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Providing Services to Persons with Co-Occurring Disorders in Substance Abuse Treatment Part II Assessment and Strategies

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This distance learning course package was developed for CEUMatrix by Robert Shearer, Ph.D. It is based on information found in the *TIP 42 Substance Abuse Treatment for Persons with Co-Occurring Disorders (*Center for Substance Abuse Treatment. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2005.

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About the Instructor:

Dr. Robert A. Shearer is a retired professor of Criminal Justice, Sam Houston State University. He received his Ph.D. in Counseling and Psychology from Texas A & M University, Commerce. Prior to teaching Criminal Justice, he taught Educational Psychology at Mississippi State University on campus and in the extension program across rural Mississippi during the civil rights era.

He has been teaching, training, consulting and conducting research in the fields of Criminal Justice, human behavior, and addictions for over thirty-six years. He is the author of over sixty professional and refereed articles in Criminal Justice and behavior. He is also the author of *Interviewing: Theories, Techniques, and Practices, 5th edition* published by Prentice Hall. Dr. Shearer has also created over a dozen measurement, research, and assessment instruments in Criminal Justice and addictions.

He has been a psychotherapist in private practice and served as a consultant to dozens of local, state, and national agencies. His interests continue to be substance abuse program assessment and evaluation. He has taught courses in interviewing, human behavior, substance abuse counseling, drugs-crime-social policy, assessment and treatment planning, and educational psychology. He has also taught several university level psychology courses in the Texas Department of Criminal Justice Institutional Division, led group therapy in prison, trained group therapists, and served as an expert witness in various courts of law.

He has been the president of the International Association of Addictions and Offender Counseling and the editor of the *Journal of Addictions and Offender Counseling* as well as a member of many Criminal Justice, criminology, and counseling professional organizations prior to retirement.

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Substance Abuse Treatment for Persons With Co-occurring Disorders: Part II Assessment and Strategies

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

In the second section of the course, there is a presentation of guidelines for developing a successful therapeutic relationship with individuals who have COD. The section describes specific techniques for counselors that appear to be the most successful in treating clients with COD and introduces guidelines that are important for the successful use of all of these techniques.

Course Goals/objectives
The goals and objectives for the first section of this course are for the student understand:

- Screening and basic assessment for COD
- The assessment process

The goals and objectives for the second section of this course are for the student to understand:

- Guidelines for a successful therapeutic relationship with a client who has COD
- Techniques for working with clients with COD

Substance Abuse Treatment for Persons With Co-Occurring Disorders

Stanley Sacks, Ph.D.
Consensus Panel Chair

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Consensus Panel Co-Chair

A Treatment Improvement Protocol

TIP 42

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

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4 Assessment

In This Chapter…

Overview

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

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

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

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

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

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

Screening and Basic Assessment for COD

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

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

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

Screening

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

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

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

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

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

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

Basic Assessment

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

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

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

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

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

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

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

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

Treatment Planning

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

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

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

Case 1: Maria M.

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

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

The Role of Assessment Tools

A frequent question asked by clinicians is

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

The answer is

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

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

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

Case 2: George T.

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

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

Case 3: Jane B.

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

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

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

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

The Assessment Process

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

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

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

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

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

Assessment Step 1: Engage the Client

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

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

No wrong door

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

Twelve Steps in the Assessment Process

Step 1: Engage the client
Step 2: Identify and contact collaterals (family, friends, other providers) to gather additional information
Step 3: Screen for and detect COD
Step 4: Determine quadrant and locus of responsibility
Step 5: Determine level of care
Step 6: Determine diagnosis
Step 7: Determine disability and functional impairment
Step 8: Identify strengths and supports
Step 9: Identify cultural and linguistic needs and supports
Step 10: Identify problem domains
Step 11: Determine stage of change
Step 12: Plan treatment

Figure 4-1
Assessment Considerations

Engagement:

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

Multidimensional severity/level of functioning profile:

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

What specific services are needed to address these priorities?

What "dose" or intensity of services is needed?

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

How will outcomes be measured?

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

Source: Adapted from Mee-Lee 1998.

Trauma sensitivity

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

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

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

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

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

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

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

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

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

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

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

Safety screening

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

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

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

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

harm. See Potential Risk of Harm on page 77.

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

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

Screening for past and present mental disorders

Screening for past and present mental disorders has three goals:

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

Safety Screening in Mental Health Settings

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

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

Potential Risk of Harm

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

  Minimal risk of harm:

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

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

  Low risk of harm:

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

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

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

  Moderate risk of harm:

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

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

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

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

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

  Serious risk of harm:

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

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

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

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

  Extreme risk of harm:

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

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

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

Source: AACP 2000*a*.

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

A number of screening, assessment, and treatment planning tools are available to assist the substance abuse treatment team. For assessment of specific disorders and/or for differential diagnosis and treatment planning, there are literally hundreds of assessment and treatment planning tools. NIAAA operates a web-based service that provides quick information about alcoholism treatment assessment instruments and immediate online access to most of them, and the service is updated continually with new information and assessment instruments (www.niaaa.nih.gov/publications/Assesing%20Alcohol/index.pdf). NIDA has a publication from a decade ago (Rounsaville et al. 1993) that provides broad background information on assessment issues pertinent to COD and specific information about numerous mental health, treatment planning, and substance abuse tools. Of course, NIDA continues to explore issues related to screening and assessment (e.g., see www.drugabuse.gov/DirReports/DirRep203/DirectorReport6.html and www.drugabuse.gov/Meetings/Childhood/Agenda/agenda.html). The mental health field contains a vast array of screening and assessment devices, as well as subfields devoted primarily to the study and development of evaluative methods. Almost all Substance Abuse and Mental Health Services Administration TIPs, which are available online (www.kap.samhsa.gov), have a section on assessment, many have appendices with wholly reproduced assessment tools or information about locating such tools, and TIPs 31, 16, 13, 11, 10, 9, 7, and 6 are centered specifically on assessment issues.

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

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

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

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

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

Mental Health Screening Form-III

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

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

Mini-International Neuropsychiatric Interview

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

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

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

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

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

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

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

Brief Symptom Inventory-18

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

ASI

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

Screening for past and present substance use disorder

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

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

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

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

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

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

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

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

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

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

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

Trauma screening

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

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

Assessment Step 4: Determine Quadrant and Locus of Responsibility

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

The Four Quadrants

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

Assessment Step 4—Application to Case Examples

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

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

Determination of serious mental illness (SMI) status

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

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

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

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

Determination of severity of substance use disorders

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

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

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

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

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

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

Assessment Step 5: Determine Level of Care

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

- Dimension 1: Acute Intoxication and/or Withdrawal Potential

Assessment Step 5—Application to Case Examples

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

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

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

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

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

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

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

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

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

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

Assessment Step 6: Determine Diagnosis

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

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

The importance of client history

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

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

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

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

Assessment Step 6—Application to Case Examples

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

Assessment Step 6—Application to Case Example

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

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

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

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

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

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

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

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

Documenting prior diagnoses

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

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

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

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

Linking mental symptoms to specific periods

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

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

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

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

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

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

Assessment Step 7: Determine Disability and Functional Impairment

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

Assessment Step 7—Application to Case Example

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

Assessment Step 7—Application to Case Example

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

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

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

Assessing functional capability

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

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

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

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

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

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

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

Assessment Step 8: Identify Strengths and Supports

All assessment must include some specific attention to the individual's current strengths, skills, and supports, both in relation to general life functioning, and in relation to his or her ability to manage either mental or substance use disorders. This often provides a more positive approach to treatment engagement than does focusing exclusively on deficits that need to be corrected. This is no less true for individuals with serious mental disorders than it is for people with substance use disorders only.

Questions might focus on

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

Assessment Step 8—Application to Case Examples

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

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

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

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

Assessment Step 9: Identify Cultural and Linguistic Needs and Supports

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

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

Not fitting into the treatment culture

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

Assessment Step 9—Application to Case Example

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

Assessment Step 9—Application to Case Example

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

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

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

Cultural and linguistic service barriers

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

Assessment Step 10: Identify Problem Domains

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

Assessment Step 10—Application to Case Example

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

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

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

Assessment Step 11: Determine Stage of Change

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

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

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

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

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

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

Assessment Step 11—Application to Case Example

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

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

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

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

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

Assessment Step 12: Plan Treatment

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

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

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

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

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

Considerations in Treatment Matching

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

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

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

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

Assessment Process Summary

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

But—can this really be done?

