

**THE CO-OCCURRING DIALOGUES  
DISCUSSION GROUP**

**CENTER FOR SUBSTANCE ABUSE TREATMENT(CSAT)  
(July 2000-February 2001)**

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**SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)  
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DIVISION OF STATE AND COMMUNITY ASSISTANCE  
JULY 2001**

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## **OVERVIEW**

The Co-occurring Dialogues electronic discussion list, which focuses on issues related to dual diagnosis, represents an expansion of the services of the CSAT Treatment Improvement Exchange and is a frequently used service. The impetus for this service was the Co-occurring Institute discussions at the June 2000 State Systems Development Programs (SSDP) Conference sponsored by CSAT and the Division of State and Community Assistance. The initial membership included participants in the Institute and others who previously expressed an interest in this topic. For purposes of the discussion list, dual diagnosis is defined as a mental disorder plus substance abuse. Other issues are obviously relevant, such as learning disabilities, HIV, and other medical conditions.

Subscription to the Co-occurring Dialogues discussion list is free and unrestricted. To subscribe, an individual only needs to send an e-mail to dualdx@treatment.org. The Co-occurring Dialogues list has over 500 subscribers. Discussion focuses on issues related to dual diagnosis. Membership is open and the list is moderated. For example, traffic was heavy in the first 2 weeks of February 2001, when there were 70 messages posted to the list. With a moderated discussion list, the moderator screens messages before they are distributed to the members of the list. This prevents “message loops” and also serves to keep discussions on topic.

When the discussion list began, much of the communication related to information regarding meetings, trainings, and announcements. With much anticipation, the first real question from the field was submitted on the morning of August 23, 2000. By 2 p.m., the person posing the question had received many helpful responses. It was amazing to watch!

The purpose of this summary is to provide an overview of the discussion list activity for the first 6 months of its existence. Little attempt is made to capture the in-depth philosophical discussions. Rather, the focus is on collating and saving the resources that were mentioned. Several resource appendices are attached. These appendices represent a collection of self-identified field resources that appeared on the discussion list. Some subscribers may have only provided sketchy information. Therefore, we have attempted to fill in gaps, when possible. **These resources are not endorsed, reviewed, or approved by SAMHSA/CSAT/DSCA; they were, however, accurate during the period covered by this report.** It is anticipated that these listings may eventually become free standing, with periodic updates, on the SAMHSA/CSAT/TIE/Dual Disorders Special Topics Web Page.

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## **DISCUSSION GROUP WORKGROUP**

A small workgroup consisting of the CSAT Project Officer, the contractual Web master, and three field representatives was established to solicit input and guidance regarding the discussion group. The field representatives were selected by CSAT and include consumers, providers, and governmental treatment systems. They participate in periodic conference calls to review activities, communications, and other issues, as needed.

## **MEMBERSHIP**

As of March 1, 2001, there were 528 subscribers. Part of the original goal was to attract participants from all possible arenas including providers, clinicians, foundations, consumers/recovery community, educators, researchers/evaluators, Federal/State/local governmental agencies, organizations, credentialing entities, and others. (See attachments A and B).

The membership list remains protected by CSAT. Other than self-identification in communication and resource exchanges, only e-mail addresses are available to assess the forum in any way. Based on limited and generic information, we are still very pleased with the diversity of the subscribers who are partially described below.

- Thirty-nine States (government entities)
- International subscribers from at least five countries
- Public libraries
- Military
- Top leaders in the field
- National organizations such as National Association of State Alcohol and Drug Abuse Directors (NASADAD), National Association of State Mental Health Program Directors (NASMHP), National Mental Health Association (NMHA), Join Together, and American Society of Addiction Medicine (ASAM)
- Nationally recognized research/evaluation organizations
- Federal agencies such as SAMHSA, FDA, OSOPHS, AHRQ, HRSA, IHS, and CDC
- Many nationally recognized treatment organizations such as Phoenix House and Foundations Associates
- Self-identified consumers
- Front line treatment staff
- More than 20 universities including Brown, Dartmouth, Drexel, New York University, Brandeis, Columbia, Yale, and Universities of Connecticut, Iowa, Washington, Kansas, Maryland, and Pennsylvania

Feedback from the field regarding the electronic discussion list is very positive, and suggestions for improvement have already been implemented.

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A brief sampling of comments includes:

“... the list has provided a unique and invaluable opportunity to raise issues and to network with other professionals across the nation and even around the world. The Center for Substance Abuse Treatment is providing leadership and support that is very much appreciated by those of us in the field.”

“Kudos for a very successful start for this discussion group!”

“The Co-occurring (discussion list) is rapidly becoming, I believe, one of the most fruitful and living, breathing on-line vehicles created in the field to date.”

“You have gotten something hot going with this. Congratulations!”

And, finally, one subscriber ended her communication with a pertinent thought from the anthropologist , Margaret Mead:

*“Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it is the only thing that has.”*

## TOPIC SUMMARIES

**The following text has come verbatim from the many subscribers to the list. It has been edited for grammar, syntax, and clarity.**

### DEFINING DUAL DIAGNOSIS

Over time, dual diagnosis (the older term) has been used to apply to any number of combinations of disorders from more than one diagnostic category. An example: a mental illness/substance abuse (MISA) and a mental illness/chemical abuse (MICA). MISA or MICA does define one generic dual diagnosis combination and rules out other combination such as mentally ill/HIV, substance abuse/mental retardation, and so on. Dual disorder is another term that has been used.

More recently, the term “co-occurring disorders” was developed to encompass a major mental illness and a substance abuse or dependence diagnosis, although some would include a broader range of disorders. There is more than one disorder in need of treatment, neither of which is pre-eminent and, both of which need treatment, ideally in an integrated manner. There are a lot of discussions and ideas related to relative degrees of severity for each disorder. There are some meaningful approaches to assessment of the relationship between the disorder and necessary treatment. Also, there is a lot of discussion about whether or not each disorder needs to be treated and stabilized before proceeding to address the other(s). Some other discussions even suggest that co-occurring disorders represent a separate entity, over and above the inclusive diagnosis. Conventional wisdom is that co-occurring disorders are the expectation rather than the

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exception.

Labeling never works well; approaching clients with a holistic view may work better. But at the same time, it is helpful to have symptoms or diagnosis stated and developed through clearer language for who/what the professionals treat.

Integrated treatment needs to deal with everything that is present and not make assumptions about what might go away. If you have someone with depression and alcoholism, you shouldn't worry too much at the beginning about which might be causing which. Deal with both and then, when the person has some "clean" time, you can make further assessments. The systemic problem is that when someone presents for treatment with symptoms of both, it takes time and treatment to sort out the truly dually disordered from those with a single disorder or from those with a single disorder-substance abuse-who have psychiatric symptoms. However, programs pressed by managed care and other payers, are not given the weeks or even months it takes to get someone clean and dry to see if there are co-occurring symptoms.

