, family, marital, or other skill-based approaches with patient education, screening, and
referral for substance use issues. Generally, the focus on substance use problems is inadequate.

Some addiction and mental health providers have attempted to adopt specific practices targeting specific disorders with manual-guided evidence-based treatments. Since some of these practices were developed for certain populations (e.g., women) and settings (e.g., long-term outpatient), providers have been forced to adapt them to their unique settings and patient populations. Nonetheless, this is a sincere effort to provide psychosocial treatment services in an integrated, enhanced fashion.

Psychosocial interventions should be administered by a trained clinician with experience in therapies for co-occurring disorders or therapies. At the current time, there are not many evidence-based treatments, although many are in the development and testing stages. SAMHSA has been making some strides in creating a National Registry of Evidence-based Programs and Practices (NREPP). This effort is in its early stages and far from the level of detail, protocol, and sophistication needed for a comparison with the FDA-approval process used for pharmacological agents. But studies with PTSD (Hein et al. 2004), depression (Brown and Ramsey 2000), social phobia (Randall et al. 2001), and other diagnostically heterogeneous groups (McEvoy and Nathan 2007) support CBT as a generically effective treatment. Studies of MET find that it also has applicability across diagnostic groups (DiClemente et al 2008). TSF and IMR (Illness Management and Recovery) both embrace the model of recovery that is one beyond symptom remission, and they focus instead on life transformation, service to others, well-being, and spirituality.

Therefore, the following combination of evidence-based therapies for persons with co-occurring disorders is a logical extension:

\[
\text{MET} \rightarrow \text{CBT} \rightarrow \text{TSF}
\]

• • •
As described in the *Clinical Administrator’s Guidebook* and *Screening and Assessment*, two separate components of the Co-occurring Disorders Program, it is clinically important to consider the stage of patient motivation (and treatment behavior) when matching specific interventions. For example, it would not be appropriate to put a patient in the Precontemplative stage for a substance use disorder in an ongoing relapse prevention group. Likewise, it would not be appropriate to put an alcoholic patient at the Maintenance stage in an early-engagement program with education on the basics of addiction, instead of a program that covered long-term relapse prevention.

Different evidence-based practices are indicated for patients at certain stages of motivation to change behavior. The graphic below shows the stage-wise model of readiness for change. This model does not match treatment approaches to patient readiness with patients who suffer from both substance use and...
mental health disorders. Instead, this model shows how treatment approaches for substance use disorders should match patient readiness. This model is helpful in understanding how different levels of patient motivation correlate to appropriate stages and approaches to treatment.

The important practice for programs and clinicians is to assess a patient’s stage of motivation and treatment readiness, perhaps by using the Stage of Motivation and Treatment Readiness for Co-occurring Disorders (SOMTR-COD) assessment form found in Screening and Assessment. This form is designed for repeated and updated assessment. Patients at different stages of motivation should theoretically have treatment matched accordingly.

Thus, as outlined in the Clinical Administrator’s Guidebook, a stage-wise assessment pertains to the clinical importance of assessing motivation to change and utilizing help for both substance use and mental health related problems.
Stage-wise treatment (also as outlined in the *Clinical Administrator’s Guidebook*) pertains to the clinical importance of matching services to a patient’s motivation for change and treatment. Stage-wise matching will be associated with improved patient experience and outcomes.

ICT considers the stage of motivation and stage of treatment. The table below indicates exactly how.

**FIGURE 4**

**Title to come**

<table>
<thead>
<tr>
<th>EVIDENCE-BASED PRACTICE</th>
<th>MET</th>
<th>CBT</th>
<th>TSF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage of motivation</td>
<td>Precontemplation or contemplation</td>
<td>Action</td>
<td>Maintenance</td>
</tr>
<tr>
<td>Stage of treatment</td>
<td>Engagement or persuasion</td>
<td>Active</td>
<td>Relapse prevention</td>
</tr>
<tr>
<td>Goal</td>
<td>Ascertaining and developing motivation for change and taking steps</td>
<td>Developing resources and skills to change</td>
<td>Sustaining change, making life changes, and enhancing well-being and recovery</td>
</tr>
<tr>
<td>Practices</td>
<td>• Assessment and feedback • Identifying goals • Developing discrepancy • Defining steps for action</td>
<td>• Functional analysis • New coping skills • Alternative activities • Modifying social supports</td>
<td>• Connection with peer recovery support groups • Beginning work on lifestyle changes</td>
</tr>
</tbody>
</table>

- **ICT is therefore a combination of evidence-based treatments with stage-wise considerations, specifically tailored to persons with co-occurring substance use and psychiatric disorders.**
Assessing Substance Use and Psychiatric Problems

Goals

- Review the patient’s/group members’ assessment data about substance use and mental health problems.
- Provide feedback to the patient about the assessment.
- Begin to determine the patient’s desire to change and resolve problems.

Time

- 45–50 minutes for individual session
- 60–90 minutes for group session

Handouts Needed

- Handout 2: Mental Health Problems and the Symptoms That Bother Me (pages x–x)
- Handout 3: Substance Use Problems and the Symptoms That Bother Me (pages x–x)
- Handout 4a: Substance Use Problems: Part I (pages x–x)
- Handout 4b: Substance Use Problems: Part II (pages x–x)
Clinical Introduction to Module 2

If ICT is being conducted in an addiction treatment program, substance use disorder diagnoses and a list of consequences are probably available to you. If ICT is being conducted in a mental health setting, it is likely that mental health diagnoses are available. In either situation, the complete range of information may not be accessible and certainly has not been processed with the patient in a motivational enhancement technique.

Depending on the assessment information that is available, you may need to orient the patient to any existing assessment or diagnostic information that was provided (when, where, and to whom) or may need to be gathered at this juncture. Curriculum 1 Screening and Assessment provides guidance on the type of material that may be useful to obtain at this time. Refer to this data or, if not already gathered, strategies and tools outlined in curriculum 1 Screening and Assessment can be implemented.

The most important aspect to MET technique is seeing your role as expert collaborator—the “copilot.” Be sure to review “MET Seven Clinical Techniques,” found in appendix B. Naturally, you may already have some expertise. You probably already have assessment information and beliefs about what will likely be most effective with this patient. Your task will be to utilize these techniques to engage the patient in this therapeutic process.

When reviewing assessment information with the patient, you can decide whether to begin with mental health or substance use problems and symptoms. Generally, in addiction treatment settings, patients will be more comfortable describing their substance use problems first. In this circumstance, beginning with substance use and then going into mental health concerns may be a good choice.

Conversely, in mental health settings, patients expect their emotional or psychiatric issues to be dealt with. Attending to those first and then proceeding to substance use issues may be prudent.

Another approach is to let the patient know that you will be exploring his or her feelings about mental health and substance use issues. Allow the patient to choose which one to begin with. For practical purposes, mental health problems are considered first below.
Mental Health Problems

In curriculum Screening and Assessment, a number of self-report screening measures and assessment measures are described. In this module, utilize these measures to guide the conversation with the patient.

If you are using the Modified Mini Screen (MMS), note where the patient scored on the scales pertaining to mood, anxiety, and thought disorders. (Anything more than two yes responses on either of these scales is potentially indicative of a psychiatric disorder.)

If you are using the Mental Health Screening Form–III (MHSF–III), you can review where the patient endorsed a yes as indicative of the potential for a disorder.

If you used the specific screening measures outlined in curriculum Screening and Assessment (the CED-D, SIAS, or PCL), note where the patient scored on these scales pertaining to depression, social anxiety/phobia, or PTSD symptoms.

Another approach is to ask the patient about his or her awareness of specific diagnoses. Then query about the symptoms he or she has that characterize, or at least that he or she associates, with this diagnosis. At this juncture, you want to develop a list of mental health problems and symptoms in the patient’s own words, if possible.

Substance Use Problems

A clinician has a number of self-report screening measures and assessment measures for assessing addiction. In treatment, DSM-IV-TR is most often used to diagnose addiction. Handouts 3 and 4 will assist you in assessment and diagnosis.
Suggested Module Outline

Step 1: Introduce Module 2

1. To introduce this module, you may use the following script:

   I am going to ask you to think about the kinds of problems that trouble you. This is probably the reason you and I are meeting. Remember that, unlike other therapies or programs, here I am going to be interested in both your mental health and your substance use issues. So, the purpose of this session is for you to help me clearly understand what you might see as a problem, especially as it could pertain to drugs or alcohol and emotional issues.

2. Review with the patient any existing assessment or diagnostic information that you have. If necessary, remind him or her when, where, and to whom the information was given. You might say to the patient:

   You already talked with _______ about some of these issues when you were first assessed.

   or:

   Some of these issues you have already talked about with ________ , and some other issues we may need to explore a little today.

3. Afterward, consider completing this introductory step with a statement similar to the following:

   I am glad we have the opportunity to gather (or review) some information about your mental health issues and your relationships with substances. I am hoping you feel okay in describing these matters with me. If you have any reservations or questions, now would be a good time to let me know.
**Step 2: Obtain Assessment Information**

Note: As mentioned in the introduction to this module, you can decide whether to begin with mental health problems, begin with substance use problems and symptoms, or explore feelings about mental health and substance use issues. You should refer to any screening and assessment measures used. For practical purposes, mental health problems are considered first.

Guide the patient in a conversation about his or her awareness of specific diagnoses. Ask the patient to describe *in his or her own words* the symptoms he or she associates with this diagnosis.

**Step 3: Complete Handout 2**

1. Handout 2, Mental Health Problems and the Symptoms That Bother Me, allows the patient to list his or her problems and symptoms. Ask the patient to identify and name the emotional or mental health problem. This may be “depression” or “anger” or “bipolar disorder” or “guilt” or whatever the patient indicates.

2. Instruct the patient to indicate what symptoms or things are attached to that problem.

   For example, a person who indicates “depression” might specify that she feels “sad, remorseful, lethargic, and worthless,” and that she “sometimes thinks about suicide.” A person who indicates that the problem is “PTSD” might say that he avoids certain kinds of people or situations that are reminders. He may list “nightmares” or “flashbacks” among the symptoms. The key here is that the patient should list his or her own symptoms.

3. If the patient seems to be struggling, ask if he or she has certain symptoms that you know may be associated with his or her particular disorder. In some cases, a patient may have already described some symptoms but not be recalling them as they complete handout 2.
Step 4: Complete Handout 3

*Note:* Handout 3, Substance Use Problems and the Symptoms That Bother Me, pertains specifically to substance use problems. In some cases, patients will fully acknowledge that they have a problem with a particular substance and will be able to quickly list the symptoms or consequences that are associated with their substance use disorder. In other instances, you will need to assess their substance use and help them identify from a list of potential symptoms those that apply to them. The key here is that the patient lists his or her own symptoms.

1. Handout 3, Substance Use Problems and the Symptoms That Bother Me, allows the patient to list his or her problems and symptoms. Ask the patient to identify and “name” his or her substance use problems. The patient may list them simply as “alcohol” or “cocaine” or “marijuana” or “meth.”

2. Ask the patient to list the symptoms or things that are attached to that problem.

   For example, a patient who identifies “alcohol” as a problem might specify “hangovers” and “blackouts” or “DUIs” as symptoms or things. A patient who lists the problem as “meth” might indicate that he or she now has “tooth decay” or “gum disease” as a symptom.

3. If the patient seems to be struggling, ask if he or she has certain symptoms that you know may be associated with a particular substance use disorder or dependency. In some cases, a patient may have already described some symptoms but may not be recalling them as they complete handout 2.

Step 5: Complete Handout 4

*Note:* Handout 4, Substance Use Problems: Part I, provides a list of the most common classes of substances: alcohol, cannabis, opiates, stimulants, depressants, and others, such as hallucinogens. For a complete list of substances that fall into these categories, please consult the NIDA Web site: www.drugabuse.gov (or see the substance resource at the end of this manual). Part I also lists the criteria for dependency from the DSM-IV. Substance Use Problems: Part II also lists those substances and some typical consequences that many people with substance use disorders have identified as being a result of their addiction.

1. Ask the patient what his or her substance use has been like.

2. Have the patient fill out handout 4, parts I and II, as directed.
**Instructions:** In thinking about the information you provided your clinician during your first interview or what you recently discussed, you and your clinician will make a list of the problems that bother you most. You both will also list symptoms related to these problems. Your clinician will help you with this handout.