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

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

Figure 4-3
Considerations in Treatment Matching

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

Figure 4-3 (continued)
Considerations in Treatment Matching

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

Figure 4-3 (continued)
Considerations in Treatment Matching

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

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

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

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

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

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

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

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

5 Strategies for Working With Clients With Co-Occurring Disorders

In This Chapter...

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

Techniques for Working With Clients With COD

Overview

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

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

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

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

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

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

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

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

Guidelines for Developing Successful Therapeutic Relationships With Clients With COD

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

related to treatment completion among clients with few psychiatric symptoms.

Challenges for the clinician

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

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

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

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

Advice to the Counselor: Forming a Therapeutic Alliance

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

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

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

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

Maintain a Recovery Perspective

Varied meanings of "recovery"

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

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

Implications of the recovery perspective

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

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

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

Advice to the Counselor: Maintaining a Recovery Perspective

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

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

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

Stages of change and stages of treatment

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

Client empowerment and responsibility

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

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

Continuous support

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

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

Continuity of treatment

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

Manage Countertransference

Though somewhat dated and infrequently used in the COD literature, the concept of "countertransference" is useful for understanding how the clinician's past experience can influence current attitudes toward a particular client.

"Transference" describes the process whereby clients project attitudes, feelings, reactions, and images from the past onto the clinician. For example, the client may regard the clinician as an "authoritative father," "know-it-all older brother," or "interfering mother."

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

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

Advice to the Counselor: Managing Countertransference

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

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

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

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

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

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

Monitor Psychiatric Symptoms

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

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

Advice to the Counselor: Monitoring Psychiatric Symptoms

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

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

and consult with clients' physicians whenever appropriate.

Status of symptoms

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

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

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

Potential for harm to self or others

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

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

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

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

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

Use Supportive and Empathic Counseling

Definition and importance

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

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

Confrontation and empathy

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

Using an Empathic Style

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

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

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

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

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

Employ Culturally Appropriate Methods

Understanding the client's cultural background

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

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

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

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

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

Advice to the Counselor: Using Culturally Appropriate Methods

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

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

Source: Center for Mental Health Services 2001.

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

Cultural perceptions and diagnosis

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

Cultural differences and treatment: Empirical evidence on effectiveness

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

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

Increase Structure and Support

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

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

Techniques for Working With Clients With COD

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

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

Definition and description

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

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

Key Techniques for Working With Clients Who Have COD

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

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

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

Guiding principles of motivational interviewing

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

1. Expressing empathy

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

2. Developing discrepancies

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

3. Rolling with resistance

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

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

Guiding Principles of Motivational Interviewing

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

Source: Miller and Rollnick 2002, pp. 36–41.

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

4. Supporting self-efficacy

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

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

"Change talk"

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

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

"Decisional balance"

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

Matching motivational strategies to the client's stage of change

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

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

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

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

Figure 5-1
Stages of Change

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

Source: Adapted from Prochaska et al. 1992.

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

Motivational interviewing and co-occurring disorders

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

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

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

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

Figure 5-2
Motivational Enhancement Approaches

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

Figure 5-2 (continued)
Motivational Enhancement Approaches

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

Source: Reproduced from Samet et al. 1996 (used with permission).

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

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

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

change and the assessment of stage of readiness determined by interviewers for their 39 outpatients with diagnoses of both schizophrenia and a substance use disorder. In view of these observations, clinicians should be careful to establish a mutual agreement on the issue of readiness to change with their clients.

Applying the motivational interviewing approach to clients with COD

To date, motivational interviewing strategies have been applied successfully to the treatment of clients with COD, especially in

- Assessing the client's perception of the problem
- Exploring the client's understanding of his or her clinical condition

Figure 5-3
A Four-Session Motivation-Based Intervention

Session 1—Introduction, Assessment, and Information Feedback		
Goals	**Therapeutic Activities**	**Purpose**
Establish therapeutic alliance and collaborative approach Begin to develop discrepancy (raise awareness of the extent of use and negative consequences)	Introduce intervention	• To elicit reasons and motivations for attending • To establish understanding of the nature and purpose of the intervention
	Assess and discuss readiness to change	• To establish mutual understanding of attitudes toward substance use and prospects for change • To convey respect for the client's attitudes • To evaluate using open-ended and structured techniques
	Feedback of current use, consequences, and risks	• To foster client's awareness of extent of use, comparison to norms, negative consequences, and risks of pattern of use
Session 2—Decisional Balance		
Goals	**Therapeutic Activities**	**Purpose**
Continue emphasis on therapeutic alliance and collaborative approach Place more emphasis on developing discrepancy	Review Session 1 and introduce Session 2	• To let the client know what to expect (alleviates anxiety) • To help the client remember insights/reactions to reinforce gains
	Decisional balance	• To help the client identify and verbalize salient cons of using and pros of quitting • To foster dissatisfaction with use, and interest in quitting, clarifying barriers to change

Figure 5-3 (continued)
A Four-Session Motivation-Based Intervention

Session 3—Strivings and Efficacy

Goals	Therapeutic Activities	Purpose
Continue emphasis on developing discrepancy Place more emphasis on self-efficacy	Review Session 2 and introduce Session 3	• To reorient the client to the treatment process and reinforce past gains
	Assess and discuss expectancies with regard to behavior change	• To monitor changes in perceived importance and self-efficacy to change substance use • To shore up motivation for change or address reasons for low motivation
	Strivings list	• To develop discrepancy between a future with and without change in substance use by verbalizing personal aspirations, likely negative effects of use to achieving goals, and potential facilitative effects of abstinence

Session 4—Goals and Action Plan

Goals	Therapeutic Activities	Purpose
Reinforce motivational gains (in perceived importance of change, self-efficacy) To leave the client with a clear plan of action	Review treatment	• To reinforce motivational changes • To extend the principle of providing periodic summaries of discussion throughout the course of each session • To use repetition to compensate for deficits in attention and memory
	Elicit goals and develop written plan of action	• To help identify and clarify specific, realistic goals around substance use reduction • To help develop a plan of action, including mobilizing external supports and internal resources • To help the client anticipate barriers and solve problems around him

Source: Carey et al. 2001.

- Examining the client's desire for continued treatment
- Ensuring client attendance at initial sessions
- Expanding the client's assumption of responsibility for change

Future directions include

- Further modification of MI protocols to make them more suitable for clients with COD, particularly those with serious mental disorders
- Tailoring and combining MI techniques with other treatments to solve the problems (e.g., engagement, retention, etc.) of all treatment modalities

See the text box below for a case study applying MET.

Design Contingency Management Techniques To Address Specific Target Behaviors

Description

Contingency Management (CM) maintains that the form or frequency of behavior can be altered through a planned and organized system of positive and negative consequences. CM

Case Study: Using MET With a Client Who Has COD

Gloria M. is a 34-year-old African-American female with a 10-year history of alcohol dependence and 12-year history of bipolar disorder. She has been hospitalized previously both for her mental disorder and for substance abuse treatment. She has been referred to the outpatient substance abuse treatment provider from inpatient substance abuse treatment services after a severe alcohol relapse.

Over the years, she sometimes has denied the seriousness of both her addiction and mental disorders. Currently, she is psychiatrically stable and is prescribed valproic acid to control the bipolar disorder. She has been sober for 1 month.

At her first meeting with Gloria M., the substance abuse treatment counselor senses that she is not sure where to focus her recovery efforts—on her mental disorders or her addiction. Both have led to hospitalization and to many life problems in the past. Using motivational strategies, the counselor first attempts to find out Gloria M.'s own evaluation of the severity of each disorder and its consequences to determine her stage of change in regard to each one.

Gloria M. reveals that while in complete acceptance and an active stage of change around alcohol dependence, she is starting to believe that if she just goes to enough recovery meetings she will not need her bipolar medication. Noting her ambivalence, the counselor gently explores whether medications have been stopped in the past and, if so, what the consequences have been. Gloria M. recalls that she stopped taking medications on at least half a dozen occasions over the last 10 years; usually, this led her to jail, the emergency room, or a period of psychiatric hospitalization. The counselor explores these times, asking: Were you feeling then as you were now—that you could get along? How did that work out? Gloria M. remembers believing that if she attended 12-Step meetings and prayed she would not be sick. In response to the counselor's questions, she observes, "I guess it hasn't ever really worked in the past."