There is much data that suggest addictive disease is actually present long before the behavioral consequences allow for classification. However, the data from the national comorbidity survey indicate that the mental health problem came first most of the time, several years ahead of the substance abuse, the second disorder, which typically develops 6 to 10 years later. Addressing the matter by diligently addressing childhood mental health problems seems to be the best bet for targeting substance abuse prevention efforts. Other studies showed a lot of evidence about children with diagnosable mental disorders who are at a higher risk of developing substance abuse disorders than other children.. The findings with regard to temporal ordering aren't necessarily uniform across studies or across mental disorders/substances. For this reason, professionals think that it is a good idea to address the prevention of addiction with persons at the earliest stage of their mental illness.

The substance abuse field has a long history of providing prevention activities for youth and young adults, which focus on increasing their awareness of the risks involved in using substances and the early detection of an addictive disorder. The mental health field does not have such a tradition. If, as many clients report, the substance use helps at least initially in reducing some of their mental health symptoms, then many individuals with co-existing disorders may have introduced and maintained alcohol and other drugs into their lives as a result of self-medication. Providing information to young people about how to identify if they have potential symptoms of a mental disorder may prevent a percentage of this population from developing a second disorder.

Dual diagnosis historically meant a combination of standard mental health diagnosis plus one other important group that psychiatrists have tended to exclude from their interest at some point (for example, mental illness plus substance abuse, mental illness plus developmental disability, axis one vs. axis two, and so on). Then, the separation became institutionalized as the advocates for the excluded groups got organized. Medical conditions needed to be addressed. Substance

abuse was one of many issues that was part of every psychiatric assessment. Substance abuse and dependence are part of the DSM (they are psychiatric diagnoses). Dual diagnosis is an arbitrary political separation that has done nothing good for the clients with either diagnosis

## **WOMEN WITH DUAL DIAGNOSIS**

### **Pregnant Women**

In the United States, there are treatment programs that specifically serve pregnant women with co-occurring disorders. In Florida, specifically in South Central Florida, the Tri-County Human Services, Inc. has two residential programs that serve this population. One is the Residential Assessment and Stabilization Unit for Women services for pregnant and postpartum women as a priority, and accommodating mothers with minor children. Primary services orient toward substance abuse, psycho education, and psychotherapy, and the women are assisted with psychotropic medications. Women diagnosed with co-occurring mental illness also receive mental health services through concurrent services with another provider. The Florida Center for Addictions and Dual Disorders is another program that serves women and men with co-occurring mental illness and substance dependence. This program serves pregnant women, if they are no more than 5 months pregnant and have no major medical complications at admission. Both programs participate in the Triad Women's Project, also part of Tri-County Human Services. The Project is a SAMHSA-funded program to study the outcomes of services integration and enhanced interventions for women with co-occurring substance abuse, mental illness, a history of trauma, and their children.

The States of Virginia, California, and Illinois have programs for pregnant women with a dual diagnosis. The Project Link program in Virginia serves women who are pregnant or with very young children who also have a co-occurring substance abuse or dual diagnosis problem. The Project Pride Program under East Bay Community Recovery Project in Oakland, California, serves women who must be California residents and make a commitment to participate in the program for one year. They also must be cognitively intact enough to participate in a modified therapeutic community. The Women's Treatment Center program in Chicago also provides psychiatric services and case management.

### **Homeless Women**

Journey House in Kentucky is a dual diagnosis residence for homeless women who have severe, persistent mental illness and chemical dependency. The outcome and success documented during the 18 months of this program is remarkable.

## **TRAUMA AND DUAL DIAGNOSIS**

Fifty-five percent of dually diagnosed people in Maine report unrecognized and untreated histories of childhood physical and/or sexual abuse in both mental health and substance abuse fields, and over 75 percent of people in treatment programs have histories of childhood physical abuse.

The literature on trauma and dual diagnosis reports prevalence rates greater than 55 percent. It makes the important point to find programs that incorporate recognition and treatment of symptoms related to trauma. Its impact can make a significant difference in the treatment and recovery of these dually afflicted people. NASMHPD, CSAT and SAMHSA's Women and Violence (study) published a report on trauma as it applies to co-occurring disorders. NASMHPD published a report in July of 1998, about behavioral healthcare issues of persons with histories of physical and sexual abuse, and CSAT published a report about substance abuse treatment for persons with child abuse and neglect issues.

Programs exist in several States that work with trauma and co-occurring disorders. One is the SARC House Program in Madison, Wisconsin, which has a trauma component. Massachusetts has funded three projects related to trauma and co-occurring disorders in women: one is the WELL Project in Franklin County. Florida State University has a program for trauma intervention and works with women with Post Traumatic Stress Disorder through a variety of therapeutic approaches. For school age children, there is a nationally evaluated program called Second Step.

## **CO-OCCURRING PREVALENCE DATA**

In the early to mid 1990s, researchers investigated the prevalence of substance abuse and dependence among chronically mentally ill patients. The results of the research showed that there is 15 to 40 percent of substance dependence among chronically mental ill patients. The researchers also investigated the prevalence of mental illness among substance abusing/dependent patients and found that 56 percent of patients with D&A disorders have an Axis I or II psychiatric disorder.

Other investigations show that 70 percent of cocaine abusers were diagnosed with Axis II personality disorder and 40 percent of opiate abusers were diagnosed with Axis II personality disorders.

## **TRAINING NEEDS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES**

The National Alliance for Developmental Disabilities has information on provision of substance abuse services to the developmentally disabled population. Dan Thomasulo, a New Jersey-based psychologist, is training in the area of developmental disabilities and substance abuse treatment. The Research and Training Center at Wright State University School of Medicine (the SARDI program) has resource information about services to those who are developmentally disabled.

## **SUBSTANCE ABUSE LINKED TO EATING DISORDERS**

Experts have estimated that of the five million Americans who suffer from eating disorders, at least half have an addiction problem. At a conference sponsored by the National Center for Addiction and Substance Abuse at Columbia University in New York, Dr. Steven Hyman (National Institute of Mental Health) said bulimics are more likely to have substance abuse issues than anorexics. He speculated that addiction and bulimia could originate in the same area of the brain, because both are disorders of learning.

Dr. Karen Spedowski (a psychologist at the Kaiser Permanent Chemical Dependency Recovery Program in Santa Clara, California) says that treating chemical dependency may be more straightforward than treating eating disorders, which are much more ambiguous. She explained that an eating disorder is characterized by a gradual stepping away from symptoms, and takes longer to develop than the substance abuse problems. Terence Williams, professor of psychology at Rutgers University in Piscataway, New Jersey, says that eating disorders and addiction are linked. He noted that there are superficial similarities, such as cravings and lack of control. He also says that all eating disorders should not be lumped in one category, since there are major differences in the characteristics of anorexics and bulimics.

## **DD TREATMENT IN PRISON**

Integrated services for persons with co-occurring disorders are now considered optimal for individuals with more severe forms of mental illness and comorbid substance use disorder. Recognizing the need for identification of and specialized services for individuals who are dually diagnosed, the Florida Department of Corrections initiated a collaboration with the Louis de la Parte Florida Mental Health Institute in 1995 to develop a comprehensive service plan for this population. Funded by a grant from CSAT's Office of Justice Programs Residential Substance Abuse Treatment for State Prisoners, this achieved fruition in 1997 with the establishment of two treatment programs for persons with co-occurring disorders in the Florida prison system. Currently, a program for males, located at Zephyrhills Correctional Institution, serves 80 treatment inmates and 10 peer facilitators. A female program at Broward Correctional Institution serves 40 treatment inmates and 10 peer facilitators. It is important progress to develop a template matching types of correctional program interventions with types of individuals with co-occurring disorders. However, the referral for treatment in prisons/detention settings should not be any less precise than it would be in the civilian community. A treatment recommendation needs to be the result of a comprehensive evaluation. Acceptance by the client of such a referral should be voluntary, but there can be a variety of ways to positively potentiate a choice for treatment.

