Substance Abuse Treatment: Addressing the Specific Needs of Women

A Treatment Improvement Protocol

TIP 51

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Substance Abuse Treatment: Addressing the Specific Needs of Women

A Treatment Improvement Protocol

TIP 51

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

1 Choke Cherry Road
Rockville, MD 20857

Acknowledgments

This publication was prepared under contract numbers 270-99-7072 and 270-04-7049 by the Knowledge Application Program (KAP), a Joint Venture of The CDM Group, Inc., and JBS International, Inc., for the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Andrea Kopstein, Ph.D., M.P.H., Karl D. White, Ed.D., and Christina Currier served as the Contracting Officer's Representatives.

Disclaimer

The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS.

Public Domain Notice

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

Electronic Access and Copies of Publication

This publication may be ordered from or downloaded from SAMHSA's Publications Ordering Web page at http://store.samhsa.gov. Or, please call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

Recommended Citation

Substance Abuse and Mental Health Services Administration. *Substance Abuse Treatment: Addressing the Specific Needs of Women*. Treatment Improvement Protocol (TIP) Series, No. 51. HHS Publication No. (SMA) 13-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.

Originating Office

Quality Improvement and Workforce Development Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

HHS Publication No. (SMA) 13-4426
First Printed 2009
Revised 2010, 2012, and 2013

Please share your thoughts about this publication by completing a brief online survey at:

https://www.surveymonkey.com/r/KAPPFS

The survey takes about 7 minutes to complete and is anonymous.
Your feedback will help SAMHSA develop future products.

Contents

What Is a TIP? ..... **vii**
Consensus Panel ..... **ix**
Editorial Board ..... **xi**
KAP Expert Panel and Federal Government Participants ..... **xiii**
Foreword ..... **xv**
Executive Summary ..... **xvii**
Chapter 1—Creating the Context **1**
Overview 1
Creating the Context 1
Gender Responsive Treatment Principles 4
Women's Biopsychosocial Uniqueness 6
Organization of This TIP 15
Chapter 2—Patterns of Use: From Initiation to Treatment **17**
Overview 17
Initiation of Use Among Women 18
Risk Factors Associated with Initiation of Substance Use and the Development of Substance Use Disorders Among Women 18
Patterns and Prevalence of Substance Use Among Women 26
Prevalence of Substance Abuse and Dependence Among Women 30
Chapter 3—Physiological Effects of Alcohol, Drugs, and Tobacco on Women **37**
Overview 37
Physiological Effects and Consequences of Substance Abuse In Women 38
Physiological Effects: Factors of Influence 38
Physiological Effects of Alcohol 40
Physiological Effects of Licit and Illicit Drugs 46
Physiological Effects of Tobacco Use 48
Effects of Alcohol, Drugs, and Tobacco Use on Pregnancy and Birth Outcomes 48
Effects of Alcohol and Illicit Drugs on HIV/AIDS Status 52
Chapter 4—Screening and Assessment **57**
Overview 57
The Difference Between Screening and Assessment 58
Screening and Assessment: Factors of Influence 58

Screening 60
Assessment 74
Chapter 5—Treatment Engagement, Placement, and Planning 83
Overview 83
Barriers to Treatment Engagement 83
Treatment Engagement Strategies 87
Considerations in Treatment Placement and Planning 92
Levels of Care 92
Chapter 6—Substance Abuse Among Specific Population Groups and Settings 103
Overview 103
Racially and Ethnically Diverse Women 104
Sexual Orientation and Women 123
Women Later in Life 127
Women in Rural America 130
Resources for Other Special Populations and Settings 133
Women in the Criminal Justice System 134
Women Who Are Homeless 135
Chapter 7—Substance Abuse Treatment for Women 137
Overview 137
Treatment Retention 137
Women's Treatment Issues and Needs 143
Addressing Tobacco Use with Women in Treatment 177
Chapter 8—Recovery Management and Administrative Considerations 181
Overview 181
Continuing Care 181
Treatment Outcome 182
Support Systems for Women 186
Administrative Considerations 187
Appendix A: Bibliography 197
Appendix B: CSAT's Comprehensive Substance Abuse Treatment Model for Women and Their Children 273
Appendix C: Screening and Assessment Instruments 297
Appendix D: Allen Barriers to Treatment Instrument 307
Appendix E: DSM-IV-TR Criteria for Posttraumatic Stress Disorder 311
Appendix F: Integration Self-Assessment for Providers 313
Appendix G: Resource Panel Members 319
Appendix H: Cultural Competency and Diversity Network Participants 323
Appendix I: Field Reviewers 325
Appendix J: Acknowledgments 333
Index 335

Figures

1-1 A Woman's Life in Context 3
1-2 Interrelated Elements in the Comprehensive Treatment Model 4
2-1 Use of Illicit Drugs, Alcohol, or Tobacco by Females Aged 12 or Older, Past Year and Past Month, Numbers in Thousands and Percentages, 2006 29
2-2 Past Month Substance Use, Based on Combined 2006 and 2007 Data: National Survey on Drug Use and Health (NSDUH) 30
2-3 Percentages of Past-Year Abuse of or Dependence on Alcohol or Any Illicit Drug by Gender and Age, 2006 31
2-4 Percentages of Past-Year Abuse of or Dependence on Alcohol or Any Illicit Drug Among Women Aged 18 or Older by Age Group: 2003 32
2-5 Percentage of Admissions to Substance Abuse Treatment Programs by Racial/Ethnic Group in 2006 33
2-6 Primary Substance of Abuse Among Women Admitted for Substance Abuse Treatment by Racial/Ethnic Group by Percentage. 34
4-1 The CAGE Questionnaire 62
4-2 The TWEAK Questionnaire: Women 64
4-3 The T-ACE Questionnaire 64
4-4 5Ps Screening 65
4-5 Questions to Screen for Trauma History 69
4-6 Questions Regarding Sexual Abuse. 71
4-7 STaT: Intimate Partner Violence Screening Tool 72
4-8 General and Specific Screening Questions for Persons with Possible Eating Disorders 73
4-9 Available Screening and Assessment Tools in Multiple Languages 80
5-1 Percentages of Reasons for Not Receiving Substance Use Treatment in the Past Year Among Women Aged 18–49 Who Needed Treatment and Who Perceived a Need for It: 2004–2006 85
5-2 PROTOTYPES 91
5-3 Services Needed in Women's Substance Abuse Treatment 93
6-1 Group Therapy: Promising Practices and Strategies for African-American Women 113
7-1 Violence and Women 156
7-2 PTSD Symptoms 162
7-3 Helpful Skills for Trauma Victims 163
7-4 Common Definitions of Eating Disorders and Behaviors 175
8-1 Women-Specific Predictors of Relapse and Reactions to Relapse 184
8-2 Women's Recovery Group: Manual-Based Relapse Prevention 185
8-3 Goals and Training Guidelines for Point-of-Entry Staff (Non–Substance-Abuse Treatment Providers) 190
8-4 Goals and Training Guidelines for Substance Abuse Treatment Counselors 191
8-5 State Standard Examples of Gender-Specific Treatment 195
B-1 Interrelated Elements in the Comprehensive Treatment Model 276
B-2 Elements of Clinical Treatment Services 277
B-3 Elements of Clinical Support Services 279

B-4 Elements of Community Support Services 280
B-5 Clinical Treatment Services for Children 281
B-6 Clinical Support Services for Children 282
B-7 Interrelated Elements of Clinical Treatment and Support Services for Women and Their Children 284

Advice to the Clinician and Administrator Boxes

Chapter 2
Using Patterns of Use as a Clinical Guide 35
Chapter 3
Substance Use and Birth Outcomes 50
Chapter 4
Culturally Responsive Screening and Assessment 59
Substance Abuse Screening and Assessment Among Women 61
At-Risk Screening for Drug and Alcohol Use During Pregnancy 66
Mental Health Screening and Women 75
General Guidelines for Selecting and Using Screening and Assessment Tools 76
General Guidelines of Assessment for Women 81
Chapter 5
The Impact of Trauma and Prenatal Care 102
Chapter 6
Substance Abuse Treatment and Hispanic/Latina Women 106
Substance Abuse Treatment and African-American Women 114
Substance Abuse Treatment and Asian- and Pacific-American Women 116
Substance Abuse Treatment and Native-American Women 121
Substance Abuse Treatment and Lesbian and Bisexual Women 125
Substance Abuse Treatment and Older Women 129
Substance Abuse Treatment and Women in Rural Areas 132
Chapter 7
Relational Model Approach 144
Considerations in Involving the Partner in Treatment 146
Women with Co-Occurring Disorders 158
When is a Woman Ready for Trauma Processing? 167
Retraumatization 169
Women With Eating Disorders 177
Chapter 8
Postpartum Relapse Prevention 186

What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at http://store.samhsa.gov.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

Consensus Panel

Chair

Norma B. Finkelstein, Ph.D., M.S.W.
Executive Director
Institute for Health & Recovery
Cambridge, Massachusetts

Co-Chair

Juana Mora, Ph.D.
Professor
Northridge Chicano/a Studies Department
California State University, Northridge
Northridge, California

Workgroup Leaders

Karen Allen, Ph.D., R.N., FAAN
Professor/Chair
Department of Nursing
Andrews University
Berrien Springs, Michigan

Hortensia Amaro, Ph.D.
Distinguished Professor
Center on Health and Social Science Research
Director
Institute on Urban Health Research
Northeastern University
Boston, Massachusetts

Stephanie S. Covington, Ph.D., LCSW
Co-Director
Center for Gender and Justice
Institute for Relational Development
La Jolla, California

Francine Feinberg, Psy.D., CISCW
Executive Director
Meta House
Whitefish Bay, Wisconsin

Beth Glover Reed, Ph.D.
Associate Professor
Social Work and Women's Studies
School of Social Work
University of Michigan
Ann Arbor, Michigan

Brenda L. Underhill, M.S., CAC
President
Underhill and Associates
El Cerrito, California

Panelists

Belinda Biscoe, Ph.D.
Assistant Vice President for Public and Community Services
Director, Region VII Comprehensive Assistance Center
Director, Education, Training, Evaluation, Assessment and Measurement Department (E-TEAM)
University of Oklahoma
Norman, Oklahoma

Vivian B. Brown, Ph.D.
Founder, Board Member Emeritus
PROTOTYPES
Culver City, California

Margaret A. Cramer, Ph.D.
Clinical Psychologist/Instructor
Massachusetts General Hospital
Boston, Massachusetts

Gloria Grijalva-Gonzales
Certified Sr. Substance Abuse Case Manager/
Counselor
Allies Project
San Joaquin County
Stockton, California

Tonda L. Hughes, Ph.D., R.N.
Professor
Department of Health Systems Science
University of Illinois at Chicago
Chicago, Illinois

Marty A. Jessup, Ph.D., R.N., M.S.
Associate Adjunct Professor
Department of Family Health Care Nursing
Institute for Health and Aging
University of California, San Francisco
San Francisco, California

Karol A. Kaltenbach, Ph.D.
Clinical Associate Professor of Pediatrics,
Psychiatry and Human Behavior
Director, Maternal Addiction Treatment
Education and Research
Department of Pediatrics
Jefferson Medical College
Thomas Jefferson University
Philadelphia, Pennsylvania

Robin A. LaDue, Ph.D.
Clinical Psychologist
Department of Psychiatry and
Behavioral Sciences
University of Washington
Renton, Washington

LaVerne R. Saunders, B.S.N., R.N., M.S.
Founder/Partner
Dorrington & Saunders and Associates
Framingham, Massachusetts

Starleen Scott-Robbins, M.S.W., LCSW
Women's Treatment Coordinator
Best Practice Consultant
Developmental Disabilities and Substance Abuse
Services
Division of Mental Health
North Carolina Department of Health and
Human Services
Raleigh, North Carolina

Sally J. Stevens, Ph.D.
Executive Director
Southwest Institute for Research on Women
University of Arizona
Tucson, Arizona

Sharon Wilsnack, Ph.D.
Professor
Department of Clinical Neuroscience
Medical School for the Public
School of Medicine & Health Sciences
University of North Dakota
Grand Forks, North Dakota

Rita Zimmer, M.P.H.
Founder
Women in Need, Inc.
New York, New York

Editorial Board

Gene Burkett, M.D., B.S., FRCOG, FACOG, Diplomate American Board, OB/GYN
Professor
Obstetrics and Gynecology
University of Miami School of Medicine

Jacqueline Butler, M.S.W., LISW, LPCC, CCDC III, CJS
Professor of Clinical Psychiatry (Social Work)
University of Cincinnati, College of Medicine
Executive Director
The Crossroads Center

Grace Chang, M.D., M.P.H.
Associate Professor of Psychiatry,
Harvard Medical School
Brigham and Women's Hospital

Elena Flores, Ph.D.
Associate Professor
Counseling Psychology Department
School of Education
University of San Francisco

Jacki McKinney
Executive Director
National People of Color Consumer Survivor Network

Lisa Najavits, Ph.D.
Associate Professor of Psychology
Harvard Medical School

Dace Svikis, Ph.D.
Associate Professor
Virginia Commonwealth University

William White, M.A.
Senior Research Consultant
Chestnut Health Systems/Lighthouse Institute

KAP Expert Panel and Federal Government Participants

Barry S. Brown, Ph.D.
Adjunct Professor
University of North Carolina at Wilmington
Carolina Beach, North Carolina

Jacqueline Butler, M.S.W., LISW, LPCC, CCDC III, CJS
Professor of Clinical Psychiatry
College of Medicine
University of Cincinnati
Cincinnati, Ohio

Deion Cash
Executive Director
Community Treatment and Correction Center, Inc.
Canton, Ohio

Debra A. Claymore, M.Ed.Adm.
Owner/Chief Executive Officer
WC Consulting, LLC
Loveland, Colorado

Carlo C. DiClemente, Ph.D.
Chair
Department of Psychology
University of Maryland Baltimore County
Baltimore, Maryland

Catherine E. Dube, Ed.D.
Independent Consultant
Brown University
Providence, Rhode Island

Jerry P. Flanzer, D.S.W., LCSW, CAC
Chief, Services
Division of Clinical and Services Research
National Institute on Drug Abuse
Bethesda, Maryland

Michael Galer, D.B.A.
Chairman of the Graduate School of Business
University of Phoenix - Greater Boston Campus
Braintree, Massachusetts

Renata J. Henry, M.Ed.
Director
Division of Alcoholism, Drug Abuse, and Mental Health
Delaware Department of Health and Social Services
New Castle, Delaware

Joel Hochberg, M.A.
President
Asher & Partners
Los Angeles, California

Jack Hollis, Ph.D.
Associate Director
Center for Health Research
Kaiser Permanente
Portland, Oregon

Mary Beth Johnson, M.S.W.
Director
Addiction Technology Transfer Center
University of Missouri—Kansas City
Kansas City, Missouri

Eduardo Lopez, B.S.
Executive Producer
EVS Communications
Washington, DC

Holly A. Massett, Ph.D.
Academy for Educational Development
Washington, DC

Diane Miller
Chief
Scientific Communications Branch
National Institute on Alcohol Abuse
and Alcoholism
Bethesda, Maryland

Harry B. Montoya, M.A.
President/Chief Executive Officer
Hands Across Cultures
Espanola, New Mexico

Richard K. Ries, M.D.
Director/Professor
Outpatient Mental Health Services
Dual Disorder Programs
Seattle, Washington

Gloria M. Rodriguez, D.S.W.
Research Scientist
Division of Addiction Services
NJ Department of Health and Senior Services
Trenton, New Jersey

Everett Rogers, Ph.D.
Center for Communications Programs
Johns Hopkins University
Baltimore, Maryland

Jean R. Slutsky, P.A., M.S.P.H.
Senior Health Policy Analyst
Agency for Healthcare Research & Quality
Rockville, Maryland

Nedra Klein Weinreich, M.S.
President
Weinreich Communications
Canoga Park, California

Clarissa Wittenberg
Director
Office of Communications and Public Liaison
National Institute of Mental Health
Kensington, Maryland

Consulting Members:

Paul Purnell, M.A.
Social Solutions, L.L.C.
Potomac, Maryland

Scott Ratzan, M.D., M.P.A., M.A.
Academy for Educational Development
Washington, DC

Thomas W. Valente, Ph.D.
Director, Master of Public Health Program
Department of Preventive Medicine
School of Medicine
University of Southern California
Alhambra, California

Patricia A. Wright, Ed.D.
Independent Consultant
Baltimore, Maryland

Foreword

The Treatment Improvement Protocol (TIP) series fulfills the Substance Abuse and Mental Health Services Administration's (SAMHSA's) mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

Pamela S. Hyde, J.D.
Administrator
Substance Abuse and Mental Health Services Administration

Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

9 Adapting Intensive Outpatient Treatment for Specific Populations

In This Chapter...

Justice System Population

Women

Populations With Co-Occurring Psychiatric Disorders

Adolescents

Young Adults

Many assumptions and approaches used in intensive outpatient treatment (IOT) programming were developed for and validated with middle-class, employed, adult men. This chapter presents information about how IOT can be adapted to meet the needs of specific populations: the justice system population, women, people with co-occurring mental disorders, and adolescents and young adults. Chapter 10 presents information on treatment approaches for other special groups, including minority populations.

Justice System Population

The number of people in the justice system with a history of substance use disorders has increased dramatically over the last 20 years because of increased drug-related crime, Federal and State legislation, and mandatory sentencing guidelines; many of these people are caught in a cycle of repeated incarcerations.

Between 1990 and 1999, the number of inmates sentenced to Federal prison for drug offenses rose more than 60 percent (Beck and Harrison 2001). About three-quarters of all prisoners reported some type of involvement with alcohol or drug abuse before their offenses, and an estimated 33 percent of State prisoners and 22 percent of Federal prisoners say that they had committed their current offenses while under the influence of drugs, with marijuana/hashish and cocaine/crack used most often (Mumola 1999).

Description of the Population

Justice system populations are younger than the general population, are overwhelmingly male, and are challenged with many psychosocial, medical, and financial problems (Brochu et al. 1999).

Psychosocial issues

People involved with the justice system typically have many problems related to employment and financial support, housing, education, transportation, and unresolved legal issues. Many inmates have not completed high school or earned a general equivalence diploma. Only about 55 percent were employed full time before their incarceration (Bureau of Justice Statistics 2000).

Medical and psychiatric problems

Offenders with a substance use disorder may have co-occurring psychiatric disorders. Approximately 16 percent of State inmates, 7 percent of Federal inmates, and 16 percent of jail inmates and probationers reported having mental illnesses, and nearly 60 percent of these offenders reported that they were under the influence of alcohol or drugs at the time of their offenses (Ditton 1999). People in prison have a high incidence of HIV/AIDS (Maruschak 2002), tuberculosis, sexually transmitted diseases, and hepatitis C (National Institute of Justice 1999).

A major challenge to IOT providers is to integrate substance abuse treatment with justice system processes.

Female offenders

Between 1990 and 2000, the number of women involved with the justice system (incarcerated, on probation, or paroled) increased by 81 percent (Bloom et al. 2003). Women accounted for 15 percent of the total correctional population in 1998; 90 percent were under community supervision (Glaze 2003; Harrison and Beck 2003). Seventy-two percent of the women in Federal prisons were convicted of drug offenses or committed their crimes while under the influence of drugs or alcohol (Greenfeld and Snell 1999). Female offenders with substance use disorders experienced more health, educational, and employment problems; had lower incomes; reported more depression, suicidal behavior, and sexual and physical abuse; and had more mental and physical health problems than did male offenders with substance use disorders (Langan and Pelissier 2001). More than half the female inmates in prisons had at least one child younger than 18 (Mumola 2000). The National Institute of Corrections' *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders* (Bloom et al. 2003) provides more information about female offenders.

Double stigma

Offenders often are affected by the stigma associated with involvement in the justice system, as well as the stigma associated with substance abuse. These two factors can impede an offender's ability to obtain appropriate employment or housing.

Implications for IOT

In response to the increase in drug-related judicial cases, several approaches for treating offenders who have a substance use disorder have been developed. IOT providers become involved in treating offenders when the offender is (1) referred to treatment in lieu of incarceration, (2) incarcerated, or (3) released.

Coercion frequently is used to compel offenders to participate in treatment. Coercion may be a sentence mandating treatment or a prison policy mandating treatment for inmates discovered to have a substance use disorder while incarcerated for a non-drug-related crime. For nonincarcerated offenders, a sanction for refusing to participate in treatment often is incarceration. Research indicates that treatment adherence and outcomes of clients legally referred to

treatment were the same as or better than those of clients entering treatment of their own volition (Farabee et al. 1998; Marlowe et al. 1996, 2003).

Working With the Judicial System

IOT programs provide treatment for the following justice system clients:

- **Offenders referred to treatment in lieu of incarceration.** IOT providers have developed effective partnerships with drug courts and Treatment Accountability for Safer Communities (TASC) programs to provide treatment (Farabee et al. 1998). Drug courts, begun in 1989, divert nonviolent offenders with substance use disorders into treatment instead of incarceration. Drug courts oversee the offender's treatment, coordinate justice and treatment systems procedures, and monitor progress. TASC, formerly known as Treatment Alternatives to Street Crime, identifies and assesses offenders involved with drugs and refers them to community treatment services.
- **Offenders discharged from residential substance abuse treatment who need continuing community-based treatment.** IOT programs provide stepdown, but structured, services and transitional services and links to other services for offenders who are discharged from residential treatment.
- **Offenders who need treatment and are placed under community supervision (pretrial, probation, or parole).** Many justice programs have been developed to support this type of treatment for people who are under the supervision of the justice system but are allowed to remain in the community.
- **Offenders reentering the community after incarceration.** Reentry management programs funded by various Federal agencies facilitate the transition and reintegration of prisoners released into the community. IOT providers, working closely with justice staff before individuals are released, engage offenders in treatment and support their continuing recovery through flexible, individualized approaches. TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT 1998*b*), provides more information on transition of prisoners to the community.
- **Offenders who participate in treatment while incarcerated.** IOT can be modified for use in prisons and jails, although this stretches the concept of outpatient treatment. Institutions that can segregate offenders in IOT from the rest of the incarcerated population provide a more effective and supportive structure (U.S. House Committee on the Judiciary 2000).

Forging a Working Partnership

A major challenge to IOT providers is to integrate substance abuse treatment with justice system processes. Partnerships are being forged effectively as justice agencies and treatment providers recognize that, although they have different perspectives, they can work together. Both parties need to be flexible and interact with clients on a case-by-case basis (Farabee et al. 1998). Justice officials and IOT providers need to agree on which clients are appropriate for treatment and establish clear screening and admission criteria.

Rules for Offenders in Treatment

Most justice system and IOT program partners agree that offenders in treatment must not commit another offense, must abstain from drug use, and must comply with treatment requirements. However, disagreements about additional rules may emerge. As a result, some policies and sanctions may work against the recovery they are designed to achieve. IOT program staff members can

help prevent or resolve such conflicts by discussing these matters with judges and other criminal justice officials. Staff members who are familiar with research on treatment outcomes are best suited to convey to others a realistic, convincing argument for treatment and to foster cooperation that leads to client recovery. Developing and agreeing on a process for resolving conflicts early in the collaboration may reconcile discordant opinions. For the collaboration to function smoothly, IOT program staff needs the discretion to make decisions about treatment, such as whether the offender needs a different level of care. The justice system staff needs to be confident that it will be informed of treatment progress or if sanctions are justified. The partners must agree on the following:

- **Consequences for lapses in abstinence and continued drug use.** When a client admits to a single episode of drug use in a treatment session, the counselor may view this as a positive development; this admission of use may indicate that the client has gone beyond denial and begun to work on treatment issues. Justice system staff, however, may disagree and consider any drug use grounds for incarceration. IOT staff members may agree to sanctions only when continued episodes of drug use indicate that the offender is not committed to treatment.
- **Consequences for use of alcohol.** The justice system considers alcohol a legal substance and is concerned only with illegal activity resulting from its use. Consequently, the justice agency may not apply sanctions for continued alcohol use. In contrast, treatment providers consider alcohol an addictive substance and usually enforce no-use-of-alcohol rules. The topic warrants extended conversation between partners to develop reasonable responses to alcohol use.
- **Discharge criteria.** Agreed-on discharge criteria that define treatment goals, conditions indicating therapeutic discharge, and behavior meriting immediate discharge are needed.
- **Uses of drug-testing results.** The justice system regards drug-screening test results as an objective measure of progress or nonadherence to treatment and can impose severe consequences for positive drug tests. Many IOT programs use drug test results therapeutically, to inform treatment plans and to deter clients from using substances. Both systems need to discuss how drug test results will be used.

Communication Between Systems

Clear communication between the two systems is essential. For all referrals from the justice system (pretrial services, probation, and parole), an IOT program should designate point-of-contact personnel. To ensure clients' privacy rights, programs need to have confidentiality release forms that specify the information to be shared and the length of time the forms are in effect; all clients must sign these forms. These forms permit the two agencies to communicate information about the offender for monitoring purposes.

IOT providers are advised to discuss and agree on the following communication issues with their justice system partners:

- The form and timing of updates on treatment progress from the treatment program to the justice agency
- Reportings of critical incidents, such as when an offender threatens to commit a crime or fails to appear for treatment
- Reportings from the criminal justice agency, such as when an offender is rearrested or incarcerated

Memorandum of Understanding

Once justice system and IOT program partners agree on rules, consequences, and elements of communication, the agreement

needs to be formalized in a written memorandum of understanding (MOU). The suggested elements of an MOU include

- Parameters of treatment, including the kinds of services
- Each partner's responsibilities (e.g., the criminal justice agency refers and monitors clients; the treatment program assesses and treats clients)
- The consequences for noncompliant behavior, recognizing that not every contingency can be foreseen
- Identification of which agency determines the consequences of noncompliant behavior
- The types, content, and timetable of communications and reportings required between the partners
- Definitions of critical incidents that require the treatment program to notify the justice agency

Clinical Issues and Services

Although working with clients involved with the criminal justice system is challenging, it can be rewarding. For example, approximately 60 percent of people involved with drug courts remained in treatment for at least a year, with a minimum 48-percent graduation rate (Belenko 1999). Clients involved with the justice system have unique stressors, including, but not limited to, their precarious legal situation. Clients may need help with transportation, educational services, family issues, financial issues such as obtaining welfare and Medicaid benefits and arranging restitution payments, housing such as arranging temporary shelter and permanent housing, and job skills and employment counseling. Case management can coordinate services for justice system clients.

TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT 2005*d*), provides more information about treating this population.

Staff Training

Treatment is impeded when counselors have a negative attitude toward clients, believe that clients have a poor prognosis for recovery, or are reluctant to serve offenders in general. These issues should be included in staff training and cross-training.