The counselor then works with Gloria M. to identify the best strategies she has used for dual recovery in the past. "Has there been a time you really got stable with both disorders?" Gloria M. recalls a 3-year period between the ages of 25 and 28 when she was stable, even holding a job as a waitress for most of that period. During that time, she recalls, she saw a psychiatrist at a local mental health center, took medications regularly, and attended AA meetings frequently. She recalls her sponsor as being supportive and helpful. The counselor then affirms the importance of this period of success and helps Gloria M. plan ways to use the strategies that have already worked for her to maintain recovery in the present.

assumes that neurobiological and environmental factors influence substance use behaviors and that the consistent application of reinforcing environmental consequences can change these behaviors. CM principles for substance abuse treatment have been structured around four central principles (Higgins and Petry 1999):

- The clinician arranges for regular drug testing to ensure the client's use of the targeted substance is detected readily.
- The clinician provides positive reinforcement when abstinence is demonstrated. These positive reinforcers are agreed on mutually.
- The clinician withholds the designated incentives from the individual when the substance is detected.
- The clinician helps the client establish alternate and healthier activities.

CM techniques are best applied to specific targeted behaviors such as

- Drug abstinence
- Clinic attendance and group participation
- Medication adherence
- Following treatment plan
- Attaining particular goals

The clinician may use a variety of CM techniques or reinforcers. The most common are

- Cash
- Vouchers
- Prizes
- Retail items
- Privileges

Figure 5-4 contains a checklist for a clinician designing CM programs. See also p. 124 for a case study applying CM.

Empirical evidence on the effectiveness of contingency management

A substantial empirical base supports CM techniques, which have been applied effectively to a variety of behaviors. CM techniques have demonstrated effectiveness in enhancing retention and confronting drug use (e.g., Higgins 1999; Petry et al. 2000). The techniques have been shown to address use of a variety of specific substances, including opioids (e.g., Higgins et al. 1986; Magura et al. 1998), marijuana (Budney et al. 1991), alcohol (e.g., Petry et al. 2000), and a variety of other drugs including cocaine (Budney and Higgins 1998). However, CM techniques have not been implemented in community-based settings until recently. The use of vouchers and other reinforcers has considerable empirical support (e.g., Higgins 1999; Silverman et al. 2001), but little evidence is apparent for the relative efficacy of different reinforcers. The effectiveness of CM principles when applied in community-based treatment settings and specifically with clients who have COD remains to be demonstrated.

Some examples of the use of CM techniques have direct implications for people with COD:

- *Housing and employment contingent on abstinence.* CM, where housing and employment are contingent on abstinence, has been used and studied among populations of homeless persons, many with COD (Milby et al. 1996; Schumacher et al. 1995). Results show that participants in treatment with contingencies were more likely than those in conventional treatment to test clean for drugs, to move into stable housing, and to gain regular employment following treatment.
- *Managing benefits and establishing representative payeeships.* Procedures have been established to manage benefits for persons with serious mental illness and substance use disorders (Ries and Comtois 1997) and for establishing representative payeeships for clients with COD that involve managing money and other benefits (e.g., Conrad et al. 1999). In these approaches, once abstinence is achieved, clients are allowed greater latitude for management of their own finances.
- *A token economy for homeless clients with COD.* A token economy has been developed with clients with COD in a shelter to provide immediate and systematic reinforce-

Figure 5-4
Checklist for Designing CM Programs

Step	Description
1. Choose a behavior	• One that is objectively quantifiable, occurs frequently, and is considered to be most important. • Set reasonable expectations.
2. Choose a reinforcer	• Determine available resources (in-house rewards or donations of cash or services from local businesses such as movie theaters and restaurants). • Identify intangible rewards, such as frequent positive reports to parole officers, flexibility in methadone dosing, and increased freedom (smoke breaks, passes, etc.).
3. Use behavioral principles	• Develop a monitoring and reinforcement schedule that is optimized through application of behavioral principles. • Keep the schedule simple so staff can apply principles consistently and clients can understand what is expected.
4. Prepare a behavioral contract	• Draw up a contract for the target behavior that considers the monitoring system and reinforcement schedule. • Be specific and consider alternate interpretations; have others review the contract and comment. • Include any time limitations.
5. Implement the contract	• Ensure consistent application of the contract; devise methods of seeing that staff understands and follows procedures. • Remind the client of behaviors and their consequences (their "account balance" and what is required to obtain a bonus) to increase the probability that the escalating reward system will have the desired effect.

Source: Petry 2000*a*.

ment for an array of behaviors during the engagement phase. Points were awarded for the successful accomplishment of a standard list of behaviors essential to the development of commitment, such as medication adherence, abstinence, attendance at program activities, and followthrough on referrals. Points were tallied weekly and tangible rewards (phone cards, treats, toiletries, etc.) were distributed commensurate with the earned point totals (Sacks et al. 2002).

Awareness of the principles of CM can help the clinician to focus on quantifiable behaviors that occur with a good deal of frequency and to provide the reinforcers in an immediate and consistent fashion. CM principles and methods can be accommodated flexibly and applied to a range of new situations that can increase clinician effectiveness. It should be noted that many counselors and programs employ CM principles informally when they praise or reward particular behaviors and accomplishments and that even formal use of CM principles are found in

Case Study: Using CM With a Client With COD

Initial Assessment
Mary A. is a 45-year-old Caucasian woman diagnosed with heroin and cocaine dependence, depression, antisocial personality disorder, and cocaine-induced psychotic episodes. She has a long history of prostitution and sharing injection equipment. She contracted HIV 5 years ago.

Mary A. had been on a regimen of methadone maintenance for about 2 years. Despite dose increases up to 120 mg/day, she continued using heroin at the rate of 1 to 15 bags per day as well as up to 3 to 4 dime bags per day of cocaine. After cessation of a cocaine run, Mary A. experienced tactile and visual hallucinations characterized by "bugs crawling around in my skin." She mutilated herself during severe episodes and brought in some of the removed skin to show the "bugs" to her therapist.

Mary A. had been hospitalized four times for cocaine-induced psychotic episodes. Following an 11-day stay in an inpatient dual diagnosis program subsequent to another cocaine-induced psychotic episode, Mary A. was referred to an ongoing study of contingency management interventions for methadone-maintained, cocaine-dependent outpatients.

Behaviors To Target
Mary A.'s primary problem was her drug use, which was associated with cocaine-induced psychosis and an inability to adhere to a regimen of psychiatric medications and methadone. Because her opioid and cocaine use were linked intricately, it was thought that a CM intervention that targeted abstinence from both drugs would improve her functioning. As she was already maintained on a high methadone dose, methadone dose adjustments were not made.

CM Plan
Following discharge from the psychiatric unit, Mary A. was offered participation in a NIDA-funded study evaluating lower-cost contingency management treatment (e.g., Petry et al. 2000, pp. 250–257) for cocaine-abusing methadone clients. As part of participation in this study, Mary A. agreed to submit staff-observed urine samples on 2 to 3 randomly selected days each week for 12 weeks. She was told that she had a 50 percent chance of receiving standard methadone treatment plus frequent urine sample testing of standard treatment along with a contingency management intervention. She provided written informed consent, as approved by the University's Institutional Review Board.

Mary A. was assigned randomly to the CM condition. In this condition, she earned one draw from a bowl for every urine specimen that she submitted that was clean from cocaine or opioids and four draws for every specimen that was clean from both substances. The bowl contained 250 slips of paper. Half of them said "Good job" but did not result in a prize. Other slips stated "small prize" (N=109), "large prize" (N=15), or "jumbo prize" (N=1). Slips were replaced after each drawing so that probabilities remained constant. A lockable prize cabinet was kept onsite in which a variety of small prizes (e.g., socks, lipstick, nail polish, bus tokens, $1 gift certificates to local fast-food restaurants, and food items), large prizes (sweatshirts, portable CD players, watches, and gift certificates to book and record stores), and jumbo prizes (VCRs, televisions, and boom boxes) were kept. When a prize slip was drawn, Mary A. could choose from items available in that category. All prizes were purchased through funds from the research grant.