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Integrated Services for Substance Use
and Mental Health Problems

Cognitive-Behavioral Therapy
Clinician’s Guide

Mark McGovern
and other faculty from the Dartmouth Medical School

Review copy only. Not to be duplicated or otherwise disseminated.
# TABLE OF CONTENTS

Acknowledgments ......................................................................................................................... ix
How to Build a Patient Workbook .................................................................................................... xi

## PART I

**Introduction** .................................................................................................................................. 3

Chapter 1: *Core Principles of Cognitive-Behavioral Therapy* ...................................................... 7

Chapter 2: *The Effectiveness of CBT for Co-occurring Substance Use and Psychiatric Disorders* ................................................................................................................................. 11

Chapter 3: *Translating CBT for Co-occurring Disorders into Routine Clinical Practice* .......... 15

Chapter 4: *Relationship Factors: Therapeutic Alliance and the Therapeutic Frame* ................. 17

Chapter 5: *How to Use This Guide* ................................................................................................. 21

Chapter 6: *Special Issues with CBT and Co-occurring Disorders* ............................................ 31

## PART II

**CBT for Co-occurring Disorders: Therapy Modules** .................................................................. 49

Module 1: *Introduction to CBT* .................................................................................................... 51

Module 2: *Substance Relapse and Crisis Prevention Plan* .......................................................... 57

Module 3: *Breathing Retraining* .................................................................................................... 61

Module 4: *Patient Education I: Primary Symptoms of Co-occurring Disorders* ...................... 67

Module 5: *Patient Education II: Associated Symptoms of Co-occurring Disorders* ............... 75

Module 6: *The Five Steps of Cognitive Restructuring: The First Three Steps* ......................... 87

Module 7: *Cognitive Restructuring: The Five-Step Program* .................................................... 97

Module 8: *Generalization and Beyond* .......................................................................................... 107
This curriculum describes a cognitive-behavioral therapy (CBT) approach for persons with co-occurring substance use and psychiatric disorders. This CBT curriculum is primarily designed for delivery in the context of an addiction treatment program. The addiction treatment program may be drug free, abstinence based, methadone maintenance, or medication-assisted recovery based. It is important to understand that co-occurring disorders require intensive and adequate treatment for the substance use disorder. Integrated or augmented psychiatric or psychosocial treatments may only be effective under such conditions (i.e., the patient is receiving treatment for his or her substance use disorder at the same time he or she is involved in CBT).

For the sake of convenience, the word “clinician” refers to any practitioner—counselors, supervisors, therapists, psychologists, facilitators, medical and mental health personnel, administrators, agency directors, and doctors—using these guides and curricula as part of the Co-occurring Disorders Program with patients and family members.

This curriculum may also be used in office-based or mental health programs either alone or in tandem with other services. It is important to ascertain the severity of the substance use problem to determine if this CBT treatment can be effective under these circumstances. For example, in the context of active substance use, it may be clinically necessary for the patient to be placed in a more intense level of care to stabilize the substance use problem. If, however, the patient is stable, or in a period of early or advanced recovery, then this treatment may be delivered within the context of an office-based or mental health practice.
The treatment outlined in this guide consists of several important clinical practices:

1. Asking about substance use: You must ask patients about substance use initially and throughout the course of the treatment. Patients with co-occurring disorders are at high risk for relapse to substance use. Multiple factors will make it challenging for them to sustain abstinence or to discontinue the use of substances as a primary coping strategy to manage psychiatric symptoms.

2. Asking about psychiatric symptoms: You must ask patients about psychiatric symptoms initially and throughout the course of treatment. Patients may be relying less on substances to cope with their psychiatric symptoms, such as anxiety and depression, or have more severe symptoms related to PTSD. As a result, they will be in a position to learn new coping skills. In the meantime, until they develop new coping skills through CBT, they may feel at a temporary loss for how to manage their psychiatric symptoms.

3. Establishing safety: At the first session, you must talk about issues of substance use, ongoing or acute psychiatric symptoms, and risk for self-harm, including suicide. It is important to determine if a patient is safe and stable enough to participate in the treatment. Developing a relapse prevention and crisis plan in the first session will permit an open discussion of these issues and delineate appropriate courses of action.

4. Teaching breathing retraining: Teach breathing retraining early on as a way for patients to immediately begin to manage their anxiety, and have patients practice breathing retraining throughout their treatment. Anxiety is one of the most common symptoms across all psychiatric disorders, and having a skill to manage it is important.

5. Educating patients: Using the Fact Sheet for each major psychiatric disorder (including a general one on co-occurring disorders) as a guide, you will provide patients with basic information about their disorders and related problems. These same Fact Sheets will also be used in other components of the Co-occurring Disorders Program: curriculum Integrating Combined Therapies and curriculum Family Program. Patients will also be given additional handouts in each module. For additional patient information on specific disorders, see the CD-ROM for a list of other Hazelden products.
6. Teaching cognitive restructuring (CR): You will be teaching patients how to challenge automatic thoughts that lead to upsetting feelings. CR is a core ingredient of CBT.

7. Generalization and beyond: Since CBT is a time-limited, skill-based therapy, you will need to prepare the patient for the end of treatment (termination) in advance. Explain that with time and practice he or she will continue to develop the ability to use CR even after the treatment has ended. Through this process, he or she will become his or her own clinician.

8. Discussing follow-ups to CBT: You will need to discuss with patients what types of services they will continue to receive in the addiction treatment or mental health program. Since addiction and psychiatric disorders are typically chronic and involve a vulnerability to relapse, patients will need to consider ongoing monitoring of both problems for the foreseeable future.
Although many versions of CBT exist, several principles cut across all forms to make it a more “generic” type of psychological therapy. With some variation for application to specific disorders, most CBT shares the same common ingredients. This version of CBT focuses on cognitive restructuring. Other versions of CBT may focus on behaviors, such as in imaginal or in vivo exposure to anxiety-producing situations. Yet others may focus on the development of alternative coping skills. Although the versions of CBT may lean in several different directions, they all share common principles. The execution of these basic principles makes it recognizable as CBT and distinct from other therapies. The following information describes those shared principles.

**CBT Is Present Centered**

CBT differs from many other psychological therapies in that its focus is on the present or “here and now.” It does not dwell on the long or distant causes of a problem, but instead focuses on what is happening now.

**CBT Focuses on Thoughts and Their Interpretation That Give Rise to Negative or Positive Feelings**

CBT also does not so much focus on the patient’s feelings, as much as it focuses on the thoughts that give rise to the feelings. In fact, CBT is based on the assumption that a cascade of negative thoughts lead to irrational fears, worries, hopelessness, worthlessness, avoidance, and many other negative feelings and behaviors. CBT will also help a person understand which kinds of thoughts lead to positive feelings such as hope, joy, excitement, empathy, and inspiration.

**CBT Focuses on Learning New Ways of Thinking**

The therapy is then focused on helping the patient examine the sequence of events from situations to thoughts to feelings and understand that there is more flexibility in altering thoughts than the patient may have ever imagined. The CBT clinician wedges the possibility of new ways of thinking in response to previously set interpretations about situations, events, or beliefs. This
tactical skill is taught to the patient in the context of the therapy so that the patient learns to apply this technique on his or her own. For this guide, this technique is called “cognitive restructuring” (CR).

**CBT Involves Identifying Common Styles of Thinking**

During the course of examining their ways of thinking about potentially negative situations, and how these ways of thinking lead to negative thoughts and feelings, patients will learn to recognize common thinking errors or cognitive distortions. Sometimes these distortions are less judgmentally called “common styles of thinking.” For example, one common thinking style among people with depression or anxiety disorders is “catastrophic thinking.” Catastrophic thinking, or catastrophizing, typically involves predicting the worst case scenario without evidence. Thus, a person with social anxiety may avoid group situations because he fears the worst will happen: that he will become anxious or embarrassed; he will be unable to control it; everyone will notice it; and finally he will be even more humiliated. Given this prediction of certainty, it is no wonder he avoids these kinds of situations.

**CBT Is Skill Based**

Learning new ways to process situations and thoughts so that new feelings and behaviors can emerge is a skill. CBT is focused on the clinician teaching the patient how to use this skill and how to apply it to key aspects of his or her life.

**CBT Involves Practice**

Acquiring any new skill is a combination of learning it correctly and then applying it over and over. Once a patient learns the technique of CR, he or she benefits by repetition in his or her life. The more a patient practices this skill in real-world situations, the better he or she will get at it. In fact, most successful outcomes for CBT occur when patients complete their practice exercises between sessions. These exercises enable the patient to replace formerly automatic thoughts that
led to negative feelings (such as anxiety or depression) with reflexive thoughts that are more flexible and positive.

**CBT Requires Clinician Activity**

The CBT clinician in many ways is a teacher or coach. Certain skills are first presented and explained. The patient demonstrates the skill in the session. This sequence is repeated several times with different examples. The patient is assigned practice (homework) between sessions. This material is carefully reviewed at the start of each new session. Clinicians are not passive and are more instructional. At the same time, the CBT clinician is tuned into the patient’s needs, comfort, and learning styles. The clinician adjusts the pace, the timing, and, to some extent, the approach to maximize the patient’s chances for success.

**CBT Is Time Limited**

CBT is time limited. The goal of the clinician is to make sure the patient can serve as his or her own clinician by learning and internalizing the skills of CR so thoroughly that the clinician is no longer needed. The time-limited nature of CBT is underscored several times at the outset of the therapy, and the patient is reminded throughout the course of the treatment. Many patients, particularly those having experience with other therapies, initially find this difficult to accept. Often these very same patients learn in time to appreciate the autonomy of CBT. They become proud of their capacity to do the techniques on their own.

Follow-up or booster sessions are not uncommon, so they may be incorporated into the generalization phase of CBT. CBT could also be built into “recovery check-ups” that may occur for patients in maintenance or relapse prevention stages. For more information about recovery check-ups, see module 20 in curriculum Integrating Combined Therapies.

**Summary**

Although there are different manifestations or applications of CBT, most share common principles and ingredients. It is important for the CBT clinician to be familiar with these principles. Clinicians new to CBT may need to consider how these principles are similar or different from their typical therapeutic strategies and assumptions. A skilled CBT clinician will also answer patients’ questions about how CBT works and how it may differ from their own previous therapy experiences.
The Effectiveness of CBT for Co-occurring Substance Use and Psychiatric Disorders

CBT is a well-established evidence-based practice for both substance use and psychiatric disorders. It has been found effective with a heterogeneous group of disorders and therefore might be considered a generic practice that can be helpful with any mental health or behavioral problem.

The sections below briefly review the evidence for the effectiveness of CBT as applied to both substance use and psychiatric disorders, as well as for co-occurring disorders.

**CBT and Substance Use Disorders**

In the largest multisite trials ever conducted by the National Institute on Alcoholism and Alcohol Abuse (NIAAA) and the National Institute on Drug Abuse (NIDA), CBT was the only intervention researched for both agencies. In the NIAAA Project MATCH studies, CBT was compared to motivational enhancement therapy (MET) and Twelve Step facilitation (TSF) therapy and was found equally effective. (Note that the combination of these treatment approaches fits into a stage-wise treatment model and is adapted for persons with co-occurring disorders in curriculum 2 Integrating Combined Therapies.)

In the NIDA multisite Collaborative Cocaine Treatment Study, cognitive therapy (CT) was compared to three other manual-guided treatments: supportive-expressive psychotherapy (SEP), individual drug counseling (IDC), and group drug counseling (GDC). Both IDC and GDC were designed to be “treatments-as-usual” but performed at least as well as the CT and SEP approaches.

The manuals used in the NIAAA and NIDA studies shared many of the common ingredients outlined in chapter 1 of this guide. A number of studies both before these multisite trials and since have replicated the effectiveness of CBT in reducing substance use and enhancing recovery.

Relapse prevention therapy (RPT) is also a well-established evidence-based practice for substance use disorders. RPT is by its core principles a type of CBT. RPT focuses on the antecedents and consequences of behaviors. It helps a patient recognize sequences of seemingly irrelevant events and develop alternative
coping skills. Like CBT, RPT involves a clinician that is akin to a teacher or coach. He or she encourages the patient to develop improved self-monitoring skills via practice between sessions.

CBT is also one of the most desired approaches among community clinicians in terms of training and implementation.

**CBT and Psychiatric Disorders**

Although CBT roots date back to behavior therapy and systematic desensitization, most consider the origins of CBT to have started with the work of Aaron Beck. Beck initially studied CBT for depression and found it to be as effective as medications. Since then, CBT has been studied and found effective for mood disorders as well as anxiety disorders.

Derivations of CBT have been used to help persons with schizophrenia and bipolar disorder develop new skills and improved capability to manage their illnesses. Adaptations of CBT have also been used for persons with Axis II personality disorders, specifically borderline personality disorder (with dialectical behavioral therapy). Recent studies have used single generic manuals for CBT for a heterogeneous group of psychiatric disorders and found it effective.