To provide effective substance abuse treatment to criminal justice system clients, staffs in both systems need cross-training (Farabee et al. 1999). Topics include the philosophy, approach, goals, objectives, and boundaries of both systems. Treatment providers need information about the responsibilities, structure, operations, and goals of the justice system; public safety and security concerns; and how involvement with the justice system affects offenders. Criminal justice system personnel need information about the dynamics of substance use disorders, components of treatment, how treatment can reduce recidivism, confidentiality, and co-occurring psychiatric disorders.

> For all referrals from the justice system...an IOT program should designate point-of-contact personnel.

Women

In recent years, heightened awareness and new funding have encouraged the development of specialized programs to address the treatment needs of women. The number of treatment facilities offering programs for pregnant and postpartum women rose from 1,890 in 1995 to 2,761 in 2000, and more than 5,000 facilities offered special programs for women (Substance Abuse and Mental Health Services Administration 2002). The forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT forthcoming *b*), TIP 25, *Substance Abuse Treatment and Domestic Violence*

(CSAT 1997*b*), and TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*b*), provide more information.

Description of the Population

Even though women and men who have substance use disorders have many similarities, they differ in some important ways. Women typically begin using substances later and enter treatment earlier in the course of their illnesses than do men (Brady and Randall 1999). Other differences with therapeutic implications are briefly surveyed below. Discussions of strategies for addressing women-specific treatment issues follow.

Violence

Women with substance use disorders are more likely than men with substance use disorders to have been physically or sexually abused as children (Bartholomew et al. 2002; Simpson and Miller 2002). In addition, women who have a substance use disorder are more likely to be victims of domestic violence (Chermack et al. 2001), with reported rates of women in treatment who have been victims of physical and sexual violence ranging from 75 percent (Oumiette et al. 2000) to 88 percent (B.A. Miller 1998).

Mental disorders

Compared with men, women with substance use disorders have nearly double the occurrence (30.3 percent vs. 15.7 percent) of serious mental illness and past year substance use disorders (Epstein et al. 2004). These higher rates of psychiatric comorbidity are particularly evident in mood and anxiety disorders (Zilberman et al. 2003).

Parenting issues

Women in treatment often bear the sole caretaking responsibility for their children, and this role can be a substantial obstacle to seeking and remaining in treatment. Women may have difficulty finding reliable and affordable child care. They may fear losing custody of their children because of their substance use, and this fear may deter them from entering treatment. At the same time, women (and men) who abuse substances are more likely to abuse or neglect their children (National Clearinghouse on Child Abuse and Neglect Information 2003).

Welfare issues

Some States require that individuals receiving welfare benefits be screened and treated for substance use disorders; failure to enroll in or dropping out of treatment may jeopardize benefits (Legal Action Center 1999). Such requirements can help retain a client in an IOT program, and a case manager should coordinate treatment with welfare staff.

Pregnancy

Substance use during pregnancy can mean poor prenatal care, unregistered delivery, and low-weight and premature babies (Howell et al. 1999). Heavy or binge alcohol or drug use during pregnancy can result in negative consequences for the child such as neurological damage, including fetal alcohol syndrome (American Academy of Pediatrics 2000).

Relationships

A woman's substance use disorder is often influenced by her partner. Women with male partners who use substances are retained in treatment for a shorter time than women with substance-free partners (Tuten and Jones 2003). Conversely, a woman's partner can have a positive influence on treatment through support and participation in treatment.

Implications for IOT

Effective treatment for women cannot occur in isolation from the social, health, legal, and other challenges facing female clients. Some studies suggest that gender-specific treatment may be advantageous for female

clients (Grella et al. 1999), producing higher success rates in women-only groups or programs. However, research to date on the best treatment for women is inconclusive (Blume 1998).

Barriers to treatment entry and retention

Once a woman decides to seek help, she may face a long wait because of the lack of appropriate treatment. In addition, she faces gender-specific barriers and issues that may affect entry and retention in treatment such as

- Concerns about fulfilling her responsibilities as a mother, wife, or partner
- Fears of retribution from an abusive spouse or partner
- Gender and cultural insensitivity of some treatment programs
- Threat of legal sanction, such as loss of child custody
- Lack of affordable or reliable child care
- The disproportionate societal intolerance and stigma associated with substance abuse in women compared with men
- Ineligibility for treatment medications if she is pregnant or may become pregnant
- Having few other women in treatment with her

Entry and assessment

A woman entering treatment needs to feel that the environment is safe and supportive. IOT program staff members who are understanding, respectful, optimistic, and nurturing can build a positive, therapeutic relationship. It may help if the intake counselor is a woman. The client may be fearful, confused, in withdrawal, or in denial, and staff members need to be patient and supportive, understanding that it is empowering for the client to choose when to provide information and what information to provide. Additional ways to facilitate entry include providing help with child care and extending program hours for working women.

Using a comprehensive assessment, staff members can identify the client's strengths and weaknesses and work with her to develop specific treatment goals and a treatment plan. Because of the likelihood of victimization and presence of co-occurring psychiatric disorders, female clients need careful assessments for psychiatric disorders and history of childhood trauma and adult victimization. Chapter 5 discusses intake forms that can be used or modified to gather these data. Victimization experiences may be hidden beneath shame and guilt but, as trust develops, the client can discuss these events.

A woman entering treatment needs to feel that the environment is safe and supportive.

Clinical Issues and Strategies

Some women-specific programs are based on the philosophy that supporting and empowering women improve treatment success. Some programs advocate using predominantly female staff in professional and support positions. Providing enhanced services that respond to the social service needs of women is important for effective substance abuse treatment for women with children (Marsh et al. 2000; Volpicelli et al. 2000).

Treatment components specific to women

Exhibit 9-1 identifies core clinical needs and service elements that should be addressed in IOT for women (CSAT 1994*d*).

It is important to identify issues that the client is uncomfortable discussing in a group setting. As a woman feels more comfortable, she may be able to discuss them. Relapse prevention techniques may need to be modified for women. There is some evidence that

Exhibit 9-1

Core Treatment Needs and Service Elements for Women

Core Treatment Needs	Service Elements
Relationships with family and significant others	Provide family or couples counseling
Feelings of low self-esteem and self-efficacy	Address in group and individual counseling Identify and build on the client's strengths
History of physical, sexual, and emotional abuse	Avoid using harsh confrontational techniques that could retraumatize the client Hold individual and group therapy sessions or refer for treatment
Psychiatric disorders	Refer for or provide evaluation and treatment of psychiatric disorders, medication management, and therapy
Parenting, child care, and child custody	Hold parenting classes Develop substance abuse prevention services for children Provide or arrange for licensed child care, including a nursery for infants and young children and afterschool programs for older children Assist with Head Start enrollment
Medical problems	Refer for medical care, including reproductive health, pregnancy testing, and testing for or treating of infectious diseases
Gender discrimination and harassment	Ensure that the program has policies against harassment and that they are enforced

women's relapses are related to negative mood, more so than men's (Rubin et al. 1996). Also, women may do better in women-only counseling groups (Hodgins et al. 1997).

Therapeutic styles

Women who abuse substances may benefit more from supportive therapies than from other approaches and need a treatment environment that is safe and nurturing (Cohen 2000). Safety includes appropriate boundaries between counselor and client, physical and emotional safety, and a therapeutic relationship of respect, empathy, and compassion (Covington 2002).

For women with low self-esteem and a history of abuse, harsh confrontational approaches may further diminish their self-image and retraumatize them. Less aggressive approaches based on understanding and trust are more likely to effect change (Miller and Rollnick 2002). The confrontational approach of "breaking down" a person in treatment and rebuilding her as a recovering person may be overly harsh and not conducive to treating women (Covington 1999).

Woman clients can be referred to mutual-help groups such as Women for Sobriety and 12-Step groups that are sensitive to the needs of women. Some areas have women-only Alcoholics Anonymous (AA) and Narcotics Anonymous meetings, and some groups provide onsite child care. *A Woman's Way Through the Twelve Steps* (Covington 1994) and its companion workbook can help women adapt the 12 Steps for their use (Covington 2000).

Considerations for domestic violence survivors

IOT providers need to consider the safety of the client, develop and implement a personal safety plan for her, and notify the proper authorities if she is in danger. TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT 1997*b*), provides additional information.

Treatment for pregnant women

Because of the possible harm to fetuses, it is important to provide comprehensive treatment services to pregnant women who abuse substances. IOT has produced positive results for pregnant women, and retention in treatment is facilitated by provision of support services such as child care, parenting classes, and vocational training (Howell et al. 1999). Elements of one model program for pregnant women include (CSAT 1993*a*; Howell et al. 1999)

- A family-centered approach with pregnancy and parenting education and mother–child play groups
- Interdisciplinary staff
- Counselor continuity
- Physical and mental health services
- Child care and transportation services
- Housing services that address homelessness or unstable and unsafe housing conditions

Other programs have found that being flexible and responsive to clients' needs and using nonconfrontational approaches improve the health of the women and newborns (Whiteside-Mansell et al. 1999).

Staffing and Training

Making a treatment program gender sensitive requires changes in staffing, training, and treatment approaches. Female program staff and advisory board members may be more sensitive to the needs of female clients. However, male clinicians can work effectively with female clients.

Training on issues and resources specific for women is necessary. Both female and male staff members should be trained about the ramifications for treatment of sexual, physical, and emotional abuse and partner violence. Training should overcome the tendency to blame the victim. Other training needs may include assessment techniques for violence or abuse, appropriate referrals

to mental health professionals, coordinating services with other agencies, and food programs that serve women and children. To prevent sexual harassment of female clients, program rules should be explicit and strictly enforced. Providers need to become familiar with the duty-to-warn requirement as it pertains to reporting child abuse and neglect and partner violence.

Populations With Co-Occurring Psychiatric Disorders

In the field of substance abuse treatment, people with both psychiatric and substance use disorders are said to have co-occurring mental disorders.

Description of the Population

Many clients with co-occurring disorders are in IOT. The Drug Abuse Treatment Outcome Study found that 39 percent of admissions to substance abuse treatment met *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R) (American Psychiatric Association 1987) diagnostic criteria for an antisocial personality disorder, 11.7 percent met criteria for a major depressive episode, and 3.7 percent met criteria for a general anxiety disorder (Flynn et al. 1996). Other studies support these findings (Compton et al. 2000; Merikangas et al. 1998).

Most people with co-occurring mental and substance use disorders are not receiving appropriate care.

According to the Treatment Episode Data Set, people admitted to treatment who had a co-occurring psychiatric disorder were less likely than people admitted with only substance use disorders to be in the labor force. They were more likely to be women, abuse alcohol, and be referred through alcohol or drug abuse treatment providers and other health care providers than people admitted for substance abuse only (who were more likely to be have been referred by the criminal justice system) (Office of Applied Studies 2003*a*).

Group characteristics

When a client has co-occurring disorders, both the client and IOT counselor are presented with many challenges, such as

- Interacting symptoms that complicate treatment
- Increased biopsychosocial disruptions such as increased family problems, violent victimization, financial instability, homelessness, incarceration, suicidal ideation or attempts, and medical problems

Barriers to accessing treatment

Most people with co-occurring mental and substance use disorders are not receiving appropriate care (Watkins et al. 2001). Two of the numerous barriers to treatment are limited access to treatment and poor coordination between treatment systems.

In addition, historically, substance abuse and psychiatric treatments were provided in separate settings, and it was believed that one disorder must be stabilized before the other disorder could be treated, resulting in fragmented services. Clients were caught between two systems (Drake et al. 2001). The different treatment approaches led to misunderstandings between mental health and substance abuse treatment providers. Mental health providers may use more motivational and supportive techniques and professionally trained staff, whereas substance abuse treatment programs use more confrontational approaches, which may be distressing

for clients with co-occurring disorders, and often combine peer support with professionally trained counselors (Minkoff 1994). Some substance abuse treatment providers and recovering peers still may harbor antimedication attitudes and not understand the benefit of psychotropic medications.

Implications for IOT

Although clients with co-occurring psychiatric disorders may be challenging, they benefit from treatment (Dixon et al. 1998). Treatment has produced marked reductions in suicide attempts, mental health visits, and reports of depression (Karageorge 2002). Clients with less serious mental disorders appear to do well in traditional substance abuse treatment settings (Sloan and Rowe 1998), and outpatient treatment can be an effective setting for treating substance use disorder in clients with less serious mental disorders (Flynn et al. 1996). Long-term approaches seem more effective than short-term acute care (Bixler and Emery 2000). Clients with psychotic conditions, however, might pose insurmountable challenges for most IOT programs.

Theoretical Background

Integrated treatment

For the past two decades, integrated treatment has been proposed as an effective treatment approach. Minkoff (1994) presents a theoretical framework that considers both disorders chronic, primary, biologically based mental illnesses that are likely to be lifelong, but he suggests that conjoint treatment could reduce symptoms of both disorders effectively and promote recovery. His general treatment principles follow:

- Recognize that the basic elements and processes of addiction treatment are the same for clients who have a psychiatric disorder as for those without one.
- Include education, empathic confrontation of denial, relapse prevention, and involvement with both professional- and peer-led groups.
- Modify standard substance abuse treatment by simplifying interventions, accommodating cognitive limitations if necessary, adapting step or group work, and using mutual-help groups for people with co-occurring psychiatric disorders.
- Develop interventions specific to each phase of treatment.
- Provide comprehensive services that cover treatment of both disorders.

In a review of the literature on treating substance use disorders and co-occurring schizophrenia, Drake and colleagues (1998*b*) found that integrated treatment, especially when delivered for 18 months or longer, resulted in significant reduction in substance abuse and, in some cases, in substantial rates of remission, reductions in hospitalizations, and improvements in other outcomes. Many IOT programs do not treat clients with serious mental disorders such as schizophrenia on a regular basis and do not have the advantages of the programs cited in Drake and colleagues' review (e.g., intensive case management, 18-month treatment window). Charney and colleagues had similar success treating clients with co-occurring depression over a 6-month period (2001). Treatment retention and outcome improved when psychiatric services were provided at the substance abuse treatment facility.

Integrated treatment coordinates substance use and mental disorder interventions to treat the whole client and

- Recognizes the importance of ensuring that entry into *one* system provides access to *all* needed systems
- Emphasizes the association between the treatment models for mental disorders and addiction
- Advocates the concomitant treatment of both disorders
- Follows a staged approach

- Uses treatment strategies from both the mental health and substance abuse treatment fields

Conceptual framework

The National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors, with support from the Substance Abuse and Mental Health Services Administration (SAMHSA), developed a conceptual framework of four quadrants to classify service coordination and help providers categorize treatment according to the severity of symptoms of both disorders (see exhibit 9-2) (Substance Abuse and Mental Health Services Administration 2002).

Clients in category I often are identified in primary care, educational, or community settings and may need consultation services for prevention and early intervention services. Clients in categories II and III generally present or are referred for treatment for their more severe disorder—either mental or substance use disorder—often leaving them with little or no care for the other disorder. These clients may be referred to IOT programs, and care requires collaboration between mental health and IOT providers. Clients in category IV generally need comprehensive, integrated treatment (Substance Abuse and Mental Health Services Administration 2002).

Clinical Issues and Strategies

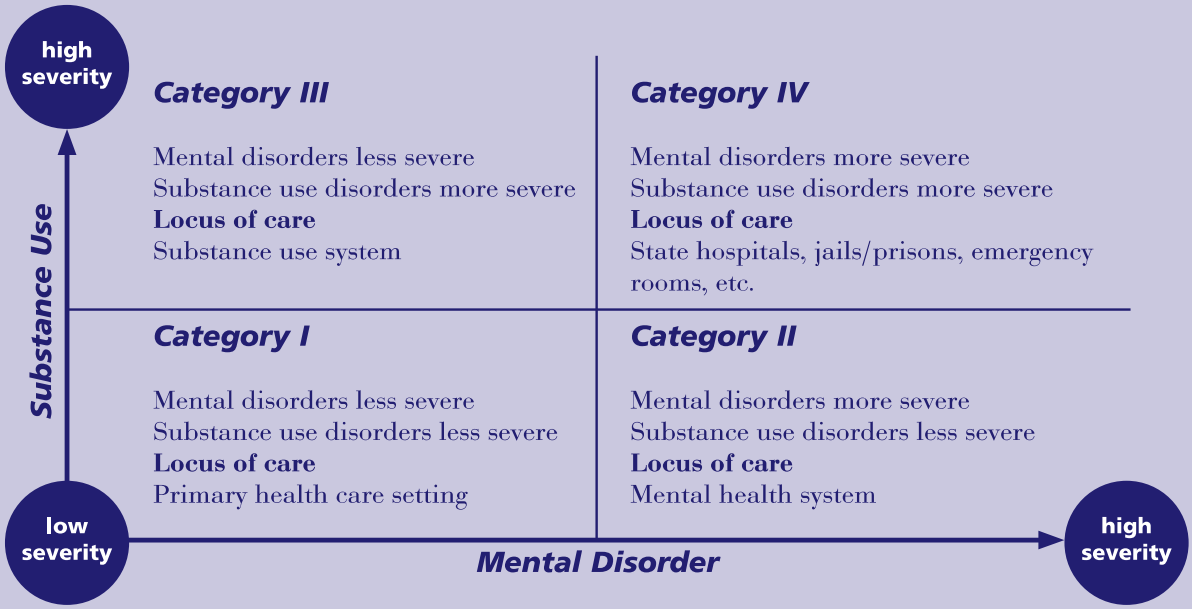
Modifications to clinical approaches and service elements to assist clients with mental disorders are essential. When financial or other limitations require the provision of care in separate settings, treatment services need to be coordinated assertively and efficiently.

Core treatment needs and service elements

Screening. All clients need to be screened for co-occurring psychiatric disorders to

Exhibit 9-2

SAMHSA's Service Coordination Framework for Co-Occurring Disorders



determine whether they have signs and symptoms warranting a comprehensive psychological assessment. These signs and symptoms may be subtle, and clients may minimize or deny symptoms because of fear of stigma.

Assessment. A thorough assessment should be performed either by a clinician trained in both areas or by clinicians from each field. On occasion, symptoms of acute or chronic alcohol and drug toxicity or withdrawal can mimic those of psychiatric disorders. The client should be observed closely for worsening conditions that warrant transfer to a more appropriate facility or to determine whether treatment for withdrawal symptoms is needed. Conversely, substance abuse can mask psychiatric symptoms, which may appear during the initial stages of abstinence. Programs should be organized around the premise that co-occurring disorders are common; assessment should proceed as soon as it is possible to distinguish the substance-induced symptoms from other independent conditions. Particular attention should be paid to the following:

- Psychiatric history of the client and family including diagnoses, previous treatment, and hospitalizations
- Current symptoms and mental status
- Medications and medication adherence
- Safety issues such as thoughts of suicide, self-harm, or harming others
- Severe psychiatric symptoms that result in the inability to function, communicate effectively, or care for oneself

This information can be augmented by objective measurement with assessment tools such as those described in the TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*e*).

Many programs have rigid guidelines for the initial mental health assessment and evaluation, including the initial psychopharmacology evaluation, such as requiring a certain length of abstinence. Programs should be flexible about assessment, removing these barriers when possible. Similarly, denial of access to evaluation or treatment for a substance use disorder because an individual is taking a prescribed psychotropic medication is inappropriate. Clients should continue taking medication for a serious mental disorder while being treated for their substance use disorders (Minkoff 2002).

Treatment engagement. Some clients with co-occurring psychiatric disorders, especially severe disorders, may have difficulty committing to and staying in treatment. Providing continuous support and outreach, assisting with immediate problems (such as housing), monitoring individual needs, and helping clients access services help develop a therapeutic treatment relationship. In the absence of such support, clients with co-occurring psychiatric disorders may be at high risk for dropping out (Drake and Mueser 2000).

Treatment planning. Factors to consider when developing a treatment plan for these clients include the client's psychiatric status, housing, social support, income, medication adherence, and symptom management. By understanding the client's strengths and goals, IOT program staff can develop a treatment plan that is consistent with the client's needs. Regular reassessments monitor the client's progress in both conditions and are the basis for adjustments to the treatment plan. Increased individual sessions and smaller group sizes also are indicated.

Referral. Clients with psychiatric disturbances that require secure inpatient treatment setting, 24-hour medical monitoring, or detoxification (such as clients who are actively suicidal or hallucinating) should be referred to a facility equipped to provide appropriate care. The American Society of Addiction Medicine provides placement criteria for clients with co-occurring psychiatric disorders (Mee-Lee et al. 2001).

Mental health care

Any IOT program that serves a significant number of clients with co-occurring psychiatric

disorders should include mental health specialists and psychiatric consultants on the treatment team.

Prescribing psychiatrist. It is ideal to have a psychiatrist with substance abuse treatment expertise on site to provide assessment and treatment services, on a full-time, part-time, or consultant basis (Charney et al. 2001). This approach overcomes problems with offsite referral such as the client's lack of transportation and the difficulty of working with another agency. However, when funding or other constraints prohibit providing mental health care services on site, other options are (1) employing a master's-level clinical specialist who can treat clients, consult with other staff members on mental disorders, and function as the liaison with psychiatric consultants or (2) establishing a working relationship with a mental health care agency to provide onsite care.

Medication provision and monitoring. Appropriate psychotropic medications are essential. Pharmacological advances over the past decade have resulted in medications with improved effectiveness and fewer side effects. Psychotropic medications stabilize clients, control their symptoms, and improve their functioning. The IOT program counselor can

- Refer the client to a psychiatrist or other mental health care provider for treatment evaluation.
- Help arrange appointments with the mental health care provider and encourage the client to keep them.
- Become familiar with common psychotropic medications, their indications, and their side effects.
- Instruct the client on the importance of complying with the medication regimen.
- Report symptoms and behavior to the prescribing psychiatrist and other staff members to assist in the determination of medication needs.
- Use peers or peer groups to monitor medication and to support the client's proper use of medication.
- Monitor side effects.

A helpful resource is *Psychotherapeutic Medications 2003: What Every Counselor Should Know* (Mid-America Addiction Technology Transfer Center 2000).

Collaboration with mental health care agencies

If circumstances prevent the provision of mental health care services in the IOT program, a collaborative relationship with a mental health agency can be established. One way to form this relationship is through an MOU that ensures that psychiatric services are adequate and comprehensive. The MOU specifies referral procedures, responsibilities of both parties, communication channels, payment requirements, emergency contacts, and other necessary procedures. TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), provides more information about setting up formal mechanisms for working with other agencies.

Case management services provide assistance with service coordination when clients with co-occurring disorders require treatment in two or more systems of care. TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998*a*), provides extensive details about case management.

Modified program structure

Treating clients with co-occurring psychiatric disorders in an IOT program often necessitates modifying the program structure or approach.

Separate treatment tracks in IOT. Separate tracks for clients with both disorders allow clients to be grouped together to address issues pertinent to them in group sessions. This arrangement particularly helps clients

with severe co-occurring psychiatric disorders. Establishing a separate track may entail organizational change as the agency modifies its scheduling, staffing, and training needs.

Staged approaches. Staged approaches provide successive interventions geared to the client's current stage of motivation and recovery and address varying levels of severity and disability of the co-occurring disorders (Drake et al. 1998*a*; Minkoff 1989). The model developed by Osher and Kofoed (1989) includes four overlapping stages—engagement, persuasion, active treatment, and relapse prevention—that integrate treatment principles from both fields. The model advocates treatment components consisting of low-intensity, highly structured programs; case management services; provision of appropriate detoxification; toxicology screening; family involvement; and participation in mutual-help groups. Other staged approaches are described in Minkoff (1989) and Prochaska and DiClemente (1992).

Working with clients with co-occurring psychiatric disorders

When mental and substance use disorders co-occur, both disorders require specific and appropriately intensive primary treatment and need to be individualized for each client according to diagnosis, phase of treatment, level of functioning, and assessment of level of care based on acuteness, severity, medical safety, motivation, and availability of recovery support (Minkoff 2002).

The treatment of clients with substance use and high-severity psychiatric disorders (schizophrenia or schizoaffective disorder) differs from the treatment of clients who have anxiety or mood disorders and a substance use disorder. Clients with severe disorders often are the most difficult to treat. Examples of approaches that attempt to integrate and modify psychiatric and substance abuse treatments to meet the needs of the client are (1) a skills-based approach, (2) dual-recovery therapy, (3) assertive community treatment, and (4) money-management therapy (Ziedonis and D'Avanzo 1998).

The treatment of clients with substance use and mood or anxiety disorders incorporates approaches such as cognitive–behavioral therapy, which addresses both disorders. Several other components, such as relaxation training, stress management, and skills training, are emphasized in the treatment of both types of disorders (Petrakis et al. 2002).

Some clients may have cognitive deficits that make it difficult for them to comprehend written material or to comply with program assignments. Materials can be adapted to express ideas and concepts simply and concretely, incorporating stepped assignments and using visual aids to reinforce information. TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998*e*), provides more information on accommodating clients with disabilities.

Pharmacological advances... have resulted in medications with improved effectiveness and fewer side effects.

The therapeutic relationship

Establishing a trusting, therapeutic relationship is essential during the engagement process and throughout treatment. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*e*), suggests the following guidelines for developing a therapeutic relationship with clients with both disorders:

- Maintain a belief that recovery is possible.
- Manage countertransference.

- Monitor psychiatric symptoms.
- Provide additional structure and support.
- Use supportive and empathic counseling.
- Use culturally appropriate methods.

The clinician's ease in establishing and maintaining a therapeutic alliance is affected by comfort with the client. IOT program clinicians may find working with some clients with psychiatric illnesses unsettling or feel threatened by them and may have difficulty forming a therapeutic alliance with them. Consultation with a supervisor is important, and with experience, training, supervision, and mentoring, the problem can be overcome.

Confrontational approaches may be ineffective for clients with co-occurring psychiatric disorders because they may be unable to tolerate stressful interpersonal challenges. When counseling clients with co-occurring psychiatric disorders, it is helpful if the counselor is empathic and firm at the same time. By setting limits on negative behaviors, counselors provide structure for clients. Another assertive intervention involves counselors' supplying feedback that consists of a straightforward and factual presentation of the client's conflicting thoughts or problem behavior. Provided in a caring manner, such feedback can be both "confrontive" and caring. The ability to do this well is often critical in maintaining the therapeutic alliance with a client who has co-occurring psychiatric disorders (see chapter 5 in TIP 42 [CSAT 2005*e*]). TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*c*, p. 41), provides more information.

Group treatment... is used widely and effectively with clients with co-occurring disorders.