## **STANDARDS**

There are States planning how to comply with the new Federal regulations governing opioid treatment programs which should be final and released to the public soon. The State of Virginia (DMRMHSA) is planning to amend their State regulations to be in compliance with the new Federal regulations. Rhode Island currently has policies and procedures under review in order to comply. Legislation will be prepared if necessary. However, it is anticipated that the State can

accomplish most of the changes through regulation. Michigan is starting to look at the State standards and intends to use the new ASAM PPC 2R as a guide.

Some reports of patients who query their clinic managers and counselors about these important changes in Federal regulations hear comments such as: “it won’t apply to us,” “what are you talking about?”, “nothing is changing or doesn’t matter” or, “we don’t have to comply.” The field may not understand that these are the most important changes in the opioid addiction field treatment arena in 30 years.

### **COORDINATED CARE**

In the redesign or refinement of chemical dependency and mental health treatment to better address the needs of persons with co-occurring disorders, it is important to acknowledge the degree to which the separate systems are doing a commendable job addressing the needs of some persons who have co-occurring disorders. This foundation of good mental health and addiction treatment will help to build some much needed integrated services for persons with co-occurring disorders. It will be a good way to encourage new funding to help redesign some programs and to create new ones. This does not mean taking funding from the separate service systems and handicapping their ability to do good work with those they are serving who are not dually diagnosed. We should advocate for additional funding to address the needs of the un-served persons with co-occurring disorders. Emphasizing the strengths of dedicated professionals in the separate systems and emphasizing evidence-based practice that would help to better address the needs of persons with co-occurring disorders, the advocacy strategy should be geared toward the expansion of the work with this population. New and better integrated services should be funded with new and better resources. It is a mistake to use an advocacy strategy that shifts resources from one part of the field to the other or to emphasize that a small piece of what we do needs a major overhaul. The message ought to be one that emphasizes the knowledge, experience, success, and commitment to expand our system using evidence-based strategies to better address a population of underserved persons whom we continue to learn more about both from the successes with them and the failures.

The states are devising innovative approaches to ensure that both psychological and medical needs are being met. Mathematica Policy Research, Inc., commissioned by the Center for Health Care Strategies, conducted a study of care coordination in five states, which is summarized in a new policy brief called “Care Coordination and Managed Care: Emerging Issues for States and Managed Care Organizations (MCOs).” This study suggests that most Medicaid managed care programs do recognize that expanding medical case management to include referrals for social services may not be enough for individuals with special health care needs. Shifting the paradigm to ensure creative problem solving through advocacy is the emerging role for care coordinators in the context of Medicaid managed care. Achieving this shift will require collaboration among all stakeholders: the States, MCOs, providers, advocates, and patients with their families.

Missouri is doing some very interesting and innovative service provision that braids but does not blend mental health and substance abuse money. Texas has excellent integrated programs for dual diagnosis.

The National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) have been collaborating in recent years to help systems move toward more effective treatment of co-occurring disorders. CSAT and CMHS support has been critical to these efforts. The strong relationship between NASADAD and NASMHPD and CMHS and CSAT continues to be key as some of the thorny issues involved in building collaborations between the fields are worked through. A number of those issues have been reflected in the discussion on this discussion list. NASMHPD is being supported by the CMHS to work closely with NASADAD, States, and communities to conduct in-depth case studies of successful, integrated co-occurring service programs and how they are funded. This project will look closely at the ways in which strong integrated programs managed to finance co-occurring services. The objective is to duplicate their successes and make more money available overall for treating co-occurring disorders rather than further handicap the mental health and substance abuse systems by taking money from one to give to the other.

### **ANGER**

There was mention of a short intervention program for which each module is 2 hours long. The purpose of this program is to introduce clients to anger management issues. At the conclusion of the program, staff will refer people in need of follow up to the appropriate resources. It is very important to make the 2-hour periods as dynamic as possible with some didactic material, a short film, and some experiential exercises.

### **MEDICATIONS**

Lithium is a very difficult drug to dose correctly. It has what is called a “narrow therapeutic window.” This drug is not effective when the dose is too low and can be toxic if too high. The appropriate dose must be individually set for each patient and the therapeutic dose’s range is small. Many drugs, when taken with Lithium, can affect the absorption and/or metabolism of Lithium. When any of these changes take place, it may be necessary to titrate the Lithium dose again.

Adding or subtracting drugs from a regimen that includes methadone should be done carefully and clients should speak with their physician or pharmacist before making any changes. Organ function, other drugs, and other nutritional supplements need to be considered carefully when a patient takes a drug with a narrow therapeutic window.

People who have used substances for years may have mental disorders that were caused by the substance use or were exacerbated by the substance use. These people should be medicated appropriately by a psychiatrist.

Some medications also are helpful in mitigating cravings and withdrawal. Some people find being on SSRIs helpful in dealing with cravings from alcohol. A good psychiatrist will not only be able to prescribe medications for common uses, but also for less well known uses. Examples are the use of Cloaziril to help Borderline Personality Disorders clients stop cutting or using SSRIs to help control sexually compulsive behaviors. One way that the brain will try to maintain homeostasis is by eliminating receptor sites for neurotransmitters. If someone uses drugs long enough, will the brain lose the ability to re-establish these receptors after the substance use stops? If the answer is that the loss of receptor sites becomes permanent, it may help to explain the high incidence of depression in alcoholics and why some addicts seem to lose the ability to feel enjoyment in more normal activities (possibly due to loss of dopamine sites). For some, the speediness of some of these medications actually stimulates the cravings. About 30 different medications have been tried for cocaine cravings in controlled trials and all have been disappointing. Various things may work for particular individuals, but be careful about generalizing. The SSRIs are sometimes quite helpful for sexually compulsive behaviors; however, it is a fine line, and when men feel it is interfering with performance, they discontinue taking the medicines, often without mentioning it in treatment until a relapse episode is explored.

## **LEGISLATIVE**

California's Proposition 36 is an important initiative, but it is not perfect. For the past 16 years, State funding for alcohol and drug treatment has decreased when you control for inflation and changing demographics. Without question, there has been a spending increase for prison construction, with about 27 prisons. Also there are approximately 9,000 people in custody in State treatment beds. However, most have substantial waiting lists for treatment. It seems immoral to deny voluntary treatment in the health care system, but to have treatment on demand in the prison system. All Proposition 36 does is communicate the will of people in suggesting that it makes more sense to direct finite resources upstream and, within the health care system, strike a balance where none has existed.