In addition to the draws from the bowl for clean urine specimens, for each week of consecutive abstinence from both cocaine and opioids Mary A. earned bonus draws. The first week of consecutive cocaine and opioid abstinence resulted in five bonus draws, the second week resulted in six bonus draws, the third week seven and so on. In total, Mary A. could earn about 200 draws if she maintained abstinence throughout the 12-week study.

Clinical Course
Mary A. earned 175 draws during treatment, receiving prizes purchased for a total of $309. She never missed a day of methadone treatment, attended group sessions regularly, and honored all her individual counseling sessions at the clinic. At 6-month follow-up, she had experienced only one drug use lapse, which she self-reported. Her depression cleared with her abstinence, and so did her antisocial behavior. She was pleased with the prizes and stated, "Having good stuff in my apartment and new clothes makes me feel better about myself. When I feel good about me, I don't want to use cocaine."

Source: Adapted from Petry et al. 2001*b*.

programs where attainment of certain levels and privileges are contingent on meeting certain behavioral criteria.

Use Cognitive–Behavioral Therapeutic Techniques

Description

Cognitive–behavioral therapy (CBT) is a therapeutic approach that seeks to modify negative or self-defeating thoughts and behavior. CBT is aimed at both thought and behavior change (i.e., coping by thinking differently and coping by acting differently). One cognitive technique is known as "cognitive restructuring." For example, a client may think initially, "The only time I feel comfortable is when I'm high," and learn through the counseling process to think instead, "It's hard to learn to be comfortable socially without doing drugs, but people do so all the time" (TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* [CSAT 1999*a*], pp. 64–65). CBT includes a focus on overt, observable behaviors—such as the act of taking a drug—and identifies steps to avoid situations that lead to drug taking. CBT also explores the interaction among beliefs, values, perceptions, expectations, and the client's explanations for why events occurred.

An underlying assumption of CBT is that the client systematically and negatively distorts her view of the self, the environment, and the future (O'Connell 1998). Therefore, a major tenet of CBT is that the person's thinking is the source of difficulty and that this distorted thinking creates behavioral problems. CBT approaches use cognitive and/or behavioral strategies to identify and replace irrational beliefs with rational beliefs. At the same time, the approach prescribes new behaviors the client practices. These approaches are educational in nature, active and problem-focused, and time-limited.

CBT for substance abuse

CBT for substance abuse combines elements of behavioral theory, cognitive social learning theory, cognitive theory, and therapy into a distinctive therapeutic approach that helps clients recognize situations where they are likely to use substances, find ways of avoiding those situations, and learn better ways to cope with feelings and situations that might have, in the past, led to substance use (Carroll 1998).

Advice to the Counselor: Using Contingency Management Techniques

The consensus panel recommends that substance abuse treatment clinicians and programs employ CM techniques with clients with COD in such activities as

- Providing refreshments for attendance at groups or social activities
- Monitoring urine specimens
- Checking medication adherence
- Rewarding clients for obtaining particular goals in their treatment plan
- Reinforcing appropriate verbal and social behavior

CBT for people with substance use disorders also addresses "coping behaviors." Coping "refers to what an individual does or thinks in a relapse crisis situation so as to handle the risk for renewed substance use" (Moser and Annis 1996, p. 1101). The approach assumes that "substance abusers are deficient in their ability to cope with interpersonal, social, emotional, and personal problems. In the absence of these skills, such problems are viewed as threatening, stressful, and potentially unsolvable. Based on the individual's observation of both family members' and peers' responses to similar situations and on their own initial experimental use of alcohol or drugs, the individual uses substances as a means of trying to address these problems and the emotional reactions they create" (CSAT 1999*a*, p. 71). The clinician seeks to help the client increase his coping skills so he will not use drugs in high-stress situations. (See TIP 34 [CSAT 1999*a*] for a more detailed explanation of the theoretical background of CBT and how it is applied in substance abuse treatment.)

CBT and COD

Distortions in thinking generally are more severe with people with COD than with other substance abuse treatment clients. For example, a person with depression and an alcohol use disorder who has had a bad reaction to a particular antidepressant may claim that all antidepressant medication is bad and must be avoided at all costs. Likewise, individuals may use magnification and minimization to exaggerate the qualities of others, consistently presenting themselves as "losers" who are incapable of accomplishing anything. Clients with COD are, by definition, in need of better coping skills. The Substance Abuse Management Model in the section on Relapse Prevention Therapy later in this chapter provides a pertinent example of how to increase behavioral coping skills.

Grounding

Some clients with COD, such as those who have experienced trauma or sexual abuse, can benefit from a particular coping skill known as "grounding" (Najavits 2002). Many such clients frequently experience overwhelming feelings linked to past trauma, which can be triggered by a seemingly small comment or event. Sometimes, this sets off a craving to use substances. Grounding refers to the use of strategies that soothe and distract the client who is experiencing tidal waves of pain or other strong emotions, helping the individual anchor in the present and in reality. These techniques work by directing the mental focus outward to the external world, rather than inward toward the self. Grounding also can be referred to as "centering," "looking outward," "distraction," or "healthy detachment" (Najavits 2002).

Grounding "can be done anytime, anywhere, by oneself, without anyone else noticing it. It can also be used by a supportive friend or partner who can guide the patient in it when the need arises" (Najavits 2002, p. 125). It is used commonly for PTSD, but can be applied to substance abuse cravings, or any other intense negative feeling, such as anxiety, panic attacks, and rage. Grounding is so basic and simple that it gives even the most impaired clients a useful strategy. However, it must be practiced frequently to be maximally helpful. For a lesson plan and other materials on grounding, see Najavits 2002. See also the section on PTSD in chapter 8 and appendix D of this TIP.

Roles of the client and clinician

CBT is an active approach that works most effectively with persons who are stabilized in the acute phase of their substance use and mental disorders. To be effective, the clinician and the client must develop rapport and a working alliance. The client's problem is assessed extensively and thorough historical data are collected. Then, collaboratively, dysfunctional automatic thoughts, schemas, and cognitive distortions are identified. Treatment consists of the practice of adaptive skills within the therapeutic environment and in homework sessions. Booster sessions are used following

Case Study: Using CBT With a Client With COD

Jack W. is referred to the substance abuse treatment agency for evaluation after a positive urine test that revealed the presence of cocaine. He is a 38-year-old African American. Initially, Jack W. engages in treatment in intensive outpatient therapy three times weekly, has clean urine tests, and seems to be doing well. However, after 2 months he starts to appear more depressed, has less to say in group therapy sessions, and appears withdrawn. In a private session with the substance abuse treatment counselor, he says that, "All this effort just isn't worth it. I feel worse than I did when I started. I might as well quit treatment and forget the job. What's the point?" The counselor explores what has changed, and Jack W. reveals that his wife has been having a hard time interacting with him as a sober person. Now that he is around the house more than he used to be (he was away frequently, dealing drugs to support his habit), they have more arguments. He feels defeated.

In the vocabulary of CBT, Jack W. demonstrates "all or nothing" thinking (I might as well lose everything because I'm having arguments), overgeneralization, and discounting the positive (he is ignoring the fact that he still has his job, has been clean for 2 months, looks healthier and, until recently, had an improved outlook). His emotionally clouded reasoning is blackening the whole recovery effort, as he personalizes the blame for what he sees as failure to improve his life.

Clearly, Jack W. has lost perspective and seems lost in an apparently overwhelming marital problem. The counselor, using a pad and pencil, draws a circle representing the client and divides it into parts, showing Jack that they represent physical health, his work life, his recovery, risk for legal problems, and family or marriage. He invites Jack to review each one, comparing where he is now and where he was when he first arrived at the clinic in order to evaluate the whole picture. Jack observes that everything is actually getting better with the exception of his marriage. The counselor helps Jack gain the skills needed to stand back from his situation and put a problem in perspective. He also negotiates to determine the kind of help that Jack would see as useful in his marriage. This might be counseling for the couple or an opportunity to practice and rehearse ways of engaging his wife without either of them becoming enraged.

If Jack's depression continues despite these interventions, the counselor may refer him to a mental health provider for evaluation and treatment of depression.

termination of treatment to assist people who have returned to old maladaptive patterns of thinking.