Clients with co-occurring psychiatric disorders may become demoralized and despairing because of the complexity of having two disorders and the slow pace of improvement in symptoms and functioning. Inspiring hope is a necessary task of the IOT program clinician. Some suggestions include

- Demonstrating an understanding and acceptance of the client
- Helping the client clarify the nature of his or her difficulties
- Communicating to the client that the clinician will help the client help himself or herself
- Expressing empathy and a willingness to listen to the client
- Assisting the client in solving external problems immediately
- Fostering hope for positive change

Group treatment

Group treatment, a mainstay of IOT, is used widely and effectively with clients with co-occurring disorders (Weiss et al. 2000), including clients with schizophrenia (Addington and el-Guebaly 1998). Several approaches can be used: 12-Step based, educational, supportive, and social skills improvement. These group interventions have demonstrated success in increasing treatment engagement and abstinence rates and decreasing the need for hospitalization (Drake et al. 1998*a*). Some examples of groups follow:

- **Psychoeducational groups** increase clients' awareness of both problems in a safe and positive environment.
- **Psychiatric disorders groups** present topics such as signs and symptoms of mental disorders, use of medications, and the effects of mental disorders on substance use problems.
- **Medication management groups** provide a forum for clients to learn about medication and its side effects and help the counselor develop solutions to compliance problems.
- **Social skills training groups** provide opportunities to learn how to handle

common social situations by teaching clients to solicit support, develop drug and alcohol refusal skills, and develop effective strategies to cope with pressures to discontinue their prescribed psychiatric medication. Group participants role play situations and practice appropriate responses. Reinforcing the difference between substances of abuse and treatment medications is another simple but important activity of these groups.
- **Onsite support groups** are led by an IOT staff facilitator and provide an arena for discussing problems and practicing new coping skills.

Group treatment may need to be modified and augmented with individual counseling sessions for clients with both disorders. The clients' ability to participate in counseling depends on their level of functioning, stability of symptoms, response to medication, and mental status. Some clients cannot tolerate the emotional intensity of interpersonal interactions in group sessions or may have difficulty focusing or participating. Many clients with a serious mental illness (schizophrenia, schizoid and paranoid personality) have difficulty participating in groups but can be incorporated gradually into a group setting at their own pace. Clients with less severe psychiatric disorders may have little problem participating in group sessions. Some suggestions for working with groups of clients with co-occurring disorders include

- Orally communicate in a brief, simple, concrete, and repetitive manner.
- Affirm accomplishments instead of using disapproval or sanctions.
- Address negative behavior rapidly in a positive manner.
- Be sensitive and responsive to needs of the client.
- Shorten sessions.
- Organize smaller groups.
- Use more focused, but gentle directional techniques.

Mutual-help groups in the community

The consensus panel encourages the use of "double trouble" mutual-help recovery groups for people with co-occurring psychiatric disorders. Because all attendees have a co-occurring psychiatric disorder, they are less likely to be subject to the misunderstanding and conflicting messages about their psychiatric symptoms or use of psychotropic medications that sometimes occur in traditional 12-Step-oriented groups (Magura et al. 2003). These groups do not provide clinical or counseling interventions; members help one another achieve and maintain recovery and be responsible for their personal recovery.

Various dual recovery organizations have been established by people in recovery and usually are based on the AA model but adapted for people with both disorders, including

- Double Trouble in Recovery (www.doubletroubleinrecovery.org)
- Dual Disorders Anonymous
- Dual Recovery Anonymous (www.draonline.org)
- Dual Diagnosis Anonymous

The research on traditional 12-Step groups is not definitive, but attendance at such groups may be beneficial for some clients with co-occurring psychiatric disorders (Kelly et al. 2003). However, clients with severe mental disorders may have difficulty attending these groups (Jordan et al. 2002). Some people with co-occurring disorders attend both dual disorder and traditional mutual-help groups (Laudet et al. 2000*b*). In one study, most AA respondents had positive attitudes toward people with co-occurring disorders and 93 percent indicated that such individuals should continue taking their psychotropic medications (Meissen et al. 1999). AA has published *The A.A. Member—Medications and Other Drugs* (Alcoholics Anonymous World Services 1991), a helpful booklet that discusses AA members' use of

medications when prescribed by a physician knowledgeable about alcoholism (visit www.alcoholics-anonymous.org to order).

Relapse prevention

In addition to learning techniques to prevent relapse to substance abuse, clients with co-occurring psychiatric disorders may benefit from learning to recognize worsening psychiatric symptoms, manage symptoms, or seek support from a "buddy" or a mutual-help group. Some providers suggest that clients keep "mood logs" to increase their awareness of how they feel and the situational factors that trigger negative feelings or symptoms. Other techniques include affect or emotion management, including how to identify, contain, and express feelings appropriately. Several relapse prevention interventions for clients with both disorders have been developed (Evans and Sullivan 2000; Weiss et al. 2000).

Other issues

Family education and support. Clients with co-occurring disorders frequently have unsatisfactory relationships with their families. Some clients with psychiatric disorders remain dependent on their families for an extended period, creating complicated family dynamics. Other clients may be estranged from or have strained relationships with family members, partners, or children. Groups for family members can be a venue for education and support. Psychoeducation combines fundamental information, guidance, and support and allows for low-key engagement and continued assessment opportunities. Family members and significant others need to understand the implications of both disorders and the ways that one disorder, if not properly monitored and treated, can worsen the symptoms of the other.

At times more intensive family intervention may require removing clients from stressful family relationships and helping them toward independence. Some families may be in need of intensive family therapy and should be referred for appropriate care.

Peer networks. Developing supportive peer networks to replace friends who use substances is an important component of recovery and needs to be addressed in treatment. When a client's family is not supportive, other, more supportive networks can be sought.

Discharge planning and continuing care

Because people with co-occurring psychiatric disorders have two chronic conditions, they often require long-term care that supports their progress and can respond quickly to a relapse of either disorder. Some clients may need to continue intensive mental health care but can manage their substance use disorder by participation in support groups. Other clients may need minimal mental health care but require some form of continued formal substance abuse treatment. Participation in continuing care tends to improve treatment outcomes (Moggi et al. 1999).

Cross-Training

Ideally, an interdisciplinary staff that provides both substance abuse treatment and psychiatric services works as an integrated unit, and providers have training and expertise in both fields. Cross-training about the differing views of treatment and challenges helps staff members from both fields reach a common perspective and approach for treating clients with co-occurring psychiatric disorders.

A helpful training resource is the Mid-America Addiction Technology Transfer Center's *A Collaborative Response: Addressing the Needs of Consumers With Co-Occurring Substance Use and Mental Health Disorders*, an eight-session curriculum designed to promote a cross-disciplinary understanding between mental and substance use disorder clinicians (available at

www.mattc.org). SAMHSA's *Strategies for Developing Treatment Programs for People With Co-Occurring Substance Abuse and Mental Disorders* (Substance Abuse and Mental Health Services Administration 2003) provides information on starting a program for treating people with both disorders.

Adolescents

It is important to recognize that youth are not little adults, and IOT for adolescents should differ from that provided for adult populations (Deas et al. 2000). Adolescents experience many developmental changes, may require habilitation rather than rehabilitation, may be considered dependents legally, and may require parental consent for treatment.

Treatment for adolescents requires a comprehensive approach that addresses their social, medical, and psychological needs. The best candidates for adolescent IOT are youth who are experiencing problems as a result of recent, moderate-to-heavy use of legal or illegal substances, who have functional but ineffective coping skills, and who need a marginally structured setting, not complete removal from their living situation (CSAT 1999*f*).

TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999*d*), and TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT 1999*f*), provide additional information about screening and treating adolescents for substance abuse.

Description of the Population

Developmental changes

Adolescence is a period characterized by physical, emotional, and cognitive changes. Developmental tasks include the many transformations that move adolescents from childhood to adulthood. Physical changes include rapid growth, development of secondary sex characteristics, and fluctuations in hormonal levels. Cognitively, adolescents often have shorter attention spans than adults, have limited perspectives on the future, may be inconsistent in applying abstract thinking skills, and may be impulsive. During adolescence, morals, values, and ideals continue to develop, and intellectual interests expand. During late adolescence, youth become more introspective and sensitive to the consequences of their actions (CSAT 1999*f*) and improve their capacity for setting goals.

IOT for adolescents should differ from that provided for adult populations.

Development of substance abuse in adolescents

Many factors are associated with the onset of substance use problems in adolescents including genetic background, parental substance use and troubled family relations, individual characteristics such as cognitive dysfunction, and to some extent peer influence (Weinberg et al. 1998). Risk factors for developing a substance use disorder include a history of personality problems such as aggression or an affective disorder, school failure, distant or hostile relations with parents or guardians, family disruption, or a history of victimization (Weinberg et al. 1998).

Implications for IOT

Adolescents reach IOT by a number of paths, including parental request, school referral, and juvenile justice system mandate. The IOT provider must be prepared to meet developmental, family, psychiatric, behavioral, and other treatment challenges that may resemble those of adult clients only superficially.

Adolescents need thorough biopsychosocial, medical, and psychological assessments and may need educational, medical, mental health, and social services. Unlike adult clients, adolescents are likely to be entering treatment for the first time, may have little knowledge of the treatment process, and need more orientation than adults.

The assessment process involves a comprehensive evaluation of the adolescent's risks, needs, strengths, and motivation. Psychosocial assessment instruments appropriate for adolescents should be used. Information to gather includes school records, class schedule, and school involvement; relationships with peers; sexual activity and pressures; relationship with family members; mental and physical health status; history of abuse and trauma; and involvement with the juvenile justice system.

Family assessment

The adolescent's family consists of the main caregivers (usually parents) and anyone the client considers family. Family issues to assess include family structure and functioning, financial and housing statuses, substance use history and treatment episodes, mental and physical health, the family's feelings about the adolescent, and family members' problems with violence and involvement in the legal system. The strengths and resources available to the family need to be identified as well. IOT program staff members may want to interview the adolescent in private initially and then meet with family members.

Psychiatric assessment

Every client can benefit from a thorough psychiatric assessment by a mental health professional trained in adolescent care. As many as 60 percent of adolescents with a substance use disorder also have co-occurring psychiatric disorders (Armstrong and Costello 2002), such as anxiety, mood disorders (Kandel et al. 1999), or attention deficit/hyperactivity disorder (Weinberg et al. 1998). Adolescents should be assessed for suicide risk as well.

Diagnosis

Although some adolescents may meet the diagnostic criteria for substance dependence, many are in the early stage of involvement with alcohol or drugs. The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (American Psychiatric Association 2000) does not contain diagnostic criteria specific to adolescent substance dependence, and some adult diagnostic criteria, such as withdrawal symptoms and alcohol-related medical problems, present differently in adolescents. For these reasons, the DSM criteria have limitations when applied to adolescents (Martin and Winters 1998).

Clinical Issues and Strategies

Family involvement

Because outpatient family therapy may offer benefits superior to other outpatient treatments (Williams et al. 2000), IOT providers are encouraged to work with the family as much as possible. Chapter 6 on family therapy in this TIP and TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004*c*), provide more information.

Engaging the family. The IOT counselor can engage family members by

- Emphasizing how critical family members are to the adolescent's recovery
- Requiring (whenever possible) that a family member accompany the adolescent to the initial intake interview and including time for the family assessment during that meeting
- Encouraging family attendance at the program's family education and therapy sessions

- Helping family members participate in developing and reinforcing the behavioral contract (see below)
- Supporting family members in encouraging the adolescent to attend treatment

Treatment of the family. Family-oriented interventions have long been used to treat adolescents who abuse substances. Szapocznik and colleagues (1983, 1986) helped establish the effectiveness of family therapy in treating adolescents. The premise of family therapy is that the family plays a role in creating conditions leading to adolescent drug use and that family elements help adolescents recover (Liddle et al. 2001). Evidence shows that youth who receive family therapy have less drug use at treatment completion than those who receive peer group therapy or whose families participate in parent education or a multifamily intervention (Liddle et al. 2001).

Some family-based approaches are as follows:

- Multidimensional family therapy and multisystemic therapy expand classic family therapy models to focus on promoting change in four areas: (1) the adolescent, (2) family members, (3) family interaction patterns, and (4) influences from outside the family (Liddle 1999, 2002).
- Family cognitive–behavioral therapy integrates traditional family systems theory with techniques of cognitive–behavioral therapy. This approach considers adolescent substance abuse as a conditioned behavior that is reinforced by cues and contingencies within the family (Latimer et al. 2003).
- The adolescent community reinforcement approach focuses on teaching adolescents coping skills and changing environmental influences related to continued substance use (Godley et al. 2001).
- The family support network intervention increases parental support of an adolescent's recovery through developing a support group for parents, provides home therapy sessions combined with group sessions, and can be used with any standard adolescent treatment approach (Hamilton et al. 2001).
- The family intervention program (see exhibit 9-3) addresses many problems experienced by families with an adolescent who uses substances. It includes the family and systems that affect the family, such as schools and the community.

As many as 60 percent of adolescents with a substance use disorder also have co-occurring psychiatric disorders...

The behavioral contract

Adolescents who abuse substances may behave in disruptive, destructive, or sometimes criminal ways, such as skipping school, having poor school performance, violating curfew, being argumentative with or withdrawing from family members, joining gangs, or committing crimes.

To address these behaviors, a behavioral contract can be a valuable therapeutic tool. The clinician works with the adolescent (and his or her family) to develop a contract that specifies treatment goals, acceptable and unacceptable behaviors, and the rewards or consequences associated with each.

The conditions defined in the contract help the youth and the family understand the treatment process and what is expected of them. Once the contract is completed, the client and each family member indicate their agreement by signing the contract. IOT program staff uses the contract to guide discussions during family group sessions, to monitor progress, and to minimize the undermining of treatment by family members.

Exhibit 9-3

The Family Intervention Program

This approach partners a family therapist with a community resource specialist. The specialist helps the family establish healthy community networks. Working as a team, the therapist and specialist conduct five family therapy sessions and perform the following:

1. Assess the family system; explore the family's resources, concerns, and goals; and create a treatment plan.
2. Explore relationships among family members, identify areas of difficulty and stress, and determine the effect on the family system.
3. Determine the effect of other systems, such as schools, on the family.
4. Focus on the family's concerns and goals and include others who can help resolve problems.
5. Work on how the family can resolve issues without staff help and develop a followup plan.

Source: Fishman and Andes 2001.

Case management services for adolescents

The IOT provider may need to provide extensive case management services. The case manager works with schools to monitor a youth's compliance with the behavioral contract; coordinates medical, mental health, and social services; and works with the juvenile justice system, if needed. Caseloads are best kept to about 8 to 10 adolescents per staff member.

Group work strategies for adolescents

Treating adolescents involves bringing together youth from different areas, backgrounds, and developmental levels. Many practitioners recommend, if possible, that the groups consist of adolescents of the same gender, with similar levels of motivation for change, and of similar age. Clients in middle-to-late adolescence (ages 16 to 18) usually have different life experiences, developmental levels, and concerns than do younger adolescents. There is limited evidence of the effectiveness of treating adolescents in groups, perhaps because of the complexities just mentioned. The consensus panel reports that, with this population, approaches emphasizing structured discussions around a topic introduced by the counselor are more successful than open-ended sessions. Same-gender groups can provide a safe environment in which to explore such issues as sexuality, intimacy, self-esteem, and relationships. If programs do not have enough adolescent clients to have a treatment group, a gender-specific group session can be held weekly to discuss sensitive issues.

To foster productive group work, it is helpful to enforce clear, specific, concrete rules. IOT program staff can post the rules in the session room and ask each participant to sign a copy. Rules should prohibit bullying and teasing. Groups also commonly prohibit nostalgic stories of substance use.

Group members frequently are asked to sign a confidentiality statement promising that information shared in the group will not be repeated outside group. Other suggestions for treating adolescents in groups are

- Including activities and keeping discussions short
- Varying session content, activity level, and purpose
- Including frequent breaks

CSAT's Cannabis Youth Treatment Series offers many specific ideas for use with adolescents (Godley et al. 2001; Hamilton et al. 2001; Liddle 2002; Sampl and Kadden 2001; Webb et al. 2002).

A co-counselor is helpful in running groups for adolescents because of the complexity of adolescent issues and behavior management challenges.

Clinical considerations

Providing incentives acknowledges the efforts of youth and encourages them to persevere. Incentives should be meaningful to the youth, such as gift certificates from a music store, movie theater, or clothing store.

Other key points about treating adolescents include the following:

- A cognitive–behavioral model and motivational enhancement techniques are useful.
- Not all adolescents who use substances are dependent, and prematurely diagnosing or labeling adolescents or pressuring them to accept that they have an addictive disease may not work.
- Many adolescents respond better to motivational interviewing than to confrontation.

Exhibit 9-4 lists characteristics and behaviors of adolescents in treatment and practical treatment suggestions.

Staff Training

IOT program staff members need to understand adolescent development and treatment needs. Clinicians working with youth should

- Be flexible and able to interact warmly with adolescents.
- Observe clear and appropriate personal boundaries.
- Be able to set firm behavioral limits in a nonjudgmental or nonpunitive manner.
- Know about the substances and combinations that adolescents use, the slang in use, and the physical and behavioral effects of any new drugs.
- Have substantial knowledge of the school system.
- Understand family dynamics.

Core program staff members should include a clinical coordinator who is trained in adolescent treatment. Skills development training for staff should occur regularly on topics appropriate for adolescent treatment.

Young Adults

Some caregivers may find it difficult to recognize or accept that young adults (ages 18 to 24) are no longer legal dependents. Even though a youth still may live at home or be in school, parental responsibility changes and the young adult can make his or her own choices. Counselors may find that they need to help both the young adult client and parents realize that the client can make choices and is responsible for actions. Some young adult clients may be totally on their own, with little family contact.

The use of alcohol or drugs at an early age may have delayed normal development. Although these young clients are legally adults, they may not have grown into young adult social roles.

The young adult may be ready clinically for placement in an adult treatment group or may be placed more appropriately in an adolescent program. A thorough assessment is needed to determine appropriate placement.

IOT Programming for Young Adults

To engage and retain these clients, IOT programming can incorporate techniques used in adolescent programs. To involve young adult clients in treatment, it is important to

Exhibit 9-4

Characteristics and Behaviors of Adolescents and Treatment Suggestions

Characteristics and Behaviors of Adolescents in Treatment	Suggestions for Improving the Treatment Experience for Adolescents
Inconsistent ability for abstract thinking	Limit abstract, future-oriented activities Use mentors Avoid scare tactics and labels
Impulsive, often with short attention spans	Design activities to teach self-control skills; allow practice time
Need to belong and identify with others; vulnerability to peer influence	Create opportunities for group members to bond Help clients establish positive peer groups and develop skills in resisting negative peer pressure Promote positive peer feedback in group
Frequent emotional fluctuations	Validate feelings Acknowledge the pressures and stresses of adolescence Help youth improve stress management skills
Lack of involvement in healthy recreational activities	Help clients develop daily schedules Help youth find new recreational activities not involving substance use such as games, sports, hobbies, and religious or spiritual groups
Tendency toward pessimistic or fatalistic attitudes	Recognize fatalist attitudes such as "I'm going to die soon, anyway," and "Drugs are the only way out for me" Validate clients' anger, hopelessness, or perceived obstacles to success, but challenge youth to think positively

reach out to them through family, colleges, employers, and the court system. Treatment should be relevant to young adult concerns, interests, and social activities and be flexible enough to adapt to the client's developmental deficits. The following issues are relevant:

- **Education and employment.** Educational and job skill levels need to be assessed and addressed. Some clients who have grown up in poverty have witnessed the futility of working at a low-paying job versus the financial benefits of selling illicit drugs. These clients need special attention.
- **Family roles.** Some clients may have children and family responsibilities and need assistance in obtaining child care and developing parenting skills.
- **Separating from parents.** Young adults in treatment often have parents who are unwilling to set limits, which fosters dependence and intense attachment on the part of the clients. Parents need to understand that their enabling behavior is a barrier to their young adult's recovery. Young adult clients often require life skills development. Treatment should focus on habilitation, rather than rehabilitation.
- **Peer relationships.** Some clients may need assistance in developing and maintaining healthy peer networks and family relationships.
- **Mentoring.** A positive adult role model provides a meaningful example.
- **Community service.** Young adults in treatment can contribute to society and should be encouraged to participate in and volunteer for community or faith-based events.

10 Addressing Diverse Populations in Intensive Outpatient Treatment

In This Chapter...

What It Means To Be a Culturally Competent Clinician

Principles in Delivering Culturally Competent IOT Services

Issues of Special Concern

Clinical Implications of Culturally Competent Treatment

Sketches of Diverse IOT Client Populations

Intensive outpatient treatment (IOT) programs increasingly are called on to serve individuals with diverse backgrounds. Roughly one-third of the U.S. population belongs to an ethnic or racial minority group. More than 11 percent of Americans, the highest percentage in history, are now foreign born (Schmidley 2003).

Culture is important in substance abuse treatment because clients' experiences of culture precede and influence their clinical experience. Treatment setting, coping styles, social supports, stigma attached to substance use disorders, even whether an individual seeks help—all are influenced by a client's culture. Culture needs to be understood as a broad concept that refers to a shared set of beliefs, norms, and values among any group of people, whether based on ethnicity or on a shared affiliation and identity.

In this broad sense, substance abuse treatment professionals can be said to have a shared culture, based on the Western worldview and on the scientific method, with common beliefs about the relationships among the body, mind, and environment (Jezewski and Sotnik 2001). Treating a client from outside the prevailing United States culture involves understanding the client's culture and can entail mediating among U.S. culture, treatment culture, and the client's culture.

This chapter contains

- An introduction to current research that supports the need for individualized treatment that is sensitive to the client's culture
- Principles in the delivery of culturally competent treatment services
- Topics of special concern, including foreign-born clients, women from other cultures, and religious considerations
- Clinical implications of culturally competent treatment
- Sketches of diverse client populations, including
  - Hispanics/Latinos
  - African-Americans
  - Native Americans

  - Asian Americans and Pacific Islanders
  - Persons with HIV/AIDS
  - Lesbian, gay, and bisexual (LGB) populations
  - Persons with physical and cognitive disabilities
  - Rural populations
  - Homeless populations
  - Older adults

- Resources on culturally competent treatment for various populations

What It Means To Be a Culturally Competent Clinician

It is agreed widely in the health care field that an individual's culture is a critical factor to be considered in treatment. The Surgeon General's report, *Mental Health: Culture, Race, and Ethnicity*, states, "Substantive data from consumer and family self-reports, ethnic match, and ethnic-specific services outcome studies suggest that tailoring services to the specific needs of these [ethnic] groups will improve utilization and outcomes" (U.S. Department of Health and Human Services 2001, p. 36). The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) (American Psychiatric Association 1994) calls on clinicians to understand how their relationship with the client is affected by cultural differences and sets up a framework for reviewing the effects of culture on each client.

Mental Health: Culture, Race, and Ethnicity is the first comprehensive report on the status of mental health treatment for minority groups in the United States. This report synthesizes research data from a variety of disciplines and concludes that

- Disparities in mental health services exist for racial and ethnic minorities. These groups face many barriers to availability, accessibility, and use of high-quality care.
- The gap between research and practice is worse for racial and ethnic minorities than for the general public, with problems evident in both research and practice settings. No ethnic-specific analyses have been done in any controlled clinical trials aimed at developing treatment guidelines.
- In clinical practice settings, racial and ethnic minorities are less likely than Whites to receive the best evidence-based treatment. (It is worth noting, however, that given the requirements established by funders and managed care, clients at publicly funded facilities are perhaps *more* likely than those at many private treatment facilities to receive evidence-based care.)

Because verbal communication and the therapeutic alliance are distinguishing features of treatment for both substance use and mental disorders, the issue of culture is significant for treatment in both fields. The therapeutic alliance should be informed by the clinician's understanding of the client's cultural identity, social supports, self-esteem, and reluctance about treatment resulting from social stigma. A common theme in culturally competent care is that the treatment provider—not the person seeking treatment—is responsible for ensuring that treatment is effective for diverse clients.

Meeting the needs of diverse clients involves two components: (1) understanding how to work with persons from different cultures and (2) understanding the specific culture of the person being served (Jezewski and Sotnik 2001). In this respect, being a culturally competent clinician differs little from being a responsible, caring clinician who looks past first impressions and stereotypes, treats clients with respect, expresses genuine interest in clients as individuals, keeps an open mind, asks questions of clients and other providers, and is willing to learn.

This chapter cannot provide a thorough discussion of attributes of people from various cultures and how to attune treatment to those attributes. The information in this

chapter provides a starting point for exploring these important issues in depth. More detailed information on these groups, plus discussions of substance abuse treatment considerations, is found in the resources listed in appendix 10-A (page 197). The following resources may be especially helpful in understanding the broad concepts of cultural competence:

- *Mental Health: Culture, Race, and Ethnicity* (U.S. Department of Health and Human Services 2001) (www.mentalhealth.org/cre/default.asp). Chapter 2 discusses the ways in which culture influences mental disorders and mental health services. Subsequent chapters explain the historical and sociocultural context in which treatment occurs for four major groups—African-Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic/Latino Americans.
- Chapter 4 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*). This chapter describes steps that an IOT administrator can take to prepare an IOT organization to treat diverse clients more competently and sensitively. Chapter 4 also lists resources not found in the appendix at the end of this chapter.
- The forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT forthcoming *a*) includes an in-service training guide.

Principles in Delivering Culturally Competent IOT Services

The Commonwealth Fund Minority Health Survey found that 23 percent of African-Americans and 15 percent of Latinos felt that they would have received better treatment if they were of another race. Only 6 percent of Whites reported the same feelings (La Veist et al. 2000). Against this backdrop, it clearly is important for providers to have a genuine understanding of their clients from other cultures, as well as an awareness of how personal or professional biases may affect treatment.

Most IOT counselors are White and come from the dominant Western culture, but nearly half of clients seeking treatment are not White (Mulvey et al. 2003). This stark fact supports the argument that clinicians consider treatment in the context of culture. Counselors often feel that their own social values are the norm—that their values are typical of all cultures. In fact, U.S. culture differs from most other cultures in a number of ways. IOT clinicians and program staff members can benefit from learning about the major areas of difference and from understanding the common ways in which clients from other cultures may differ from the dominant U.S. culture.

> ...an individual's culture is a critical factor to be considered in treatment.

Treatment Principles

Members of racial and ethnic groups are not uniform. Each group is highly heterogeneous and includes a diverse mix of immigrants, refugees, and multigenerational Americans who have vastly different histories, languages, spiritual practices, demographic patterns, and cultures (U.S. Department of Health and Human Services 2001).

For example, the cultural traits attributed to Hispanics/Latinos are at best generalizations that could lead to stereotyping and alienation of an individual client. Hispanics/Latinos are not a homogeneous group. For example, distinct Hispanic/Latino cultural groups—Cuban Americans, Puerto Rican Americans, Mexican Americans, and Central and South Americans—do not think and act

alike on every issue. How recently immigration occurred, the country of origin, current place of residence, upbringing, education, religion, and income level shape the experiences and outlook of every individual who can be described as Hispanic/Latino.