## **TRAINING AND EDUCATIONAL MATERIALS FOR DUAL DIAGNOSIS SERVICES**

There are many educational materials on the topic of dual diagnosis. A video produced by Hazelden has important information about dual disorders with many consumers sharing their situations. It also includes brief but excellent presentations about the purpose of psychiatric medications, and information about depression, anxiety disorders, and co-occurring substance abuse. Gerald Rogers Productions has stories of family/parental alcoholism told from the perspective of children. Realizations Video concentrates on information about psychiatric illness; it also is one of the most comprehensive and well done films about addiction. Ashley Productions has informational materials about alcohol and alcoholism.

It is very important to provide cross training for staff working with the dually diagnosed, including a focus on the Axis II population. Clinicians who work in programs that are not designed to accept personality disordered/addicted clients still find themselves working with these individuals as they are often seriously mentally ill as well. Young staff feel overwhelmed,

but are also concerned that other, more experienced clinicians have burned out from the frustration and challenge these clients bring to treatment and become punitive.

Training resources may be found through the UNC School of Social Work. Their Behavioral Healthcare Resource Program collaborated with both the State Substance Abuse Services Section and Adult Mental Health Services Section to develop a 5-day training program. The program targets mental health and substance abuse practitioners in the field and trains practitioners together as a way to provide both content on dual disorders and strategies and activities for collaboration across service systems. In Jackson, Mississippi there was a conference called “Beyond the Barriers, Annual Conference on Co-occurring Mental Health and Substance Abuse Disorders” and Foundations Associates presented “Two Worlds Into One: A National Conference on the Future of Integrated Mental Health and Substance Abuse,” in Las Vegas, Nevada.

### **DROPOUT RATES**

Research on dropout and dual diagnosis has produced mixed and conflicting findings with regard to psychiatric diagnosis and severity of symptoms. An 18-year study of dual diagnosis treatment groups for clients with a substance use disorder and a co-existing major mental illness was completed last fall. The researchers found that on first admission to the dual diagnosis treatment groups there was a 63 percent retention rate at 30 days, a 47 percent retention rate at 90 days, a 32 percent retention rate at 60 days, and a 17 percent retention rate at one year. Second admissions had slightly higher retention rates at the same intervals and 3rd and subsequent admissions had lower retention rates. These results were then compared with seven published studies that were identified addressing group treatment for this population. Five of them had very similar retention rates and two had much higher rates but, their *N* was very small and both studies were done by the same agency. Based on the results, the researchers used the following target performance standards concerning retention for this population in groups: 65 percent retention for 30 days, 40 percent for 90 days, 30 percent for 6 months and, 20 percent for one year.

There was another study with participants in St. Louis (a CSAT-funded initiative) who were assessed at a central intake unit and referred to treatment. Among these individuals, 25 percent did not show up for treatment, 15 percent showed but dropped out before the third session, and 60 percent stayed for three or more sessions. The researchers found that those with dual diagnosis were about half as likely to show up for treatment. For participants who showed for treatment, dual diagnosis was not related to early dropout. In other words, those with dual diagnosis were as likely as others to engage in treatment once they kept an initial appointment at the treatment center. In an inpatient hospital setting, it is highly likely for the patients to stay in the program if the professionals establish a rapport and gain trust, get the patient to engage with others of similar interests, and get group support from their peers. However, keeping them in dual diagnosed treatment in the community is much more challenging. There are many ways to avoid patients’ dropout from the treatment. One is to keep them in dual diagnosed treatment in the community, so that they can obtain coping skills that will better enable them to cope with

confrontation and their fears regarding participation in treatment. Another way to help them reintegrate into the community is to get them more familiar with the community, the programs, and counsel them regarding their fears. Also, if the professionals encourage patients to utilize everyone on their treatment team, and to not become so reliant upon assistance that they find difficulty breaking away from, it will be helpful to keep them in treatment. If discharge is eminent, then discussing how to deal with these issues should begin long before they are discharged.

The professionals need to be careful using confrontation as a strategy of intervention in counseling or therapy. The dually diagnosed clients need and look for something different than the usual treatment. If a relationship is not present the client will bolt at the traditional confrontation. They will simply go away mentally or not return to group. It's better if prior to any gentle confrontation, trust is established so the client knows she/he is not just being kicked again. One suggestion is that if the person's defenses rise, immediately try to get the client to refocus, lower the defense so the client can hear what the counselor or therapist is saying, make a few suggestions, but always end the session open-ended with a statement. This will allow the client to feel as if she/he is in control, which is what the client wants. Almost always, a person will come back and start a conversation about it.

### **CONFIDENTIALITY**

Traversing confidentiality regulations in this era of service integration, partnership, and co-case management can be complex. Confidentiality rules are quite different for mental health and substance abuse. For instance, in the mental health system, parents can sign consent forms; in the substance abuse treatment system, the client must sign (including signing consent for the staff to speak with the client's parents). Children under 14 cannot seek treatment on their own in the mental health system, whereas any age individual is permitted to seek treatment under the substance abuse treatment system. For example, in Virginia, the adolescent can access substance abuse treatment without parental consent.

Each State sets the confidentiality standards for their mental health system, but at the same time all States must follow The Code of Federal Regulations (CFR) unless the State standard is stricter. In Pennsylvania, there have been struggles with confidentiality issues for persons with co-occurring disorders for some time. In Oregon, all the agencies of the Department of Human Services (alcohol and drugs, mental health, child welfare) have developed a release of information form that all agree to use. In Alaska, there is a high level of interest among providers (beyond chemical dependency (CD) providers) in obtaining training to solve the problem. Some providers have even decided to adopt the more stringent CD Federal Confidentiality Regulations for use with all clients in order to facilitate inter-organizational communication.

The client's consent to release information certainly solves many problems. Problems do persist for clients with co-occurring disorders when they receive mental health treatment at one organization and chemical dependency treatment at another. The 42 CFR Part 2 is very specific about the contents of a valid release and about the fact that a general medical records release is not sufficient. CD programs are usually quite adept at sorting this out. Problems sometimes occur in the organizations attempting to communicate with CD programs when they use releases that are quite appropriate and legal for their own organization but do not meet the requirements of 42 CFR Part 2.

One of the problems seems to be the complexity of the rule. It also raises the bar for confidentiality related to psychotherapy notes and mental health in general. Confidentiality for substance abuse under 42 CFR Part 2 has been very tight for a long time, and is fairly clear. In addition, dual diagnosis (especially integrated delivery programs) falls under two rules, and this is not specifically addressed. It was addressed generally, but there's still too much room for misinterpretation. The specified penalties included in the rule are severe and it is anticipated that this would make clinicians and policymakers wary, especially with litigious populations.

### **ALTERNATIVE TREATMENT**

The people who work with dual diagnosis patients are moving toward using other alternative treatment. The Surgeon General's report and the National Institutes of Health address alternative treatment.

Several of the programs within Regional Behavior Health Authority in Tucson, Arizona use *acu-detox* (alternative treatment) with positive results. *Acu-detox* has a specific protocol, developed over 20 years ago by Dr. Michael Smith at Lincoln Memorial Hospital in the Bronx. It is acupuncture of five points on the ear. The National Association of Detoxification Acupuncture certifies trainers who then train mostly addiction treatment clinicians to perform this procedure on individuals withdrawing from alcohol and other drugs. The acupuncture detox protocol is an alternative treatment that has been used for several years with patients with co-occurring disorders. This treatment reports to be effective both subjectively and objectively.