For psychiatric disorders, CBT is perhaps the most effective psychosocial intervention. In combination with the FDA-approved medications for the psychiatric disorder, concomitant CBT is the treatment of choice. In the case of some disorders, such as PTSD and social phobia, CBT has been found more effective than medication, both in terms of the magnitude of patient change and also the durability of change over time.

For psychiatric disorders, CBT is perhaps the most effective psychosocial intervention.
CBT for Co-occurring Substance Use and Psychiatric Disorders

In both NIDA and NIAAA funded research, versions of CBT have been applied to persons with anxiety disorders (such as panic disorder and social phobia) and alcohol dependence, and persons with PTSD and cocaine dependence. These studies, although limited by rather restrictive patient-inclusion criteria, converge in finding that CBT is effective for the symptoms of both substance use and psychiatric disorders. Two recent studies—one on people with bipolar disorder and the other on people with PTSD—have also found that CBT is promising in its effectiveness for patients in community addiction treatment programs who have a variety of substance and polysubstance use disorders.

Summary

Taken together, these studies suggest that the core principles of CBT for co-occurring substance use and psychiatric disorders have a strong evidence base.
Although CBT has widespread and generic effectiveness for many disorders, it is not readily available in routine clinical practice settings. Some have argued that this may be because CBT requires purposeful effort on the part of the clinician, rather than a more passive approach. Others have noted that CBT may be difficult to learn and even more difficult to deliver with adherence and competence.

Another reason may be that many of the manuals for CBT are very specific for particular disorders (for example, depression, anxiety disorders, PTSD, or bipolar disorder). However, most practitioners do not see patients with one particular psychiatric or substance use disorder. In fact, a more complex and heterogeneous patient profile is likely the rule. Patients often have problems with multiple substances, including alcohol and drugs or more than one drug. Further, patients may have more than one psychiatric disorder and certainly not all patients will present with the same disorder. Thus, a generic CBT manual that could address a range of psychiatric and substance use disorders, while still using the core principles, is needed.

This curriculum is intended to be a practical, ready-to-use CBT guide (with patient handouts) that can be used in routine clinical practice with a broad range of persons who suffer from co-occurring substance use and psychiatric disorders.
This guide is an adaptation of *Cognitive Behavioral Therapy for PTSD in People with Severe Mental Illness: Therapist Manual*, which was itself adapted and simplified for persons with PTSD and co-occurring substance use disorders treated in community addiction treatment programs. These community addiction treatment programs range from intensive outpatient drug-free ones to methadone maintenance clinics in urban and rural settings. This CBT guide was developed for use by addiction and mental health clinicians who have limited training and expertise in CBT. Thus, it is designed to be simple and easy to use.

Researchers who study implementation effectiveness of evidence-based treatment have found several good predictors of a treatment’s success in routine clinical practice. They include the following:

- The practice is simple to do and easy to learn.
- Clinicians are motivated to learn and do it.
- Clinicians see that their patients get better.
- The agency within which the practice is being delivered values it, and there is supervisory support for it.
- There are financial incentives to support it, or at least no financial factors to undermine it.

This guide should meet the first three criteria. We expect this guide to appeal to clinicians for its simplicity and ease of use. In addition, clinicians will likely be motivated to learn CBT and can expect to see their patients improve as a result of their efforts in CR. The fourth and fifth criteria are beyond the scope of our control.

**Summary**

This curriculum is meant to be a practical, ready-to-use CBT guide that can be used in routine clinical practice with a broad range of persons who suffer from co-occurring substance use and psychiatric disorders.
Those who develop, study, and write about evidence-based practices acknowledge that it is essential for the delivery of the practice to occur within the context of a good relationship in order to be effective. Interestingly, some studies (such as the NIDA Collaborative Cocaine Treatment Study and NIAAA Project MATCH) that compared a group of evidence-based practices found that the therapeutic relationship accounts for considerable effects, sometimes above and beyond the properties of any specific intervention.

Taken to an extreme, some clinicians posit that effective therapy is all about the relationship between the clinician and patient. In the early days of psychotherapy research, scientist-practitioners such as Hans Strupp and others labeled this relationship a “nonspecific” factor, as if it could be considered somehow separate from the type of therapy being delivered or the specific technique being practiced. Other nonspecific factors included the positive safe and caring relationship, the expectation of change, the effect of time, homeostatic properties (a person starting out feeling bad will eventually return to a more baseline state), unconditional positive regard, and simply having a coherent explanation of the problem.

A less polemical interpretation of this issue suggests that both the type of practice and the relationship within which it occurs are critical to effective treatment. Most studies of practices, including CBT, have found the particular evidence-based treatment under study to be even more effective when compared with practices delivered by good clinicians with good relationships with patients. The effectiveness of CBT was above and beyond these treatments as usual.
disadvantage of giving up responsibility was that the world seemed scarier, less predictable, and less under her control. Examining these advantages and disadvantages helped her identify and challenge the more fundamental belief that “the world is an extremely unpredictable and dangerous place.” After analyzing her thoughts in the payoff matrix, she could retain or change her thoughts, which allowed her to make informed choices based on the perceived advantages and disadvantages of each alternative. Such an analysis illustrates to patients the price they pay for adhering to unrealistic beliefs concerning responsibility for traumatic events.

When conducting a payoff matrix, you will find that for patients one of the most common disadvantages of giving up unrealistic thoughts or beliefs about control or responsibility over events lies within accepting a view of the world that recognizes a certain amount of unpredictable risk and danger. Some patients may experience relief when they are able to develop more realistic perceptions of risk and danger. However, some patients experience high levels of anxiety when they perceive there to be any risk, and this anxiety may serve as a barrier to developing more realistic perceptions.

In these circumstances, rather than attempting to modify a patient’s perceptions of risk, it is preferable to help the patient accept that level of risk in the world. The patient may need to understand and accept that a certain amount of risk in living is inescapable. To get on with his or her life, the patient needs to work on accepting the risks he or she faces on a day-to-day basis and is likely to face in the future. Patients who accept this risk can then be helped to modify their beliefs concerning excessive control over or responsibility for past and future events.

For patients who absolutely cannot accept this degree of risk, the clinician can focus the discussion on exploring possible lifestyle changes that might reduce those perceptions of risk even further. However, these patients will need a great deal of help in learning that no one can escape all risks.
Patient Education I:
Primary Symptoms of Co-occurring Disorders

Goals

• Help the patient understand the nature of the psychiatric symptoms and how they intersect with substance use.
• Review the description and causes of a patient's specific disorder.
• Help the patient conduct an analysis specific to symptoms related to psychiatric problems.

Time

This module may take more than one session to complete.
• 45–50 minutes for an individual session
• 60–90 minutes for a group session

Handouts Needed

• Handout 4A: Primary Symptoms of Co-occurring Disorders (page 7)
• Handout 4B: Primary Symptoms of the Mental Health Problem (pages 9–10)
• Handout 5: Goals: Positive Psychology (page 11)

From the Patient Educational Fact Sheets select
• the Co-occurring Disorders fact sheet (page x)
• the appropriate fact sheet for the patient’s disorder

Review copy only. Not to be duplicated or otherwise disseminated.
Suggested Session Outline

**Step 1: Review Practice/Homework**

Ask the patient if he or she continued to practice the breathing retraining exercise twice a day as instructed. If not, explore any issues the patient may have encountered that prevented him or her from practicing. If the patient did practice, explore the benefits of practice.

Ask the patient if he or she attended peer support group(s) between sessions. Discuss this if appropriate.

**Step 2: Discuss Handout 4A, Primary Symptoms of Co-occurring Disorders**

Review handout 4A with your patient (or group).

The primary goal of patient education is to help the patient understand the nature of his or her psychiatric symptoms and how they intersect with substance use. Although you will gather important information about the patient’s symptoms, the emphasis is on education rather than clinical assessment. Encourage active participation. Ask the patient to describe his or her own experience with the symptoms of his or her disorder and how each symptom applies (or doesn’t) to him or her. Some symptoms he or she may “identify” with; the patient may feel that other symptoms do not apply. Make the patient educational material more personally meaningful and, therefore, more memorable. Connect the psychiatric symptoms to substance use. Explain how substance use works, how it helps the patient, how it hurts, and if possible, help the patient to understand the sequence of events that led to substance use. This will help the patient acquire the CR skill later on. Refer to the handouts and complete them with the patient in the session.

There are ten Patient Educational Fact Sheets specific to psychiatric disorders. They are located on the CD-ROM. There is also one general fact sheet about co-occurring disorders. Every patient should receive this handout.
The specific handouts are as follows:

**Anxiety disorders:**
- Generalized Anxiety Disorder (GAD)
- Social Anxiety
- PTSD
- Panic Disorder
- Obsessive-Compulsive Disorder

**Mood disorders:**
- Major Depression
- Dysthymia
- Bipolar Disorder

**Thought disorders:**
- Schizophrenia
- Schizoaffective Disorder

It will usually be clear what handout should be used. Patients may have more than one diagnosis, in which case all the handouts that apply should be distributed. In individual formats, you may insert the appropriate handout into the patient workbook in advance. In group formats, you may do the same with each new member of the group, or you may start the group by describing the list of handouts and having patients select the one(s) that apply to them. The risk here is that patients may not know their diagnosis, so it will be important that they explain how it is they selected a particular handout for a psychiatric disorder.

**Step 3: Hand Out the Appropriate Patient Educational Fact Sheet and the Co-occurring Disorders Fact Sheet**

Once the fact sheet on the specific disorder has been distributed, use the following format:

**Review the Description of the Specific Disorder with the Patient**

Go over the detailed description of the disorder, discussing what it is and what it is not. Go over the basic symptoms. Ask the patient if this description fits with his or her understanding of the psychiatric disorder. It might also be useful to talk about when he or she was first diagnosed and what his or her reaction was.
**Review the Causes of the Specific Disorder with the Patient**

In this segment, it is important to be sure that the patient can talk about his or her understanding of why he or she has the disorder. Attend to matters of guilt or self-blame.

**Review the Section Entitled “What Are the Usual Treatments for _______?” from the Patient Educational Fact Sheet**

The purpose of this section is to review the treatment the patient has received or is presently receiving for his or her mental health issue. Inquire specifically about treatments the patient may have had pertaining to his or her mental health diagnosis.

**Step 4: Discuss Handout 4B, Primary Symptoms of the Mental Health Problem**

At this juncture, pass out handout 4B to the patient (or group members). Handout 4B will ask the patient to list the symptoms of the disorder or disorders he or she has. It will also provide the patient a chance to identify which symptoms pertain to him or her and how.

Have the patient fill out handout 4B. You should have already discussed the causes of the patient’s disorder with the patient in step 3. However, if the patient hasn’t reviewed the causes of his or her disorder, this handout will require him or her to refer to the appropriate fact sheet.

Be sure to assess the patient’s experience and motivation to deal with his or her psychiatric disorder. You may want to discuss the appropriate use of medications for the psychiatric disorder, attitudes regarding medication use, and other relevant matters. It is important to support the patient’s use of appropriate medications, in combination with CBT, as perhaps the best treatment available for his or her co-occurring disorders.

**Step 5: Discuss Handout 5, Goals: Positive Psychology**

This segment of patient education is focused on positive psychology—helping the person identify goals that his or her symptoms have gotten in the way of. This exercise also is designed to end this module on a positive note, because this part of CBT—focusing on the symptoms and how they apply to the patient—can sometimes be overwhelming to patients. Until patients reach the modules on CR, the only resources they have to rely on are the breathing retraining exercises and their
positive expectancy for help from you. Focusing on what they want for themselves is exciting to many patients and adds to their motivation to address the obstacles of their psychiatric disorder.

As a way of introducing this exercise with handout 5, you may use the following script:

Many patients seek treatment because they want to eliminate the negative effects of mental health problems from their lives. They want to be less depressed, nervous, out-of-control, isolated, emotionally eviscerated, or angry; however, patients are generally even more motivated to change because of the positive things that will happen for them. Now I want you to think about how your mental health problem has interfered with your life and the things you want for yourself. Examples of some things you may want are a job, relationships, ability to leave the house, sexual relations, or ability to drive a car.

Pass out handout 5 and walk through the symptoms of the patient’s psychiatric disorder. List how each interferes with his or her life, and then have the patient list what things are possible if he or she weren’t so bothered by these symptoms. End by listing the three most important things a patient could do if he or she were symptom-free. It is important to try to focus on tangible goals. Concrete goals that can be measured, such as behavioral changes or trying new activities, are best.