Many people also have overlapping identities, with ties to multiple cultural and social groups in addition to their racial or ethnic group. For example, a Chinese American also may be Catholic, an older adult, and a Californian. This individual may identify more closely with other Catholics than with other Chinese Americans. Treatment providers need to be careful not to make facile assumptions about clients' culture and values based on race or ethnicity.

Culture is only a starting point for exploring an individual's perceptions, values, and wishes.

To avoid stereotyping, clinicians must remember that each client is an individual. Because culture is complex and not easily reduced to a simple description or formula, generalizing about a client's culture is a paradoxical practice. An observation that is accurate and helpful when applied to a large group of people may be misleading and harmful if applied to an individual. It is hoped that the utility of offering broad descriptions of cultural groups outweighs the potential misunderstandings. When using the information in this chapter, counselors need to find a balance between understanding clients in the context of their culture and seeing clients as merely an extension of their culture. Culture is only a starting point for exploring an individual's perceptions, values, and wishes. How strongly individuals share the dominant values of their culture varies and depends on numerous factors, including their education, socioeconomic status, and level of acculturation to U.S. society.

Differences in Worldview

A first step in mediating among various cultures in treatment is to understand the Anglo-American culture of the United States. When compared with much of the rest of the world, this culture is materialistic and competitive and places great value on individual achievement and on being oriented to the future. For many people in U.S. society, life is fast paced, compartmentalized, and organized around some combination of family and work, with spirituality and community assuming less importance.

Some examples of this worldview that differ from that of other cultures include

- **Holistic worldview.** Many cultures, such as Native-American and Asian cultures, view the world in a holistic sense; that is, they see all of nature, the animal world, the spiritual world, and the heavens as an intertwined whole. Becoming healthy involves more than just the individual and his or her family; it entails reconnecting with this larger universe.
- **Spirituality.** Spiritual beliefs and ceremonies often are central to clients from some cultural groups, including Hispanics/Latinos and American Indians. This spirituality should be recognized and considered during treatment. In programs for Native Americans, for example, integrating spiritual customs and rituals may enhance the relevance and acceptability of services.
- **Community orientation.** The Anglo-American culture assumes that treatment focuses on the individual and the individual's welfare. Many other cultures instead are oriented to the collective good of the group. For example, individual identity may be tied to one's forebears and descendants, with their welfare considered in making decisions. Asian-American and Native-American clients may care more about how the substance use disorder

harms their family group than how they are affected as individuals.

- **Extended families.** The U.S. nuclear family consisting of parents and children is not what most other cultures mean by family. For many groups, family often means an extended family of relatives, including even close family friends. IOT programs need a flexible definition of family, accepting the family system as it is defined by the client.
- **Communication styles.** Cultural misunderstandings and communication problems between clients and clinicians may prevent clients from minority groups from using services and receiving appropriate care (U.S. Department of Health and Human Services 2001). Understanding manifest differences in culture, such as clothing, lifestyle, and food, is not crucial (with the exception of religious restrictions on dress and diet) to treating clients. It often is the invisible differences in expectations, values, goals, and communication styles that cause cultural differences to be misinterpreted as personal violations of trust or respect. However, one cannot know an individual's communication style or values based on that person's group affiliation (see appendix 10-A for more information and resources on cross-cultural communication).
- **Multidimensional learning styles.** The Anglo-American culture emphasizes learning through reading and teaching. This method sometimes is described as linear learning that focuses on reasoned facts. Other cultures, especially those with an oral tradition, do not believe that written information is more reliable, valid, and substantial than oral information. Instead, learning often comes through parables and stories that interweave emotion and narrative to communicate on several levels at once. The authority of the speaker may be more important than that of the message. Expressive, creative, and nonverbal interventions that are characteristic of a specific cultural group can be helpful in treatment. Cultures with this kind of rich oral tradition and learning pattern include Hispanics/Latinos, African-Americans, American Indians, and Pacific Islanders.

Common issues affecting the counselor–client relationship include the following:

- **Boundaries and authority issues.** Clients from other cultures often perceive the counselor as a person of authority. This may lead to the client's and counselor's having different ideas about how close the counselor–client relationship should be.
- **Respect and dignity.** For most cultures, particularly those that have been oppressed, being treated with respect and dignity is supremely important. The Anglo-American culture tends to be informal in how people are addressed; treating others in a friendly, informal way is considered respectful. Anglo Americans generally prefer casual, informal interactions even when newly acquainted. However, some other cultures view this informality as rudeness and disrespect. For example, some people feel disrespected at being addressed by their first names.
- **Attitudes toward help from counselors.** There are wide differences across cultures concerning whether people feel comfortable accepting help from professionals. Many cultures prefer to handle problems within the extended family. The clinician and client also may harbor different assumptions about what a clinician is supposed to do, how a client should act, and what causes illness (U.S. Department of Health and Human Services 2001).

Issues of Special Concern

The IOT consensus panel recommends that IOT programs look at the following areas of special concern:

- Whether the program is prepared to adequately serve foreign-born clients living within their catchment area

- Whether the special needs of their minority or foreign-born women clients are being addressed adequately
- Whether the program needs to make any content adjustments out of respect for the religious orientation of current or potential clients

Foreign-Born Clients

In 2002, according to the U.S. Census Bureau, about 32.5 million U.S. residents were foreign born, of whom 52 percent came from Latin America and 26 percent from Asia (Schmidley 2003). Eleven percent were born in another country and may be speaking or learning English as a second language. Migration is a stressful life event, and immigrants are at risk for substance abuse because of stress, isolation, and the lack of social support they experience in adjusting to their new country.

The reason for a person's immigration is considered an important factor in the level of stress that immigrants experience as they settle into a new life. Refugees typically have been forced to abandon their countries and former lives, leaving their belongings behind, to relocate to a different and sometimes unwelcoming new world in which language, social structures, and community resources may be totally unfamiliar (Jezewski and Sotnik 2001). This displacement can be particularly difficult for older refugees.

Clinical considerations

Having a personal history of abuse and trauma is recognized as a major factor in substance use disorders and in the inability to maintain recovery. A large percentage of Asian-American and Hispanic-American immigrants show clinical evidence of posttraumatic stress disorder (PTSD) as a result of exposure to severe trauma, such as genocide, war, torture, or extreme threat of death or serious injury (U.S. Department of Health and Human Services 2001). In some samples, up to 70 percent of refugees from Vietnam, Cambodia, and Laos met diagnostic criteria for PTSD, compared with about 4 percent with a prevalence for PTSD in the U.S. population as a whole (U.S. Department of Health and Human Services 1999). For this reason, treatment for foreign-born clients often needs to address both substance use and the client's background of abuse and violence.

Other clinical issues include the following:

- **Mistrust of authority.** Immigrants and refugees from many regions of the world feel extreme mistrust of government based on the atrocities committed in their countries of origin or fear of deportation by U.S. authorities. This mistrust can be a barrier to entering treatment and to obtaining services.
- **Extreme sense of stigma.** Clients from other cultures view mental disorders, including substance abuse, much more negatively than does the general U.S. population (U.S. Department of Health and Human Services 1999). In some Asian cultures, this stigma is so strong that a person's substance dependence is thought to reflect poorly on the family lineage, diminishing the marriage and economic prospects for the client and for other family members.
- **Level of acculturation.** Providers should take into account a client's level of acculturation in assessment and treatment. Generally speaking, foreign-born persons have rates of substance use lower than U.S.-born counterparts; the more acculturated the person is to the United States, the more that person's use approaches U.S. substance-using norms. Among Hispanics/Latinos, substance use disorders are less frequent in those who were born outside the United States (Turner and Gil 2002). For example, foreign-born Cuban Americans have lower lifetime use of alcohol and start drinking later in life than do U.S.-born Cuban Americans (Vega et al. 1993). However, being born in the United States does not mean necessarily that a

person is acculturated. In a later study, Vega and colleagues (1998) found that the highest rates of substance abuse among Hispanic/Latino adolescents were seen in those who were born in the United States but had low acculturation levels. The researchers attributed these results to the fact that these adolescents faced the language problems of foreign-born Hispanics/Latinos and the acculturation conflicts of U.S.-born Hispanics/Latinos.

Implications for IOT providers

IOT providers who want to reach out to foreign-born clients in their community and serve them better should become more knowledgeable about the history and experiences of the newcomers. One way to start is by researching and reading about these cultural groups. Providers also should get to know newcomer populations by visiting community refugee and immigrant organizations, such as their Mutual Assistance Associations. Representatives of these associations can identify the need for substance abuse treatment among their constituents, as well as provide advice and suggestions about designing culturally specific services.

Providers can consider setting up an IOT group in the immigrants' native language. For example, it has been found that linguistic Spanish-only groups are helpful for recently arrived Hispanic/Latino immigrants. One note on language: In addition to native-language treatment groups, programs should provide services in English for those clients who want them. Many immigrants understand that not knowing English can be a barrier, and they are motivated to improve their English-language skills.

Some suggestions for programs that establish language-specific groups include the following:

- A program catering to a language-specific population needs to facilitate communication in that language. All documents in the program should be adapted. The program also can have a phone message in the clients' native language, with calls returned by a counselor who speaks the language.
- The important issues that immigrants face need to be addressed as part of the treatment program. These issues include cultural differences between the dominant culture and their native culture, sense of displacement, lack of community, language problems, accessing social services, and finding employment.
- The clients' cultural attitudes and values about substance use should shape program content. Clients need to acquire an understanding of how their native cultural attitudes differ from the values of U.S. society, which involves understanding U.S. laws, social expectations, and way of life.
- Using the terminology of the treatment field becomes a challenge because many words are difficult to translate and the meanings can vary according to the culture. Often, the counselor needs to translate both a word *and* its meaning in the English language and U.S. culture. For example, in Russian the concept of denial is positive. This concept generally translates into Russian as "It is good to deny that you have a problem." Likewise, "defenses" also translates as a positive concept. The word "defense" in Russian refers to a tool for addressing rude or disrespectful behavior from another person. In translation, these words carry the connotation of "To be defended and in denial are good tools to handle one's problems."

> ...mistrust can be a barrier to entering treatment and to obtaining services.

- Immigrant clients may need many social and educational support services that may be difficult for the clients to access because of language and cultural barriers. Often clients are not familiar with the existence, range, and purpose of these needed

Cultural Issues in a Russian-Language IOT Program

The ChangePoint IOT Program for Russian immigrants in Portland, Oregon, usually has about 15 clients in treatment at a time. Clients are immigrants from all over Russia, and most are religious refugees. The newcomers generally stay in family groups that immigrate together, so these clients have close family connections.

Clients learn about the social and legal expectations regarding substance use in the United States. The group work focuses on the cultural attitudes that these Russian clients bring to their substance use and treatment. Examples of differing U.S.–Russian cultural values that the program helps clients understand include

- **Acceptable levels of alcohol use.** Alcohol use among Russian clients is higher than average for the United States. In Russia, drinking enormous quantities of alcohol is tolerated provided the person behaves appropriately.
- **Legal expectations.** Russians tend to view the law in a "black or white" context. In Russia, there is zero tolerance for any blood alcohol level (BAL) when driving. When clients hear that a BAL below 0.08 is legal in the United States, they think, "I can drink and drive as long as I'm under 0.08 or as long as I'm careful."
- **Attitudes about money and treatment.** Russian clients may assume that the program will understand if they cannot pay their bills on time. Russian people expect that they will be paid regularly, often lend money to family and friends, and feel a high level of trust that they will be paid back. This translates into an expectation that the program also will trust them to pay their bills at some time in the future.

supports, and some fear or are confused by the complexities of government procedures; their access to these services may be impeded by the documentation processes that bureaucracies often require. IOT case management can broker needed support services. One model for doing this, called culture brokering, consists of conflict resolution and problemsolving strategies designed to help two cultures communicate and cooperate. In the context of cultural competence, the two cultures are represented by clients who are foreign born or disabled and treatment providers. (See cirrie.buffalo.edu/cbrokering.html for more information.)

Women From Other Cultures

Immigrant women face the same barriers to treatment that confront many Anglo-American women—restricted availability of child care, low income, unsupportive spouses, lack of health insurance benefits, and lack of education and job skills—but have the added barrier of being outsiders to the culture.

- **View the woman's behavior and treatment goals in the context of her culture.** Treatment needs to be sensitive to the cultural mores and female roles in that woman's culture and to the client's level of acculturation. Some societies can be paternalistic and dominated by men, with women expected to play traditional roles as wives and mothers. A woman client may have values and attitudes that reflect that culture. Her substance use disorder, her attitudes about her addiction, and her perception of her recovery options occur within that cultural framework. It is therefore important to understand the client's level of comfort with what is expected in treatment. Treatment goals should depend on the woman's hopes and should conform to the cultural role she wants for herself.
- **Expect to work within complex, conflicting value systems.** Women from male-dominated cultures often are raised to be

gentle, passive, and selfless in serving their husbands and families. Some counselors may want to push such women toward independence and self-assertion but should be aware that these attributes may not be personally or culturally desirable for foreign-born female clients.

Often, treatment must be more intensive for poor immigrant women than for immigrant women with more economic resources. Treatment programs that enhance women's economic autonomy through social and employment support are effective in reducing substance use (Gregoire and Snively 2001). As with many women in treatment, foreign-born women may need transportation to their medical and legal appointments, as well as to substance abuse treatment sessions. Other services should include

- **Domestic violence intervention.** Staff members need to understand the factors in clients' home life that interfere with recovery, such as domestic violence or having a significant other who also uses substances.
- **Multidisciplinary meetings with other caregivers.** The IOT staff can organize multidisciplinary meetings for the client that involve all referring agencies. Staff from the referring agencies should be encouraged to attend and develop a plan to address any issues that may be interfering with the client's treatment.
- **Parenting classes.** Parenting classes help women meet some of the stipulations required by State departments of child and family services. In addition, some child-rearing practices in other cultures may not be acceptable in American culture, and classes offer the chance for women to learn more acceptable practices.

Religious Orientation

IOT providers need to ensure that their program is welcoming to people from all religious faiths and that no treatment practices are a barrier to those from non-Christian religions. Programs should address specifically the following issues:

- **Religious acceptance and tolerance within the program.** Local religious leaders can educate substance abuse treatment providers about traditions and practices. Providers, in turn, can educate religious leaders about services that are available. In the years immediately following the attacks of September 11, 2001, American Muslims experienced increased incidents of bias, discrimination, overt hostility, abuse, and violence. Collaborating with local imams can help treatment providers and the religious community reach out and aid people more effectively (Goodman 2002). Intolerance by other clients in treatment should not be condoned and needs to be addressed. (For a brief introduction on responding to the mental health needs of Arab Americans and American Muslims in the wake of terrorism, see Goodman [2002].)
- **Knowledge of religious customs.** Providers need to understand and accommodate the religious customs of individual clients. A culturally sensitive IOT program should ask about clients' dietary preferences, special holidays, and religious customs (e.g., daily prayers).
- **Preparing clients for mutual-help programs.** Non-Christian clients who are referred to mutual-help programs for continuing care should be informed that meetings often incorporate elements of Christianity. As an example, the Lord's Prayer, which comes from the Christian Bible, frequently is selected for closing Alcoholics Anonymous (AA) meetings. Because this is a Christian prayer, it potentially is offensive to the religious point of view of such groups as Jews, Muslims, Hindus, and Buddhists. Jewish mutual-help meetings exist in many communities. The Web site of Jewish Alcoholics, Chemically Dependent Persons and Significant Others at www.jacsweb.org provides additional information. Many areas of the country have secular mutual-help

meetings. Providers should become familiar with these meetings, so they can direct their non-Christian clients to them.
- **Support from religious leaders.** Clients whose religious faith is central to their lives should be encouraged to seek help from their religious leaders and from fellow believers.

Clinical Implications of Culturally Competent Treatment

IOT programs should take the following steps to ensure culturally competent treatment for their clients:

- Assess the program for policies and practices that might pose barriers to culturally competent treatment for diverse populations. Removing these barriers could entail something as simple as rearranging furniture to accommodate clients in wheelchairs or as involved as hiring a counselor who is from the same cultural group as the population the program serves. Chapter 4 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), provides more information about assessing program needs.
- Ensure that all program staff receive training about the meaning and benefits of cultural competence in general and about the specific cultural beliefs and practices of client populations that the program serves.
- Incorporate family and friends into treatment to support the client. Although family involvement is often a good idea in an IOT program, it may be particularly effective given the importance of family in many cultures. Some clients left families and friends behind when they came to the United States. Helping these clients build support systems is critical.
- Provide program materials on audiotapes, in Braille, or in clients' first languages. All materials should be sympathetic to the culture of clients being served.
- Ensure that client materials are written at an appropriate reading level. People who are homeless and those for whom English is a second language may need materials written at an elementary school reading level.
- Include a strong outreach component. People who are unfamiliar with U.S. culture may be unaware that substance abuse treatment is available or how to access it.
- Hire counselors and administrators and appoint board members from the diverse populations that the program serves. Chapter 4 of TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*), provides more information about recruiting and hiring diverse staff members.
- Incorporate elements from the culture of the populations being served by the program (e.g., Native-American healing rituals or Talking Circles).
- Partner with agencies and groups that deliver community services to provide enhanced IOT services, such as child care, transportation, medical screening and services, parenting classes, English-as-a-second-language classes, substance-free housing, and vocational assistance. These services may be necessary for some clients to be able to stay in treatment.
- Provide meals at the program facility. This may bring some clients (e.g., those who are elderly or homeless) into treatment and induce them to stay.
- Make case management services available for clients who need them.
- Emphasize structured programming, as opposed to open-ended discussion, in group therapy settings.
- Base treatment on clients' strengths. Experienced providers report that this approach works well with clients from many cultures and is the preferred approach for clients struggling with self-esteem or empowerment.
- Use a motivational framework for treatment, which seems to work well with clients from many cultures. Basic principles

of respect and collaboration are the basis of a motivational approach, and these qualities are valued by most cultures.
- Encourage clients to participate in mutual-help programs to support their recovery. Although the mutual-help movement's roots are in White, Protestant, middle-class American culture, data show that members of minorities benefit from mutual-help programs to the same extent as do Whites (Tonigan 2003).

Sketches of Diverse IOT Client Populations

The following demographic sketches focus on diverse clients who may be part of an IOT caseload. These descriptions characterize entire groups (e.g., number of people, geographic distribution, rates of substance use) and include generalized cultural characteristics of interest to the clinician. This type of cultural overview is only a starting point for understanding an individual. To serve adequately clients from the diverse groups described here, IOT providers need to get to know their clients and educate themselves. Appendix 10-A (page 197) contains an annotated list of resources on cultural competence in general, as well as resources listed by population group. These resources include free publications available from government agencies—in particular the Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention—and describe population-specific treatment guidelines and strategies.

Hispanics/Latinos

Hispanics/Latinos include individuals from North, Central, and South America, as well as the Caribbean. Hispanic people can be of any race, with forebears who may include American Indians, Spanish-speaking Caucasians, and people from Africa. Great disparities exist among these subgroups in education, economic status, and labor force participation. In 2002, the Hispanic/Latino population totaled 37.4 million, more than 13 percent of the total U.S. population, and it is now the largest ethnic group in the Nation. Mexican Americans are the largest subgroup, representing more than two-thirds of all Hispanics/Latinos in the United States (Ramirez and de la Cruz 2003).

All [program] materials should be sympathetic to the culture of clients being served.

Two-thirds of the Hispanic/Latino people in the United States were born here. As a group, they are the most urbanized ethnic population in the country. Although poverty rates for Hispanics/Latinos are high compared with those of Whites, by the third generation virtually no difference in income exists between Hispanic/Latino and non-Hispanic/Latino workers who have the same level of education (Bean et al. 2001).

Celebrations and religious ceremonies are an important part of the culture, and use of alcohol is expected and accepted in these celebrations and ceremonies. In the interest of family cohesion and harmony, traditional Hispanic/Latino families tend not to discuss or confront the alcohol problems of family members. Among Hispanics/Latinos with a perceived need for treatment of substance use disorders, 23 percent reported the need was unmet—nearly twice the number of Whites who reported unmet need (Wells et al. 2001). Studies show that Hispanics/Latinos with substance use disorders receive less care and often must delay treatment, relative to White Americans (Wells et al. 2001). De La Rosa and White's (2001) review of the role social support systems play in substance use found that family pride and parental involvement are more influential

among Hispanic/Latino youth than among White or African-American youth. The 2000 Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Household Survey on Drug Abuse (NHSDA) found that nearly 40 percent of Hispanics/Latinos reported alcohol use. Five percent of Hispanics reported use of illicit substances, with the highest rate occurring among Puerto Ricans and the lowest rate among Cubans (Office of Applied Studies 2001). Hispanics/Latinos accounted for 9 percent of admissions to substance abuse treatment in 2000 (Office of Applied Studies 2002).

...only 20 percent of American Indians and Alaska Natives live on reservations or trust lands...

Spanish-language treatment groups are helpful for recently arrived Hispanic/Latino immigrants. Programs in areas with a large population of foreign-born Hispanics/Latinos should consider setting up such groups, using Spanish-speaking counselors. AA has Spanish-language meetings in many parts of the country, especially in urban areas.

African-Americans

African-Americans make up 13 percent of the U.S. population and include 36 million residents who identify themselves as Black, more than half of whom live in a metropolitan area (McKinnon 2003). The African-American population is extremely diverse, coming from many different cultures in Africa, Bermuda, Canada, the Caribbean, and South America. Most African-Americans share the experience of the U.S. history of slavery, institutionalized racism, and segregation (Brisbane 1998).

Foreign-born Africans living in America have had distinctly different experiences from U.S.-born African-Americans. As one demographer points out, "Foreign-born African-Americans and native-born African-Americans are becoming as different from each other as foreign-born and native-born Whites in terms of culture, social status, aspirations and how they think of themselves" (Fears 2002, p. A8). Nearly 8 percent of African-Americans are foreign born; many have grown up in countries with majority Black populations ruled by governments consisting of mostly Black Africans.

The 2000 NHSDA found that 34 percent of African-Americans reported alcohol use, compared with 51 percent of Whites and 40 percent of Hispanics/Latinos. Only 9 percent of African-American youth reported alcohol use, compared with at least 16 percent of White, Hispanic/Latino, and Native-American youth (Office of Applied Studies 2001). Six percent of African-Americans reported use of illicit substances, compared with 6 percent of Whites and 5 percent of Hispanics/Latinos (Office of Applied Studies 2001). African-Americans accounted for 24 percent of admissions to substance abuse treatment in 2000 (Office of Applied Studies 2002). Among African-Americans with a perceived need for substance abuse treatment, 25 percent reported the need was unmet—more than twice the number of Whites who reported unmet need (Wells et al. 2001).

Native Americans

The Bureau of Indian Affairs recognizes 562 different Native-American tribal entities. (The term "Native American" as it is used here encompasses American Indians and Alaska Natives.) Each tribe has unique customs, rituals, languages, beliefs about creation, and ceremonial practices. On the 2000 census, about 2.5 million Americans listed themselves as Native Americans and 1.6 million Americans listed themselves as at least partly Native American, accounting for

4.1 million people or 1.5 percent of the U.S. population (Ogunwole 2002).

Currently only 20 percent of American Indians and Alaska Natives live on reservations or trust lands, where they have access to treatment from the Indian Health Service. More than half live in urban areas (Center for Substance Abuse Prevention 2001). The 2000 NHSDA found that 35 percent of Native Americans reported alcohol use. Thirteen percent of Native Americans reported use of illicit substances (Office of Applied Studies 2001). Among all youth ages 12 to 17, the use of illicit substances was most prevalent among Native Americans—22 percent (Office of Applied Studies 2001). Native Americans begin using substances at higher rates and at a younger age than any other group (U.S. Government Office of Technology Assessment 1994). Native Americans accounted for 3 percent of admissions to substance abuse treatment in 2000 (Office of Applied Studies 2002). More than three-quarters of all Native-American admissions for substance use are due to alcohol. Alcoholism, often intergenerational, is a serious problem among Native Americans (CSAT 1999*b*). One study found that rates for alcohol dependence among Native Americans were higher than the U.S. average (Spicer et al. 2003) but not as high as often had been reported. Thirty percent of men in culturally distinct tribes from the Northern Plains and the Southwest were alcohol dependent, compared with the national average of 20 percent of men. Among the Northern Plains community, 20 percent of women were alcohol dependent, compared with the national average of 8.5 percent. Only 8.7 percent of all women in the Southwest were found to be alcohol dependent.

Among Native Americans, there is a movement toward using Native healing traditions and healers for the treatment of substance use disorders. Spiritually based healing is unique to each tribe or cultural group and is based on that culture's traditional ceremonies and practices.

Asian Americans and Pacific Islanders

Asian Americans and Pacific Islanders are the fastest growing minority group in the United States, making up more than 4 percent of the U.S. population and totaling more than 12 million. They account for more than one-quarter of the U.S. foreign-born population. The vast majority live in metropolitan areas (Reeves and Bennett 2003); more than half live in three States: California, New York, and Hawaii (Mok et al. 2003). Nearly 9 out of 10 Asian Americans either are foreign born or have at least one foreign-born parent (U.S. Census Bureau 2003). Asian Americans represent many distinct groups and have extremely diverse cultures, histories, and religions.

Pacific Islanders are peoples indigenous to thousands of islands in the Pacific Ocean. Pacific Islanders number about 874,000 or 0.3 percent of the population. Fifty-eight percent of these individuals reside in Hawaii and California (Grieco 2001).

Grouping Asian Americans and Pacific Islanders together can mask the social, cultural, linguistic, and psychological variations that exist among the many ethnic subgroups this category represents. Very little is known about interethnic differences in mental disorders, seeking help, and use of treatment services (U.S. Department of Health and Human Services 2001).

The 2000 NHSDA found that 28 percent of Asian Americans and Pacific Islanders reported alcohol use. Only 7 percent of adolescent Asian Americans and Pacific Islanders reported alcohol use, compared with at least 16 percent of White, Hispanic/Latino, and Native-American youth (Office of Applied Studies 2001). Three percent of Asian Americans and Pacific Islanders reported use of illicit substances (Office of Applied Studies 2001). As a group Asian Americans and Pacific Islanders have the lowest rate of illicit substance use, but significant intragroup differences exist.

Koreans (7 percent) and Japanese (5 percent) use illicit substances at much greater rates than Chinese (1 percent) and Asian Indians (2 percent) (Office of Applied Studies 2001). Asian Americans and Pacific Islanders accounted for less than 1 percent of admissions to substance abuse treatment in 2000 (Office of Applied Studies 2002).