### **YOUTH DUAL DIAGNOSIS TREATMENT**

The issue of adolescence is obviously enormous. The adolescents are technically still children and, therefore, their parents are part of the picture. Based on study findings, adolescents want their parents to be involved in their treatment and treatment decisions. It is important to think about how much responsibility an adolescent can/should shoulder. Also critical is how to strike the balance between respecting their input, and giving them some "say" in their treatment, yet recognizing that they may not yet be ready to shoulder full adult responsibility. The adolescents need to be treated differently than adults in some regards. Adolescents want to be heard and respected. They want some input into their treatment and they want to know their options. An example of this was the Federation of Families for Children's Mental Health study that held its annual convention in Washington, D.C. More than 1500 people at the morning plenary session heard a presentation by adolescents with dual disorders and their families. They were

dramatizing a SAMHSA/CMHS report of a focus group (100 treated adolescents and 50 of their family members). The name of their report was “Blamed and Ashamed.” Many ended up in the criminal justice system for lack of services in their communities. The young people reported that they had not been able to get integrated or coordinated services. They all reported that their mental health problem had developed first. They called for peer counseling and involving their families in their treatment.

In Colorado, treatment professionals from Adolescent Services (Alcohol and Drug Abuse Division from Colorado Department of Human Services) have struggled with the issue around the appropriate treatment approach to blend MH and SA. They have an Adolescent Co-occurring Committee that meets monthly to address this issue and recently completed Statewide focus groups to address the issue.

The adolescent population needs different protocols. It is imperative that the two fields (mental health/substance abuse) work together to develop the protocols in something approaching a seamless way. There are fundamental developmental differences so profound that they require a liberal analysis of the adolescent population’s treatment needs. For example, children and adolescents are notoriously more difficult to diagnose than adults, because they are still developing. The diagnostic criteria have generally been written with adults in mind and, even when separate criteria have been developed for children, they are sometimes just miniaturized adult criteria developed without adequate understanding of maturational developmental processes. Another example is the dangerousness of labeling, where the risk exists of focusing on labels rather than on innate resilience and strengths an adolescent may possess. With youth, these risks are magnified particularly because there are institutional proclivities to perpetuate an initial incorrect or inadequate childhood diagnoses/label, and to fail to update the initial label in light of unfolding events (child with mental health diagnosis is now abusing alcohol or drugs). Furthermore, youth may buy into a label for a while, but it is their nature that they come (rightly or wrongly) to reject it. This has serious disease management implications and profound striving for health possibilities.

The role of the family is another example to explain the differences between youth treatment and adult treatment. The youth are embedded in their families in far more dependent ways than the average adult. Often adult-based family therapies are premised on a separation model, but most youth cannot duplicate this model, even if it were desirable.

When treating adolescents, it has been fairly clear that dually diagnosed adolescents appear to be self-medicating. If that is true, the professionals need to identify these young people, treat the mental illness, and spare them the problems that years of substance abuse will give them. If they abuse substances for a period of time, their brains will eventually allow for the use of alcohol/drugs and remaining sober will be difficult. There also is need to find ways to treat the whole person, rather than simply diagnosing an ailment. In other words, treatment must be holistic and integrated and respectful.

Programs like the Sanctuary Model address addictive type disorders. The model is within a milieu of care that integrates trauma theory with therapeutic community principles in the context of nonviolence. It has been implemented in five different inpatient psychiatric settings between 1991 and the present. Three pilot programs are now underway for children and adolescent residential settings. Also, there is a manual that includes screening that has been revised to be useful for both adults and adolescents. It includes an on-going evaluation form to assess the predisposition and/or presence of substance abuse among children and adolescents. The continual contrast between child/adolescent and adult cases over the course of 2 years has been extremely enlightening.

## **TREATMENT**

There are numerous references to the need for integrated services (simultaneous treatment for a substance use disorder and other mental illness) for patients with severe co-occurring disorders. Research exists that support this modality for improving treatment outcomes for that population. But it is important to explain what it means when people talk about integrated treatment.

A national expert consensus panel as part of the SAMHSA managed care initiative that generated a report in 1998 entitled, “Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competences, and Training Curricula” describes a consensus model for designing a comprehensive, continuous, integrated system of care. An important part of the conceptual framework used in this report was to define an integrated model for service matching, recognizing that there is no correct integrated “treatment approach” so much as multiple correct interventions. These interventions have to be matched at any point in time to individuals according to whether there are continuity of care interventions or episodic interventions; subtypes of dual diagnoses; specific diagnosis; stage of change; stage of treatment; severity of disability and extent of case management required. Also important is the availability of external supports/external contingencies. And in a managed care system, separate determination of level of care based on multidimensional level of care assessment such as ASAM and LOCUS is important.

Clinical experience, common sense, consumer, and family requests all call for integrated treatment for the person, which integrates the disorders within a single self. Only an integrated, holistic assessment and treatment plan is logically and clinically justified. Dual disorders are now so prevalent, that they are an expectation, not an exception. Many programs still focus on the single disorder client. Few have been designed or redesigned from the ground up to deal with this expectation or with the reality of interactivity.

The questions are then on the table: Why is there resistance to integrated treatment among funding, licensing, and provider agencies at the Federal, State, and local levels? Could it be different training, different jargons, tradition, protection of traditional ways of working, fear of change, protection of existing funding sources and allocations, and separate stigmas?

Simultaneous treatment for MISA does not necessarily mean that services are integrated. When the availability of services and training dictate simultaneous versus integrated treatment, the coordination of treatment is imperative for a positive outcome. The integrated treatment for MISA clients means that the client can discuss both her/his mental illness and substance use disorders with the same clinician, within the perimeters of the group offered at the site, and among the other clients. The treatment plan will address both issues as well as the relationship between both disorders. Treatment for MISA means giving both issues the attention they deserve at any given time. The amount of attention needed for each issue will fluctuate just as the amount of attention on any single issue will fluctuate.

### **ANNOUNCEMENTS**

The discussion list was created for communication among researchers, educators, treatment agencies, and others interested in exploring, investigating, and contributing to the Dual Diagnosis topic. One result has been to provide the field with information about the different activities, workshops, conventions, and training related to the topic of dual diagnosis.