The client with COD is an active participant in treatment, while the role of the clinician is primarily that of educator. The clinician collaborates with the client or group in identifying goals and setting an agenda for each session. The counselor also guides the client by explaining how thinking affects mood and behavior. Clients with COD may need very specific coping skills to overcome the combined challenges of their substance abuse and their mental disorder. For example, Ziedonis and Wyatt (1998, p. 1020) address the need to target "the schizophrenic's cognitive difficulties (attention span, reading skills, and ability to abstract)." Their approach for these clients includes role-playing to help build communication and problemsolving skills.

Some specific CBT strategies for programs working with clients with COD are described below. See also the text box above for a case example.

Use Relapse Prevention Techniques

Description

Marlatt defines relapse as "a breakdown or setback in a person's attempt to change or modify any target behavior" (1985, p. 3). NIDA elaborates this definition by describing relapse as "any occasion of drug use by recovering

Adapting CBT for Clients With COD

- Use visual aids, including illustrations and concept mapping (a visual presentation of concepts that makes patterns evident).
- Practice role preparation and rehearse for unexpected circumstances.
- Provide specific in vivo feedback on applying principles and techniques.
- Use outlines for all sessions that list specific behaviorally anchored learning objectives.
- Test for knowledge acquisition.
- Make use of memory enhancement aids, including notes, tapes, and mnemonic devices.

Source: Adapted from Peters and Hills 1997.

addicts that violates their own prior commitment and that often they regret almost immediately" (NIDA 1993, p. 139), and adds Relapse Prevention Therapy (RPT) to its list of effective substance abuse treatment approaches. Relapse can be understood not only as the event of resuming substance use, but also as a process in which indicators of increasing relapse risk can be observed prior to an episode of substance use, or lapse (Daley 1987; Daley and Marlatt 1992).

A variety of relapse prevention models are described in the literature (e.g., Gorski 2000; Marlatt et al. 1999; Monti et al. 1993; NIDA 1993; Rawson et al. 1993). However, a central element of all clinical approaches to relapse prevention is anticipating problems that are likely to arise in maintaining change and labeling them as high-risk situations for resumed substance use, then helping clients to develop effective strategies to cope with those high-risk situations without having a lapse. A key factor in preventing relapse is to understand that relapses are preceded by triggers or cues that signal that trouble is brewing and that these triggers precede exposure to events or internal processes (high-risk situations) where or when resumed substance use is likely to occur. A lapse will occur in response to these high-risk situations unless effective coping strategies are available to the person and are implemented quickly and performed adequately. Clinicians using relapse prevention techniques recognize that lapses (single episodes or brief returns to drug use) are an expected part of overcoming a drug problem, rather than a signal of failure and an indication that all treatment progress has been lost. Therapy sessions aimed at relapse prevention can occur individually or in small groups, and may include practice or role-play on how to cope effectively with high-risk situations.

According to Daley and Marlatt (1992), approaches to relapse prevention have many common elements. Generally they focus on the need for clients to

1. Have a broad repertoire of cognitive and behavioral coping strategies to handle high-risk situations and relapse warning signs.
2. Make lifestyle changes that decrease the need for alcohol, drugs, or tobacco.
3. Increase healthy activities.
4. Prepare for interrupting lapses, so that they do not end in full-blown relapse.
5. Resume or continue to practice relapse prevention skills even when a full-blown relapse does occur by renewing their commitment to abstinence rather than giving up the goal of living a drug-free life.

RPT is an intervention designed to teach individuals who are trying to maintain health behavior changes how to anticipate and cope with the problem of relapse (Marlatt 1985). RPT strategies can be placed in five categories: Assessment Procedures, Insight/Awareness Raising Techniques, Coping Skills

Training, Cognitive Strategies, and Lifestyle Modification (Marlatt 1985). RPT *Assessment Procedures* are designed to help clients appreciate the nature of their problems in objective terms, to measure motivation for change, and to identify risk factors that increase the probability of relapse. *Insight/Awareness Raising Techniques* are designed to provide clients with alternative beliefs concerning the nature of the behavior change process (e.g., to view it as a learning process) and, through self-monitoring, to help clients identify patterns of emotion, thought, and behavior related to both substance use and co-occurring mental disorders. *Coping Skills Training* strategies include teaching clients behavioral and cognitive strategies. *Cognitive Strategies* are used to manage urges and craving, to identify early warning signals, and to reframe reactions to an initial lapse. Finally, *Lifestyle Modification Strategies* (e.g., meditation and exercise) are designed to strengthen clients' overall coping capacity.

In Marlatt's model of RPT, lapses are seen as a "fork in the road" or a "crisis." Each lapse contains the dual elements of "danger" (progression to full-blown relapse) and "opportunity" (reduced relapse risk in the future due to the lessons learned from debriefing the lapse). The goal of effective RPT is to teach clients to recognize increasing relapse risk and to intervene at earlier points in the relapse process in order to encourage clients to progress toward maintaining abstinence from drugs and living a life in which lapses occur less often and are less severe.

Specific aspects of RPT might include

- Exploring with the client both the positive and negative consequences of continued drug use ("decisional balance," as discussed in the motivational interviewing section of this chapter)
- Helping clients to recognize high-risk situations for returning to drug use
- Helping clients to develop the skills to avoid those situations or cope effectively with them when they do occur
- Developing a "relapse emergency plan" in order to exercise "damage control" to limit the duration and severity of lapses
- Learning specific skills to identify and cope effectively with drug urges and craving

Clients also are encouraged to begin the process of creating a more balanced lifestyle to manage their COD more effectively and to fulfill their needs without using drugs to cope with life's demands and opportunities. In the treatment of clients with COD, it often is critical to consider adherence to a medical regimen required to manage disruptive and disorganizing symptoms of mental disorder as a relapse issue. In terms of medication adherence, a "lapse" is defined as not taking the prescribed drugs one needs rather than the resumption of taking illicit drugs for self-medication or pleasure seeking.

Empirical evidence related to relapse prevention therapy

Carroll (1996) reviewed 24 randomized controlled trials of RPT among smokers and abusers of alcohol, marijuana, cocaine, opioids, and other drugs. While many of the studies were of smokers—in which Carroll noted the strongest support for RPT in terms of improved outcomes for relapse severity, durability of effects, and client-treatment matching, as compared to no-treatment controls—comparable results were found for alcohol and illicit drugs as well. Of particular importance was the observation that the positive effects of RPT treatment were greater among those with higher severities of both psychiatric symptoms and addiction impairment, which suggests the technique would be helpful in the treatment of clients with COD.

In a meta-analytic review of 26 published and unpublished studies using Marlatt's RPT model, Irvin et al. (1999) found that RPT generally was effective particularly for alcohol problems and was most effective when applied to alcohol or polysubstance use disorders, combined with medication. The efficacy of RPT has been demonstrated sufficiently to

Advice to the Counselor: Using Relapse Prevention Methods

The consensus panel recommends using the following relapse prevention methods with clients with COD:

- Provide relapse prevention education on both mental disorders and substance abuse and their interrelations.
- Teach skills to help the client handle pressure for discontinuing psychotropic medication and to increase medication adherence.
- Encourage attendance at dual recovery groups and teach social skills necessary for participation.
- Use daily inventory to monitor psychiatric symptoms and symptoms changes.
- If relapse occurs, use it as a learning experience to investigate triggers with the client. Reframe the relapse as an opportunity for self-knowledge and a step toward ultimate success.

be included by NIDA (1999*a*) as a recommended approach "to supplement or enhance—not replace—existing treatment programs" (p. 35).

Adaptations for clients with COD

Several groups have developed relapse prevention interventions aimed at clients with different mental disorders or substance use diagnoses (see Evans and Sullivan 2001). Weiss and colleagues (1998) developed a 20-session relapse prevention group therapy for the treatment of clients with co-occurring bipolar and substance use disorders. This group stressed concepts of importance to both disorders—for example, it contrasts "may as well" thinking, which allows for relapse and failure to take medication, with "it matters what you do." It also teaches useful skills relevant to both disorders, such as coping with high-risk situations and modifying lifestyle to improve self-care (p. 49). Ziedonis and Stern (2001) have developed a dual recovery therapy, which blends traditional mental health and addiction treatments (including both motivational enhancement therapy and relapse prevention) for clients with serious mental illness. Also, Nigam and colleagues (1992) developed a relapse prevention group for clients with COD.