Persons With HIV/AIDS

In the United States, more than 918,000 people are reported as having AIDS (Centers for Disease Control and Prevention 2004). HIV is still largely a disease of men who have sex with men and people who inject drugs; these groups together account for nearly four-fifths of all cases of HIV/AIDS (Centers for Disease Control and Prevention 2004). Minorities have a much higher incidence of infection than does the general population. Although African-Americans make up only 13 percent of the U.S. population, they accounted for 50 percent of new HIV infections in 2004 (Centers for Disease Control and Prevention 2004). HIV is spreading most rapidly among women and adolescents. In 2000, females accounted for nearly half of new HIV cases reported among 13- to 24-year-olds. Among 13- to 19-year-olds, females accounted for more than 60 percent of new cases (Centers for Disease Control and Prevention 2002). HIV/AIDS is increasing rapidly among African-American and Hispanic/Latino women. Although they represent less than a quarter of U.S. women, these groups account for more than four-fifths of the AIDS cases reported among women; African-American women account for 64 percent of this total (Centers for Disease Control and Prevention 2004). Gay people who abuse substances also are at high risk because they are more likely to engage in risky sex after alcohol or drug use (Greenwood et al. 2001).

The development of new medications—and combinations of medications—has had a significant effect on the length and quality of life for many people who live with HIV/AIDS. However, these new treatment protocols require clients to take multiple medications on a complicated regimen. Clients with HIV often present with a cluster of problems, including poverty, indigence, homelessness, mental disorders, and other medical problems.

Lesbian, Gay, and Bisexual Clients

LGB individuals come from all cultural backgrounds, ethnicities, racial groups, and regions of the country. Cultural groups differ in how they view their LGB members. In Hispanic culture, matters of sexual orientation tend not to be discussed openly. LGB members of minority groups often find themselves targets of discrimination within their minority culture and of racism in the general culture.

Because of inconsistent research methods and instruments that do not ask about sexual orientation, no reliable information is available on the number of people who use substances among LGB individuals (CSAT 2001). Studies indicate, however, that LGB individuals are more likely to use alcohol and drugs, more likely to continue heavy drinking into later life, and less likely to abstain from using drugs than is the general population. They also are more likely to have used many drugs, including such drugs as Ecstasy, ketamine ("Special K"), amyl nitrite ("poppers"), and gamma hydroxybutyrate during raves and parties. These drugs affect judgment, which can increase risky sexual behavior and may lead to HIV/AIDS or hepatitis (Centers for Disease Control and Prevention 1995; Greenwood et al. 2001; Woody et al. 1999).

Persons With Physical and Cognitive Disabilities

Nearly one-sixth of all Americans (53 million) have a disability that limits their

functioning. More than 30 percent of those with disabilities live below the poverty line and generally spend a large proportion of their incomes to meet their disability-related needs (LaPlante et al. 1996). Most people with disabilities can and want to work. But those with skills tend to be underemployed or unemployed. The combination of depression, pain, vocational difficulties, and functional limitations places people with physical disabilities at increased risk of substance use disorders (Hubbard et al. 1996).

Those with cognitive or physical disabilities are more likely than the general population to have a substance use disorder but less likely to receive effective treatment (Moore and Li 1998). Many community-based treatment programs do not currently meet the Federal requirements of the Americans with Disabilities Act. An IOT program is likely to have clients who present with a variety of disabilities. Experienced clinicians report that an appreciable number of individuals with substance use disorders have unrecognized learning disabilities that can impede successful treatment. People who have the same disability may have differing functional capacities and limitations.

Treating substance use disorders in persons with disabilities is an emerging field of study. Culture brokering is a treatment approach that was developed to mediate between the culture of a foreign-born person and the health care culture of the United States. This model helps rehabilitation providers understand the role that culture plays in shaping the perception of disabilities and treatment (Jezewski and Sotnik 2001). Culture brokering is an extension of techniques that IOT providers already practice, including assessment and problemsolving.

Rural Populations

In 2000, nearly 20 percent of the U.S. population (55.4 million people) lived in nonmetropolitan areas; the nonmetropolitan population increased 10.2 percent from 1990 to 2000 (Perry and Mackun 2001). The economic base and ethnic diversity of these populations, not just their isolation, are critical factors. This population includes people of Anglo-European heritage in Appalachia and in farming and ranching communities of the Midwest and West, Hispanic/Latino migrant farm workers across the South, and Native Americans on reservations.

Treating substance use disorders in persons with disabilities is an emerging field of study.

Despite this diversity, rural communities from different parts of the country have commonalities: low population density, limited access to goods and services, and considerable familiarity with other community members. People living in rural situations also share broad characteristics that affect treatment. These characteristics are

- Overall higher resistance to seeking help because of pride in self-sufficiency
- Concerns about confidentiality and resistance to participating in group work because in small communities "everyone knows everyone else"
- A sense of strong individuality and privacy, sometimes coupled with difficulty in expressing emotions
- A culturally embedded suspicion of treatment for substance use and mental disorders, although this varies widely by area

Among adults older than age 25, the rate of alcohol use is lower in rural areas than in metropolitan areas. But rates of heavy alcohol use among youth ages 12 to 17 in rural areas are almost double those seen in metropolitan areas (Office of Applied Studies 2001). Women in rural areas have higher

rates of alcohol use and alcoholism than women in metropolitan areas (American Psychological Association 1999). However, in one study, urban residents received substance abuse treatment at more than double the rate of their rural counterparts (Metsch and McCoy 1999). Researchers attribute this disparity to the relative unavailability and unacceptability of substance abuse treatment in rural areas of the United States (Metsch and McCoy 1999).

Homeless Populations

Approximately 600,000 Americans are homeless on any given night. One census count of people who are homeless found about 41 percent were White, 40 percent were African-American, 11 percent were Hispanic, and 8 percent were Native American. Compared with all U.S. adults, people who are homeless are disproportionately African-American and Native American (Urban Institute et al. 1999). Homeless populations include groups of people who are

- **Transient.** These individuals may stay temporarily with others or have a living pattern that involves rotating among a group of friends, relatives, and acquaintances. These individuals are at high risk of suddenly finding themselves on the street. For some, continued living in other people's residences may be contingent on providing sex or drugs.
- **Recently displaced.** Some people may be employed but have been evicted from their homes. Their housing instability may be related to financial problems resulting from substance use.
- **Chronically homeless.** These individuals may have severe substance use and mental disorders and are difficult to attract into traditional treatment settings. Reaching these individuals requires the IOT program to bring its services to the homeless through a variety of creative outreach and programming initiatives.

Approximately two-thirds of people who are homeless report having had an alcohol, drug, or mental disorder in the previous month (Urban Institute et al. 1999). Three-quarters of people who are homeless and need substance abuse treatment do not receive it (Magura et al. 2000). For 50 percent of people who are homeless and admitted to treatment, alcohol is the primary substance of abuse, followed by opioids (18 percent) and crack cocaine (17 percent) (Office of Applied Studies 2003*b*). Twenty-three percent of people who are homeless and in treatment have co-occurring disorders, compared with 20 percent who are not homeless (Office of Applied Studies 2003*b*). People who are homeless are more than three times as likely to receive detoxification services as people who are not homeless (45 percent vs. 14 percent) (Office of Applied Studies 2003*b*).

In addition to the resources found in appendix 10-A, the following clinical guidelines will assist providers in treating people who are homeless:

- Clients who are homeless often drop out of treatment early. Meeting survival needs of clients who are homeless is integral to successful outcomes. An IOT program needs to provide safe shelter, warmth, and food, in addition to the components of effective treatment provided to other clients who use substances, including extensive continuing care (Milby et al. 1996).
- Individuals who are homeless benefit from intensive contact early in treatment. Clients who attend treatment an average of 4.1 days per week are more successful than those attending fewer days (Schumacher et al. 1995).
- The Alcohol Dependence Scale, the Alcohol Severity Index, and the personal history form have been found to be reliable and valid screening tools for this population (Joyner et al. 1996). Reliability is higher when items are factual and based on a recent time interval and when individuals are interviewed in a protected setting.

- Case management must be available to ease access to and coordinate the variety of services needed by clients who are homeless and abuse substances. Case management should arrange for stable, safe, and drug-free housing. The availability of housing is a powerful influence on recovery. Making such housing contingent on abstinence has been shown to be a useful strategy (Milby et al. 1996). Case management also should coordinate medical care, including psychiatric care, with vocational training and education to help individuals sustain a self-sufficient life.
- Providers should work with homeless shelters to provide treatment services. Strategies include (1) working with staff members at shelters and with public housing authorities to find and arrange for housing, (2) locating the IOT program within a homeless shelter or at least providing core elements of IOT at the shelter, and (3) placing a substance abuse treatment specialist at the shelter as a liaison with the IOT program.

Older Adults

The number of older adults needing treatment for substance use disorders is expected to increase from 1.7 million in 2001 to 4.4 million by 2020. This increase is the result of a projected 50-percent increase in the number of older adults as well as a 70-percent increase in the rate of treatment need among older adults (Gfroerer et al. 2003). America's aging cohort of baby boomers (people born between 1946 and 1964) is expected to place increasing demands on the substance abuse treatment system in the coming years, requiring a shift in focus to address their special needs. This older generation will be more ethnically and racially diverse and have higher substance use and dependence rates than current older adults (Korper and Council 2002).

As a group, older people tend to feel shame about substance use and are reluctant to seek out treatment. Many relatives of older individuals with substance use disorders also are ashamed of the problem and rationalize the substance use or choose not to address it. Diagnosing and treating substance use disorders are more complex in older adults than in other populations because older people have more—and more interconnected—physical and mental health problems. Barriers to effective treatment include lack of transportation, shrinking social support networks, and financial constraints.

Oslin and colleagues (2002) find that older adults had greater attendance and lower incidence of relapse than younger adults in treatment and conclude that older adults can be treated successfully in mixed-age groups, provided that they receive age-appropriate individual treatment. When treating older clients, IOT programs need to be involved actively with the local network of aging services, including home- and community-based long-term care providers. Older individuals who do not see themselves as abusers—particularly those who misuse over-the-counter or prescription drugs or do not understand the problems caused by alcohol and drug interactions—need to be reached through wellness, health promotion, social service, and other settings that serve older adults. In addition, IOT programs can broaden the multicultural resources available to them by working through the aging service network to link up with diverse language, cultural, and ethnic resources in the community.

> ...older adults ha[ve] greater attendance and lower incidence of relapse than younger adults...

IOT programs that develop geriatric expertise can provide an essential service by making consultation available to staff members at IOT programs that face similar challenges, along with inservice training, coordination of interventions, and care

conferences designed to solve problems and develop care plans for individuals. There also may be opportunities to make this expertise available to caregivers and participants in settings where older adults receive interdisciplinary care (e.g., a support group for family caregivers or a discussion group for participants at a social daycare or adult day health center).

Appendix 10-A. Cultural Competence Resources

Many resources listed below are volumes in the TIP and Technical Assistance Publication (TAP) Series published by CSAT. TIPs and TAPs are free and can be ordered from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at www.ncadi.samhsa.gov or (800) 729-6686 (TDD, [800] 487-4889). The full text of each TIP can be searched and downloaded from www.samhsa.gov/centers/csat2002/publications.html.

The Health Resources and Services Administration lists cultural competence assessment tools, resources, curricula, and Web-based trainings at www.hrsa.gov/culturalcompetence.

General

The Journal of Ethnicity in Substance Abuse—This quarterly journal (formerly *Drugs and Society*) explores culturally competent strategies in individual, group, and family treatment of substance abuse. The journal also investigates the beliefs, attitudes, and values of people who abuse substances to understand the origins of substance abuse for different populations. Visit www.haworthpress.com/web/JESA to find out more.

Cultural Issues in Substance Abuse Treatment (CSAT 1999*b*)—This booklet contains population-specific discussions of treatment for Hispanic Americans, African-Americans, Asian Americans and Pacific Islanders, and American Indians and Alaska Natives, along with general guidelines on cultural competence. Order from SAMHSA's NCADI.

Chapter 4, "Preparing a Program To Treat Diverse Clients," in TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment* (CSAT 2006*f*)—This chapter includes an introduction to cultural competence and why it matters to treatment programs, as well as information on assessing a diverse population's treatment needs and conducting outreach to attract clients and involve the community. This chapter also includes a list of resources for assessment and training, in addition to culture-specific resources.

The forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT forthcoming *a*)—This volume addresses screening, assessment, and treatment planning; case management; counseling for specific cultural groups; and engaging and retaining diverse clients in the context of cultural competence.

"Alcohol Use Among Special Populations" (National Institute on Alcohol Abuse and Alcoholism 1998)—This special issue of the journal *Alcohol Health & Research World* (now called *Alcohol Research & Health*) includes articles on alcohol use in Asian Americans and Pacific Islanders, African-Americans, Alaska Natives, Native Americans, and Hispanics/Latinos. Authors also address such topics as alcohol availability and advertising in minority communities, special populations in AA, and alcohol consumption in India, Mexico, and Nigeria. Visit pubs.niaaa.nih.gov/publications/arh22-4/toc22-4.htm to download the articles.

Mental Health: Culture, Race, and Ethnicity (U.S. Department of Health and Human Services 2001)—This publication describes the disparities in mental health services that affect minorities, presents evidence of the need to address those disparities, and documents promising strategies to eliminate them. Visit www.mentalhealth.samhsa.gov/cre/default.asp to download a copy of this publication.

Cultural Competence Works: Using Cultural Competence To Improve the Quality of Health Care for Diverse Populations and Add Value to Managed Care Arrangements (Health Resources and Services Administration 2001)—This booklet bases its recommendations for implementing cultural competence

on practices already in place in health care programs across the country. Along with its general discussions of culturally competent care, the publication includes descriptions of the programs from which the recommendations are drawn and a list of resources. Visit minority-health.pitt.edu/archive/00000278 to download a copy of this publication.

Counseling the Culturally Different: Theory and Practice, Third Edition (Sue and Sue 1999)—This book offers a conceptual framework for counseling across cultural lines and includes treatment recommendations for specific cultural groups, with individual chapters on counseling Hispanics/Latinos, African-Americans, Asian Americans, and Native Americans and special sections on women, gay and lesbian people, and persons who are elderly and disabled.

Bridges to Recovery: Addiction, Family Therapy, and Multicultural Treatment (Krestan 2000)—This volume of essays discusses substance abuse treatment for Native-American, African-American, West Indian, Asian-American, Mexican-American, and Puerto Rican families.

The Cultural Context of Health, Illness, and Medicine (Loustaunau and Sobo 1997)—This book, written by a sociologist and an anthropologist, examines the ways in which cultural and social factors shape understandings of health and medicine. Although its discussions are not specific to substance abuse, they address the effect of social structures on health, differing conceptions of wellness, and cross-cultural communication.

Pocket Guide to Cultural Health Assessment, Third Edition (D'Avanzo and Geissler 2003)—This quick reference guide has individual sections on 186 countries, each of which lists demographic information (e.g., population, ethnic and religious descriptions, languages spoken), political and social information, and health care beliefs.

American Cultural Patterns: A Cross-Cultural Perspective, Second Edition (Stewart and Bennett 1991)—This book focuses on aspects of American culture that are central to understanding how American society functions. The authors examine perceptions, thought processes, language, and nonverbal behaviors and their effect on cross-cultural communication.

Promoting Cultural Diversity: Strategies for Health Care Professionals (Kavanagh and Kennedy 1992)—This text discusses strategies for learning about diversity and techniques for communicating effectively with culturally diverse populations. Case studies are used to illustrate the practical applications of cross-cultural communication.

Hispanics/Latinos

Materials for clients

NCADI has publications and videotapes for clients, parents, and employers available in Spanish. Visit www.ncadi.samhsa.gov.

The National Institute on Drug Abuse (NIDA) offers a number of publications in Spanish. Visit www.nida.nih.gov.

Relapse prevention workbooks in Spanish can be purchased at www.tgorski.com.

The Hazelden Foundation offers a collection of Spanish fellowship books and videotapes approved by AA and Narcotics Anonymous. Visit www.hazelden.org.

Materials for counselors

CSAP Substance Abuse Resource Guide: Hispanic/Latino Americans (Center for Substance Abuse Prevention 1996*b*; www.ncadi.samhsa.gov/govpubs/MS441/)—This resource guide provides information and referrals to help prevention specialists, educators, and community leaders better meet the needs of the Hispanic/Latino community. Order from SAMHSA's NCADI.

Quality Health Services for Hispanics: The Cultural Competency Component (National

Alliance for Hispanic Health 2000)—This book includes sections on the culture, language, and history of Hispanics/Latinos in the United States, Hispanic/Latino health status, guidelines for education and outreach, recommendations for working cross-culturally, and case studies. Visit www.ask.hrsa.gov/detail.cfm?id=PC00029 to order this volume.

"Counseling Latino Alcohol and Other Substance Users/Abusers: Cultural Considerations for Counselors" (Gloria and Peregoy 1996)—This article discusses Hispanic/Latino cultural values as they relate to substance use and presents a substance abuse counseling model for use with Hispanic/Latino clients.

"Drugs and Substances: Views From a Latino Community" (Hadjicostandi and Cheurprakobkit 2002)—The researchers explore perceptions and use of licit and illicit substances in a Hispanic/Latino community. The primary concerns of the community are the increasing availability and use of substances among Hispanic/Latino youth.

"Acculturation and Latino Adolescents' Substance Use: A Research Agenda for the Future" (De La Rosa 2002)—This article reviews literature on the effects of acculturation to Western values on Hispanic/Latino adolescents' mental health and substance use, discusses the role that acculturation-related stress plays in substance use, and suggests directions for treatment and further research.

"Cultural Adaptations of Alcoholics Anonymous To Serve Hispanic Populations" (Hoffman 1994)—This article evaluates two specific adaptations to 12-Step fellowship: one adapts conceptions of machismo and the other is less confrontational.

African-Americans

Chemical Dependency and the African American: Counseling and Prevention Strategies, Second Edition (Bell 2002)—This book from the co-founder of the Institute on Black Chemical Abuse explores the dynamics of race, culture, and class in treatment and examines substance abuse and recovery in the context of racial identity.

Cultural Competence for Health Care Professionals Working With African-American Communities: Theory and Practice (Center for Substance Abuse Prevention 1998*a*)—This book provides tips for health care workers. Order from SAMHSA's NCADI or download at www.hawaii.edu/hivandaids/links.htm.

Relapse Prevention Counseling for African Americans: A Culturally Specific Model (Williams and Gorski 1997)—This book examines the way that cultural factors interact with relapse prevention efforts in African-Americans.

Relapse Prevention Workbook for African Americans: Hope and Healing for the Black Substance Abuser (Williams and Gorski 1999)—This workbook leads readers through clinical exercises designed to help them avoid relapse due to race-related issues.

"Drug Treatment Effectiveness: African-American Culture in Recovery" (Bowser and Bilal 2001)—This article endeavors to explain African-Americans' high rates of substance abuse and low rates of recovery. Culture is seen as both a problem and a solution; some African-American coping strategies act as barriers, but successful treatment programs incorporate African-American cultural elements.

Native Americans

Materials for clients

GONA (Gathering of Native Americans) is a community development and empowerment training process that uses Native-American trainers. A GONA curriculum provides structure for Native-American community gatherings and is available from SAMHSA. Visit p2001.health.org/CTI05/Cti05ttl.htm.

A significant recovery movement for Native-American people is the Red Road to Recovery developed by Gene Thin Elk, a Lakota elder. Many individuals, especially in urban areas, have achieved and maintained sobriety by following the Red Road. The Red Road to Recovery addresses the cognitive, affective, and experiential needs of Native Americans who are rebuilding their lives from substance use and mental disorders and presents a system of cultural values that promote an abstinent and balanced lifestyle. The following Web sites offer information on GONA, the Red Road to Recovery, and other Native-American recovery resources:

- www.naigso-aa.org. This Web site of the Native-American Indian General Service Office of Alcoholics Anonymous includes a link to information on Talking Circles. Talking Circles are common practice in Native-American treatment settings.
- www.whitebison.org. This Web site offers information about the Wellbriety Movement (a Native-American recovery movement that emphasizes health and abstinence), which includes information about Wellbriety for youth, children of people who abuse alcohol, and people in prison. The site also includes a Talking Circle chat room, training information and materials, and books, videotapes, and audiotapes on recovery.

Materials for counselors

Health Promotion and Substance Abuse Prevention Among American Indian and Alaska Native Communities: Issues in Cultural Competence (Center for Substance Abuse Prevention 2001)—This volume frames the development of substance abuse prevention and treatment efforts in the context of health disparities that have affected Native-American and Alaskan-Native communities in rural and urban settings, as well as on reservations. Grounded in traditional healing practices, the volume examines innovative approaches to substance abuse prevention. Order from SAMHSA's NCADI.

Substance Abuse Resource Guide: American Indians and Native Alaskans (Center for Substance Abuse Prevention 1998*b*)—A substance abuse resource guide for American Indians and Alaska Natives, including books, articles, classroom materials, posters, and Web sites. Order from SAMHSA's NCADI.

"Addiction and Recovery in Native America: Lost History, Enduring Lessons" (Coyhis and White 2002)—This journal article provides recommendations for treatment based on the history of addiction in Native-American communities.

Promising Practices and Strategies To Reduce Alcohol and Substance Abuse Among American Indians and Alaska Natives (American Indian Development Associates 2000)—This report collects descriptions of successful substance abuse prevention efforts by Native-American groups. It also includes a literature review and list of Federal resources. Visit www.ojp.usdoj.gov/americannative/promise.pdf to download the report.

"Morning Star Rising: Healing in Native American Communities" (Nebelkof et al. 2003)—This special issue of the *Journal of Psychoactive Drugs* is devoted to healing in Native-American communities, with 13 articles on various aspects of prevention and treatment. Contact Haight-Ashbury Publications at (415) 565-1904.

Walking the Same Land—This videotape presents young Indians who are returning to traditional cultural ways to strengthen their recovery from substance abuse. It includes aboriginal men from Australia and Mohawk men from New York. Order from SAMHSA's NCADI.

Asian Americans and Pacific Islanders

Asian and Pacific Islander American Health Forum (www.apiahf.org/resources/index.htm)— This site provides links to information and resources.

Asian Community Mental Health Services (www.acmhs.org)—This site provides links to information and describes a substance abuse treatment program in Oakland, California.

Substance Abuse Resource Guide: Asian and Pacific Islander Americans (Center for Substance Abuse Prevention 1996*a*; ncadi.samhsa.gov/govpubs/MS408)—This guide contains resources appropriate for use in Asian and Pacific Islander communities. It also contains facts and figures about substance use and prevention within this diverse group.

Asian American Mental Health: Assessment Theories and Methods (Kurasaki et al. 2002)—This compendium of essays highlights conceptual, theoretical, methodological, and practice issues related to Asian-American mental health assessment. This text focuses on important questions about the cultural nature of diagnostic and assessment processes.

Responding to Pacific Islanders: Culturally Competent Perspectives for Substance Abuse Prevention (Center for Substance Abuse Prevention 1999)—This book examines the culture-specific factors that affect substance abuse prevention in Pacific Islander communities. Order from SAMHSA's NCADI.

"Communicating Appropriately With Asian and Pacific Islander Audiences" (Center for Substance Abuse Prevention 1997)—This *Technical Assistance Bulletin* discusses population characteristics, lists cultural factors related to substance use in nine distinct ethnic groups, and presents guidelines on developing effective prevention materials for these populations. Visit ncadi.samhsa.gov/govpubs/MS701 to download the bulletin.

Opening Doors: Techniques for Talking With Southeast Asian Clients About Alcohol and Other Drug Issues—This program is available on videocassette in Vietnamese and Khmer with English subtitles. Order from SAMHSA's NCADI, and visit store.health.org/catalog/productDetails.aspx?ProductID=15136 to view it on the Web.

Persons With HIV/AIDS

TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT 2000*c*)—This TIP discusses the medical aspects of HIV/AIDS (epidemiological data, assessment, treatment, and prevention), the legal and ethical implications of treatment, the counseling of patients with HIV/AIDS, the integration of treatment and enhanced services, and funding sources for programs.

The Hawaii AIDS Education and Training Center has numerous resources available for download at www.hawaii.edu/hivandaids/links.htm.

LGB Populations

The Web site of the National Association of Lesbian and Gay Addiction Professionals is a clearinghouse for information and resources, including treatment programs and mutual-help groups, organized by State. Visit www.nalgap.org.

Substance Abuse Resource Guide: Lesbian, Gay, Bisexual, and Transgender Populations (Center for Substance Abuse Prevention 2000)—This publication lists books, fact sheets, magazines, newsletters, videos, posters, reports, Web sites, and organizations that increase understanding of issues important to lesbian, gay, bisexual, and transgender clients. Download the resource guide from ncadi.samhsa.gov/referrals/resguides.aspx?InvNum=MS489.

A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals (CSAT 2001)—This book addresses issues of interest to clinicians and administrators. It discusses treatment approaches for this population, ways to improve services to LGB clients, steps for starting LGB-sensitive programs, organizational missions, and strategies for building alliances to provide services. Order from SAMHSA's NCADI.

Counseling Lesbian, Gay, Bisexual, and Transgender Substance Abusers: Dual Identities, Second Edition (Finnegan and McNally 2002)—This guide examines different counseling approaches and provides practical treatment suggestions for LGB populations. The book includes an organization audit of attitudes and practices, plus a list of resources and other suggested readings.

*Addiction and Recovery in Gay and Lesbian Person*s (Kus 1995)—This book examines the incidence of substance use among gay and lesbian people and special concerns when treating this population, including HIV/AIDS, homophobia, gay and lesbian mutual-help groups, and special needs of rural gay and lesbian clients.

Addictions in the Gay and Lesbian Community (Guss 2000)—This volume includes personal experiences of substance use and recovery and research into the sources of and treatment for substance use disorders in gay and lesbian clients. The book also includes techniques for assessing and treating LGB clients, including adolescents.

Persons With Physical and Cognitive Disabilities

IOT programs should link with local groups that offer specialized housing, vocational training, and other supports for people who are disabled. The Centers for Independent Living (CILs) are organizations run by and for persons with disabilities to provide mutual-help and advocacy. CILs and Client Assistance Programs were developed to provide a third party to broker the interaction between clients and the service system. The Special Olympics may be able to help locate recreational activities appropriate for individual clients.

Materials for clients

For a catalog of AA literature available on audiocassettes, in Braille, and in large print, as well as a list of closed-caption videotapes, AA books in American Sign Language on videotape, and easy-to-read literature, contact Alcoholics Anonymous General Service Office, P.O. Box 459, Grand Central Station, New York, NY 10163 or orders@aa.org.

Materials for counselors

Coping With Substance Abuse After TBI—This report answers basic questions about substance use and traumatic brain injury (TBI) and includes recommendations from clients with TBI who are now abstinent. Download the publication at www.mssm.edu/tbicentral/resources/publications/tbi_consumer_reports.shtml.

TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT 1998*e*)—This volume discusses screening, treatment planning, and counseling for clients with disabilities. The book includes a compliance guide for the Americans with Disabilities Act, a list of appropriate terms to use when referring to people with disabilities, and screening instruments for use with this population, including an Education and Health Survey and an Impairment and Functional Limitation Screen.

TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998*a*)—This TIP discusses various models of case management and provides information on linking with service providers and evaluation. Chapter 5 explores the use of case management services with special needs populations.

TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT 2000*a*)—This volume examines the role that employment plays in recovery from substance use disorders, with special attention to referral relationships and their capacity to expand the services available to clients and enhance the resources available to programs.

Substance Abuse Resources and Disability Issues Program at Wright State School

of Medicine (www.med.wright.edu/citar/sardi)—This Web site offers products for professionals and persons with disabilities, including a training manual with an introduction on substance abuse and the deaf culture, as well as a Web course on substance abuse and disability.

National Center for the Dissemination of Disability Research's Guide to Substance Abuse and Disability Resources (www.ncddr.org/du/products/saguide)—This Web site provides links to books, journal articles, newsletters, training manuals, audiotapes, and videotapes on substance abuse and individuals who are disabled.

Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals (www.mncddeaf.org)—This Web site includes links to articles on substance abuse treatment of individuals who are deaf and to manuals and videotapes for use in treatment.

Co-Occurring and Other Functional Disorders Cluster Cultural Diversity Training Guide (www.med.wright.edu/citar/sardi/publications.html)—This guide recommends topics and methods for initial staff training in cultural diversity for programs serving clients who are disabled and includes a list of references on multicultural counseling.

Ohio Valley Center for Brain Injury Prevention and Rehabilitation (www.ohiovalley.org/abuse)—This Web site includes guidelines for treating people with substance use disorders and traumatic brain injury and links to other resources.

Center for International Rehabilitation Research and Information Exchange (cirrie.buffalo.edu/mseries.html)—This Web site includes downloadable versions of cultural guides that describe the demographics and attitudes toward disability of 11 countries, including countries in Asia, Central America, and the Caribbean. The site also includes a booklet that describes culture brokering, a practice in which counselors mediate between cultures to improve service delivery.

Rural Populations

TAP 17, *Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas* (CSAT 1995*b*)—The papers in this volume describe providers' experiences across a variety of treatment issues relevant to rural substance abuse treatment, including domestic violence, enhanced service delivery, building coalitions and networks, and practical measures to improve treatment.

TAP 20, *Bringing Excellence to Substance Abuse Services in Rural and Frontier America* (CSAT 1996)—The papers in this volume examine innovative strategies and policies for treating substance use disorders in rural and frontier America. Topics include rural gangs and crime, needs assessment approaches, coalitions and partnerships, and minorities and women in treatment.

Rural Substance Abuse: State of Knowledge and Issues (Robertson et al. 1997)—This NIDA Research Monograph examines rural substance abuse from many perspectives, looking at substance use among youth and at the health, economic, and social consequences of substance use. The final section of the book addresses ethnic and migrant populations, including rural Native Americans, African-Americans, and Mexican Americans. Visit www.nida.nih.gov/PDF/Monographs/Monograph168/Download168.html to download the monograph.

Homeless Populations

National Resource Center on Homelessness and Mental Illness (www.nrchmi.samhsa.gov/pdfs/bibliographies/Cultural_Competence.pdf)—This Web site has an annotated, online bibliography of journal articles, resource guides, reports, and books that address cultural competence. Many resources discuss substance use disorders.

"The Effectiveness of Social Interventions for Homeless Substance Abusers" (American Society of Addiction Medicine 1995)—This special issue of the *Journal of Addictive Diseases*

includes 11 articles that examine important aspects of treating people who are homeless, including retaining clients, residential versus nonresidential treatment, enhanced services, treating mothers who are homeless, and clients with co-occurring disorders.

The U.S. Department of Housing and Urban Development has compiled a list of local agencies by State and other resources to assist people who are homeless. Visit www.hud.gov/homeless/index.cfm.

The U.S. Department of Health and Human Services offers assistance and resources for people who are homeless. For example, the Health Care for the Homeless Program provides grants to community-based organizations in urban and rural areas for projects aimed at improving access for the homeless to primary health care, mental health care, and substance abuse treatment. Visit aspe.hhs.gov/homeless/index.shtml.

Substance Abuse Treatment: What Works for Homeless People? A Review of the Literature (Zerger 2002)—This report links research on homelessness and substance abuse with clinical practice and examines various treatment modalities, types of interventions, and methods for engaging and retaining people who are homeless. Download the report from National Health Care for the Homeless Council's Web site at www.nhchc.org/Publications/SubstanceAbuseTreatmentLitReview.pdf.

National Resource Center on Homelessness and Mental Illness (www.nrchmi.samhsa.gov)—This Web site lists trainings and workshops (such as the National Training Conference on Homelessness for People With Mental Illness and/or Substance Use Disorders), technical assistance, and fact sheets and other publications on homelessness.

Older Adults

TIP 26, *Substance Abuse Among Older Adults* (CSAT 1998*d*)—This volume discusses the relationship between aging and substance abuse and offers guidance for screening, assessing, and treating substance use disorders in older adults.

Substance Abuse Relapse Prevention for Older Adults: A Group Treatment Approach (CSAT 2005*c*)—This manual presents a relapse prevention intervention that uses a cognitive–behavioral and self-management approach in a counselor-led group setting to help older adults overcome substance use disorders. Order from SAMHSA's NCADI.

Substance Abuse by Older Adults: Estimates of the Future Impact on the Treatment System (Korper and Council 2002)—This report examines substance abuse treatment services for older adults in the context of increased demand in the future and calls for better documentation of substance abuse among older adults and prevention and treatment strategies that are tailored to subgroups of older adults, such as immigrants and racial and ethnic minorities. Download the report at www.drugabusestatistics.samhsa.gov/aging/toc.htm.

Alcohol and Aging (Beresford and Gomberg 1995)—This book for clinicians covers topics such as diagnosis and treatment, mental disorders, interactions of alcohol and prescription medications, and the biochemistry of intoxication for older adults.

Alcoholism and Aging: An Annotated Bibliography and Review (Osgood et al. 1995)—This volume surveys 30 years of research on older adults who use alcohol, providing abstracts of articles, books and book chapters, and research studies on the prevalence, effects, diagnosis, and treatment of alcohol use in older adults.

Administration on Aging (www.aoa.gov/prof/adddiv/adddiv.asp)—This Web site offers information on cultural competence, including resources on aging and ethnic minorities and the booklet, *Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and Their Families,* which can be downloaded at www.aoa.gov/prof/adddiv/cultural/addiv_cult.asp.

Appendix A—Bibliography

Addington, J., and el-Guebaly, N. Group treatment for substance abuse in schizophrenia. *Canadian Journal of Psychiatry* 43(8):843–845, 1998.

Alcoholics Anonymous World Services. *The A.A. Member—Medications and Other Drugs*. New York: Alcoholics Anonymous World Services, 1991.

Allen, J.P., and Columbus, M., eds. *Assessing Alcohol Problems: A Guide for Clinicians and Researchers.* Treatment Handbook Series 4. NIH Publication No. 95–3723. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, 1995.

Amass, L., and Kamien, J.B. A tale of two cities: Financing two voucher programs for substance abusers through community donations. *Experimental and Clinical Psychopharmacology* 12(2):147–155, 2004.

American Academy of Pediatrics. Fetal alcohol syndrome and alcohol-related neurodevelopmental disorders. *Pediatrics* 106:358–361, 2000.

American Indian Development Associates. *Promising Practices and Strategies To Reduce Alcohol and Substance Abuse Among American Indians and Alaska Natives.* Washington, DC: Office of Justice Programs, 2000.

American Medical Association. Role of Self-Help in Addiction Treatment. Res. 713, A-98. 1998. www.ama-assn.org/ama1/pub/upload/mm/388/referral_treatment.pdf [accessed April 26, 2004].

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R). Washington, DC: American Psychiatric Association, 1987.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV). Washington, DC: American Psychiatric Association, 1994.

American Psychiatric Association. *Practice Guidelines for Treatment of Patients With Substance Use Disorders: Alcohol, Cocaine, Opioids.* Washington, DC: American Psychiatric Association, 1995.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR). Washington, DC: American Psychiatric Association, 2000.

American Psychological Association (APA). *APA Rural Initiative: 1999 Year in Review.* Washington, DC: APA, 1999. www.apa.org/rural/report99.html [accessed February 11, 2004].

American Society of Addiction Medicine. The effectiveness of social interventions for homeless substance abusers (special issue). *Journal of Addictive Diseases* 14(4), 1995.

American Society of Addiction Medicine. Relationship Between Treatment and Self Help: A Joint Statement of the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry, 1997. www.asam.org/ppol/aaap.htm [accessed February 11, 2004].

Armstrong, T.D., and Costello, E.J. Community studies on adolescent substance use, abuse, or dependence and psychiatric comorbidity. *Journal of Consulting and Clinical Psychology* 70:1224–1239, 2002.

Avants, S.K.; Margolin, A.; Kosten, T.R.; Rounsaville, B.J.; and Schottenfeld, R.S. When is less treatment better? The role of social anxiety in matching methadone patients to psychosocial treatments. *Journal of Consulting and Clinical Psychology* 66(6):924–931, 1998.

Barker, R.L. *The Social Work Dictionary*, Fourth Edition. Washington, DC: National Association of Social Workers, 1999.

Bartholomew, N.G.; Rowan-Szal, G.A.; Chatham, L.R.; Nucatola, D.C.; and Simpson, D.D. Sexual abuse among women entering methadone treatment. *Journal of Psychoactive Drugs* 34(4):347–354, 2002.

Bean, F.D.; Trejo, S.J.; Crapps, R.; and Tyler, M. *The Latino Middle Class: Myth, Reality, and Potential.* Los Angeles, CA: Tomás Rivera Policy Institute, 2001.

Beck, A.J., and Harrison, P.M. Prisoners in 2000. *Bureau of Justice Statistics Bulletin.* Washington, DC: Office of Justice Programs, August 2001. www.ojp.gov:80/bjs/abstract/p00.htm [accessed February 11, 2004].

Belenko, S. Research on drug courts: A critical review, 1999 update. *National Drug Court Institute Review* 2(2):1–59, 1999.

Bell, P. *Chemical Dependency and the African American: Counseling and Prevention Strategies*, Second Edition. Center City, MN: Hazelden Publishing, 2002.

Beresford, T., and Gomberg, E., eds. *Alcohol and Aging.* New York: Oxford University Press, 1995.

Bigelow, G.E., and Silverman, K. Theoretical and empirical foundations of contingency management treatments for drug abuse. In: Higgins, S.T., and Silverman, K., eds. *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions.* Washington, DC: American Psychological Association, 1999, pp. 15–31.

Bixler, J.B., and Emery, B.D. Successful programs for individuals with co-occurring mental health and substance abuse disorders: Examples from five states. *A Report of the Joint NASMHPD-NASADAD*

Task Force on Co-Occurring Mental Health and Substance Abuse Disorders. Alexandria, VA: National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors, 2000.

Bloom, F.; Owen, B.; and Covington, S. *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders.* Washington, DC: National Institute of Corrections, June 2003. nicic.org/pubs/2003/018017.pdf [accessed February 11, 2004].

Blume, S.B. Understanding addictive disorders in women. In: Graham, A.W.; Shultz, T.K.; and Wilford, B.B., eds. *Principles of Addiction Medicine*, Second Edition. Chevy Chase, MD: American Society of Addiction Medicine, Inc., 1998, pp.1173–1190.

Bowser, B.P., and Bilal, R. Drug treatment effectiveness: African-American culture in recovery. *Journal of Psychoactive Drugs* 33(4):391–402, 2001.

Boylin, W.M., and Doucette, J. Multifamily therapy in substance abuse treatment with women. *American Journal of Family Therapy* 25(1):39–47, 1997.

Bradley, B.P.; Gossop, M.; Phillips, G.T.; and Legarda, J.J. The development of an opiate withdrawal scale (OWS). *British Journal of the Addictions* 82:1139–1142, 1987.

Brady, K.T., and Randall, C.L. Gender differences in substance use disorders. *Psychiatric Clinics of North America* 22(2):241–252, 1999.

Brems, C.; Johnson, M.E.; and Namyniuk, L.L. Clients with substance abuse and mental health concerns: A guide for conducting intake interviews. *Journal of Behavioral Health Services Research* 29(3):327–334, 2002.

Brisbane, F.L. Introduction: Diversity among African Americans. In: Center for Substance Abuse Prevention (CSAP). *Cultural Competence for Health Care Professionals Working With African-American Communities: Theory and Practice.* CSAP Cultural Competence Series 7. DHHS Publication No. (SMA) 98–3238. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998, pp. 1–8.

Brochu, S.; Guyon, L.; and Desjardins, L. Comparative profiles of addicted adult populations in rehabilitation and correctional services. *Journal of Substance Abuse Treatment* 6(2):173–182, 1999.

Brown, T.G.; Seraganian, P.; Tremblay, J.; and Annis, H. Matching substance abuse aftercare treatments to client characteristics. *Addictive Behavior* 27:585–604, 2002.

Budney, A.J., and Higgins, S.T. *A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction.* Manual 2: Therapy Manuals for Drug Addiction Series. NIH Publication No. 98–4309. Rockville, MD: National Institute on Drug Abuse, 1998.

Bureau of Justice Assistance. *Integrating Drug Testing Into a Pretrial Services System: 1999 Update.* Washington, DC: Office of Justice Programs, July 1999. bja.ncjrs.org/publications/#1 [accessed April 8, 2004].

Bureau of Justice Statistics. *Correctional Populations in the United States, 1997.* Washington, DC: Office of Justice Programs, November 2000. www.ojp.usdoj.gov/bjs/abstract/cpus97.htm [accessed February 11, 2004].

Busto, U.E.; Sykora, K.; and Sellers, E.M. A clinical scale to assess benzodiazepine withdrawal. *Journal of Clinical Psychopharmacology* 9:412–416, 1989.

Campbell, J.C. Prediction of homicide of and by battered women. In: Campbell, J.C., ed. *Assessing Dangerousness: Violence by Sexual Offenders, Batterers, and*

Child Abusers. Thousand Oaks, CA: Sage Publications, 1995, pp. 96–113.

Carey, K.B., and Correia, C.J. Severe mental illness and addictions: Assessment considerations. *Addictive Behaviors* 23(6):735–748, 1998.

Carroll, K.M. Integrating psychotherapy and pharmacotherapy in substance abuse treatment. In: Rodgers, F.; Keller, D.S.; and Morgenstern, J., eds. *Treating Substance Abuse: Theory and Technique.* New York: Guilford Press, 1996*a*, pp. 286–318.

Carroll, K.M. Relapse prevention as a psychosocial treatment: A review of controlled clinical trials. *Experimental and Clinical Psychopharmacology* 4(1):46–54, 1996*b*.

Carroll, K.M. *A Cognitive–Behavioral Approach: Treating Cocaine Addiction.* Manual 1: Therapy Manuals for Drug Addiction Series. NIH Publication No. 94–4308. Rockville, MD: National Institute on Drug Abuse, 1998.

Carroll, K.M.; Nich, C.; Ball, S.A.; McCance, E.; and Rounsaville, B.J. Treatment of cocaine and alcohol dependence with psychotherapy and disulfiram. *Addiction* 93(5):713–727, 1998.

Catalano, R.F.; Gainey, R.R.; Fleming, C.B.; Haggerty, K.P.; and Johnson, N.O. An experimental intervention with families of substance abusers: One-year follow-up of the Focus on Families project. *Addiction* 94(2):241–254, 1999.

Catalano, R.F.; Haggerty, K.P.; Gainey, R.R.; and Hoppe, M. Reducing parental risk factors for children's substance misuses: Preliminary outcomes with opiate-addicted parents. *Substance Use & Misuse* 32(6):699–721, 1997.

Center for Substance Abuse Prevention. *Substance Abuse Resource Guide: Asian and Pacific Islander Americans.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996*a*. ncadi.samhsa/gov/pubs/govpubs/MS408 [accessed March 4, 2004].

Center for Substance Abuse Prevention. *Substance Abuse Resource Guide: Hispanic/Latino Americans.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996*b*. ncadi.samhsa.gov/govpubs/MS441 [accessed March 4, 2004].

Center for Substance Abuse Prevention. Communicating appropriately with Asian and Pacific Islander audiences. *Technical Assistance Bulletin,* June 1997. ncadi.samhsa.gov/govpubs/MS701 [accessed February 11, 2004].

Center for Substance Abuse Prevention. *Cultural Competence for Health Care Professionals Working With African-American Communities: Theory and Practice.* Cultural Competence Series 7. DHHS Publication No. (SMA) 98–3238. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*a*.

Center for Substance Abuse Prevention: *Substance Abuse Resource Guide: American Indians and Alaska Natives.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*b*. ncadi.samhsa.gov/govpubs/MS419 [accessed March 4, 2004].

Center for Substance Abuse Prevention. *Responding to Pacific Islanders: Culturally Competent Perspectives for Substance Abuse Prevention.* Cultural Competence Series 8. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999.

Center for Substance Abuse Prevention. *Substance Abuse Resource Guide: Lesbian, Gay, Bisexual, and Transgender Populations.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000. ncadi.samhsa.gov/

referrals/resguides.aspx?InvNum=MS489 [accessed February 11, 2004].

Center for Substance Abuse Prevention. *Health Promotion and Substance Abuse Prevention Among American Indian and Alaska Native Communities: Issues in Cultural Competence*. Cultural Competence Series 9. DHHS Publication No. (SMA) 99–3440. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001.

Centers for Disease Control and Prevention. Increasing morbidity and mortality associated with abuse of methamphetamine—United States, 1991–1994. *Morbidity and Mortality Weekly Report* 44(47):882–886, 1995.

Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report* 14:1–48, 2002.

Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report* 16:1–46, 2004.

Charney, D.A.; Paraherakis, A.M.; and Gill, K.J. Integrated treatment of comorbid depression and substance use disorders. *Journal of Clinical Psychiatry* 62(9):672–677, 2001.

Chermack, S.T.; Walton, M.A.; Fuller, B.E.; and Blow, F.C. Correlates of expressed and received violence across relationship types among men and women substance abusers. *Psychology of Addictive Behaviors* 15(2):140–151, 2001.

Chick, J.; Lehert, P.; and Landron, F. Does acamprosate improve reduction of drinking as well as aiding abstinence? *Journal of Psychopharmacology* 17(4):397–402, 2003.

Claus, R.E., and Kindleberger, L.R. Engaging substance abusers after centralized assessment: Predictors of treatment entry and dropout. *Journal of Psychoactive Drugs* 34:25–31, 2002.

Cohen, M. *Counseling Addicted Women: A Practical Guide*. Thousand Oaks, CA: Sage Publications, 2000.

Compton, W.M., III; Cottler, L.B.; Phelps, D.L.; Ben Abdallah, A.; and Spitznagel, E.L. Psychiatric disorders among drug dependent subjects: Are they primary or secondary? *American Journal on Addictions* 9(2):126–134, 2000.

Conner, K.R.; Shea, R.R.; McDermott, M.P.; Grolling, R.; Tocco, R.V.; and Baciewicz, G. The role of multifamily therapy in promoting retention in treatment of alcohol and cocaine dependence. *American Journal on Addictions* 7(1):61–73, 1998.

Connors, G.J., and Dermen, K.H. Characteristics of participants in Secular Organizations for Sobriety (SOS). *American Journal of Drug and Alcohol Abuse* 22:281–295, 1996.

Connors, G.J.; Donovan, D.M.; and DiClemente, C.C. *Substance Abuse Treatment and the Stages of Change: Selecting and Planning Interventions*. New York: Guilford Press, 2001*a*.

Connors, G.J.; Tonigan, J.S.; and Miller, W.R. A longitudinal model of intake symptomatology, AA participation, and outcome: Retrospective study of the Project MATCH outpatient and aftercare samples. *Journal of Studies on Alcohol* 62:817–825, 2001*b*.

Cornish, J.W.; Metzger, D.; Woody, G.E.; Wilson, D.; McLellan, A.T.; Vandergrift, B.; and O'Brien, C.P. Naltrexone pharmacotherapy for opioid dependent federal probationers. *Journal of Substance Abuse Treatment* 14(6):529–534, 1997.

Covington, S. *A Woman's Journey Home: Challenges for Female Offenders and Their Children*. Washington, DC: Urban Institute, 2002.

Covington, S.S. *A Woman's Way Through the Twelve Steps*. Center City, MN: Hazelden Information Education, 1994.

Covington, S.S. *Helping Women Recover: A Program for Treating Addiction.* San Francisco: Jossey-Bass, 1999.

Covington, S.S. *A Woman's Way Through the Twelve Steps Workbook.* Center City, MN: Hazelden Information Education, 2000.

Coyhis, D., and White, W.L. Addiction and recovery in Native America: Lost history, enduring lessons. *Counselor* 3(5):16–20, 2002.

Crnkovic, A.E., and DelCampo, R.L. A systems approach to the treatment of chemical addiction. *Contemporary Family Therapy* 20(1):25–36, 1998.

Crowley, T.J. Research on contingency management treatment of drug dependence: Clinical implications and future directions. In: Higgins, S.T., and Silverman, K., eds. *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions.* Washington, DC: American Psychological Association, 1999, pp. 345–370.

CSAT (Center for Substance Abuse Treatment). *Pregnant, Substance-Using Women*. Treatment Improvement Protocol (TIP) Series 2. DHHS Publication No. (SMA) 95–3056. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993*a*, reprinted 1995.

CSAT (Center for Substance Abuse Treatment). *Screening for Infectious Diseases Among Substance Abusers.* Treatment Improvement Protocol (TIP) Series 6. DHHS Publication No. (SMA) 93–2048. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993*b*.

CSAT (Center for Substance Abuse Treatment). *Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients.* Treatment Improvement Protocol (TIP) Series 10. DHHS Publication No. (SMA) 94–3004. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*a*.

CSAT (Center for Substance Abuse Treatment). *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse.* Treatment Improvement Protocol (TIP) Series 9. DHHS Publication No. (SMA) 94–2078. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*b*.

CSAT (Center for Substance Abuse Treatment). *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse.* Treatment Improvement Protocol (TIP) Series 8. DHHS Publication No. (SMA) 94–2077. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*c*.

CSAT (Center for Substance Abuse Treatment). *Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*d*.

CSAT (Center for Substance Abuse Treatment). *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 7. DHHS Publication No. (SMA) 94–2076. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*e*.

CSAT (Center for Substance Abuse Treatment). *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases.* Treatment Improvement Protocol (TIP) Series 11. DHHS Publication No. (SMA) 94–2094. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994*f*.

CSAT (Center for Substance Abuse Treatment). *Detoxification From Alcohol and Other Drugs*. Treatment

Improvement Protocol (TIP) Series 19. DHHS Publication No. (SMA) 95–3046. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*a*.

CSAT (Center for Substance Abuse Treatment). *Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas: 1994 Award for Excellence Papers.* Technical Assistance Publication (TAP) Series 17. DHHS Publication No. (SMA) 95–3054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*b*.

CSAT (Center for Substance Abuse Treatment). *The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers.* Treatment Improvement Protocol (TIP) Series 18. DHHS Publication No. (SMA) 95–3047. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*c*.

CSAT (Center for Substance Abuse Treatment). *Bringing Excellence to Substance Abuse Services in Rural and Frontier America: 1996 Award for Excellence Papers.* Technical Assistance Publication (TAP) Series 20. DHHS Publication No. (SMA) 97–3134. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1996.

CSAT (Center for Substance Abuse Treatment). *A Guide to Substance Abuse Services for Primary Care Clinicians.* Treatment Improvement Protocol (TIP) Series 24. DHHS Publication No. (SMA) 97–3139. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997*a*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment and Domestic Violence.* Treatment Improvement Protocol (TIP) Series 25. DHHS Publication No. (SMA) 97–3163. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1997*b*.

CSAT (Center for Substance Abuse Treatment). *Comprehensive Case Management for Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27. DHHS Publication No. (SMA) 98–3222. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*a*.

CSAT (Center for Substance Abuse Treatment). *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community.* Treatment Improvement Protocol (TIP) Series 30. DHHS Publication No. (SMA) 98–3245. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*b*.

CSAT (Center for Substance Abuse Treatment). *Naltrexone and Alcoholism Treatment.* Treatment Improvement Protocol (TIP) Series 28. DHHS Publication No. (SMA) 98–3206. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*c*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Among Older Adults.* Treatment Improvement Protocol (TIP) Series 26. DHHS Publication No. (SMA) 98–3179. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*d*.

CSAT (Center for Substance Abuse Treatment). *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities.* Treatment Improvement Protocol (TIP) Series 29. DHHS Publication No. (SMA) 98–3249. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998*e*.

CSAT (Center for Substance Abuse Treatment). *Brief Interventions and Brief Therapies for Substance Abuse.* Treatment Improvement Protocol (TIP) Series 34. DHHS Publication No. (SMA) 99–3353. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*a*.

CSAT (Center for Substance Abuse Treatment). *Cultural Issues in Substance Abuse Treatment.* DHHS Publication No. (SMA) 99–3278. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*b*.

CSAT (Center for Substance Abuse Treatment). *Enhancing Motivation for Change in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 35. DHHS Publication No. (SMA) 99–3354. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*c*.

CSAT (Center for Substance Abuse Treatment). *Screening and Assessing Adolescents for Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 31. DHHS Publication No. (SMA) 99–3282. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*d*.

CSAT (Center for Substance Abuse Treatment). *Treatment for Stimulant Use Disorders.* Treatment Improvement Protocol (TIP) Series 33. DHHS Publication No. (SMA) 99–3296. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*e*.

CSAT (Center for Substance Abuse Treatment). *Treatment of Adolescents With Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 32. DHHS Publication No. (SMA) 99–3283. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999*f*.

CSAT (Center for Substance Abuse Treatment). *Integrating Substance Abuse Treatment and Vocational Services.* Treatment Improvement Protocol (TIP) Series 38. DHHS Publication No. (SMA) 00–3470. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000*a*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues.* Treatment Improvement Protocol (TIP) Series 36. DHHS Publication No. (SMA) 00–3357. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000*b*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment for Persons With HIV/AIDS.* Treatment Improvement Protocol (TIP) Series 37. DHHS Publication No. (SMA) 00–3410. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2000*c*.

CSAT (Center for Substance Abuse Treatment). *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals.* DHHS Publication No. (SMA) 01–3498. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001.

CSAT (Center for Substance Abuse Treatment). *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction.* Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04–3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004*a*.

CSAT (Center for Substance Abuse Treatment). *The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation and the HIPAA Privacy Rule: Implications for Alcohol and Substance Abuse Programs.* DHHS Publication No.