**APPENDICES****A. TREATMENT RESOURCES****ADDICTION****Center for Addictive Problems**<http://www.capqualitycare.com>**Addiction Treatment Watchdog**<http://www.atwatchdog.org>**American Academy of Addiction**<http://www.aaap.org>**American Society of Addiction Medicine (ASAM)**<http://www.asam.org>**ADOLESCENTS****Adolescent Co-Occurring Committee****Addiction Technology Transfer Centers (ATTC)**<http://nattc.org>**Coordinating Center for the Women and Violence Studies**

(518) 439-7415

**National Clearinghouse**<http://www.health.org/>**National Gains Center**<http://www.prainc.com/gains/>**National Institute of Drug Abuse (NIDA)**<http://www.nida.nih.gov/>**Setting up Chemical Dependency Component to an Adolescent Psychiatric Unit**

Sanctuary Model

Jennings, Ann

[Ann.Jennings@state.me.us](mailto:Ann.Jennings@state.me.us)

**Successful DD Work with Adolescents with Co-occurring Disorders**

Kathleen Sciacca

Dual Diagnosis Website <http://www.pobox.com/>**Therapeutic Communities of America (TCA)**<http://www.tcanet.org/>**ALTERNATIVE TREATMENT****Acu-detox**<http://www.acudetox.com/><http://www.asianatural.com/acudetox><http://www.ursa-major.spdce.com><http://www.jadecampus.com>**Chapter 18**<http://www.mentalhealth.org/hp2010>**DHHS: Healthy People 2010**<http://www.health.gov/healthypeople/>**The Surgeon General's Report**<http://www.surgeongeneral.gov/library/mentalhealth/home.html>**National Center for Complementary and Alternative Medicine (NCCAM) at the National Institute of Health (NIH)**<http://www.nccam.nih.gov>**ANGER****Margaret Cramer, PhD.**Department of Psychiatry at Harvard University  
Women, PTSD and Chemical Dependence**Patrick Reilly**[reilly.patrick\\_m@sanfrancisco.va.gov](mailto:reilly.patrick_m@sanfrancisco.va.gov)

(415) 750-2004

**ASSESSMENT****Addiction Severity Index (ASI)**<http://www.niaaa.nih.gov/publications/asi.htm>

**HARE Psychopathy Scale**

William "Bill" Sarasin, MA  
MDCH-DSAQP  
(517) 335-8644

**Level of Care Utilization Systems (LOCUS)**

<http://www.comm.psych.pitt.edu>

**Millon Clinical Multiaxial Inventory (MCMI-III NCS)**

1-800-627-7271

**Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-2R)**

<http://www.asam.org/ppc/ppc2.htm>

**Practical Adolescent Dual Diagnostic Interview (PADDI)**

Norman G. Hoffmann, Ph.D.

Evince Clinical assessments

PO Box 17305, Smithfield, RI 02917

Tel: (401) 231-2055

Toll Free in USA: (800) 755-6299

Clinical Associate Professor of Community Health, Brown University

**Recovery Attitude and Treatment Evaluator (RAATE)**

<http://www.niaaa.nih.gov/publications/raate.htm>

**Scale of Independent Behavior-Revised (SIB-R)**

<http://www.isd.net/bhill/sibr.html>

**University of Rhode Island Change Assessment Scale (URICA)**

<http://www.niaaa.nih.gov/publications/urica.htm>

**CLUSTER GROUP****Center for Substance Abuse Treatment (CSAT)'s Co-Occurring and Other Functional Disorders Cluster Group**

<http://www.dualdiagnosis.org/library/dualnetwork/cofd-granteessummer01.html>

**Cluster Grant Activities**

Contact person: Linda White Young

(301) 443-8392

## **CO-OCCURRING PREVALENCE DATA**

### **DDX and the Adolescent**

<http://www.datos.org>

### **Mental Health Dissemination Network of Arizona (MHDNA) Implementation Forum Co-Occurring Mental Health and Substance Use**

<http://www.asmentalhealth.org/forum/11-9-00/bkground.html>

## **COMMUNITY SUPPORT**

### **Dual Recovery Anonymous**

(888) 869-9230

### **Double Trouble Groups**

(800) 643-7462

### **MISA Meetings-Chicago Area**

#### **Women's Group**

- 393 Knollwood Court, Plum Groves Estates, Palatine (Sunday-5pm)
- Way Back Inn-201 Second Avenue, Maywood (Sunday 8pm)
- 5710 N. Broadway, Room 208, Chicago (Monday 2pm)
- Open Meeting-2700 N. Lakeview, Room 101, Chicago (Monday 2:15pm)

### **Katie Wells**

Adolescent Services

Alcohol and Drug Abuse Division

Colorado Department of Human Services

### **Gateway Bellville**

Illinois

(618) 234-9002, x. 3001

## **CONFIDENTIALITY**

### **The Legal Action Center**

(212) 243-1313 (New York City)

(202) 544-5478 (Washington, DC)

## **DRUG TESTING**

### **Patch Drug Testing**

Challenges <http://www.challenges-program.com>

*ALL STATEMENTS/ANALYSES/CONCLUSIONS REPRESENT ONLY THE INFORMATION OFFERED BY SUBSCRIBERS.  
IT IS NOT INTENDED AS A TOTAL REPRESENTATION/DISCUSSION OF ANY TOPIC*

**ELDERLY****Michigan Alcoholism Screening Test Geriatric Version (MAST-G)****HOMELESS****Journey House**

Residential program for homeless women with dual diagnosis

Contact person: Kathy Dobbins

[Dobbinsk@iglou.com](mailto:Dobbinsk@iglou.com)

Louisville, Kentucky

**National Resource Center on Homelessness and Mental Illness (NRC)**

<http://www.prainc.com/nrc/index.html>

**INTEGRATED TREATMENT PROGRAMS****Adult Comprehensive Day Treatment**

Fairfax County Mental Health Service, Mount Vernon

Gary Lupton, LPC, LMFT

(703) 799-2755

**Arapahoe House**

8801 Lipan Street

Thornton, Colorado 80221

(303) 657-3700

**Behavioral Health Center**

Patt Penn, Director of Research and Evaluation

La Frontera Center, Inc.

Tucson, Az

<http://www.lafrontera.org>

**Bryn Mawr Program**

More information contact to: Arc of Anchorage

(907) 277-6677

**Circle Program**

Colorado Mental Health Institute at Pueblo

1600 W. 24<sup>th</sup> Street

Pueblo, Colorado 81003

Dave Stephens, Psy.D., CAC III

Psychologist, Circle Program (719) 546-4797

**Cornerstones**

Adult program  
Mellissa Anderson  
(703) 227-7107  
[mellissa\\_anderson@co.fairfax.va.us](mailto:mellissa_anderson@co.fairfax.va.us)

**Dual Diagnosis Program Directory**

<http://www.cgibin.erols.com/ksciacca/cgi-bin/db.cgi>

**Florida Center for Addictions and Dual Disorders**

Tri-County Human Services, Inc  
Dr. Debra King-Ferro, Program Director  
[Dking-Ferro@TCHSonline.com](mailto:Dking-Ferro@TCHSonline.com)

**Foundation Associates**

(615) 742-1000

**Gemini House**

Mental Health center of Greater Manchester  
Manchester, NH  
Anna Pousland  
(603) 998-4111 x.4119

**Jack Baker, Psychologist**

Mohawk Valley  
(315) 797-6800 x. 4114  
Jeff Rohacek  
McPike Addiction Treatment Center x.4860

**REBT-SMART**

<http://www.smartrecovery.org>

**Sunrise II**

Adolescent Program  
Tom Cook  
(703) 648-0884  
[tom\\_cook@co.fairfax.va.us](mailto:tom_cook@co.fairfax.va.us)

**Transitional Living Center**

Rob Mandel, MA  
Case manager  
Southwest Florida Addiction Services  
2917 Grand Avenue