**Step 6: Assign Practice/Homework**

This module is flexible and allows you and the patient to decide what to complete together during the session and what to assign as homework. This module may take one or two sessions. Two approaches to homework are possible. The first involves going as far as possible with the primary symptoms of the psychiatric disorder and goals in the first session, and then asking the patient to complete the remainder for homework to be reviewed and discussed in the next session. The second approach is to do an overview of the module and complete one or two symptoms for each disorder cluster and an example of a goal, and then ask the patient to add to the list between visits. The next visit would then involve discussing his or her additions to the handouts.

Encourage the patient to attend other treatment and possibly peer support group(s) between sessions.
Encourage the patient to practice breathing retraining twice a day before the next session. Emphasize that practicing the skill on a regular basis when he or she is not distressed (such as when getting up in the morning) will help develop and internalize the skill better. Then, he or she will be able to use it better in times when it’s really needed.

**Step 7: Write Your Clinical Observations**

Ask yourself the following questions to help you evaluate the effectiveness of this module. It might be more insightful if you actually record the answers on a separate sheet of paper.

- Did the patient make good connections between his or her symptoms and the educational material?
- Does the patient seem to be struggling with issues pertaining to stigma, excessive self-blame or guilt, or minimization?
- Did the patient freely describe the symptoms he or she is presently struggling with?
- What was the patient’s emotional response to the material?
- Was the patient able to generate goals? Did you foster some sense of hope for him or her to achieve them?

**Step 8: Review the Therapeutic Alliance**

In our experience with CBT for co-occurring disorders, delivering this module effectively and completing it with patients is pivotal for patients in determining whether they will either finish or drop out of the treatment. If negative feelings and symptoms are focused on and no specific skills are provided to patients at this stage of the program, then patients may drop out of treatment. We have found three therapeutic alliance strategies to be helpful at this juncture.

First, try to “normalize” a negative emotional response, and affirm a patient’s experience and communication of it as *non-avoidant*. Avoidance, although protective, keeps symptoms going. Second, suggest to the patient that the “core” of CBT, CR, is designed specifically to address these negative emotional responses, including avoidance. Last, you can advise the patient that this can be a difficult juncture in the treatment but that it passes quickly. Using the breathing retraining skill is also particularly helpful at this time for patients who have been practicing it.
Step 9: Complete the Clinician and Supervisor Checklists

In conclusion, review the Clinician Checklist (and, if appropriate, the Supervisor Checklist) found on the program CD-ROM and in the three-ring binder following the handouts, and record the appropriate information for each patient and/or group.

...
Many people seek treatment in order to eliminate the negative symptoms of their mental health problems from their lives; however, people are generally more motivated to change because of the positive things that will happen. Think about how your mental health symptoms have interfered with your life and made you unable to obtain the things you want for yourself. Examples of such things may be a job, relationships, ability to leave the house, sexual relations, or driving a car.

1. Answer the questions below and fill in the appropriate boxes.

<table>
<thead>
<tr>
<th>What are your three worst symptoms?</th>
<th>What are the major ways these symptoms interfere with your life?</th>
<th>What would you like to do if these symptoms were out of your way?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. What are the top three things or goals you could do/achieve if you were symptom free?

a. .................................................................................................................................

b. .................................................................................................................................

c. .................................................................................................................................
Medication Management
Clinician’s Guide

Mary Brunette, M.D.,
and other faculty from the Dartmouth Medical School
CONTENTS

Acknowledgments ........................................................................................................ ix

PART 1

Introduction to Part 1: Medication Management ................................................. 3
Chapter 1: Rationale for Medication Treatment of Co-occurring Disorders ........ 5
Chapter 2: Co-occurring Disorders and Stages of Change .................................. 7
Chapter 3: Differentiating Substance-Induced Disorders from Primary Mental Health Disorders ............................................................. 11
Chapter 4: General Principles in Medication Management: Initiating Treatment .................. 19
Chapter 5: General Principles in Medication Management: Continuing Care ........ 25
References for Part 1 ................................................................................................. 31

PART 2

Introduction to Part 2: Medications Used to Treat Co-occurring Disorders ........... 35
Chapter 6: Antidepressants ..................................................................................... 37
Chapter 7: Antianxiety Agents—Anxiolytics ............................................................ 51
Chapter 8: Hypnotics ............................................................................................. 59
Chapter 9: Mood Stabilizers and Other Agents Used to Treat Bipolar Disorder ........ 67
Chapter 10: Antipsychotics .................................................................................... 83
References for Part 2 ............................................................................................... 99
Welcome to *Medication Management*, an important component of the Co-occurring Disorders Program: Integrated Services for Substance Use and Mental Health Problems, developed by faculty from the Dartmouth Medical School.

Directed to physicians, other medical staff, and clinicians, this *Medication Management* guide focuses on the knowledge and skills for medication treatment of persons with concurrent psychiatric and substance use disorders. This integrated treatment approach involves offering both mental health and substance use disorder services at the same time and in one setting. People receive a consistent message about their treatment and recovery while engaging in services for both disorders, which improves recovery outcomes.

**Utilizing Medication Management**

This curriculum includes a three-ring binder that contains a guide for clinicians and other medical practitioners, along with a CD-ROM. Practitioners should read part 1 of the guide first for an overview of how medication can be used to support integrated treatment of persons with co-occurring disorders.

Part 1 of *Medication Management* covers

- the psychiatric symptoms of intoxication or withdrawal
- general principles in medication management
- ways to collaborate with the patient to prepare a medication plan
- how to utilize treatment strategies tailored to the stage of change
- the monitoring of mental health and substance use symptoms
- techniques to encourage a patient’s adherence to the medication plan
- best practices in initiating medication treatment and providing continuing care
Part 2 of *Medication Management* is a comprehensive, reproducible medication reference that includes information about specific medications used to treat patients with co-occurring disorders. This information includes indications, administration, side effects, drug interactions, and other relevant prescribing information. Part 2 is also included on the CD-ROM.

The medications discussed in part 2 are grouped into five sections:

- antidepressants
- antianxiety agents
- hypnotics
- mood stabilizers and other agents to treat bipolar disorder
- antipsychotics

Reproducible handouts for patients are also included on the CD-ROM. These handouts cover the following eight topics:

- Coping with Manic and Hypomanic Symptoms
- Coping with Cravings
- Coping with Anxiety: Symptoms and Strategies
- Coping with Sleep Problems
- Coping with Hallucinations
- Healthy Sleep Practices
- Managing Stress
- Developing Leisure and Recreational Activities

These handouts are appropriate for all patients who may or may not currently use a medication for a co-occurring disorder. These handouts cover common challenges faced by people with co-occurring disorders who are in recovery. Because many of these handouts briefly discuss the benefit of appropriate medication use in promoting recovery from mental health and substance use disorders, these handouts are beneficial for patients who are taking medications. Clinicians can copy these handouts and utilize them to reinforce the information and skills discussed in treatment.

* * *

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You may already be aware that many people with substance use disorders experience co-occurring mental health disorders. Several large epidemiologic studies have demonstrated this co-occurrence. For example, the National Epidemiologic Survey on Alcohol and Related Conditions (Grant et al. 2004) showed that the odds of having a mood disorder are four times higher in patients with alcohol dependence and are 12.5 times higher in patients with a drug dependence than in patients who do not have alcohol or drug dependence, respectively. The risk of having an anxiety disorder is also higher in patients with alcohol or drug dependence (odds ratios of 2.6 and 6.2, respectively). Overall, approximately two-thirds of patients seen in addiction treatment settings have co-occurring mental health disorders (Regier et al. 1990). Prescribers can therefore benefit from knowing how to treat both disorders, and patients benefit from receiving treatment for both disorders concurrently.

**Medication Is Effective in Treating Mental Health Disorders**

Prescription medications have been developed and tested for all of the Axis I psychiatric disorders. Effective medication options exist for the treatment of most of the major disorders, including mood disorders such as major depression (Hansen et al. 2005) and bipolar disorder (Stahl 2008); anxiety disorders (Kapczinski et al. 2003) including post-traumatic stress disorder (Zhang and Davidson 2007), panic disorder (Furukawa, Watanabe, and Churchill 2007), social anxiety disorder (Stein, Ipser, and van Balkom 2000), generalized anxiety disorder, and other anxiety disorders; schizophrenia and other psychotic disorders (Joy, Adams, and Lawrie 2006); and bulimia (Hay and Bacaltchuk 2007).

Placebo-controlled trials have demonstrated that medications for psychiatric disorders reduce or eliminate symptoms. For example, antidepressant medications such as the selective serotonin reuptake inhibitors (SSRIs) consistently reduce symptoms of depression by 30 percent to 60 percent overall and lead to complete remission in a significant proportion of patients. Effective psychotherapies have also been developed and tested for many mental health disorders and can be
utilized without medications for patients with mild or moderate disorders. However, medication is an important mainstay of treatment for patients with more severe and/or long-standing mental illness symptoms. This *Medication Management* clinician’s guide will discuss appropriate medication treatment for mental health conditions in patients with co-occurring disorders.

* * *
Co-occurring Disorders and Stages of Change

This chapter focuses on

- choosing treatment interventions based on the stages of change model of recovery
- diagnosing mental health symptoms in people with substance use disorders
- using medication to treat mental health disorders in patients with co-occurring substance use disorders

Both substance use and mental health disorders tend to be long-term health disorders that may wax and wane over time. Recovery involves using new strategies to manage the illnesses. It usually takes time for individuals to come to the awareness that illness symptoms and behaviors are problematic, and then more time to learn the skills to manage the illnesses. Different treatment strategies are effective at different stages of readiness to change.

Substance use and mental health disorders may be considered in terms of Prochaska’s stages of change: precontemplation, contemplation, preparation, action, and maintenance (relapse prevention) (see Table 1: Stages of Change—Substance Use and Mental Health Disorders on page 8). This material will focus on the four major stages: precontemplation, contemplation, action, and relapse prevention.

Most people abuse alcohol or other drugs, or experience mental health symptoms, for some time before they realize they are experiencing a disorder that is impairing their ability to function. This is the precontemplation stage, when people do not consider their substance use or symptoms to be a problem. People eventually begin to realize, sometimes with the help of a clinician, family member, or friend, that the substance use or mental health symptoms are causing problems for them. When people are considering the pros and cons of substance use or symptoms, they are in the contemplation stage of change. When people are actively working to control symptoms or substance dependence, they are in the action stage. When the mental health symptoms or substance dependence is controlled, and people are working to prevent relapse, they are in the relapse prevention stage.
Utilize Treatment Strategies Tailored to the Stage of Change

Appropriate treatment depends on where the patient falls within the spectrum of readiness to change related to the disorders the patient is experiencing. In the precontemplation stage, clinicians can develop a trusting relationship with patients by getting to know them and addressing their concerns. In the contemplation stage, clinicians can provide education about the illnesses, help patients set treatment goals, and help them work toward their goals. Motivational interviewing is a counseling style that clinicians can use in this stage and other stages to help patients recognize the impact of their substance use or mental illness on their ability to reach their own personal goals (see Integrating Combined Therapies, a component of the Co-occurring Disorders Program, for more information about motivational interviewing). Motivational interviewing increases motivation to address the substance use or mental health disorder symptoms.

Once a person decides to take steps to reduce or stop substance use, or to control his or her mental health disorder symptoms (the action stage of change), medications, substance dependence counseling, cognitive-behavioral therapy, or other interventions may help him or her make changes to control the substance use
or mental health disorder symptoms. During this time, the person may be in early recovery from the substance use disorder (reduced use or recently discontinued use), and the mental health disorder may be in partial remission with decreased symptoms or recent remission of symptoms.

In the final Prochaska stage, relapse prevention, the individual has discontinued substance use for a significant period of time and is engaged in ongoing behaviors to sustain recovery from the substance use disorder. The individual has implemented strategies, such as medication and cognitive or behavioral coping strategies, in order to reduce and control his or her mental health disorder symptoms and is engaged in ongoing behaviors to prevent relapse of the psychiatric disorder.

Notably, a person may be in different stages for the substance use disorder and the mental health disorder. People often focus on one or the other disorder and don’t recognize the presence of two problems. For example, a person may achieve remission from the substance use disorder but remain in the contemplation stage for a bipolar disorder for some time before being willing and able to make changes in relation to it. In addition, people do not necessarily progress through the stages of change in an orderly, sequential fashion. They may take a long time in one stage and move quickly through another. They may move backward through stages when a lapse or relapse occurs.