(SMA) 04-3947. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004*b*. www.hipaa.samhsa.gov/download2/SAMHSAHIPAAComparisonClearedPDFVersion.pdf [accessed April 5, 2005].

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment and Family Therapy.* Treatment Improvement Protocol (TIP) Series 39. DHHS Publication No. (SMA) 04–3957. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004*c*.

CSAT (Center for Substance Abuse Treatment). Acamprosate: A new medication for alcohol use disorders. *Substance Abuse Treatment Advisory* 4(1), 2005*a*.

CSAT (Center for Substance Abuse Treatment). *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 05-4048. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005*b*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Relapse Prevention for Older Adults: A Group Treatment Approach.* DHHS Publication No. 05-4053. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005*c*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment for Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 44. DHHS Publication No. (SMA) 05–4056. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005*d*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment for Persons With Co-Occurring Disorders.* Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05–3922. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005*e*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment: Group Therapy.* Treatment Improvement Protocol (TIP) Series 41. DHHS Publication No. (SMA) 05–3991. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005*f*.

CSAT (Center for Substance Abuse Treatment). *Client's Handbook: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders.* DHHS Publication No. (SMA) 06–4154. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*a*.

CSAT (Center for Substance Abuse Treatment). *Client's Treatment Companion: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders.* DHHS Publication No. (SMA) 06–4155. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*b*.

CSAT (Center for Substance Abuse Treatment). *Counselor's Family Education Manual: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders.* DHHS Publication No. (SMA) 06–4153. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*c*.

CSAT (Center for Substance Abuse Treatment). *Counselor's Treatment Manual: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders.* DHHS Publication No. (SMA) 06–4152. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*d*.

CSAT (Center for Substance Abuse Treatment). *Detoxification and Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 45. DHHS Publication No. (SMA) 06–4131. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*e*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse: Administrative Issues in Outpatient Treatment.* Treatment Improvement Protocol (TIP) Series 46. DHHS Publication No. (SMA) 06–4151. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*f*.

CSAT (Center for Substance Abuse Treatment). *Therapeutic Community Curriculum: Participant's Manual.* DHHS Publication No. (SMA) 06-4122. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*g*.

CSAT (Center for Substance Abuse Treatment). *Therapeutic Community Curriculum: Trainer's Manual.* DHHS Publication No. (SMA) 06-4121. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006*h*.

CSAT (Center for Substance Abuse Treatment). *Improving Cultural Competence in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, forthcoming *a*.

CSAT (Center for Substance Abuse Treatment). *Substance Abuse Treatment: Addressing the Specific Needs of Women.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, forthcoming *b*.

da Costa, C.L.; Younes, R.N.; and Lourenco, M.T. Stopping smoking: A prospective, randomized, double-blind study comparing nortriptyline to placebo. *Chest* 122:403–408, 2002.

Daley, D.C. *Relapse Prevention Workbook for Recovering Alcoholics and Drug Dependent Persons*, Third Edition. Holmes Beach, FL: Learning Publications, 2001.

Daley, D.C. *Dual Disorders: Relapse Prevention Workbook*, Second Edition. Center City, MD: Hazelden Foundation, 2003.

Daley, D.C., and Marlatt, G.A. *Managing Your Drug or Alcohol Problem: Therapist Guide*. San Antonio, TX: Psychological Corporation, 1997.

Daley, D.C.; Marlatt, G.A.; and Spotts, C.E. Relapse prevention: Clinical models and specific intervention strategies. In: Graham, A.W.; Schultz, T.K.; Mayo-Smith, M.F.; Ries, R.K.; and Wilford, B.B., eds. *Principles of Addiction Medicine*, Third Edition. Chevy Chase, MD: American Society of Addiction Medicine, 2003, pp. 467–485.

Daley, D.C.; Mercer, D.; and Carpenter, G. *Drug Counseling for Cocaine Addiction: The Collaborative Cocaine Treatment Study Manual.* Manual 4: Therapy Manuals for Drug Addiction Series. NIH Publication No. 99–4380. Rockville, MD: National Institute on Drug Abuse, 1999.

Daley, D.C., and Thase, M.E. *Dual Disorders Recovery Counseling: Integrated Treatment for Substance Use and Mental Health Disorders.* Independence, MO: Independence Press, 2002.

D'Avanzo, C., and Geissler, E. *Pocket Guide to Cultural Health Assessment*, Third Edition. Mosby's Pocket Series. Philadelphia: Elsevier, 2003.

Deas, D.; Riggs, P.; Langenbucher, J.; Goldman, M.; and Brown, S. Adolescents are not adults: Developmental considerations in alcohol users. *Alcoholism*,

Clinical and Experimental Research 24:232–237, 2000.

De La Rosa, M. Acculturation and Latino adolescents' substance use: A research agenda for the future. *Substance Use & Misuse* 37(4):429–456, 2002.

De La Rosa, M.R., and White, M.S. A review of the role of social support systems in the drug use behavior of Hispanics. *Journal of Psychoactive Drugs* 33(3):233–240, 2001.

De Leon, G. Therapeutic communities for addictions: A theoretical framework. *International Journal of the Addictions* 30(12):1603–1645, 1995.

De Leon, G. *The Therapeutic Community: Theory, Model, and Method.* New York: Springer Publishing, 2000.

De Leon, G., and Jainchill, N. Circumstance, motivation, readiness, and suitability as correlates of treatment tenure. *Journal of Psychoactive Drugs* 18:203–208, 1986.

De Leon, G.; Melnick, G.; Kressel, D.; and Jainchill, N. Circumstances, motivation, readiness, and suitability (the CMRS Scales): Predicting retention in therapeutic community treatment. *American Journal of Drug and Alcohol Abuse* 20(4):495–515, 1994.

DiClemente, C.C., and Hughes, S.O. Stages of change profiles in outpatient alcoholism treatment. *Journal of Substance Abuse* 2:217–235, 1990.

Ditton, P.M. Mental health and treatment of inmates and probationers. *Bureau of Justice Statistics Special Report.* Washington, DC: Office of Justice Programs, July 1999. www.ojp.usdoj.gov/bjs/abstract/mhtip.htm [accessed February 11, 2004].

Dixon, L.; McNary, S.; and Lehman, A. Remission of substance use disorder among psychiatric inpatients with mental illness. *American Journal of Psychiatry* 155(2):239–243, 1998.

Drake, R.E.; Essock, S.M.; Shaner, A.; Carey, K.B.; Minkoff, K.; Kola, L.; Lynde, D.; Osher, F.C.; Clark, R.E.; and Rickards, L. Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services* 52:469–476, 2001.

Drake, R.E.; McHugo, G.J.; Clark, R.E.; Teague, G.B.; Xie, H.; Miles, K.; and Ackerson, T.H. Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: A clinical trial. *American Journal of Orthopsychiatry* 68(2):201–215, 1998*a*.

Drake, R.E.; Mercer-McFadden, C.; Mueser, K.T.; McHugo, G.J.; and Bond, G.R. Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin* 24(4):589–608, 1998*b*.

Drake, R.E., and Mueser, K.T. Psychosocial approaches to dual diagnosis. *Schizophrenia Bulletin* 26:105–118, 2000.

Edwards, J.T. *Treating Chemically Dependent Families: A Practical Systems Approach for Professionals.* Minneapolis, MN: Johnson Institute, 1990.

Edwards, M.D., and Steinglass, P. Family therapy treatment outcomes for alcoholism. *Journal of Marital and Family Therapy* 21(4):475–509, 1995.

Ehrman, R.N.; Robbins, S.J.; and Cornish, J.W. Results of a baseline urine test predict levels of cocaine use during treatment. *Drug and Alcohol Dependence* 62(1):1–7, 2001.

Eisen, M.; Keyser-Smith, J.; Dampeer, J.; and Sambrano, S. Evaluation of substance use outcomes in demonstration projects for pregnant and postpartum women and their infants: Findings from

a quasi-experiment. *Addictive Behaviors* 25(1):123–129, 2000.

Epstein, E.E., and McCrady, B.S. Behavioral couples treatment of alcohol and drug use disorders: Current status and innovations. *Clinical Psychology Review* 18(6):689–711, 1998.

Epstein, J.; Barker, P.; Vorburger, M.; and Murtha, C. *Serious Mental Illness and Its Co-Occurrence With Substance Use Disorders, 2002.* Analytic Series A-24. DHHS Publication No. (SMA) 04–3905. Rockville, MD: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, 2004. www.oas.samhsa.gov/CoD/Cod.htm [accessed August 17, 2004].

Evans, K., and Sullivan, J.M. *Dual Diagnosis: Counseling the Mentally Ill Substance Abuser*, Second Edition. New York: Guilford Press, 2000.

Fals-Stewart, W., and Birchler, G.R. A national survey of the use of couples therapy in substance abuse treatment. *Journal of Substance Abuse Treatment* 20:277–283, 2001.

Fals-Stewart, W.; Birchler, G.R.; and O'Farrell, T.J. Behavioral couples therapy for male substance-abusing patients: Effects on relationship adjustment and drug-using behavior. *Journal of Consulting and Clinical Psychology* 64:959–972, 1996.

Farabee, D.; Prendergast, M.; and Anglin, M.D. The effectiveness of coerced treatment for drug-abusing offenders. *Federal Probation* 62:3–10, 1998.

Farabee, D.; Prendergast, M.; Cartier, J.; Wexler, H.; Knight, K.; and Anglin, M.D. Barriers to implementing effective correctional drug treatment programs. *Prison Journal* 79:150–162, 1999.

Farabee, D.; Rawson, R.; and McCann, M. Adoption of drug avoidance activities among patients in contingency management and cognitive–behavioral treatments. *Journal of Substance Abuse Treatment* 23(4):343–350, 2002.

Fears, D. A Diverse—and Divided—Black Community. *Washington Post*, February 24, 2002, pp. A1, A8.

Festinger, D.S.; Lamb, R.J.; Marlowe, D.B.; and Kirby, K.C. From telephone to office: Intake attendance as a function of appointment delay. *Addictive Behaviors* 27(1):131–137, 2002.

Finnegan, D.G., and McNally, E.B. *Counseling Lesbian, Gay, Bisexual, and Transgender Substance Abusers: Dual Identities*, Second Edition. Binghamton, NY: Haworth Press, 2002.

Finney, J.W.; Hahn, A.C.; and Moos, R.H. The effectiveness of inpatient and outpatient treatment for alcohol abuse: The need to focus on mediators and moderators of setting effects. *Addiction* 91(12):1773–1796; discussion 1803–1820, 1996.

Fiorentine, R. After drug treatment: Are 12-Step programs effective in maintaining abstinence? *American Journal of Drug and Alcohol Abuse* 25(1):93–116, 1999.

First, M.B.; Spitzer, R.L.; Gibbon, M.; and Williams, J.B.W. *Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I), Clinician Version.* Washington, DC: American Psychiatric Association, 1997.

Fishman, H.C., and Andes, F. Enhancing family therapy: The addition of a community resource specialist. *Journal of Marital and Family Therapy* 27(1):111–116, 2001.

Fishman, J.; Reynolds, T.; and Riedel, E. A retrospective investigation of an intensive outpatient substance abuse treatment program. *American Journal of Drug and Alcohol Abuse* 25(2):185–196, 1999.

Flynn, P.M.; Craddock, S.G.; Luckey, J.W.; Hubbard, R.L.; and Dunteman, G.H. Comorbidity of antisocial personality and mood disorders among psychoactive substance-dependent treatment clients. *Journal of Personality Disorders* 10(1):56–67, 1996.

Folstein, M.F.; Folstein, S.E.; and McHugh, P.R. Mini-Mental State: A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research* 12:189–198, 1975.

Forman, R. One AA meeting doesn't fit all: Six keys to prescribing 12-Step programs. *Current Psychiatry*, October 2002, pp. 1, 10, 16–24.

Frank, E.; Winkleby, M.A.; Altman, D.G.; Rockhill, B.; and Fortmann, S.P. Predictors of physician's smoking cessation advice. *JAMA* 266:3139–3144, 1991.

Fudala, P.J.; Yu, E.; MacFadden, W.; Boardman, C.; and Chiang, C.N. Effects of buprenorphine and naloxone in morphine-stabilized opioid addicts. *Drug and Alcohol Dependence* 50:1–8, 1998.

Fuller, R.K., and Gordis, E. Refining the treatment of alcohol withdrawal: Editorial. *JAMA* 272:557–558, 1994.

Gastfriend, D.R. Placement matching: Challenges and technical progress. In: *Proceedings: Tenth Annual Meeting & Symposium, December 2–5, 1999*. Prairie Village, KS: American Academy of Addiction Psychiatry, 1999, pp. 18–19. www.aaap.org/meetings/proceedings.pdf [accessed February 11, 2004].

Gaston, L. Reliability and criterion-related validity of the California Psychotherapy Alliance Scales—patient version. *Psychological Assessment* 3:68–74, 1991.

Gfroerer, J.; Penne, M.; Pemberton, M.; and Folsom, R. Substance abuse treatment need among older adults in 2020: The impact of the aging baby-boom cohort. *Drug and Alcohol Dependence* 69(2):127–135, 2003.

Glaze, L.E. Probation and parole in the United States, 2002. *Bureau of Justice Statistics Bulletin*. Washington, DC: Office of Justice Programs, August 2003. www.ojp.usdoj.gov/bjs/pub/pdf/ppus02.pdf [accessed February 11, 2004].

Gloria, A.M., and Peregoy, J.J. Counseling Latino alcohol and other substance users/abusers: Cultural considerations for counselors. *Journal of Substance Abuse Treatment* 13:119–126, 1996.

Glover, E.D.; Glover, P.N.; and Payne, T.J. Treating nicotine dependence. *American Journal of the Medical Sciences* 326(4):183–186, 2003.

Godlaski, T.M.; Leukefeld, C.; and Cloud, R. Recovery: With and without self-help. *Substance Use & Misuse* 32(5):621–627, 1997.

Godley, S.H.; Meyers, R.J.; Smith, J.E.; Karvinen, T.; Titus, J.C.; Godley, M.D.; Dent, G.; Passetti, L.; and Kelberg, P. *The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users*. Cannabis Youth Treatment Series, Volume 4. DHHS Publication No. (SMA) 01–3489. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2001.

Goldenberg, I., and Goldenberg, H. *Family Therapy: An Overview*, Second Edition. Brooks Grove, CA: Brooks/Cole Publishing Co., 1985.

Goodman, D. Arab Americans and American Muslims express mental health needs. *SAMHSA News* 10(1):2–3, 2002.

Gorski, T.T. The CENAPS® model of relapse prevention therapy (CMRPT®). In: Carroll, K.M., ed. *Approaches to Drug Abuse Counseling*. NIH Publication No. 00–4151. Rockville, MD: National

Institute on Drug Abuse, 2000, pp. 23–38.

Gorski, T.T., and Kelley, J.M. *Counselor's Manual for Relapse Prevention With Chemically Dependent Criminal Offenders.* Technical Assistance Publication (TAP) Series 19. DHHS Publication No. (SMA) 96–3115. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1996.

Gorski, T.T.; Kelley, J.M.; Havens, L.; and Peters, R.H. *Relapse Prevention and the Substance-Abusing Criminal Offender.* Technical Assistance Publication (TAP) Series 8. DHHS Publication No. (SMA) 95–3071. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1993, reprinted 1995.

Gottheil, E.; Weinstein, S.P.; Sterling, R.C.; Lundy, A.; and Serota, R.D. A randomized controlled study of the effectiveness of intensive outpatient treatment for cocaine dependence. *Psychiatric Services* 49(6):782–787, 1998.

Greenfeld, L.A., and Snell, T.L. Women offenders. *Bureau of Justice Statistics Special Report.* Washington, DC: Office of Justice Programs, December 1999, revised October 2000. www.ojp.usdoj.gov/bjs/abstract/wo.htm [accessed February 11, 2004].

Greenwood, G.L.; White, E.W.; Page-Shafer, K.; Bein, E.; Osmond, D.H.; Paul, J.; and Stall, R.D. Correlates of heavy substance use among young gay and bisexual men: The San Francisco Young Men's Health Study. *Drug and Alcohol Dependence* 61(2):105–112, 2001.

Gregoire, T.K., and Snively, C.A. The relationship of social support and economic self-sufficiency to substance abuse outcomes in a long-term recovery program for women. *Journal of Drug Education* 31(3):221–237, 2001.

Grella, C.E.; Polinsky, M.L.; Hser, Y.-I.; and Perry, S.M. Characteristics of women-only and mixed-gender drug abuse treatment programs. *Journal of Substance Abuse Treatment* 17:37–44, 1999.

Grieco, E.M. The Native Hawaiian and other Pacific Islander population: 2000. *Census 2000 Brief.* C2KBR/01-14. Washington, DC: U.S. Census Bureau, 2001.

Grosenick, J.K., and Hatmaker, C.M. Perceptions of the importance of physical setting in substance abuse treatment. *Journal of Substance Abuse Treatment* 18:29–39, 2000.

Gruber, K.; Chutuape, M.A.; and Stitzer, M.L. Reinforcement-based intensive outpatient treatment for inner city opiate abusers: A short-term evaluation. *Drug and Alcohol Dependence* 57:211–223, 2000.

Guardia, J.; Caso, C.; Arias, F.; Gual, A.; Sanahuja, J.; Ramirez, M.; Mengual, I.; Gonzalvo, B.; Segura, L.; Trujols, J.; and Casas, M. A double-blind, placebo-controlled study of naltrexone in the treatment of alcohol-dependence disorder: Results from a multicenter trial. *Alcoholism, Clinical and Experimental Research* 26(9):1381–1387, 2002.

Guss, J.R., ed. *Addictions in the Gay and Lesbian Community.* New York: Haworth Press, 2000.

Guydish, J.; Sorensen, J.L.; Chan, M.; Werdegar, D.; Bostrom, A.; and Acampora, A. A randomized trial comparing day and residential drug abuse treatment: 18-month outcomes. *Journal of Consulting and Clinical Psychology* 67(3):428–434, 1999.

Guydish, J.; Werdegar, D.; Sorensen, J.L.; Clark, W.; and Acampora, A. Drug abuse day treatment: A randomized clinical

trial comparing day and residential treatment programs. *Journal of Consulting and Clinical Psychology* 66(2):280–289, 1998.

Hadjicostandi, J., and Cheurprakobkit, S. Drugs and substances: Views from a Latino community. *American Journal of Drug and Alcohol Abuse* 28(4):693–710, 2002.

Hamilton, N.L.; Brantley, L.B.; Tims, F.M.; Angelovich, N.; and McDougall, B. *Family Support Network for Adolescent Cannabis Users.* Cannabis Youth Treatment Series, Volume 3. DHHS Publication No. (SMA) 01–3488. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2001.

Harrison, P.M., and Beck, A.J. Prisoners in 2002. *Bureau of Justice Statistics Bulletin.* Washington, DC: Office of Justice Programs, July 2003. www.ojp.usdoj.gov/bjs/pub/pdf/p02.pdf [accessed February 11, 2004].

Hasin, D.S.; Trautman, K.D.; Miele, G.M.; Samet, S.; Smith, M.; and Endicott, J. Psychiatric Research Interview for Substance and Mental Disorders (PRISM): Reliability for substance abusers. *American Journal of Psychiatry* 153:1195–1201, 1996.

Health Resources and Services Administration. *Cultural Competence Works: Using Cultural Competence To Improve the Quality of Health Care for Diverse Populations and Add Value to Managed Care Arrangements.* Washington, DC: U.S. Department of Health and Human Services, 2001.

Heather, N.; Luce, A.; Peck, D.; Dunbar, B.; and James, I. Development of a treatment version of the Readiness to Change Questionnaire. *Addiction Research* 7:63–68, 1999.

Heather, N.; Rollnick, S.; and Bell, A. Predictive validity of the Readiness to Change Questionnaire. *Addiction* 88:1667–1677, 1993.

Higgins, S.T. Some potential contributions of reinforcement and consumer-demand theory to reducing cocaine use. *Addictive Behaviors* 21(6):803–816, 1996.

Higgins, S.T. Introduction. In: Higgins, S.T., and Silverman, K., eds. *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions.* Washington, DC: American Psychological Association, 1999, pp. 3–13.

Higgins, S.T.; Budney, A.J.; Bickel, W.K.; Foerg, F.E.; Ogden, D.; and Badger, G.J. Outpatient behavioral treatment for cocaine dependence: One year outcomes. *Experimental and Clinical Psychopharmacology* 3:205–212, 1995.

Higgins, S.T., and Silverman, K., eds. *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions.* Washington, DC: American Psychological Association, 1999.

Higgins, S.T.; Wong, C.J.; Badger, G.J.; Ogden, D.E.; and Dantona, R.L. Contingent reinforcement increases cocaine abstinence during outpatient treatment and 1 year of follow-up. *Journal of Consulting and Clinical Psychology* 68(1):64–72, 2000.

Hodgins, D.C.; el-Guebaly, N.; and Addington, J. Treatment of substance abusers: Single or mixed gender programs. *Addiction* 92(7):805–812, 1997.

Hoffman, F. Cultural adaptations of Alcoholics Anonymous to serve Hispanic populations. *International Journal of Addiction* 29(4):445–460, 1994.

Hoffman, J.A.; Jones, B.; Caudill, B.D.; Mayo, D.W.; and Mack, K.A. The living in balance counseling approach. In: Carroll,

K.M., ed. *Approaches to Drug Abuse Counseling*. NIH Publication No. 00–4151. Rockville, MD: National Institute on Drug Abuse, 2000, pp. 39–60.

Hoffmann, N.G.; Halikas, J.A.; Mee-Lee, D.; and Weedman, R.D. *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders.* Chevy Chase, MD: American Society of Addiction Medicine, 1991.

Howell, E.M.; Heiser, N.; and Harrington, M. A review of recent findings on substance abuse treatment for pregnant women. *Journal of Substance Abuse Treatment* 16:195–219, 1999.

Hser, Y.I.; Polinsky, M.L.; Maglione, M.; and Anglin, M.D. Matching clients' needs with drug treatment services. *Journal of Substance Abuse Treatment* 16(4):299–305, 1999.

Hubbard, J.R.; Everett, A.S.; and Khan, M.A. Alcohol and drug abuse in patients with physical disabilities. *American Journal of Drug Abuse* 22(2):215–231, 1996.

Humphreys, K.; Moos, R.H.; and Cohen, G. Social and community resources and long-term recovery from treated and untreated alcoholism. *Journal of Alcoholism Studies* 58:231–238, 1997.

Hurt, R.D.; Offord, K.P.; Croghan, I.T.; Gomez-Dahl, L.; Kottke, T.E.; Morse, M.E.; and Melton, L.J., III. Mortality following inpatient addictions treatment: Role of tobacco use in a community-based cohort. *JAMA* 275:1097–1103, 1996.

Inciardi, J.A. *A Corrections-Based Continuum of Effective Drug Abuse Treatment: Research Preview.* Washington, DC: National Institute of Justice, U.S. Department of Justice, June 1996.

Institute of Medicine. *Bridging the Gap Between Practice and Research: Forging Partnerships With Community-Based Drug and Alcohol Treatment.* Washington, DC: National Academy Press, 1998.

Irvin, J.E.; Bowers, C.A.; Dunn, M.E.; and Wang, M.C. Efficacy of relapse prevention: A meta-analytic review. *Journal of Consulting and Clinical Psychology* 67:563–570, 1999.

Jaffe, J.H., and O'Keefe, C. From morphine clinics to buprenorphine: Regulating opioid agonist treatment of addiction in the United States. *Drug and Alcohol Dependence* 70:S3–S11, 2003.

Jainchill, N. Substance dependency treatment for adolescents: Practice and research. *Substance Use & Misuse* 35(12–14):2031–2060, 2000.

Jezewski, M.A., and Sotnik, P. *Culture Brokering: Providing Culturally Competent Rehabilitation Services to Foreign-Born Persons.* Buffalo, NY: Center for International Rehabilitation Research Information and Exchange, 2001. cirrie.buffalo.edu/cbrokering.html [accessed February 11, 2004].

Joe, G.W.; Simpson, D.D.; and Broome, K.M. Effects of readiness for drug abuse treatment on client retention and assessment of process. *Addiction* 93:1177–1190, 1998.

Johnson, K.M., and Beale, C.L. The rural rebound. *Wilson Quarterly* 22(2):16–27, 1998.

Johnson, J.L., and Leff, M. Children of substance abusers: Overview of research findings. *Pediatrics* 103:1085–1099, 1999.

Johnson, R.E., and McCagh, J.C. Buprenorphine and naloxone for heroin dependence. *Current Psychiatry Reports* 2:519–526, 2000.

Johnson, R.E.; Strain, E.C.; and Amass, L. Buprenorphine: How to use it right. *Drug and Alcohol Dependence* 70:S59–S77, 2003.

Jordan, L.C.; Davidson, W.S.; Herman, S.E.; and Boots Miller, B.J. Involvement in 12-Step programs among persons with dual diagnoses. *Psychiatric Services* 53:894–896, 2002.

Joyner, L.M.; Wright, J.D.; and Devine, J.A. Reliability and validity of the Addiction Severity Index among homeless substance misusers. *Substance Use & Misuse* 31(6):729–751, 1996.

Kadden, R.; Carroll, K.M.; Donovan, D.; Cooney, N.; Monti, P.; Abrams, D.; Litt, M.; and Hester, R., eds. *Cognitive–Behavioral Coping Skills Therapy Manual: A Clinical Research Guide for Therapists Treating Individuals With Alcohol Abuse and Dependence.* Project MATCH Monograph Series, Volume 3. NIH Publication No. 94–3724. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, 1995.

Kandel, D.B.; Johnson, J.G.; Bird, H.R.; Weissman, M.M.; Goodman, S.H.; Lahey, B.B.; Regier, D.A.; and Schwab-Stone, M.E. Psychiatric comorbidity among adolescents with substance use disorders: Findings from the MECA study. *Journal of the American Academy of Child and Adolescent Psychiatry* 38:693–699, 1999.

Karageorge, K. *Mental Health Status of Male and Female Clients Before and After Substance Abuse Treatment*. NEDS Fact Sheet 135. Fairfax, VA: National Evaluation Data Services, 2002.

Katz, E.C.; Gruber, K.; Chutuape, M.A.; and Stitzer, M.L. Reinforcement-based outpatient treatment for opiate and cocaine abusers. *Journal of Substance Abuse Treatment* 20(1):93–98, January 2001.

Kavanagh, K., and Kennedy, P.H. *Promoting Cultural Diversity: Strategies for Health Care Professionals.* Thousand Oaks, CA: Sage Publications, 1992.

Kelly, J.F.; McKellar, J.D.; and Moos, R. Major depression in patients with substance use disorders: Relationship to 12-Step self-help involvement and substance use outcomes. *Addiction* 98(4):499–508, 2003.