Ft. Myers, Fl 33901  
(941) 338-2877

**West Central Behavior Health\*\*\***

Mary R. Woods  
2 Whippleplace, Suite 202  
Lebanon, NH 03766  
(603) 448-0126

**LEGISLATIVE**

**Tom McDaniels**

Legal Action Center  
Washington, D.C.  
(202) 544-5478

**LICENSURE AND CERTIFICATION**

**Co-Occurring Practitioners Certificate of Competence and Certification Manual**

Connecticut Certification Board, Inc  
<http://www.ccb-inc.org/coocmanual.html>

**Licensure Legislation HB817-Missouri**

<http://www.house.state.mo.us/bills01/biltx01/intro01/Hbo8171.htm>

**Mental Illness and Substance Abuse (MISA) Registration**

Illinois Alcohol and Other Drugs Abuse Professional Certification Association, Inc.  
(IAODAPCA)  
Nicollette Surico  
(312) 814-6415

**METHADONE**

**Lindesmith Center**

888 Seventh Avenue, New York, NY, 10106  
[lindesmith@sorosny.org](mailto:lindesmith@sorosny.org)

**Mark Parrino, President**

President, American Methadone Treatment Association

**Methadone Today**

<http://www.methadonetoday.org>

**Narcotics Anonymous World Services**

<http://www.na.org/bull29.htm>

**Optimizing Response to Methadone Maintenance Treatment (Abstracts)**

<http://www.biopsychiatry.com/methadone.htm>

**Therapeutic Living Facility for clients in a methadone program**

State Hawaii alcohol and Drug Abuse Division

**ORAL SWAB TECHNOLOGY****Bendiner Labs**

47 Third Avenue NY, NY 10003

(212) 254-2300

<http://www.bendinerlab.com>

**Comprehensive Toxicology Services**

<http://www.comtox.com>

(800) 442-0438

**Intercept**

Oral drug test that cover substances that also cover the urinalysis.

[http://www.4intercept.com/press/1\\_26\\_2001.html](http://www.4intercept.com/press/1_26_2001.html)

**PREGNANT WOMEN DUAL DIAGNOSIS****Families in Recovery**

(802) 258-2806

Fax: (802) 258-2806

**Project Pride East Bay Community Recovery Project**

Oakland, California

(510) 446-7150

<http://www.ebcprp.org>

**Prototypes**

Culver City, California

**Rappahannock Area Community Services Board**

Program for Teen Parents

(540) 582-3980

**Tri-County Human Services, Inc.**  
(863) 701-1994

**Woman's Treatment Center**  
Chicago, Illinois  
(312) 814-6415

### **REGULATIONS**

**Advocates for Recovery through Medicine(ARM) Pamphlets**  
<http://www.hometown.aol.com/armconn/myhomepage/news.html>  
-Improving trust between programs and patients  
-Low Dose? High Dose? What is the effective dose for you?

### **STANDARDS**

**Craig Stenning**  
[Cstenning@mhrh.state.ri.us](mailto:Cstenning@mhrh.state.ri.us)

**Joyce Washburn**  
[washburnjoy@state.mi.us](mailto:washburnjoy@state.mi.us)

### **SCREENING TOOL**

**Dartmouth Adult Life Inventory (DALI)**

**Mental Health Screening Form**  
<http://www.asapnys.org/resources.html>

**Mental Illness Screening Form (MISF)**  
Mental Illness, Drug Addiction and Alcoholism (MIDAA) Service Manual  
<http://www.pobox.com/~dualdiagnosis>

**UNCOPE**  
Screening instrument used on arrestees.

### **SEVERELY MENTAL ILLNESS**

**Mentally Illness Chronically Addicted (MICA)**  
Richmond State Hospital  
Richmond, Indiana

**SEXUAL OFFENDERS AND DUAL DIAGNOSIS****Perpetrators' Group (Court mandated program)**

Gordon McInnis

[Gordon.mcinnis@bowencenter.org](mailto:Gordon.mcinnis@bowencenter.org)

Tim Nussbaum

[Tim.nussbaum@bowencenter.org](mailto:Tim.nussbaum@bowencenter.org)**STATE OF RECOVERY****Motivational Interviewing**<http://www.motivationalinterview.org>**SUPPORT GROUP****Everyone recovery groups**<http://www.dualdiagnosisfriendly.org/erg.html>**Methadone Maintenance Friendly**<http://www.dualdiagnosisfriendly.org/mmf.html>**SUICIDE****SPANUSA**<http://www.spanusa.org/home.html>[http://www.nmhag.org/education/suicide\\_prevention.html](http://www.nmhag.org/education/suicide_prevention.html)**TOBACCO****Tobacco Documents Online**<http://www.tobaccodocuments.org>**Tobacco Information and Prevention Source (TIPS)**<http://www.cdc.gov/tobacco/>**TREATMENT****Alan Marlatt, Ph.D.**

Harm reduction works

<Http://www.2.potsdam.edu./alcohol-info/expertopinion/harmreductionworks.html>

**National Clearinghouse for Alcohol and Drug Information (NCADI)**

<http://www.health.org>

**National Recovery**

Affiliated with the American Humanist Association

7 Harwood Drive

PO Box 146, Hamherst, NY 14226-0146

**Secular Organizations for Sobriety**

PO Box 15781

North Hollywood, CA 91615-5781

**Women for Sobriety**

PO Box 618

Quakertown, PA 18951

**TRAINING/EDUCATION****Co-Occurring Mental and Substance Use Disorder Online Training**

<http://www.athealth.com>

**Double Trouble**

(800) 643-7462

**Dual Diagnosis Recovery Network**

<http://www.foundati@bellsouth.net>

**Dual Recovery Anonymous**

(888) 869-9230

**Fairfax/Falls Church Community Services Board**

Mental Health Services

14150 Park East Circle, Suite 200

Chantilly, VA 20151

(703) 968-4027

<http://www.toad.net>

**Hazelden Distance Learning Center for Addiction Studies**

<http://www.dlcas.com>

**Marist College**

Curriculum for the ATTC

Cheryl Whitley

**Substance Abuse and Mental Health Services Administration (SAMHSA)**

<http://www.samhsa.gov>

**Texas Commission on Alcohol and Drug Abuse (TCADA)**

<http://www.tcada.state.tx.us>

**TRAINING NEEDS FOR PERSONS WITH DD**

Dan Thomasulo (psychologist)

(732) 264-9501

**VIOLENCE AND SCHOOL AGE KIDS****Second Step**

Program for School Age Kids-CMHS

<http://www.colorado.edu/cspv/blueprint/query/index.html>

**WOMEN , CO-OCCURRING DISORDER AND TRAUMA****Community Connection in Washington DC****TREM Group****Consumer-based Model**

Rene Andersen

(413) 536-2401

Holyoke, MA

**Program for Trauma Intervention (PTSD and women)**

Florida State University

(850) 644-1588, (850) 681-2255, (850) 644-9598

[cfgley@garnet.acns.fsu.edu](mailto:cfgley@garnet.acns.fsu.edu)

**SARC House**

Madison, Wisconsin

**Substance Abuse and Mntal Health Services Administration (SAMHSA) Women and Violence Project**

Policy Research Association Inc

(518) 429-7415

Joe Cocozza

**Sidran Foundation**

Esther Giller  
(410)825-8888

**TRIAD Model**

Arthur Cox, Sr., and Colleen Clark  
(813) 974-9022

<http://www.fmhi.usf.edu/cmh/research/exemplary/triad.html>

Florida, US

**WELL Project**

Franklin County, Massachusetts

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“Promise of Recovery” (focuses on DD issues)  
“Double Trouble” (videos)  
“Soft is the Heart of a Child” (older version of the story)

Hazelden  
“Out of the Tunnel: Into the Light” “Twelve Steps and Dual Disorders”  
DD Series (videos)

Illinois Newsletter  
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Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA)

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## **CENTER FOR SUBSTANCE ABUSE TREATMENT ELECTRONIC DISCUSSION LIST**

As an expansion of services to the CSAT Treatment Improvement Exchange on the World Wide Web (<http://www.treatment.org>), the Division of State and Community Assistance has established an electronic discussion list titled “Co-occurring Dialogues.” This new Discussion Group focuses on issues related to dual diagnosis. For the purposes of this activity, dual diagnosis is defined as a mental disorder and substance abuse.