**Recovery and Remission**

Often, the term “recovery” has been used for controlling addiction symptoms, and the term “remission” has been used in reference to mental illness symptoms. In general, patients can be categorized into one of three primary stages of substance use:

1. Active use—symptoms of intoxication and withdrawal may be present
2. Early recovery—substance use has stopped, symptoms of withdrawal may be present
3. Late recovery—stable abstinence without symptoms of intoxication or withdrawal

Patients who are actively using or who are in early recovery often have psychiatric symptoms related to substance use that are caused by intoxication or withdrawal rather than by an independent mental health disorder. Patients who are in treatment for co-occurring mental health disorders will experience a
gradual reduction in symptoms, first moving into partial remission, and then into full remission. The progress of the substance use disorder and the mental health disorder may not be parallel, as illustrated in Table 2: Stages of Recovery—Substance Use Disorder (SUD) and Mental Health Disorder (MHD).

### TABLE 2

#### Stages of Recovery: Substance Use Disorder (SUD) and Mental Health Disorder (MHD)

<table>
<thead>
<tr>
<th>STAGE</th>
<th>SUD ACTIVE USE</th>
<th>SUD EARLY RECOVERY</th>
<th>SUD LATE RECOVERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHD Active Symptoms</td>
<td>Active substance use/active MHD symptoms</td>
<td>Early recovery from substance use/active MHD symptoms</td>
<td>Late recovery from substance use/active MHD symptoms</td>
</tr>
<tr>
<td>MHD Partial Remission</td>
<td>Active substance use/partial MHD remission</td>
<td>Early recovery from substance use/partial MHD remission</td>
<td>Late recovery from substance use/partial MHD remission</td>
</tr>
<tr>
<td>MHD Full Remission</td>
<td>Active substance use/full MHD remission</td>
<td>Early recovery from substance use/full MHD remission</td>
<td>Late recovery from substance use/full MHD remission</td>
</tr>
</tbody>
</table>

Medication treatment is appropriate for patients in the action and relapse prevention stages of change for the mental health disorder. Because people may move back and forth between contemplation and these stages, clinicians must maintain an awareness of where patients are at and use motivational counseling strategies to help patients maintain motivation to address the mental health disorder.
Studies show that patients with a mental health disorder and a co-occurring substance use disorder have a better chance at recovery when they receive integrated treatment for both disorders. Clinicians are commonly challenged, however, to differentiate the symptoms of a patient’s mental health disorder from the symptoms, including intoxication and withdrawal, of alcohol or other drug use. Further complicating matters, intoxication and withdrawal from substance use can cause a variety of substance-induced psychiatric disorders, which have been recently reviewed by Schuckit (2006). Most commonly, stimulants and cannabis can induce psychotic symptoms, and alcohol can induce depressive symptoms. These substance-induced syndromes must be differentiated from independent mental health disorders.

**Review the Patient’s History**

People with substance use disorders who are in periods of active use may have a wide variety of alcohol and other drug use patterns. Some may use daily, during which time they may be intoxicated throughout the day and wake up the next morning in a state of withdrawal from the substance. Others may use intermittently, experiencing intoxication after use, mild withdrawal upon discontinuation of use, and then days or weeks without intoxication or withdrawal symptoms. Some individuals may use heavily every day, such that if they were to stop, they would experience significant withdrawal symptoms for a period of weeks to months.

The key issue for clinicians to remember is that intoxication and withdrawal from substances can produce psychiatric symptoms and can mimic psychiatric disorders. Clinicians must carefully review the patient’s history to clarify whether psychiatric symptoms are induced by the substance use disorder (intoxication or withdrawal) or are due to an independent psychiatric disorder. This can be best achieved by creating a patient’s “life timeline,” in which the dates of the development of the specific symptoms of the substance use disorder(s) are detailed and periods of use and abstinence are identified (see Table 3: Timeline—Onset of Substance Use and Mental Health Disorders on page 12). The dates of the
development of symptoms of the psychiatric disorder(s) are also identified on the timeline. Psychiatric symptoms must be present prior to the development of the substance use disorder or during a period of abstinence in order for the health disorder to be considered a separate (not substance-induced) disorder.

### TABLE 3

**Timeline for Determining Independence of Psychiatric Symptoms for Patients in Treatment for Alcoholism**

---

In practice, however, identification of clear periods of abstinence and psychiatric symptoms can be difficult, especially if these periods are not recent or if the substance use started at a very early age prior to the usual age of onset of psychiatric disorders. In this situation, clinicians must consider whether the psychiatric symptoms are similar to what would be expected for the substance being used (see next chapter and DSM-IV-TR [American Psychiatric Association 2000]). If the psychiatric symptoms would not be expected to occur during intoxication or withdrawal from that substance, then the clinician can more confidently diagnose the psychiatric disorder.

For example, when a person with alcohol use disorder experiences persisting psychosis, a psychotic disorder can probably be diagnosed with confidence even though the person has been drinking regularly during the entire year the psychosis has been experienced. This is because repeated alcohol intoxication, while causing impairments, does not cause symptoms of schizophrenia (hallucinations, bizarre delusions, disorganized speech and behavior). In addition, a family history of mental health disorders should be assessed. When a strong family history of a mental health disorder is similar to the patient’s symptoms, the diagnosis of an independent mental health disorder is more likely. Getting a health history from family members can be important to confirm a family history of mental health disorders as well as confirm the presence of psychiatric symptoms during periods of abstinence.

Clinicians and other medical practitioners should be aware that intoxication and withdrawal from substances can cause characteristic psychiatric symptoms. Following is a list of commonly used substances—alcohol, sedative-hypnotics, marijuana, stimulants, hallucinogens, stimulant hallucinogens, club drugs, inhalants, and opioids—and the typical psychiatric symptoms the use of each can cause.

**Alcohol**

Alcohol is a central nervous system depressant, as are benzodiazepines and opioids. In addition to the symptoms listed in DSM-IV-TR, intoxication is characterized by a “high,” relaxation, and psychomotor impairment (slowed reflexes and inaccurate movement). In people who use large amounts of alcohol regularly, symptoms of depression are common, can be severe, and typically will resolve within four weeks of abstinence. Suicidal thinking can be associated with depression, and suicide is the fourth major factor in the early mortality associated with alcohol dependence.
Integrated Services for Substance Use
and Mental Health Problems

Family Program
Clinician’s Guide

Kim T. Mueser, Ph.D.
and other faculty from the Dartmouth Medical School

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# TABLE OF CONTENTS

How to Build a Workbook ................................................................. ix
Introduction ................................................................................ xi

## PART I

Chapter 1: Working with Families .................................................. 3
Chapter 2: The Basics of Family Collaboration ............................... 13
Chapter 3: Engaging Families in Treatment ................................... 23
Chapter 4: Psychoeducation with Individual Families ...................... 39
Chapter 5: Conducting Multiple-family Psychoeducation Groups .......... 57
Chapter 6: Adapting the Family Psychoeducation Program ............... 71

## PART II

**Single-family Psychoeducation Sessions**

Orientation to the Family Psychoeducation Program .......................... 85
Session 1: Psychoeducation about the Psychiatric Disorder ............... 89
Session 2: Psychoeducation about the Co-occurring Substance Use Disorder .................. 97

## PART III

**Multiple-family Psychoeducation Topics**

Topic 1: Medications for Co-occurring Disorders .......................... 107
Topic 2: The Stress-Vulnerability Model of Co-occurring Disorders .......... 115
Topic 3: The Role of the Family ....................................................... 123
Topic 4: Effective Communication ................................................ 129
Topic 5: Coping with Symptoms I .................................................. 137

Review copy only. Not to be duplicated or otherwise disseminated.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic 6: Getting the Most Out of Medications</td>
<td>147</td>
</tr>
<tr>
<td>Topic 7: Managing Stress</td>
<td>153</td>
</tr>
<tr>
<td>Topic 8: Coping with Cravings</td>
<td>159</td>
</tr>
<tr>
<td>Topic 9: Developing Leisure and Recreational Activities</td>
<td>169</td>
</tr>
<tr>
<td>Topic 10: Preventing Relapses</td>
<td>175</td>
</tr>
<tr>
<td>Topic 11: Coping with Symptoms II</td>
<td>183</td>
</tr>
<tr>
<td>Topic 12: Solving Problems and Achieving Goals</td>
<td>193</td>
</tr>
<tr>
<td>References</td>
<td>199</td>
</tr>
</tbody>
</table>
Families are important in most people’s lives, and they have a particularly important role in the lives of persons with co-occurring psychiatric and substance use disorders. However, families are often ill-equipped to deal with the challenges associated with helping a loved one with co-occurring disorders. This family psychoeducation program teaches families about the nature of co-occurring disorders and their treatment. Families also learn how to help a loved one manage his or her psychiatric disorder and develop a sober and rewarding life.

The family program is designed to be fifteen weeks long. However, it can be adapted to the requirements of special settings by either reducing or increasing the length of the program. The program includes both single-family and multiple-family group formats, and it can be implemented in any addiction or mental health treatment setting, including inpatient, residential, or outpatient settings. Treatment conduct the psychoeducation both with individual families and multiple-family groups. These clinicians are also either members of the patient’s treatment team or have regular contact with the team in order to facilitate a collaborative relationship between the family and the team.

Participants in the program include individuals with co-occurring disorders, their family members, and any other people who have a caring relationship with the person. Individuals with any co-morbid addiction and psychiatric disorder may benefit from the program, although the educational curriculum regarding psychiatric disorders focuses on anxiety disorders, mood disorders, and schizophrenia-spectrum disorders.
The clinician’s guide to the Family Program component of the Co-occurring Disorders Program is divided into three parts. Part I focuses on the goals and basic ingredients of family collaboration, the specific clinical skills for implementing the family psychoeducation program, and adaptations that can be made to the curriculum for specific settings or to address the special needs of families. Parts II and III describe the curriculum for the single-family and multiple-family sessions and provide suggested outlines for the sessions.

The Family Program includes fact sheets and handouts in the three-ring binder that can be duplicated using a copy machine. The fact sheets and handouts appear on the accompanying CD-ROM as PDFs that can be printed using a computer. A ninety-minute DVD called A Guide for Living with Co-occurring Disorders: Help and Hope for Clients and Their Families is also available. It provides an educational overview of co-occurring disorders, offers interviews with people who have them, and discusses ways that patients can participate in treatment to better manage their recovery from both disorders.

Editor’s Note: For the sake of convenience, the word “clinician” refers to any practitioner—counselors, supervisors, therapists, psychologists, facilitators, medical and mental health personnel, administrators, agency directors, and doctors—using the Family Program as part of the Co-occurring Disorders Program with patients and family members.
Chapter 1 focuses on the importance of engaging and working with the families of persons with co-occurring disorders. In addition to providing a rationale for working with families, this chapter describes the goals of a collaborative relationship between treatment professionals and families.

Who Are Family?
When considering the role of the family in the treatment of persons with co-occurring disorders, it is important to first establish who should be considered family. The word “family” generally refers to relatives by blood or by marriage, such as spouses, parents, siblings, children, grandparents, or aunts and uncles. Some people, however, define family to include a broader array of individuals who are close to them, such as boyfriends, girlfriends, close friends, or members of the clergy. Clinicians are encouraged to adopt this broader definition. The term “family” is used throughout this guide to refer to any nonprofessional individual who has a caring relationship with the patient and whose collaboration with treatment providers has the potential to improve the long-term course of the patient’s co-occurring disorder.

The Importance of Family Work
In recent years, there has been a growing recognition of the importance of families to the management and long-term outcome of individuals with either psychiatric (Baucom et al. 1998; Mueser and Glynn 1999; O’Leary and Beach 1990) or substance use disorders (O’Farrell and Fals-Stewart 2006; Stanton and Todd 1982; Wakefield et al. 1996), or their combination (Barrowclough 2003; Mueser et al. 2003; O’Grady and Skinner 2007). This shift toward reaching out and engaging family members in treatment may be seen throughout the health services field (Adams and Drake 2006; Schäfer et al. 2006; Wennberg 1988).

Establishing collaborative relationships with family members of persons with co-occurring disorders is important for many reasons, including the following:
• Families need information about co-occurring disorders.
• Families are in a unique position to help a loved one.
• Family members have high levels of stress.
• Family involvement improves co-occurring disorders.

Families Need Information about Co-occurring Disorders
Most families know little about mental illness, substance use disorders, or their interactions. Furthermore, family members may hold inaccurate and harmful beliefs about the nature of these disorders because of the widespread social stigma of psychiatric and substance use disorders (Angermeyer and Matschinger 2003; Rasinski, Woll, and Cooke 2005). These erroneous beliefs can contribute to stress and other problems in the family.

For example, family members may believe that a patient’s substance use problems reflect a moral weakness rather than an illness. Similarly, many families do not understand the nature of psychiatric disorders, and they may criticize the individual for exhibiting symptoms such as strong feelings of anxiety, depression, guilt, or anger; dramatic mood shifts; lack of energy; paranoia; hyper-alertness; or hallucinations. Some family members do not even believe in the existence of mental illness, preferring instead to think of the person as lazy. Another common misconception is that all psychiatric problems are due to the substance use disorder, and that these problems would simply go away if long-term sobriety could be achieved. Finally, many family members do not understand how psychiatric disorders and substance use problems interact with and worsen each other.