Substance abuse management module

Roberts et al. (1999) developed *The Substance Abuse Management Module* (SAMM) based on the previously described RPT approach of Marlatt and his colleagues. SAMM originally was designed to be a component of a comprehensive approach to the treatment of co-occurring substance use dependence and schizophrenia. This detailed treatment manual illustrates many RPT techniques and focuses on the most common problems encountered by clients with severe COD. SAMM offers a detailed cognitive–behavioral strategy for each of several common problems that clients face. Each strategy includes both didactics and detailed skills training procedures including role-play practice. Emphasis is placed on rehearsing such key coping behaviors as refusing drugs, negotiating with treatment staff, acting appropriately at meetings for mutual self-help, and developing healthy habits. Both counselor and client manuals are available.

The text box beginning on p. 131 describes the SAMM protocol (Roberts et al. 1999) shows how a clinician might work with a substance abuse treatment client with COD to help the client avoid drugs.

Integrated treatment

RPT (Marlatt and Gordon 1985) and other cognitive–behavioral approaches to psychotherapy and substance abuse treatment allow clinicians to treat COD in a integrated way by

Overview of SAMM Concepts and Skills

How to Avoid Drugs (Made Simple)

The concepts and skills taught in this module are designed to help clients follow these four recommendations:

- If you slip, quit early.
- When someone offers drugs, say no.
- Don't get into situations where you can't say no.
- Do things that are fun and healthy.

Overview of Module Concepts and Skills

Clients learn how to follow these recommendations by learning key concepts and the skills. Here are four recommendations restated in terms of the module's key concepts:

Plain English	Module Concepts
If you slip, quit early.	Practice damage control.
When someone offers drugs, say no.	Escape high-risk situations.
Don't get into situations where you can't say no.	Avoid high-risk situations.
Do things that are fun and healthy.	Seek healthy pleasures.

Concepts and Skills Associated With Each Recommendation

Practice damage control

Main point: If you slip and use drugs or alcohol again, stop early and get right back into treatment. This will reduce damage to your health, relationships, and finances.

Concepts: Maintain recovery, slip versus full-blown relapse, risk reduction, abstinence violation effect, bouncing back into treatment.

Skills: Leaving a drug-using situation despite some use; reporting a slip to a support person

Escape high-risk situations

Main point: Some situations make it very hard to avoid using drugs. Be prepared to escape from these situations without using drugs. Realize that it would be much better to avoid these situations in the first place.

Concepts: High-risk situations.

Skills: Refusing drugs from a pushy dealer; refusing drugs offered by a friend.

Overview of SAMM Concepts and Skills (continued)

Avoid high-risk situations

Main point: Avoid high-risk situations by learning to recognize the warning signs that you might be headed toward drug use.

Concepts: Drug habit chain (trigger, craving, planning, getting, using), warning signs, U-turns, removing triggers, riding the wave, money management, representative payee.

Skills: Getting an appointment with a busy person; reporting symptoms and side effects; getting a support person.

Seek healthy pleasures

Main point: You can avoid drugs by focusing on the things that are most important and enjoyable to you. Do things that are fun and healthy.

Concepts: Healthy pleasures, healthy habits, activities schedule.

Skills: Getting someone to join you in a healthy pleasure; negotiating with a representative payee.

Additional Recommendations and Concepts

Understand how you learned to use drugs.

Main point: Drug abuse is learned and can be unlearned.

Concepts: Habits, reinforcement, craving, conditioning, extinction, riding the wave.

Know why you decided to quit.

Main point: Make sure you can always remember why you decided to quit using drugs.

Concepts: Advantages and disadvantages of using drugs and of not using drugs.

Carry an emergency card.

Main point: Make an emergency card that contains vital information and reminders about how and why to avoid drugs. Carry it with you at all times.

Concepts: Support person, coping skills, why quit.

Source: Adapted from Roberts et al. 1999 (used with permission).

1. Doing a detailed functional analysis of the relationships between substance use, Axis I or II symptoms, and any reported criminal conduct
2. Evaluating the unique and common high-risk factors for each problem and determining their interrelationships
3. Assessing both cognitive and behavioral coping skills deficits
4. Implementing both cognitive and behavioral coping skills training tailored to meet the specific needs of an individual client with respect to all three target behaviors (i.e., substance use, symptoms of mental disorder, and criminal conduct)

Summary of RP strategies for clients with COD

Daley and Lis (1995) summarize RP strategies that can be adapted for clients with COD, some of which are listed below:

- Regardless of the client's motivational level or recovery stage, relapse education should be provided and related to the individual's mental disorder. The latter is important, particularly because the pattern typically followed by clients with COD begins with an increase in substance use leading to lowered efficacy or discontinuation of psychiatric medication, or missed counseling sessions. As a consequence, symptoms of mental disorders reappear or worsen, the client's tendency to self-medicate through substance use is exacerbated, and the downward spiral is perpetuated.
- Clients with COD need effective strategies to cope with pressures to discontinue their prescribed psychiatric medication. One such strategy simply is to prepare clients for external pressure from other people to stop taking their medications. Rehearsing circumstances in which this type of pressure is applied, along with anticipating the possibility, enables clients with COD to react appropriately. Reinforcing the difference between substances of abuse—getting "high"—and taking psychiatric medication to treat an illness is another simple but effective strategy.
- An integral component of recovery is the use of mutual self-help and dual recovery groups to provide the support and understanding of shared experience. To maximize the effectiveness of their participation, clients with COD usually need help with social skills (listening, self-disclosure, expressing feelings/desires, and addressing conflict).

Clients can use daily self-ratings of persistent psychiatric symptoms to monitor their status. Use of the daily inventory and symptom review should be encouraged to help clients with COD to track changes and take action before deteriorating status becomes critical. See the text box on p. 134 for a case study applying RP strategies.

Use Repetition and Skills-Building To Address Deficits in Functioning

In applying the approaches described above, keep in mind that clients with COD often have cognitive limitations, including difficulty concentrating. Sometimes these limitations are transient and improve during the first several weeks of treatment; at other times, symptoms persist for long periods. In some cases, individuals with specific disorders (schizophrenia, attention deficit disorder) may manifest these symptoms as part of their disorder.

General treatment strategies to address cognitive limitations in clients include being more concrete and less abstract in communicating ideas, using simpler concepts, having briefer discussions, and repeating the core concepts many times. In addition, individuals often learn and remember better if information is presented in multiple formats (verbally; visually; or affectively through stories, music, and experiential activities). Role-playing real-life situations also is a useful technique when working with clients with cognitive limitations. For example, a client might be assigned to practice "asking for help" phone calls using a prepared script. This can be done individually with the counselor coaching, or in a group, to obtain feedback from the members.

When compared to individuals without additional disorders or disabilities, persons with COD and additional deficits often will require more substance abuse treatment in order to attain and maintain abstinence. A primary reason for this is that abstinence requires the development and utilization of a set of recovery skills, and persons with mental disorders often have a harder time learning new skills. They may require more support in smaller steps with more practice, rehearsal, and repetition. The challenge is not to provide more intensive or more complicated treatment for clients with COD, but rather to tailor the process of acquiring new skills to the needs and abilities of the client.

Case Study: Preventing Relapse in a Client With COD

Stan Z. is a 32-year-old with diagnoses of recurrent major depression, antisocial personality disorder, crack/cocaine dependence, and polysubstance abuse. He has a 15-year history of addiction, including a 2-year history of crack addiction. Stan Z. has been in a variety of psychiatric and substance abuse treatment programs during the past 10 years. His longest clean time has been 14 months. He has been attending a dual-diagnosis outpatient clinic for the past 9 months and going to Narcotics Anonymous (NA) meetings off and on for several years. Stan Z. has been clean from all substances for 7 months. Following is a list of high-risk relapse factors and coping strategies identified by Stan Z. and his counselor:

High-Risk Factor 1

Stan Z. is tired and bored "with just working, staying at home and watching TV, or going to NA meetings." Recently, he has been thinking about how much he "misses the action of the good old days" of hanging with old friends and does not think he has enough things to do that are interesting.