Subscription to the “Co-occurring Dialogues” discussion list ([dualdx@treatment.org](mailto:dualdx@treatment.org)) is free and unrestricted. Please send an e-mail to [info@treatment.org](mailto:info@treatment.org) if you desire to subscribe to this ListServ. Guidelines that further describe membership, purpose, and utilization will follow with your subscription. Please read these carefully.

This Electronic Discussion Group belongs to the field. Membership is open to anyone, but CSAT reserves the right to remove someone not interacting in a professional manner. Individuals on an international level from the research community, educators, treatment agencies and providers, the recovery community, and all levels of government are participating. CSAT/DSCA is offering the discussion list as a means of communication, idea sharing, brainstorming, sharing of exciting publications and opportunities, and so on. The “Co-occurring Dialogues” will be used to make announcements and to broadcast information, and will be used by subscribers to ask questions of their peers, to seek information, and to respond to one another’s needs.

You are invited to subscribe and to forward this notice to anyone who may be interested. For further information, contact Carol Coley at (301) 443-6539 or [ccoley@samhsa.gov](mailto:ccoley@samhsa.gov).

**[dualdx@treatment.org](mailto:dualdx@treatment.org)**

## **WELCOME TO THE CO-OCCURRING COMMUNIQUE ELECTRONIC MAILING LIST!!**

Please save this message for future reference, especially if you are not familiar with discussion lists and list servers.

FAQ/GUIDELINES for the Co-occurring Communiques  
(July 2000)

A periodic posting to explain the purpose and use of  
the Co-occurring Communiques list.

Contents:

- A. PURPOSE AND MEMBERSHIP
- B. GUIDELINES FOR MESSAGES
- C. HOW TO GET HELP WITH YOUR SUBSCRIPTION

### **A. PURPOSE AND MEMBERSHIP**

The Co-occurring Communiques is an open vehicle sponsored by the Division of State and Community Assistance (DSCA) at CSAT for communication between and among researchers, educators, treatment agencies, the recovery community, treatment providers, and all levels of government. This moderated list focuses on ideas, questions, announcements, and concerns specific to the field of dual diagnosis. Dual diagnosis is defined as a mental disorder and substance abuse. Other issues are obviously relevant, such as learning disabilities, HIV/AIDS, other medical conditions, and so on.

DSCA/CSAT may establish a task force of up to three individuals from the field to assist with planning and implementing this discussion list.

**WHO CAN SUBSCRIBE:** Subscription and posting to the Co-occurring Communiques list is unrestricted, but content and appropriateness will be moderated and CSAT reserves the right to remove a subscriber.

If you want to subscribe or unsubscribe to the Co-occurring Communiques list, send a message to [info@treatment.org](mailto:info@treatment.org). Nonmembers wanting to post an announcement on the list should send a message to the same address.

*ALL STATEMENTS/ANALYSES/CONCLUSIONS REPRESENT ONLY THE INFORMATION OFFERED BY SUBSCRIBERS.  
IT IS NOT INTENDED AS A TOTAL REPRESENTATION/DISCUSSION OF ANY TOPIC*

## B. GUIDELINES FOR MESSAGES

### 1) Only subscribed users are invited to post messages.

To post a message to all the current Co-occurring Communiques subscribers use the address: dualdx@treatment.org

### 2) Keep postings within the scope of the list.

The Co-occurring Communiques list should be used for messages of professional interest to persons in the dual diagnosis treatment field. Postings to this list should be limited to issues that are specific to dual diagnosis treatment or to the improvement of the health of those undergoing such treatment. No self-promotion, advertising of services or facilities, or lobbying will be permitted. Any subscriber who violates these rules may be removed from the list.

### 3) Always use a descriptive subject line.

The more descriptive you are, the more likely it is the right people will read and respond to your posting.

### 4) When replying, double-check the original subject line to see if it is understandable and fits your posting.

If the original subject line was meaningless or misleading, retype an appropriate subject line. If you are using the reply function to post something on a new topic, retype a new subject line.

### 5) Always give your postings a full signature.

Include your name, e-mail address, title, and organizational affiliation. Try to limit your signature to four (4) lines.

### 6) Send personal replies to the individual, not to the whole list.

**Co-occurring Communiques is configured so that replies are sent to the entire list, not just to the individual who posted the message.** This is done to facilitate group discussion. Of course, mistakes are going to be made (by new users, and/or experienced networkers when we are just too fast with the Reply key!) Unfortunately, these errors sometimes cannot be caught before they reach the entire list.

7) When you wish to send a personal reply to the individual who contributed a Co-occurring Communiques message, **you must manually replace the list address with the individual's address in the address field.** CAUTION: Your mail system may appear to have a command

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that will direct your reply to the individual rather than the list, but often this selects Co-occurring Communiques as “sender,” instead of the individual.

**8) Examples of messages that should be sent back as personal replies (posted to an individual):**

- a) All requests for copies of offered materials. These should be sent directly to the offerer.
- b) “Thank you” messages, unless they are intended to halt other list members from continuing to fill a request.
- c) Messages consisting of “Me too” or a synonym thereof.
- d) Survey responses.
- e) Very specific answers to very specific questions that are unlikely to be of general interest.

**9) Be brief: Keep paragraphs and messages short and to the point.**

Do not send long documents to the list. Instead, describe the document and give instructions for retrieving it or offer to send it to those interested. For conference announcements, send a brief message with an e-mail address for further information.

**10) Read all the incoming mail from the List before responding; someone may have already sent a reply similar to your own.**

**11)** When sending a reply to the list, do not include the header from the previous message in the body of your message (this is the part that includes “Sender”, “From”, and so on.). The list server may not distribute the message. It may end up with the dualdx@treatment.org delivery errors, never to be seen again.

**12)** When sending a reply to the list, do not include the entire previous message. Extract only those brief portions of the message that are necessary to identify the issue and make your point. Repeating long messages and headers needlessly clogs Co-occurring Communiques archives with repetitions of the same message.

**13)** Messages appearing on Co-occurring Communiques may be forwarded to other lists or individuals, as long as proper credit is given to the author.

**14)** CSAT accepts no responsibility for the opinions and information posted by users.

**C. HOW TO GET HELP WITH YOUR TIE-FORUM SUBSCRIPTION:**

Co-occurring Communiques subscribers who have TECHNICAL/SUBSCRIPTION questions should contact: info@treatment.org

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