Because family members may lack information about the nature of co-occurring disorders, they can inadvertently contribute to or worsen the course of these illnesses. For example, family members may not understand that individuals with a psychiatric disorder are often highly sensitive to even small amounts of substances. Consequently they may tolerate or even encourage the patient’s use of substances, which may lead to addiction problems and a more severe mental illness. Family members often do not understand the role of medications in the treatment of psychiatric disorders. They may have erroneous assumptions about the nature and effects of medications for psychiatric disorders. They may believe that such medications are addictive or that true sobriety can only be achieved when the individual is completely free of all substances, including prescribed medications. Family members may thus discourage their loved one from taking prescribed medications that are effective at reducing psychiatric symptoms and
preventing relapses. These symptoms and relapses can lead to a worsening of the addiction as the severity of the two disorders can interact.

Families need information about co-occurring disorders in order to avoid blaming the person and to support their relative’s adherence to recommended treatments (Clark and Drake 1992). Both psychiatric and substance use disorders have at least a partially genetic basis (Faraone, Tsuang and Tsuang 1999; Hasin, Hatzenbuehler, and Waxman 2006). Information about mental illness or substance use disorders may help family members to detect these disorders in other relatives and to encourage them to seek treatment as well (Morey and Mueser 2007).

**Families Are in a Unique Position to Help**

By virtue of their special relationship with the patient, families are in a unique position to help their loved one. Families often spend more time with the patient than does anyone on the treatment team. Regular contact enables family members to monitor the course of a loved one’s co-occurring disorder, thereby detecting possible changes in a timely manner, and getting rapid help to prevent deterioration and relapses.

Family members often know more than professionals do about the individual’s values and priorities. With that knowledge, family members can help the patient articulate meaningful goals and share them with treatment providers. They can also assist the individual in achieving his or her goals. Helping people learn the difference between unhealthy behaviors and personal values and goals is the essence of motivational interviewing (Miller and Rollnick 2002). Motivation for sobriety and the treatment of one’s psychiatric illness is most effectively achieved when people perceive that getting into recovery is critical to achieving their personal goals. Families are in an excellent position to help a loved one with co-occurring disorders come to this awareness, get into recovery, and move forward in his or her life.
Family Members Have High Levels of Stress

Having a family member with either a mental illness or substance use disorder is stressful. It should be no surprise that when the two disorders co-occur, family members experience even more stress. Understanding the reasons for this stress, and its effects on a co-occurring disorder, is important for appreciating the importance of working with families.

Co-occurring disorders can lead to high levels of stress in the family for a variety of reasons. The individual may display a range of challenging behaviors, such as aggression, stealing, social isolation, or strange or bizarre actions. The manifestation of these problems can be unpredictable, making relatives apprehensive and uncomfortable. Individuals with co-occurring disorders often have trouble meeting role expectations. They may not be able to work or go to school. They may not be able to be a good parent or contribute to the running of the household. A patient’s spouse or partner may reluctantly take on that person’s responsibilities. All of these problems can be exacerbated if the patient does not follow treatment recommendations, and subsequently experiences a worsening of their addiction and psychiatric disorder.

Family members often make substantial investments of time, money, and energy to help the patient meet basic needs, get treatment, and find some enjoyment in life. Although there are gratifications associated with helping a relative (Bulger, Wandersman, and Goldman 1993), the considerable effort invested by family members can also be a source of strain.

The stress of a close relationship with an individual with co-occurring disorders can lead to a variety of negative effects among family members (Dixon, McNary, and Lehman 1995). Depression, anxiety, and frustration are all common. Family members sometimes neglect their own health needs, and consequently suffer from poor health (Vitaliano, Zhang, and Scanlan 2003). They may neglect other basic needs as well, including social relationships outside the family, involvement in leisure and recreational activities, and their own work or school. In addition, when all of their efforts focus on the member with the co-occurring disorders, family members may fail to attend to the needs of other members. The net result of these effects on the family can be hopelessness, loss of energy, and disengagement from the patient (Kashner et al. 1991; Orford et al. 1998).

High levels of stress in families can worsen the quality of life for everyone, especially the quality of family relationships. Such stress can also have an impact on the course of the co-occurring disorder. Individuals with psychiatric disorders,
addiction, or both disorders who have tense, stressful, and conflict-laden relationships with their relatives are prone to relapses and worse functioning (Butzlaff and Hooley 1998; Fichter et al. 1997; Pourmand, Kavanagh, and Vaughan 2005). A worsening of the disorders can set into motion a cycle of deteriorating co-occurring disorders and greater family stress. Ultimately, in the absence of family intervention, the extraordinary stress experienced by the family, compounded by the patient's poor functioning, can lead to families giving up, withdrawing their support, and no longer being involved in the individual's life. This can have drastic consequences, including further deterioration of functioning, as well as housing instability and homelessness.

**Family Involvement Improves Co-occurring Disorders**

As previously described, families make substantial contributions to helping a loved one with co-occurring disorders meet his or her needs. These efforts are not without their payoffs. In fact, research has demonstrated that when family members are involved in the lives of people with co-occurring disorders, patients experience a better course of their disorders, including fewer relapses (Clark 2001; Schofield et al. 2001). Thus, families remain involved in the life of a member with co-occurring disorders to that person's benefit.

Family intervention programs aimed at helping families support their loved ones also have a strong evidence base. Extensive research shows that family programs are effective in improving the outcomes of addiction (Fals-Stewart, Birchler, and Kelley 2006; O'Farrell et al. 2007; Stanton and Shadish 1997) and mental illness (Baucom et al. 1998; Dixon et al. 2001), and evidence is growing supporting their beneficial effects for individuals with co-occurring disorders (Barrowclough et al. 2001; Mueser and Fox 2002).

**The Goals of Family Work**

The importance of working with families as established above naturally leads to a set of overarching goals that govern family work for co-occurring disorders:

- educate the family about co-occurring disorders
- facilitate family support for adherence to treatment and monitoring of disorders
- teach the family skills to help their loved one cope with cravings and symptoms
- encourage families to help their loved ones identify and pursue personal goals
• reduce caregiver burden on relatives
• reduce stress in the family and improve everyone’s quality of life
• develop a collaborative relationship between the family and treatment team

**Educate the Family about Co-occurring Disorders**

The lack of knowledge family members have about co-occurring disorders shows a clear need to educate them so that they can more effectively support the treatment of their loved ones. Families need to understand basic information about co-occurring disorders, including the nature of addiction, the symptoms of the psychiatric illness, how a diagnosis is established, hypothesized causes of the disorder, the treatment of the mental illness, the defining symptoms of addiction, the nature of interactions between mental illness and substance abuse disorder, and the principles of integrated treatment for both disorders (Mueser and Fox 1998). This knowledge forms the foundation for greater understanding and lower stress between family members and for improved ability of the family to support the patient’s involvement in treatment.

**Facilitate Family Support for Adherence to Treatment and Monitoring of Disorders**

A natural outgrowth of educating families is a newfound ability to support the patient’s participation in recommended treatment. Treatment for co-occurring disorders is always tailored to the individual, and it typically includes a combination of medication, individual and/or group counseling/therapy, rehabilitation, and participation in self-help groups. By understanding the principles of treatment, and with regular contact with the patient, family members are often in a good position to support adherence to recommended treatments.

In addition to supporting involvement in treatment, family members are often in a good position to monitor the course of the co-occurring disorder. By recognizing signs of a relapse or nonadherence to treatment, family members may be able to take steps to avert deterioration and relapses. For example, family members can explore real or perceived obstacles to following treatment recommendations.
and remove them. They can also contact the treatment team to take action to prevent relapses.

**Teach the Family Skills for Coping with Cravings and Symptoms**

Most people with co-occurring disorders experience the challenge of cravings for alcohol or drugs during the process of establishing sober lives. Similarly, many individuals continue to experience persistent or intermittent symptoms of their psychiatric disorder, despite active participation and follow-through on treatment recommendations. Common symptoms include depression, anxiety, sleep problems, unstable mood, and hallucinations. The combination of cravings and symptoms may be especially problematic for people with co-occurring disorders, who have often used substances in an attempt to escape from the distress they experience from their mental illness.

A wide range of techniques exists to help people resist the temptations of cravings and to cope with symptoms. Learning coping strategies for these problems requires practice. Flexibility is also necessary, as the desired strategies are tailored to meet the needs of the individual. Families can help their loved ones by supporting them in selecting, practicing, modifying, and evaluating the effectiveness of different coping strategies.

**Encourage Families to Help Their Loved Ones Identify and Pursue Personal Goals**

Effective treatment of co-occurring disorders involves helping people develop worthwhile and meaningful sober lives. When relapses of either substance use or the psychiatric disorder occur, patients and their family members tend to focus on stabilizing their lives and postpone the pursuit of personal goals. This behavior is based on the belief that people must achieve some degree of sustained abstinence and symptom remission before they are able to move forward in their lives and resume working on their goals.

However, there are problems associated with discouraging people from pursuing personally important goals before they have achieved a long period of abstinence or symptom remission. The primary motivation to become and stay abstinent, and to manage one’s psychiatric disorder, is the prospect that doing so will help change one’s life and achieve one’s goals. The more distant the attainment of those goals appears, the less potent they are for motivating the individual to learn how to manage the co-occurring disorders and to take control of his or her life. Rather than endorsing the notion of long-term and sustained stability before
making personally important changes, families need to be enlightened that the recovery process is not linear. People can begin working toward goals as soon as they are able, including soon after a relapse of either of the disorders.

Family members can play a critical role in helping their loved one identify and pursue personally meaningful goals such as improved relationships, returning to work, being a better parent, or resuming studies. They can also provide the hope their relative needs to invest efforts in achieving these goals. The family psychoeducation program addresses concerns family members may have about a loved one’s ability to work on personal goals. It can help them understand that not working on goals can lead to frustration, demoralization, and the lack of a sense of purpose, which could increase the risk of relapses. This information can encourage family members to see the value of immediately helping their loved one begin to rebuild a worthwhile life, rather than postponing their help until a longer period of stability has been achieved.

**Reduce Caregiver Burden on Relatives**

Having a close relationship with someone with co-occurring disorders can take a heavy toll on family members. Reducing this burden is an important goal of family collaboration. Family work has the potential to reduce caregiver burden in several ways.

First, the loved one learns to better manage the co-occurring disorders, and the family learns how to support the relative’s participation in treatment. This may result in fewer relapses and better functioning, thereby reducing the need for the family to address basic needs. Second, improved adherence to recommended treatments may reduce the unpredictable and distressing behaviors common in individuals whose disorders are poorly managed. This frees up time and resources that families devote to helping the individual and decreases resentment family members may have about this role they have played.

**Reduce Stress in the Family and Improve Everyone’s Quality of Life**

Stress in the family affects everyone, and contributes to a worsening course of co-occurring disorders. Reducing stress, therefore, can both improve the course of the co-occurring disorder and enhance the quality of everyone’s life.

High levels of stress in the family can also interfere with the ability of members to provide support and help one another. In addition, stress can make it difficult to resolve conflicts and problems, which are an inevitable part of having a close relationship. Learning stress reduction techniques and skills for solving
problems, communicating effectively, and achieving goals can reduce stress and enhance the appreciation and enjoyment of family members for one another.

**Develop a Collaborative Relationship between the Family and Treatment Team**

As previously described, family members are in a unique position to support their relative's adherence to treatment for their co-occurring disorders. In addition, families are often able to monitor the course of their relative's disorders and to detect important changes soon after they happen.

However, the important role families can play in supporting their relative's treatment cannot be accomplished by the family alone—it also requires the effort and cooperation of the treatment team. For this reason, an important goal of working with families is to develop a collaborative relationship between the family and the treatment team. A collaborative relationship recognizes that each one has something unique and important to contribute to improving the overall treatment and outcome of the individual with co-occurring disorders.

Most families have never had a collaborative relationship with treatment providers, and may not know what to expect from such a relationship. They may be surprised when efforts are made to reach out and engage them in treatment. Treatment providers need to let families know how much their input is valued.