Possible coping strategies for Stan Z. include the following: (1) remind him of problems caused by hanging out with people who use drugs and using drugs by writing out a specific list of problems associated with addiction; (2) challenge the notion of the "good old days" by looking closely at the "bad" aspects of those days; (3) remind him of how far he has come in his recent recovery, especially being able to get and keep a job, maintain a relationship with one woman, and stay out of trouble with the law; (4) discuss current feelings and struggles with an NA sponsor and NA friends to find out how they handled similar feelings and thoughts; and (5) make a list of activities that will not threaten recovery and can provide a sense of fun and excitement and plan to start active involvement in one of these activities.

High-Risk Factor 2

Stan Z. is getting bored with his relationship with his girlfriend. He feels she is too much of a "home body" and wants more excitement in his relationship with her. He also is having increased thoughts of having sex with other women.

Possible coping strategies for Stan Z. include the following: (1) explore in therapy sessions why he is really feeling bored with his girlfriend, noting he has a long-standing pattern of dumping girlfriends after just a few months; (2) challenge his belief that the problem is mainly his girlfriend so that he sees how his attitudes and beliefs play a role in this problem; (3) talk directly with his girlfriend in a nonblaming fashion about his desire to work together to find ways to instill more excitement in the relationship; (4) remind him of potential dangers of casual sex with a woman he does not know very well and that he cannot reach his goal of maintaining a meaningful, mutual relationship if he gets involved sexually with another woman. His past history is concrete proof that such involvement always leads to sabotaging his primary relationship.

High-Risk Factor 3

Stan Z. wants to stop taking antidepressant medications. His mood has been good for several months and he does not see the need to continue medications.

Possible coping strategies include the following: (1) discuss his concern about medications with his counselor and psychiatrist before making a final decision; (2) review with his treatment team the reasons for being on antidepressant medications; (3) remind him that because he had several episodes of depression, even during times when he has been drug-free for a long period, medication can help "prevent" the likelihood of a future episode of depression.

Source: Daley and Lis 1995, pp. 255–256.

Case Study: Using Repetition and Skills Building With a Client With COD

In individual counseling sessions with Susan H., a 34-year-old Caucasian woman with bipolar disorder and alcohol dependence, the counselor observes that often she is forgetful about details of her recent past, including what has been said and agreed to in therapy. Conclusions the counselor thought were clear in one session seem to be fuzzy by the next. The counselor begins to start sessions with a brief review of the last session. He also allows time at the end of each session to review what has just happened. As Susan H. is having difficulty remembering appointment times and other responsibilities, he helps her devise a system of reminders in big letters on her refrigerator.

Facilitate Client Participation in Mutual Self-Help Groups

Just as the strategies discussed in this chapter have proven helpful both to clients who have only substance use disorders as well as to those with COD, so the use of mutual self-help groups is a key tool for the clinician in assisting both categories of clients. In addition to traditional 12-Step groups, dual recovery mutual self-help approaches are becoming increasingly common in most large communities. The clinician plays an important role in helping clients with COD access appropriate mutual self-help resources and benefit from them. (See chapter 7 for an extended presentation of Dual Recovery Mutual Self-Help approaches tailored to meet the needs of persons with COD.) Groups for those who do not speak English may not be available, and the clinician is advised to seek resources in other counties or, if the number of clients warrants it, to initiate organization of a group for those who speak the same non-English language.

The clinician can assist the client by:

- *Helping the client locate an appropriate group.* The clinician should strive to be aware not only of what local 12-Step and other dual recovery mutual self-help groups meet in the community, but also which 12-Step groups are known to be friendly to clients with COD, have other members with COD, or are designed specifically for people with COD. Clinicians do this by visiting groups to see how they are conducted, collaborating with colleagues to discuss groups in the area, updating their own lists of groups periodically, and gathering information from clients. The clinician should ensure that the group the client attends is a good fit for the client in terms of the age, gender, and cultural factors of the other members. In some communities, alternatives to 12-Step groups are available, such as Secular Organizations for Sobriety.
- *Helping the client find a sponsor, ideally one who also has COD and is at a later stage of recovery.* Knowing that he or she has a sponsor who truly understands the impact of two or more disorders will be encouraging for the client. Also, some clients may "put people off" in a group and have particular difficulty finding a sponsor without the clinician's support.
- *Helping the client prepare to participate appropriately in the group.* Some clients, particularly those with serious mental illness or anxiety about group participation, may need to have the group process explained ahead of time. Clients should be told the structure of a meeting, expectations of sharing, and how to participate in the closing exercises, which may include holding hands and repeating sayings or prayers. They may need to rehearse the kinds of things that are and are not appropriate to share at such meetings. Clients also should be taught how to "pass" and when this would be appropriate. The counselor should be familiar enough with group function and dynamics to actually "walk the

client" through the meeting before attending.

- *Helping overcome barriers to group participation.* The clinician should be aware of the genuine difficulties a client may have in connecting with a group. While clients with COD, like any others, may have some resistance to change, they also may have legitimate barriers they cannot remove alone. For example, a client with cognitive difficulties may need help working out how he or she can physically get to the meeting. The counselor may need to write down very detailed instructions for this person that another client would not need (e.g., "Catch the number 9 bus on the other side of the street from the treatment center, get off at Main Street, and walk three blocks to the left to the white church. Walk in at the basement entrance and go to Room 5.")
- *Debriefing with the client after he or she has attended a meeting to help process his or her reactions and prepare for future attendance.* The clinician's work does not end with referral to a mutual self-help group. The clinician must be prepared to help the client overcome any obstacles after attending the first group to ensure engagement in the group. Often this involves a discussion of the client's reaction to the group and a clarification of how he or she can participate in future groups.

Case Study: Helping a Client Find a Sponsor

Linda C. had attended her 12-Step group for about 3 months, and although she knew she should ask someone to sponsor her, she was shy and afraid of rejection. She had identified a few women who might be good sponsors, but each week in therapy she stated that she was afraid to reach out, and no one had approached her, although the group members seemed "friendly enough." The therapist suggested that Linda C. "share" at a meeting, simply stating that she'd like a sponsor but was feeling shy and didn't want to be rejected. The therapist and Linda C. role-played together in a session, and the therapist reminded Linda C. that it was okay to feel afraid and if she couldn't share at the next meeting, they would talk about what stopped her.

After the next meeting, Linda C. related that she almost "shared" but got scared at the last minute, and was feeling bad that she had missed an opportunity. They talked about getting it over with, and Linda C. resolved to reach out, starting her sharing statement with, "It's hard for me to talk in public, but I want to work this program, so I'm going to tell you all that I know it's time to get a sponsor." This therapy work helped Linda C. to put her need out to the group, and the response from group members was helpful to Linda C., with several women offering to meet with her to talk about sponsorship. This experience also helped Linda C. to become more attached to the group and to learn a new skill for seeking help. While Linda C. was helped by counseling strategies alone, others with "social phobia" also may need antidepressant medications in addition to counseling.

Appendix A: Post Test and Evaluation for *Providing Services to Persons with Co-Occurring Disorders in Substance Abuse Part II*

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEUMatrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in the following manner:

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

http://www.ceumatrix.com/studentcenter

Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

NOTE: THE EXAM QUESTIONS AND /OR ANSWERS MAY BE IN A DIFFERENT ORDER IN THE ONLINE EXAM

Answer the following questions by selecting the most appropriate response.