Family members have important knowledge about their relative's personal motivations, day-to-day functioning, and adherence to recommended treatments, all of which is valuable information to the treatment team. Treatment providers have expertise about the nature of co-occurring disorders, effective treatments, and strategies for managing problems and achieving goals despite persistent symptoms. Family members can benefit from learning this information from professionals. Thus, establishing a collaborative relationship between the treatment team and the family benefits everyone involved. The person with the co-occurring disorders benefits because treatment is integrated better, disorders are monitored more closely, and family and professionals help the person achieve goals. Family members benefit as stress on the family system is reduced, and quality of life is improved. Knowing that the loved one is receiving optimal care for his or her co-occurring disorders brings relief. Last, the treatment team benefits from the collaboration because the involvement of the family makes its job easier (as the saying goes, “many hands make light work”) and renders its efforts more successful.

* * *

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Orientation to the Family Psychoeducation Program

Time

• About 30–45 minutes

Handout Needed

• *Orientation to the Family Program for Co-occurring Disorders*
  (page XX of the three-ring binder and on the CD-ROM)

Overview

This orientation session is intended to give family members a clear picture of what will happen during the family psychoeducation program. The leader first welcomes family members and reinforces their participation. Family members then receive a copy of the Orientation to the Family Program for Co-occurring Disorders handout. The goals and format of the program are reviewed, followed by a description of each of the topics in the multiple-family program. The first single-family session is scheduled at this time.
Suggested Module Outline

Step 1: Welcome the Family
1. Briefly thank the family members for coming to the orientation meeting and comment on their participation in the program. For example:

   I’m really glad to see all of you here today. You have all agreed to participate in the family psychoeducation program. Today, I’d like to spend a few minutes reviewing with you what the program is about, what it involves, and what you can expect.

2. Give each member a copy of the Orientation to the Family Program for Co-occurring Disorders handout.

Step 2: Review the Goals of the Program
1. Briefly review the goals listed on the handout. You may use this script:

   One of the goals of this program is to recognize the strengths of each family member and your family as a whole. By strengths I mean things that you or your family are good at or proud about. Every family has some strengths, and knowing what they are can be helpful in coping with challenges and achieving goals.

2. Ask family members to describe some of their family’s strengths.

3. Review the next goal. Tell family members:

   Another goal of this program is to teach families about co-occurring substance use and psychiatric disorders, and the principles of their treatment. The more everybody understands about co-occurring disorders and their treatment, the more effective treatment can be. Learning more about these disorders and their treatment leads naturally to the third goal of this program, which is to reduce relapses, rehospitalizations, detoxifications, and other such problems. With everybody working together to treat the co-occurring disorders, including your whole family and the other members of the treatment team, these problems can be prevented.
4. Ask family members to share any thoughts they have about that goal.

5. Review the other goals of the program. Ask for questions and comments from the family.

**Step 3: Discuss the Format of the Program**

1. Review the format section of the orientation sheet with the family members.
   Emphasize these facts:
   - All family members (including the person with the co-occurring disorders) will be involved in the family sessions.
   - Sessions are conducted in a low-stress environment.

2. Discuss the multiple-family program. Tell family members:
   
   **Families often find it helpful to learn about the experiences of other families coping with similar challenges, and to share their own experiences as well.**

   Cover these points:
   - The multiple-family group sessions cover a series of different educational topics.
   - Fact sheets and handouts will be provided.
   - Family members will be given the option of completing home assignments related to the educational topics.

**Step 4: Introduce the Educational Topics**

1. Review the topics that are covered in the single- and multiple-family sessions.

   **Note:** The Orientation to the Family Program for Co-occurring Disorders handout has brief descriptions of the topics. You may find it helpful to prepare more details.

2. When the different topics have been reviewed, ask family members if they have any questions.
Step 5: Discuss Clinician Availability
1. Discuss the issue of contacting you between family sessions, as well as whom family members or the patient should contact in the event of a crisis or other acute need.

Note: Remember, the clinician who is conducting the psychoeducation program should be the family's primary contact. See chapter 2.

Step 6: Schedule the First Meeting
1. Schedule a meeting time with the family to conduct the first single-family psychoeducation session, possibly during the same week, in order to take advantage of the family’s motivation to participate.

Step 7: Thank the Family for Coming
1. Ask family members if they have any final questions.
2. Thank the family members for participating.
SESSION 1
Psychoeducation about the Psychiatric Disorder

Time
• About 60 minutes

Handout Needed
• Fact sheets for ten common co-occurring disorders can be found on pages XX-XX of the three-ring binder and on the CD-ROM.

Use the fact sheet that is pertinent to the patient’s disorder(s).

Overview
After welcoming the family, the clinician begins by explaining the patient’s diagnosis, exploring what family members know about the diagnosis, and correcting common misconceptions. Next, the clinician explains the disorder’s prevalence, course, and symptoms, and elicits the family members’ experience. The session ends with a discussion of causes and treatment and a brief explanation of co-occurrence.
Suggested Session Outline

Step 1: Conduct Greetings and Make Introductions
1. Greet and welcome the family members.

2. Lead a brief, informal discussion with family members about how things have been going for them since the orientation meeting.

3. Listen for any critical issues that you may need to address later.

Step 2: Give an Overview of the Topics to Be Covered
1. Tell family members (as you write the topics on a chalkboard or whiteboard):

   Today we will talk about your relative’s psychiatric disorder. We will cover these topics:

   • diagnosis: what the disorder is and what it is not
   • prevalence: how widespread the disorder is
   • course: the onset and severity of the disorder
   • symptoms: the characteristic signs of the disorder
   • causes: why the disorder is present in some people but not others
   • treatment: how symptoms of the disorder are reduced
   • co-occurrence: the relationship between substance use and the psychiatric disorder

Step 3: Discuss the Diagnosis
1. Tell family members:

   Some of you at this point may already know (the patient)’s diagnosis, but your knowledge about what the diagnosis actually means can vary greatly. I would like to ask each of you, including (the patient), to explain what you understand about the diagnosis. What have you been told about (the patient)’s problems? Were you given a name or diagnosis?
2. Acknowledge accurate information about the diagnosis and correct false impressions.

3. Turn the discussion to talking about how the psychiatric disorder has affected each family member, including the patient. Ask each person:

   I'd like to spend a few minutes finding out about how (John's PTSD) has affected each person in your family. (Samantha), what influence has (John's PTSD) had on your life?

4. Underscore the fact that everyone in the family is affected by one member's psychiatric disorder. This realization can contribute to creating a cooperative spirit of working together to overcome problems that have resulted from the disorder.

   Note: If family members volunteer information about how the patient's substance use has affected their lives, acknowledge these contributions, and also explain that they will be talking more about the interactions between the psychiatric disorder and addiction in the next session.

5. Ask the family members if they have any questions about the diagnosis.

**Step 4: Discuss Prevalence**

1. Turn the discussion to the prevalence of the specific disorder. Tell family members:

   Family members may benefit from learning that (the patient's) psychiatric disorder is present throughout all parts of the world and affects people regardless of their religion, income, race, or gender.

2. Review the data on the prevalence of the psychiatric disorder (discussed in 1 Screening and Assessment). Tell family members:

   You are not alone. Many other families experience similar problems. The disorder is present cross-culturally; it is a legitimate disorder, and you should not blame yourselves for its cause.

3. Ask the family members if there are any questions about prevalence.
Step 5: Discuss Course

1. Turn the discussion to the onset and course of the specific psychiatric disorder. You may adapt this script:

   Some individuals experience a relatively early onset of their psychiatric disorder (e.g., between the ages of sixteen and thirty); others have a later onset. Most psychiatric disorders tend to have an episodic course, marked by variations in symptom severity.

   For some disorders, when the symptoms are severe, the person may have to be hospitalized at times to protect himself or herself and others. Hospitalization for episodes of severe symptoms is most common in schizophrenia, schizoaffective disorder, bipolar disorder, and severe depression, but it may also be necessary for individuals with severe anxiety disorders such as post-traumatic stress disorder and obsessive-compulsive disorder. In addition, many patients are vulnerable to relapses of their symptoms.

3. Ask family members to discuss the onset of the patient’s disorder.

   **Note:** If questions about the relationship between the onset of that disorder and the substance use disorder come up, point out that the fact that one disorder sometimes develops before the other doesn’t mean that the first disorder caused the second.

4. Ask family members if there are any questions about the course of the disorder.

Step 6: Discuss Symptoms

1. Turn the discussion to the symptoms of the disorder. Tell family members:

   Families need to understand how a diagnosis is established, and they need to know the characteristic symptoms of the disorder if they are to monitor these symptoms.

   A psychiatric diagnosis is based on a careful clinical interview designed to assess whether the patient has experienced specific symptoms. A psychiatric diagnosis is based on the presence of specific symptoms that occur in the absence of medical conditions, such as a tumor or an endocrine disease, or the use of substances, such as alcohol or stimulants.
This means that people with a co-occurring disorder have some or many of the symptoms of their psychiatric disorder when they are not actively using substances. Psychiatric disorders cannot be diagnosed from common medical tests, such as an X ray, CAT scan or PET scan, or blood test.

2. Enlist the patient’s help in the role of “the expert.” Tell family members:

I would like to spend a few minutes talking about specific symptoms of (the patient’s disorder). It is easy for me to give you a definition of each of these symptoms, but when it comes down to explaining what these symptoms are actually like, (John), you are the real expert. I would appreciate your help, (John), in helping your family understand more about some of these symptoms. Would that be okay with you?

*Note:* If the patient does not accept the role of the expert, review the different symptoms, but do not try to elicit the patient’s experience directly.

3. Provide a definition of a symptom and give one or two brief examples.

4. Ask the patient whether he or she has experienced that symptom and, if so, to describe what it was like.

5. Ask family members whether they were aware that the patient had experienced that particular symptom.

6. Repeat numbers 3–5 for all symptoms.

*Note:* You should not try to resolve differences between the patient’s description of symptoms and the family member’s reports about symptoms.

7. Ask family members if there are any questions about symptoms.

**Step 7: Discuss Causes**

1. Turn the discussion to the causes of the disorder.

*Note:* The information about the causes of the disorders varies somewhat from one disorder to the next. Refer to the fact sheets.
Tell family members:

All of the disorders are believed to have a biological basis that interacts with the environment. The strongest evidence for biological factors is based on genetics research, which has shown that vulnerability to specific disorders runs in families, and is evident even in people who are not raised by their biological parents.

2. Ask family members if there are any questions about the causes of the disorder.

Step 8: Discuss Treatment
1. Turn the discussion to the treatment for the psychiatric disorder. Refer to the fact sheet for information about the particular disorder.

2. Ask family members to describe their experiences with and observations about treatment.

3. Briefly explain psychological treatments (therapy) for the disorder, as well as rehabilitation for those disorders where it is a part of treatment. Tell family members:

   Treatments differ across psychiatric disorders. For some disorders, medications are essential, such as bipolar disorder, schizophrenia, or schizoaffective disorder. For the anxiety disorders, dysthymia, and major depression, medications are frequently useful, but not considered essential in every case.

4. Ask family members if there are any questions about treatment.

Step 9: Discuss Co-occurrence
1. Turn the discussion to the relationship between the psychiatric disorder, substance use, and addiction.

2. Tell family members that substance use worsens a psychiatric disorder. Elicit their experiences and observations.

3. Reinforce the point that the person will continue to have the psychiatric disorder, even if he or she is abstinent from substance use. Also note that when the person is abstinent, some psychiatric disorders (PTSD, social anxiety,
OCD, and major depression) can be successfully treated and eliminated with therapy.

4. Briefly explain that the most effective treatment for co-occurring disorders is treating the two disorders together, in an integrated fashion.

5. Ask if there are any questions about co-occurrence.

**Step 10: Suggest a Home Assignment**

1. Point out that a great deal of material was covered, and that family members may benefit from reviewing the material on their own.

2. As an optional home assignment, suggest that family members do one of the following:
   - Get together as a family and take turns reading from the fact sheet and write down any questions they may have about the information.
   - Do the same assignment, but individually instead of as a family.

**Step 11: Wrap up the Session**

1. Briefly summarize what was covered in this session.

2. Invite group members to make any comments or observations about what they found helpful.

3. Briefly describe the topic of the second session:

   **The second session will help you understand more about (the patient)’s psychiatric disorder and how it interacts with substance use.**

4. Schedule the next session.

5. Ask for any final questions.

6. Thank the family for coming.

When the session has ended, plan to make yourself available for family members who may want to ask more questions or raise an issue.
Co-occurring Disorders

What Are Co-occurring Disorders?

People are diagnosed with co-occurring disorders when they have both a substance use disorder and a psychiatric disorder.

A substance use disorder is
• alcohol abuse or alcohol dependence (alcoholism; alcohol addiction)
• drug abuse or drug dependence (drug addiction)

Alcohol or drug abuse is diagnosed when substance use persistently interferes with functioning at work, at school, and in social relationships. It is also diagnosed when substance use creates or worsens a medical condition, or when substance use occurs in dangerous situations.

Alcohol or drug dependence is a more severe condition than alcohol or drug abuse. In addition to facing more negative consequences, people with dependence have also failed to abstain from or control their use of substances. In some cases, physiological dependence may also exist, which is indicated by tolerance (needing more of a substance to get the same effect) and withdrawal (experiencing symptoms when substance use is stopped).

People are diagnosed with a psychiatric disorder when they have problems with feelings, thinking, functioning, or relationships that are not due to drug or alcohol use and are not the result of a medical illness.

Some common psychiatric disorders are
• anxiety disorders such as generalized anxiety disorder, post-traumatic stress disorder, social anxiety disorder, panic disorder, and obsessive-compulsive disorder
• mood disorders such as major depression, dysthymia, and bipolar disorder
• thought disorders such as schizophrenia or schizoaffective disorder

When people are diagnosed as having co-occurring disorders, it means that they have both disorders at the same time, or at least have had both during the past year. However, substance use and psychiatric disorders often recur. Therefore, most experts consider anyone who has had a substance use and psychiatric disorder in his or her lifetime to have co-occurring disorders.
What Co-occurring Disorders Are Not

The phrase “co-occurring disorders” does not apply to people who have a substance use disorder and some mood or relationship problems. It does not apply to people who have a psychiatric disorder and some problems related to substance use.

Of the people with a substance use disorder, about 60 to 70 percent have or had a psychiatric disorder. Of the people with a psychiatric disorder, 25 to 50 percent have or had a substance use disorder. Thus, co-occurring disorders are common, but not everyone with a substance use or psychiatric disorder has one. People with substance use disorders may have emotional problems such as depression, anxiety, or post-traumatic symptoms, but these are normal responses to life events. People with psychiatric disorders may drink alcohol or use drugs. But if their use is not problematic, they do not have co-occurring disorders.

What Are Common Problems Related to Co-occurring Disorders?

Co-occurring disorders can cause a wide variety of problems, depending on the specific substance use and psychiatric disorders people have.

Common problems relating to co-occurring disorders include

- use of alcohol or other drugs to reduce the difficulty or pain associated with psychiatric problems, which may work in the short term but usually backfires in the long run
- a psychiatric disorder that is worsening because of alcohol or drug use
- a substance use disorder that is worsening because of psychiatric problems
- difficulty getting treatment for both disorders, or difficulty benefiting from treatment
- difficulty finding supportive people who understand both disorders

What Is the Cause of Co-occurring Disorders?

There appear to be common genetic risk factors for substance use and certain psychiatric disorders, but genes alone cannot explain all cases of co-occurring disorders. Other factors include family, environment, and life stress, including traumatic life events, poverty, and early loss of significant others. In fact, these stressful experiences may trigger genetic factors that contribute to co-occurring disorders.

It is not known why people become addicted to a certain substance and not another. Some research indicates that access and exposure to substances may be the most important
reason. That is, the substances people have access to determine the type of substance use disorder.

People with a psychiatric disorder may be more biologically sensitive to the effects of substances. They may also use substances to cope with symptoms or facilitate social connections. In general, people who have a psychiatric disorder are at much greater risk of also having a substance use disorder. People who have a substance use disorder are at much greater risk of developing a psychiatric disorder. People who developed a substance use disorder when they were relatively young may not have developed good coping skills and ways of dealing with life. This may have left them vulnerable to developing a psychiatric disorder.

**How Does the Use of Alcohol and Other Drugs Affect a Co-occurring Psychiatric Disorder?**

People with a psychiatric disorder often use substances to feel better. People who are anxious may want something to make them feel calm; people who are depressed may want something to make them feel more animated; people who are fearful of others may want something to make them feel more relaxed and less inhibited; and people who are in psychological pain may want something to make them feel numb. Using alcohol or other drugs often develops into a substance use disorder. It not only fails to repair the psychiatric disorder but also prevents people from developing real coping skills, having satisfying relationships, and feeling comfortable with themselves. In short, drug and alcohol use makes psychiatric disorders worse.

**How Does a Psychiatric Disorder Affect Addiction Treatment and Recovery?**

Having a psychiatric disorder can make people more sensitive to the effects of substance use, and the consequences from excessive episodes of use or chronic long-term use can happen more rapidly. With the best of intentions, people with a psychiatric disorder may try to stop using substances. But when the substance use stops, the symptoms of the psychiatric disorder return—seemingly with a vengeance. They may wonder why they should bother trying to get clean and sober. If they manage to get into treatment, they might find that they are judged and even criticized for their psychiatric symptoms. A few treatment professionals may even hint that if only patients were more honest and willing, their psychiatric symptoms would disappear with good recovery work. In short, psychiatric problems make substance use disorders worse.
Treatment for Co-occurring Disorders

Effective treatment for co-occurring disorders has been developed only recently. In the past, many people with co-occurring disorders received inadequate care. Treatment professionals failed to understand that treating one disorder would not cause the other disorder to automatically improve. Both disorders need to be treated at the same time, which is called integrated treatment.

Integrated treatment can stabilize the symptoms of co-occurring disorders and provide the foundation for lasting recovery from substance use and psychiatric disorders. Integrated treatment involves a combination of the following:

- accurate detection and diagnosis of both disorders
- education about substance use and psychiatric disorders, their interaction, and the options for treatment
- exploration of the individual's motivation and commitment to address his or her substance use and psychiatric problems
- therapies, including cognitive-behavioral therapy (CBT), that teach new skills and provide new insights
- appropriate use of medication
- involvement of significant others in treatment, including opportunities for education and skill development
- ongoing and frequent recovery checkups, which monitor for the return of psychiatric symptoms and substance use

People with co-occurring disorders can benefit from attending peer support groups. They can also benefit from connecting with others who have co-occurring disorders and are in recovery.

Resources


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What Is Bipolar Disorder?

Bipolar disorder, also known as manic depression, affects about 1 percent of the general population. Bipolar disorder is a psychiatric disorder that causes extreme mood swings that range from mania to depression. People with bipolar disorder usually have episodes of mania or hypomania (a milder form of mania), and at different times, episodes of depression, each lasting for a few weeks or more. In between these episodes, the person has few or no symptoms. People with bipolar disorder may also experience other symptoms during these episodes, such as hallucinations or delusions. Symptoms of bipolar disorder can often disrupt work, school, family, and social life.

What Bipolar Disorder Is Not

Bipolar disorder is not simply having mood swings. Mood swings may be associated with many factors, including emotional and physiological reactions to life events and circumstances. Mood swings usually develop gradually during several days or weeks, and they involve dramatic shifts not only in mood but also in overall outlook, behavior, and energy level. These shifts last for weeks or months.

The use of certain substances, especially stimulants such as cocaine or methamphetamine, may cause symptoms that mimic, or are similar to, those of bipolar disorder. People who are high on stimulants may appear manic, and when the stimulants wear off, they're quite depressed. Health care professionals must know how to distinguish the symptoms of bipolar disorder from the symptoms of a substance use disorder.

In addition, antidepressant medications can cause manic or hypomanic symptoms in people who are taking these medications for depression or anxiety disorders. This is not bipolar disorder. If these symptoms occur in someone taking antidepressants, the prescriber should be contacted immediately to adjust the dosage or stop the medication.

What Are the Primary Symptoms of Bipolar Disorder?

The episodes of bipolar disorder include depression, mania, and a “mixed state” that includes symptoms associated with each extreme.

Mania:

• euphoric, irritable mood or anger
• decreased need for sleep
• increased goal-directed behavior, such as work, school, or exercise
• agitation
• overconfidence
• grandiosity (unrealistic beliefs of having skills, attributes, power, or money that one doesn’t actually have)
• irresponsible spending of money
• rapid speech
• increased sexual drive
• distractedness

*Depression:*
• hopelessness, sadness, discouragement, or emptiness
• loss of interest in hobbies and regular activities
• significant weight change (increase or decrease 5 percent of body weight in one month)
• oversleeping or difficulty falling asleep
• restlessness or sluggishness, with slow speech or body movements
• extreme fatigue; feeling too physically drained to complete even small tasks
• worthlessness, guilt, or constant self-criticism
• inability to concentrate or focus
• extreme irritability and frustration
• body aches, joint pain, and other physical ailments
• persistent thoughts of death or suicide

*Mixed state:*
• symptoms of mania and depression occur at the same time

**What Is the Cause of Bipolar Disorder?**
The exact cause of bipolar disorder is unknown, but it is believed that biological, genetic, and environmental factors contribute to its onset.

**What Are the Usual Treatments for Bipolar Disorder?**
The recurring mood cycles of bipolar disorder require a comprehensive treatment plan that focuses on the immediate, acute crises of mania or depression, as well as on long-term
preventative care. Treatment for bipolar disorder that combines medication with therapy and rehabilitation is often the best strategy for recovery. In addition, family programs designed to teach patients and their relatives about the disorder, how to manage it, and how to reduce stress and conflict are very helpful.

Because of the nature of bipolar disorder, there are two stages of treatment: the acute stage and the maintenance stage.

- **Acute stage:** The primary goal of this stage is to reduce or eliminate severe manic or depressive symptoms of bipolar disorder. This may be accomplished with medication, electroconvulsive therapy, hospitalization, and psychological therapy. The most effective medications for bipolar disorder are lithium, valproic acid, divalproate, anticonvulsant medications, antipsychotic medications, and antidepressants. Of these, mood stabilizers such as lithium, valproic acid, and divalproate are the most common medications used to treat bipolar disorder.

- **Maintenance stage:** The primary goals of this stage are to maintain a stable mood to prevent future episodes of mania or depression, and to foster recovery in areas such as social relationships, self-care, and work or school. This may be accomplished with medication, therapy, rehabilitation, education, and support. Therapy options may include cognitive-behavioral therapy (CBT), interpersonal therapy, and family psychoeducation. People may also benefit from individual case management and rehabilitation programs such as supported employment. Continued use of medication, even when no symptoms are present, can help prevent future episodes. In addition, knowing more about the disorder and what triggers a relapse in symptoms can help in avoiding problems and coping with setbacks. Developing a solid support system or attending a support group can also have long-lasting, positive effects on recovery.

**How Does the Use of Alcohol and Other Drugs Affect Bipolar Disorder?**

About 50 percent of people with bipolar disorder have a co-occurring substance use disorder. The use of alcohol or other substances complicates the symptoms of bipolar disorder. Those with a co-occurring substance use disorder experience more intense and frequent mood swings and are hospitalized more frequently than those without a substance use disorder. People with bipolar disorder may use drugs for reasons similar to anyone else: to cope with unpleasant feelings, to fit in when socializing with others, or just because it feels good. Many people with bipolar disorder try to self-regulate their mood swings by using alcohol or other drugs, but these efforts invariably fail in the long term. Sometimes,
during the manic phase of bipolar disorder, a person is drawn to stimulating environments such as bars, casinos, and parties. This can have disastrous consequences: worsening symptoms of bipolar disorder, increased substance use, and financial, legal, or relationship problems.

**How Does Bipolar Disorder Affect Addiction**

**Treatment and Recovery?**

A person who is actively using substances or who has just recently discontinued use may not be easily diagnosed with bipolar disorder by a health care professional. Many of the symptoms of bipolar disorder can be confused with the effects of the substances or withdrawal symptoms—and vice versa. Thus, one common problem for people in addiction treatment is that their bipolar disorder is not recognized or diagnosed, whereas another common problem is that they are diagnosed with bipolar disorder when they do not have it.

Bipolar disorder complicates addiction treatment and recovery. During the depressed phase, people are at an increased risk for relapse to substance use because of their profound negative mood, and they may even become suicidal. During the manic phase, people may underestimate the risks associated with certain behaviors, such as going to a party where there will be drug use. They may become overconfident that they can “control” their use of substances without falling back into addiction.

**Treatment for Co-occurring Bipolar and Substance Use Disorders**

The symptoms of bipolar disorder can worsen substance use, and severe addiction can worsen bipolar disorder. Therefore, the most effective treatment for co-occurring bipolar and substance use disorders is integrated treatment. This means that both disorders are treated at the same time by the same clinician or team of clinicians. Integrated treatment involves a combination of medications, skill-based therapies such as CBT, family and work support, and adequate treatment of the substance use disorder. Since medications are essential for the treatment of bipolar disorder, ongoing and close monitoring of medication adherence, symptoms, and relapse is important. Although bipolar and substance use disorders can affect a broad range of functioning, effective integrated treatment allows many people to live rewarding and highly productive lives. People with bipolar disorder can benefit from attending peer support groups, and they also can benefit from connecting with others who have these co-occurring disorders and are in recovery.
Resources


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