Chapter 4

1. A basic assessment covers information needed for treatment _____ and _____.
    a. focusing, terminating
    b. selection, focusing
    c. matching, planning
    d. planning, executing
    e. do's, don'ts

2. Lack of privacy can affect test _____.
    a. construction
    b. internal reliability
    c. acceptance
    d. validity
    e. procedures

3. Screening involves _____ scores.
    a. salient
    b. cutting edge
    c. protocol
    d. cut-off
    e. cut-out

4. In addition to basic information, the assessment can be augmented by an objective measurement. Which one of the following was <u>not</u> identified in the course?
    a. URICA
    b. ASI
    c. MAS form – III
    d. TCUDS
    e. SDS

5. The recommended period of time of abstinence to understand mental health symptoms is _____.
    a. 60 days
    b. 30 days
    c. 7 days
    d. 2 weeks
    e. 6 months

6. The number of steps in the assessment process is _____.
    a. 10
    b. 12
    c. 6
    d. 8
    e. 15

7. A diagnosis is determined in which step of the assessment process?
    a. 3
    b. 6
    c. 8
    d. 10
    e. 1

8. A treatment plan is developed in which step of the assessment process?
    a. 10
    b. 12
    c. 6
    d. 8
    e. 15

9. The clinician should engage the client through empathic _____.
    a. stabilizing
    b. attachment
    c. detachment
    d. de-connecting
    e. deconstructing

10. During the assessment process, all questioning should avoid ___ the client.
    a. recycling
    b. collaterals of
    c. re-intensifying
    d. altered states of
    e. re-traumatizing

11. Mental health screening has _____ major components in substance abuse treatment settings.
    a. 5
    b. 3
    c. 6
    d. 4
    e. 2

12. Risk of harm ranges from _____ to _____.
    a. low, extreme
    b. minimal, serious
    c. minimal, extreme
    d. low, serious
    e. low, moderate

13. The presence of command hallucinations which threaten to override usual impulse control are identified at what level of risk?
    a. crises
    b. ultimate
    c. maximum
    d. serious
    e. extreme

14. Which of the following is <u>not</u> a mental health screening instrument?
    a. MHSF – III
    b. ASI
    c. M.I.N.I.
    d. BSI – 18
    e. SCID

15. Screening for the presence of substance abuse symptoms involves how many components?
    a. three
    b. four
    c. six
    d. five
    e. ten

16. Which of the following is <u>not</u> one of the most common substance abuse screening tools?
    a. CAGE
    b. MAST
    c. DAST
    d. AUDIT
    e. SSAP

17. The error in the test concerning the four Quadrants is in _____.
    a. Quadrant I
    b. Quadrant II
    c. The title
    d. Quadrant III
    e. Quadrant IV

18. The discussion of quadrant determination _____ by _____ research.
    a. has been validated, clinical
    b. has been found reliable, statistical
    c. has not been validated, clinical
    d. has been validated, statistical
    e. has not been validated, social

19. The use of the ASAM PPC – 2R involves ____ dimensions of assessment.
    a. 4
    b. 3
    c. 6
    d. 5
    e. 7

20. When comparing the LOCUS to the ASAM PPC – 2R, the LOCUS is ____.
    a. more time consuming
    b. less valid
    c. less reliable
    d. more sensitive
    e. simpler

21. The most important diagnostic information beyond the history is_____.
    a. counter reactions
    b. abreaction
    c. transaction
    d. interaction
    e. interdiction

22. The value of the ASI is that it permits identification of problem _____.
    a. denial
    b. resistance
    c. interaction
    d. domains
    e. dominance

23. The SATS has _____ stages of engagement in treatment.
    a. 6
    b. 5
    c. 10
    d. 4
    e. 8

24. George T. (case 2) had a long history of _____.
    a. multiple personality
    b. bipolar disorder
    c. schizophrenia
    d. OCD
    e. neurasthenia

25. Through the assessment process, the counselor seeks to accomplish the aim of determining _____ for each problem.
    a. stage transaction
    b. changes and stages
    c. stage and change
    d. change of stage
    e. stage fixations

CHAPTER 5

26. In a study of clients with opioid dependence it was found fewer than _____ percent of those with weak therapeutic alliances completed treatment, while more than _____ percent completed treatment who had strong therapeutic alliances.
    a. 25, 75
    b. 50, 50
    c. 10, 90
    d. 33, 66
    e. 2, 98

27. When the client regards the clinician as an “interfering mother” or “authoritative father” it is described as _____.
    a. transference
    b. identification
    c. abreaction
    d. counter transference
    e. transactional inference

28. Blumenthal stresses that the clinician should immediately follow up appointments missed by an acutely _____ person.
    a. resistant
    b. obsessive
    c. antisocial
    d. suicidal
    e. anxious

29. Studies related to cultural differences and treatment issues among clients with COD are _____.
    a. biased
    b. plentiful
    c. common
    d. scarce
    e. unknown

30. MI is an approach that involves _____ a client's level of motivation.
    a. interpreting
    b. confronting
    c. rejecting
    d. shifting
    e. accepting

31. MI is guided by how many principles?
    a. 4
    b. 3
    c. 6
    d. 5
    e. 8

32. One way practitioners can put the principle of supporting self-efficacy into action is by evoking _____.
    a. confidential talk
    b. an interdiction
    c. confidence talk
    d. silence
    e. confrontation

33. Clients are considered to be in the maintenance stage if they remain free from addictive behavior and engage in a new incompatible behavior for more than _____.
    a. 24 months
    b. 12 months
    c. 6 months
    d. 3 months
    e. 18 months

34. In a sample of 100 inpatient clients, with COD, after motivational therapy the show rate for the initial outpatient appointment increased from _____ percent to _____ percent.
    a. 2, 25
    b. 35, 67
    c. 10, 40
    d. 33, 85
    e. 5, 50

35. There may be little agreement between clinical staff assessment of stage readiness and _____.
    a. client assessment
    b. supervisor assessment
    c. other staff assessment
    d. other clients in groups
    e. written assessments

36. Altering the form or frequency of behavior through positive and negative consequences is termed _____.
    a. CM
    b. MC
    c. CMD
    d. MM
    e. MET

37. The most common re-inforcers clinicians may use are _____.
    a. cash
    b. vouchers
    c. prizes
    d. privileges
    e. all of the above

38. A _____ economy for homeless clients with COD has been developed in a shelter during the engagement phase.
    a. systemic
    b. systematic
    c. token
    d. broken
    e. cash

39. A major tenet of CBT is that the person's _____ is the source of the difficulty.
    a. ego
    b. thinking
    c. values
    d. attitudes
    e. inner child

40. Some clients with COD, such as those who have experienced trauma, can benefit from _____.
    a. staying on the periphery
    b. looking inward
    c. flat landing
    d. grounding
    e. groundbreaking

41. CBT is an active approach for persons who are in the _____ phase of their substance use and mental disorders.
    a. chronic
    b. acute
    c. extended
    d. final
    e. action

42. RPT stands for _____.
    a. Relapse Prevention Therapy
    b. Rational Perception Techniques
    c. Recovery-Prevention-Trust
    d. Relapse Prediction Techniques
    e. Relapse Pattern Tracking

43. An approach based on RPT designed to be a componet of an approach to the treatment of co-occurring substance use dependence and schizophrenia is _____.
    a. ASAM
    b. RPT – 2
    c. SAMM
    d. MMAS
    e. MMP

44. Carry an emergency _____.
    a. kit
    b. lifeline
    c. card
    d. flashlight
    e. sobriety kit

45. In addition to major depression, crack cocaine dependence, and poly-substance abuse, Stan Z. has been diagnosed with _____ personality order.
    a. histrionic
    b. obsessive
    c. antisocial
    d. borderline
    e. passive-aggressive

CEU Matrix – The Institute for Addiction and Criminal Justice Studies
Course Evaluation – Page 2

_____

The final step in the process required to obtain your course certificate is to complete this course evaluation. These evaluations are used to assist us in making sure that the course content meets the needs and expectations of our students. Please fill in the information completely and include any comments in the spaces provided. **If you submit your evaluation online, you do not need to return this form.**

NAME:_____

COURSE TITLE: **Providing Services to Persons with Co-Occurring Disorders in Substance Abuse Part II**

DATE:_____

COURSE CONTENT		
Information presented met the goals and objectives stated for this course	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was relevant	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was interesting	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information will be useful in my work	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Format of course was clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
POST TEST		
Questions covered course materials	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Questions were clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Answer sheet was easy to use	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good

_____

COURSE MECHANICS		
Course materials were well organized	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Materials were received in a timely manner	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Cost of course was reasonable	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
OVERALL RATING		
I give this distance learning course an overall rating of:	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
FEEDBACK		
How did you hear about CEU Matrix?	☐ Web Search Engine ☐ Mailing ☐ Telephone Contact ☐ E-mail posting ☐ Other Linkage ☐ FMS Advertisement ☐ Other: _____	
What I liked BEST about this course:		
I would suggest the following IMPROVEMENTS:		
Please tell us how long it took you to complete the course, post-test and evaluation:	_____ minutes were spent on this course.	
Other COMMENTS:		