Kelly, R.C.; Mieczkowski, T.; and Sweeney, S.A. Hair analysis for drugs of abuse. Hair color and race differentials or systematic differences in drug preferences? *Forensic Science International* 107(1–3):63–86, 2000.

Kessler, R.C.; Nelson, C.B.; McGonagle, K.A.; Edlund, M.H.; Frank, R.G.; and Leaf, P.J. The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry* 66(1):17–31, 1996.

Kirby, K.C.; Amass, L.; and McLellan, A.T. Disseminating contingency management research to drug abuse treatment practitioners. In: Higgins, S.T., and Silverman, K., eds. *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions.* Washington, DC: American Psychological Association, 1999*a*, pp. 327–344.

Kirby, K.C.; Marlowe, D.B.; Festinger, D.S.; Garvey, K.A.; and LaMonaca, V. Community reinforcement training for family and significant others of drug abusers: A unilateral intervention to increase treatment entry of drug users. *Drug and Alcohol Dependence* 56:85–96, 1999*b*.

Kirby, K.C.; Marlowe, D.B.; Festinger, D.S.; Lamb, R.J.; and Platt, J.J. Schedule of voucher delivery influences initiation of cocaine abstinence. *Journal of Consulting and Clinical Psychology* 66(5):761–767, 1998.

Kohn, C.S.; Tsoh, J.Y.; and Weisner, C.M. Changes in smoking status among substance abusers: Baseline characteristics and abstinence from alcohol and drugs at 12-month follow-up. *Drug and Alcohol Dependence* 69:61–71, 2003.

Korper, S.P., and Council, C.L., eds. *Substance Use by Older Adults: Estimates of Future Impact on the Treatment System.* Analytic Series A-21. DHHS Publication No. (SMA) 03–3763. Rockville, MD: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, 2002.

Kremer, D.; Malkin, M.J.; and Benshoff, J.J. Physical activity programs offered in substance abuse treatment facilities. *Journal of Substance Abuse Treatment* 12:327–333, 1995.

Krestan, J.-A., ed. *Bridges to Recovery: Addiction, Family Therapy, and Multicultural Treatment.* New York: Free Press, 2000.

Krystal, J.H.; Cramer, J.A.; Krol, W.F.; Kirk, G.F.; and Rosenheck, R.A. Naltrexone in the treatment of alcohol dependence. *New England Journal of Medicine* 345(24):1734–1739, 2001.

Kurasaki, K.S.; Okazaki, S.; and Sue, S., eds. *Asian American Mental Health: Assessment Theories and Methods.* New York: Plenum, 2002.

Kus, R.J., ed. *Addiction and Recovery in Gay and Lesbian Persons.* New York: Haworth Press, 1995.

Laken, M.P., and Ager, J.W. Effects of case management on retention in prenatal substance abuse treatment. *American Journal of Drug and Alcohol Abuse* 22:439–448, 1996.

Laken, M.P.; McComish, J.F.; and Ager, J. Predictors of prenatal substance use and birth weight during outpatient treatment. *Journal of Substance Abuse Treatment* 14:359–366, 1997.

Langan, N.P., and Pelissier, B.M. Gender differences among prisoners in drug treatment. *Journal of Substance Abuse* 13:291–301, 2001.

LaPlante, M.P.; Kennedy, J.; Kaye, H.S.; and Wenger, B.L. Disability and employment. *Disability Statistics Abstract.* Number 11. San Francisco: Disability Statistics Center, 1996. dsc.ucsf.edu/pdf/abstract11.pdf [accessed February 11, 2004].

Latimer, W.W.; Winters, K.C.; D'Zurilla, T.; and Nichols, M. Integrated family and cognitive–behavioral therapy for adolescent substance abusers: A stage I efficacy study. *Drug and Alcohol Dependence* 71(3):303–317, 2003.

Laudet, A.; Magura, S.; Furst, R.T.; and Kumar, N. Male partners of substance-abusing women in treatment: An exploratory study. *American Journal of Drug and Alcohol Abuse* 25(4):607–627, 1999.

Laudet, A.; Magura, S.; Vogel, H.; and Knight, E. Twelve Month Follow-up on Members of a Dual Recovery Self-help Program. Poster presented at the 128th Annual Meeting of the American Public Health Association, Boston, November 2000*a*.

Laudet, A.B.; Magura, S.; Vogel, H.S.; and Knight, E. Recovery challenges among dually diagnosed individuals. *Journal of Substance Abuse Treatment* 18(4):321–329, 2000*b*.

La Veist, T.A.; Diala, C.; and Jarrett, N.C. Social status and perceived discrimination: Who experiences discrimination in the health care system, how, and why? In: Hogue, C.J.R.; Hargraves, M.A.; and Collins, K.S., eds. *Minority Health in America.* Baltimore: Johns Hopkins University Press, 2000, pp. 194–208.

Lawental, E.; McLellan, A.T.; Grissom, G.; Brill, P.; and O'Brien, C.P. Coerced treatment for substance abuse problems detected through workplace urine surveillance: Is it effective? *Journal of Substance Abuse* 8(1):115–128, 1996.

Legal Action Center. *Steps to Success: Helping Women With Alcohol and Drug*

Problems Move From Welfare to Work. New York: Legal Action Center, 1999.

Leonhard, C.; Mulvey, K.; Gastfriend, D.R.; and Shwartz, M. The Addiction Severity Index: A field study of internal consistency and validity. *Journal of Substance Abuse Treatment* 18(2):129–135, 2000.

Liddle, H.A. Theory development in a family-based therapy for adolescent drug abuse. *Journal of Clinical Child Psychology* 28(4):521–532, 1999.

Liddle, H.A. *Multidimensional Family Therapy for Adolescent Cannabis Users.* Cannabis Youth Treatment Series, Volume 5. DHHS Publication No. (SMA) 02–3660. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2002.

Liddle, H.A.; Dakof, G.A.; Parker, K.; Diamond, G.S.; Barrett, K.; and Tejeda, M. Multidimensional family therapy for adolescent drug abuse: Results of a randomized clinical trial. *American Journal of Drug and Alcohol Abuse* 27(4):651–688, 2001.

Ling, W.; Charuvastra, C.; Collins, J.F.; Batki, S.; Brown, L.S., Jr.; Kintaudi, P.; Wesson, D.R.; McNicholas, L.; Tusel, D.J.; Malkerneker, U.; Renner, J.A., Jr.; Santos, E.; Casadonte, P.; Fye, C.; Stine, S.; Wang, R.I.; and Segal, D. Buprenorphine maintenance treatment of opiate dependence: A multicenter, randomized clinical trial. *Addiction* 93(4):475–486, 1998.

Longabaugh, R.; Wirtz, P.W.; Zweben, A.; and Stout, R.L. Network support for drinking, Alcoholics Anonymous and long-term matching effects. *Addiction* 93:1313–1333, 1998.

Loustaunau, M.O., and Sobo, E.J. *The Cultural Context of Health, Illness, and Medicine.* Westport, CT: Bergin & Garvey, 1997.

Macdonald, D.I., and Kaplan, D.J. The role of the substance abuse professional. In: Graham, A.W.; Schultz, T.K.; Mayo-Smith, M.F.; Ries, R.K.; and Wilford, B.B., eds. *Principles of Addiction Medicine*, Third Edition. Chevy Chase, MD: American Society of Addiction Medicine, 2003, pp. 987–992.

Magerl, H., and Schulz, E. Methods of Saliva Analysis and the Relationship Between Saliva and Blood Concentration. Paper presented at 13th International Conference on Alcohol, Drugs and Traffic Safety, Adelaide, Australia, August 13–18, 1995. www.druglibrary.org/schaffer/Misc/driving/s3p1.htm [accessed February 11, 2004].

Magura, S.; Laudet, A.B.; Mahmood, D.; Rosenblum, A.; Vogel, H.S.; and Knight, E.L. Role of self-help processes in achieving abstinence among dually diagnosed persons. *Addictive Behaviors* 28(3):399–413, 2003.

Magura, S.; Nwakeze, P.C.; Rosenblum, A.; and Joseph, H. Substance misuse and related infectious diseases in a soup kitchen population. *Substance Use & Misuse* 35(4):551–583, 2000.

Mann, K.; Lehert, P.; and Morgan, M.Y. The efficacy of acamprosate in the maintenance of abstinence in alcohol-dependent individuals: Results of a meta-analysis. *Alcoholism, Clinical and Experimental Research* 28(1):51–63, 2004.

Marlatt, G.A., and Gordon, J.R., eds. *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors.* New York: Guilford Press, 1985.

Marlatt, G.A., and Kristeller, J.L. Mindfulness and meditation. In: Miller, W.M., ed. *Integrating Spirituality Into Treatment: Resources for Practitioners.* Washington, DC: American Psychological Association, 1999.

Marlowe, D.B.; DeMatteo, D.S.; Lamb, R.J.; and Festinger, D.S. A sober assessment of drug courts. *Federal Sentencing Reporter* 16(2):153–157, 2003.

Marlowe, D.B.; Husband, S.D.; Lamb, R.J.; Kirby, K.C.; Iguchi, M.Y.; and Platt, J.J. Psychiatric comorbidity in cocaine dependence. *American Journal on Addictions* 4:70–81, 1995.

Marlowe, D.B.; Kirby, K.C.; Bonieskie, L.M.; Glass, D.J.; Dodds, L.D.; Husband, S.D.; Platt, J.J.; and Festinger, D.S. Assessment of coercive and noncoercive pressures to enter drug abuse treatment. *Drug and Alcohol Dependence* 42(2):77–84, 1996.

Marsh, J.C.; D'Aunno, T.A.; and Smith, B.D. Increasing access and providing social services to improve drug abuse treatment for women with children. *Addiction* 95:1237–1247, 2000.

Martin, C.S., and Winters, K.C. Diagnosis and assessment of alcohol use disorders among adolescents. *Alcohol and Youth* 22:95–105, 1998. www.niaaa.nih.gov/publications/arh22-2/95-106.pdf [accessed March 3, 2004].

Martin, D.J.; Garske, J.P.; and Davis, M.K. Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology* 68:438–450, 2000.

Martino, S.; Carroll, K.M.; O'Malley, S.S.; and Rounsaville, B.J. Motivational interviewing with psychiatrically ill substance abusing patients. *American Journal on Addictions* 9(1):88–91, 2000.

Maruschak, L.M. HIV in prisons, 2000. *Bureau of Justice Statistics Bulletin.* Washington, DC: Office of Justice Programs, October 2002, revised February 2003. www.ojp.usdoj.gov/bjs/abstract/hivp00.htm [accessed February 11, 2004].

Matrix Center. *The Matrix Model of Outpatient Chemical Dependency Treatment: Family Education Guidelines and Handouts.* Los Angeles: The Matrix Center, 1989.

McCaul, M.E.; Svikis, D.S.; and Moore, R.D. Predictors of outpatient treatment retention: Patient versus substance use characteristics. *Drug and Alcohol Dependence* 62(1):9–17, 2001.

McCrady, B.S. Recent research in twelve step programs. In: Graham, A.W.; Schultz, T.K.; and Wilford, B.B, eds. *Principles of Addiction Medicine*, Second Edition. Chevy Chase, MD: American Society of Addiction Medicine, 1998, pp. 707–717.

McCrady, B.S.; Epstein, E.E.; and Hirsch, L.S. Maintaining change after conjoint behavioral alcohol treatment for men: Outcomes at 6 months. *Addiction* 94(9):1381–1396, 1999.

McCrady, B.S., and Miller, W.R., eds. *Research on Alcoholics Anonymous: Opportunities and Alternatives.* New Brunswick, NJ: Rutgers Center of Alcohol Studies, 1993.

McKay, J.R.; Alterman, A.I.; Cacciola, J.S.; Rutherford, M.J.; O'Brien, C.P.; and Koppenhaver, J. Group counseling versus individualized relapse prevention aftercare following intensive outpatient treatment for cocaine dependence: Initial results. *Journal of Consulting and Clinical Psychology* 65(5):778–788, 1997.

McKay, J.R.; Alterman, A.I.; and Rutherford, M.J. The relationship of alcohol use to cocaine relapse in cocaine dependent patients in an aftercare study. *Journal of Studies on Alcohol* 60(2):176–180, 1999.

McKay, J.R.; Lynch, K.G.; Shepard, D.S.; and Pettinati, H.M. The effectiveness of telephone-based continuing care for alcohol and cocaine dependence: 24-month outcomes. *Archives of General Psychiatry* 62(2):199–207, 2005.

McKinnon, J. The Black population in the United States: March 2002. *Current Population Reports.* P20–541. Washington, DC: U.S. Census Bureau, 2003.

McLellan, A.T.; Cacciola, J.; Kushner, H.; Peters, R.; Smith, I.; and Pettinati, H. The fifth edition of the Addiction Severity Index: Cautions, additions and normative data. *Journal of Substance Abuse Treatment* 9:461–480, 1992*a*.

McLellan, A.T.; Hagan, T.A.; Levine, M.; Gould, F.; Meyers, K.; Bencivengo, M.; and Durell, J. Supplemental social services improve outcomes in public addiction treatment. *Addiction* 93:1489–1499, 1998.

McLellan, A.T.; Hagan, T.A.; Levine, M.; Meyers, K.; Gould, F.; Bencivengo, M.; Durell, J.; and Jaffee, J. Does clinical case management improve outpatient addiction treatment? *Drug and Alcohol Dependence* 55:91–103, 1999.

McLellan, A.T.; Hagan, T.A.; Meyers, K.; Randall, M.; and Durell, J. "Intensive" outpatient substance abuse treatment: Comparisons with "traditional" outpatient treatment. *Journal of Addictive Diseases* 16(2):57–84, 1997.

McLellan, A.T.; Kushner, H.; and Metzger, D. The fifth edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment* 9:199–213, 1992*b*.

McLellan, A.T.; Lewis, D.C.; O'Brien, C.P.; and Kleber, H.D. Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA* 284(13):1689–1695, 2000.

Mee-Lee, D., and Shulman, G.D. The ASAM placement criteria and matching patients to treatment. In: Graham, A.W.; Schultz, T.K.; Mayo-Smith, M.F.; Ries, R.K.; and Wilford, B.B., eds. *Principles of Addiction Medicine*, Third Edition. Chevy Chase, MD: American Society of Addiction Medicine, 2003, pp. 453–465.

Mee-Lee, D.; Shulman, G.D.; Callahan, J.F.; Fishman, M.; Gastfriend, D.; Hartman, R.; and Hunsicker, R.J., eds. *Patient Placement Criteria for the Treatment of Substance-Related Disorders: Second Edition-Revised* (PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine, 2001.

Meezan, W., and O'Keefe, M. Multifamily group therapy: Impact on family functioning and child behavior. *Families in Society* 79(1):32–44, 1998.

Meissen, G.; Powell, T.J.; Wituk, S.A.; Girrens, K.; and Arteaga, S. Attitudes of AA contact persons toward group participation by persons with a mental illness. *Psychiatric Services* 50(8):1079–1081, 1999.

Mendelson, J., and Jones, R.T. Clinical and pharmacological evaluation of buprenorphine and naloxone combinations: Why the 4:1 ratio for treatment. *Drug and Alcohol Dependence* 70:S29–S37, 2003.

Mendelson, J.; Jones, R.T.; Welm, S.; Baggott, M.; Fernandez, I.; Melby, A.K.; and Nath, R.P. Buprenorphine and naloxone combinations: The effects of three dose ratios in morphine-stabilized, opiate-dependent volunteers. *Psychopharmacology* 141:37–46, 1999.

Mercer, D. Description of an addiction counseling approach. In: Carroll, K.M., ed. *Approaches to Drug Abuse Counseling.* NIH Publication No. 00–4151. Rockville, MD: National Institute on Drug Abuse, 2000, pp. 81–90.

Mercer, D., and Woody, G.E. *An Individual Drug Counseling Approach to Treating Cocaine Addiction: The Collaborative Cocaine Treatment Study Model.* Manual 3: Therapy Manuals for Drug Addiction. NIH Publication No. 99–4380. Rockville, MD: National Institute on Drug Abuse, 1999.

Merikangas, K.R.; Mehta, R.L.; Molnar, B.E.; Walters, E.E.; Swendsen, J.D.; Aguilar-

Gaziola, S.; Bijl, R.; Borges, G.; Caraveo-Anduaga, J.J.; Dewitt, D.J.; Kolody, B.; Vega, W.A.; Wittchen, H.-U.; and Kessler, R.C. Comorbidity of substance use disorders with mood and anxiety disorders: Results of the international consortium in psychiatric epidemiology. *Addictive Behaviors* 23:893–907, 1998.

Metsch, L.R., and McCoy, C.B. Drug treatment experiences: Rural and urban comparisons. *Substance Use & Misuse* 34(4&5):763–784, 1999.

Meyers, R.J.; Miller, W.R.; Hill, D.E.; and Tonigan, J.S. Community reinforcement and family training (CRAFT): Engaging unmotivated drug users in treatment. *Journal of Substance Abuse* 10:291–308, 1998.

Meyers, R.J.; Miller, W.R.; Smith, J.E.; and Tonigan, J.S. A randomized trial of two methods for engaging treatment-refusing drug users through concerned significant others. *Journal of Consulting and Clinical Psychology* 70:1182–1185, 2002.

Meyers, R.J.; Smith, J.E.; and Lash, D.N. The community reinforcement approach. *Recent Developments in Alcoholism* 16:183–195, 2003.

Mid-America Addiction Technology Transfer Center (MATTC). *Psychotherapeutic Medications 2003: What Every Counselor Should Know.* Kansas City, MO: MATTC, 2000. 134.193.108.18/MATTC/information/mattcProds.asp [accessed February 11, 2004].

Mieczkowski, T., and Newel, R. Patterns of concordance between hair assays and urinalysis for cocaine: Longitudinal analysis of probationers in Pinellas County, Florida. In: Harrison, L., and Hughes, A., eds. *Validity of Self-Reported Drug Use: Improving the Accuracy of Survey Estimates.* NIDA Research Monograph 167. NTIS Publication No. 97–4147. Rockville, MD: National Institute on Drug Abuse, 1997, pp. 161–199.

Mieczkowski, T.; Newel, R.; and Wraight, B. Using hair analysis, urinalysis, and self-reports to estimate drug use in a sample of detained juveniles. *Substance Use & Misuse* 33(7):1547–1567, 1998.

Miele, G.M.; Carpenter, K.M.; Cockerham, M.S.; Trautman, K.D.; Blaine, J.; and Hasin, D.S. Substance Dependence Severity Scale (SDSS): Reliability and validity of a clinician-administered interview for DSM-IV substance use disorders. *Drug and Alcohol Dependence* 59:63–75, 2000.

Milby, J.B.; Schumacher, J.E.; Raczynski, J.M.; Caldwell, E.; Engle, M.; Michael, M.; and Carr, J. Sufficient conditions for effective treatment of substance abusing homeless persons. *Drug and Alcohol Dependence* 43:39–47, 1996.

Miller, B.A. Partner violence experiences and women's drug use: Exploring the connections. In: Wetherington, C.L., and Roman, A.B., eds. *Drug Addiction Research and the Health of Women.* Rockville, MD: National Institute on Drug Abuse, 1998, pp. 407–416.

Miller, M.M. Traditional approaches to the treatment of addiction. In: Graham, A.W.; Schultz, T.K.; and Wilford, B.B, eds. *Principles of Addiction Medicine*, Second Edition. Chevy Chase, MD: American Society of Addiction Medicine, 1998, pp. 315–326.

Miller, N.S.; Ninonuero, F.G.; Klamen, D.L.; Hoffmann, N.G.; and Smith, D.E. Integration of treatment and posttreatment variables in predicting results of abstinence-based outpatient treatment after one year. *Journal of Psychoactive Drugs* 29(3):239–248, 1997.

Miller, W.R., and Rollnick, S. *Motivational Interviewing: Preparing People for Change*, Second Edition. New York: Guilford Press, 2002.

Miller, W.R., and Sanchez, V.C. Motivating young adults for treatment and lifestyle

change. In: Howard, G.S., and Nathan, P.E., eds. *Alcohol Use and Misuse by Young Adults.* Notre Dame, IN: University of Notre Dame Press, 1994, pp. 55–81.

Miller, W.R., and Tonigan, J.S. Assessing drinkers' motivation to change: The States of Change Readiness and Treatment Eagerness Scale (SOCRATES). *Psychology of Addictive Behaviors* 10(2):81–89, 1996.

Miller, W.R.; Tonigan, J.S.; and Montgomery, H.A. *Assessment of Client Motivation for Change: Preliminary Validation of the SOCRATES (Rev.) Instrument.* Albuquerque, NM: University of New Mexico, 1990.

Minkoff, K. An integrated treatment model for dual diagnosis of psychosis and addiction. *Hospital and Community Psychiatry* 40(10):1031–1036, 1989.

Minkoff, K. Models for addiction treatment in psychiatric populations. *Psychiatric Annals* 24(8):412–417, 1994.

Minkoff, K. Integration of addiction and psychiatric services. In: Minkoff, K., and Pollack, D., eds. *Managed Mental Health Care in the Public Sector: A Survival Manual.* The Netherlands: Harwood Academic Publishers, 1997, pp. 233–246.

Minkoff, K. Dual Diagnosis: An Integrated Model for the Treatment of People With Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems. Presentation at Building the Bridge: The Integration of Mental Health and Substance Abuse Services, Baltimore, August 5–7, 2002.

Moggi, F.; Ouimette, P.C.; Finney, J.W.; and Moos, R.H. Effectiveness of treatment for substance abuse and dependence for dual diagnosis patients: A model of treatment factors associated with one-year outcomes. *Journal of Studies on Alcohol* 60(6):856–866, 1999.

Mok, D.; Matthews, L.; and Mendoza, J. Changing American ethnic minority families: Highlights on Asian American, African American, and Hispanic/Latino Families. *The Family Psychologist* 19(3):4–9, 2003.

Moore, D., and Li, L. Prevalence and risk factors of illicit drug use by people with disabilities. *American Journal on Addictions* 7(2):93–102, 1998.

Moos, R.; Schaefer, J.; Andrassy, J; and Moos, B. Outpatient mental health care, self-help groups, and patients' one-year treatment outcomes. *Journal of Clinical Psychology* 57:273–287, 2001.

Moos, R.H.; Finney, J.W.; Ouimette, P.C.; and Suchinsky, R.T. A comparative evaluation of substance abuse treatment: I. Treatment orientation, amount of care, and 1-year outcomes. *Alcoholism, Clinical and Experimental Research* 23(3):529–536, 1999.

Moos, R.H., and Moos, B.S. Long-term influence of duration and intensity of treatment on previously untreated individuals with alcohol use disorders. *Addiction* 98:325–337, 2003.

Morral, A.R.; Iguchi, M.Y.; and Belding, M.A. Reducing drug use by encouraging alternative behaviors. In: Higgins, S.T., and Silverman, K., eds. *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions.* Washington, DC: American Psychological Association, 1999, pp. 203–220.

Mulvey, K.P.; Hubbard, S.; and Hayashi, S. A national study of the substance abuse treatment workforce. *Journal of Substance Abuse Treatment* 24:51–57, 2003.

Mumola, C.J. Substance abuse and treatment, State and Federal prisoners, 1997. *Bureau of Justice Statistics Special Report.* Washington, DC: Office of Justice Programs, January 1999. www.ojp.usdoj.

gov/bjs/abstract/satsfp97.htm [accessed February 11, 2004].

Mumola, C.J. Incarcerated parents and their children. *Bureau of Justice Statistics Special Report.* Washington, DC: Office of Justice Programs, August 2000. www.ojp.usdoj.gov/bjs/abstract/iptc.htm [accessed February 11, 2004].

Narcotics Anonymous. In Cooperation With Therapeutic Communities Worldwide. Presentation to the World Federation of Therapeutic Communities Conference, Cartagena, Colombia, February 1998. www.na.org/prespapers/in-cooperation.htm [accessed April 15, 2004].

Nardi, D. Addiction recovery for low-income pregnant and parenting women: A process of becoming. *Archives of Psychiatric Nursing* 12(2):81–89, 1998.

National Alliance for Hispanic Health. *Quality Health Services for Hispanics: The Cultural Competency Component.* DHHS Publication No. 99–21. Washington, DC: U.S. Department of Health and Human Services, 2000.

National Clearinghouse on Child Abuse and Neglect Information. *Substance Abuse and Child Maltreatment.* Washington, DC: U.S. Department of Health and Human Services, 2003. nccanch.acf.hhs.gov/pubs/factsheets/subabuse_childmal.cfm [accessed May 25, 2006].

National Institute of Justice. *1996–1997 Update: HIV/AIDS, STDs, and TB in Correctional Facilities.* Washington, DC: U.S. Department of Justice, July 1999. www.ojp.gov/80/nij/pubs-sum/176344.htm [accessed February 11, 2004].

National Institute on Alcohol Abuse and Alcoholism. Alcohol use among special populations (special issue). *Alcohol Health & Research World* 22(4), 1998.

National Institute on Drug Abuse (NIDA). *Assessing Drug Abuse Among Adolescents and Adults: Standardized Instruments.* The Clinical Report Series. NIH Publication No. 94–3757. Rockville, MD: NIDA, 1994.

National Institute on Drug Abuse (NIDA). *Principles of Drug Addiction Treatment: A Research-Based Guide.* NIH Publication No. 99–4180. Rockville, MD: NIDA, 1999, reprinted 2000.

National Institute on Drug Abuse (NIDA). Therapeutic community. *NIDA Research Report Series.* NIH Publication No. 02–4877. Rockville, MD: NIDA, 2002.

Naumann, P.; Langford, D.; Torres, S.; Campbell, J.; and Glass, N. Women battering in primary care practice. *Family Practice* 16(4):343–352, 1999.

Nebelkopf, E.; Philips, M.; and Native American Health Center Staff. Morning star rising: Healing in Native American communities (special issue). *Journal of Psychoactive Drugs* 35(1), 2003.

Nowinski, J.; Baker, S.; and Carroll, K.M. *Twelve Step Facilitation Therapy Manual: A Clinical Research Guide for Therapists Treating Individuals With Alcohol Abuse and Dependence.* NIAAA Project MATCH Monograph Series, Volume 1. DHHS Publication No. (ADM) 92–1893. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, 1992, reprinted 1994 and 1999.

Obert, J.L.; McCann, M.J.; Marinelli-Casey, P.; Weiner, A.; Minsky, S.; Brethen, P.; and Rawson, R. The matrix model of outpatient stimulant abuse treatment: History and description. *Journal of Psychoactive Drugs* 32(2):157–164, 2000.

O'Connor, P.G.; Oliveto, A.H.; Shi, J.M.; Triffleman, E.G.; Carroll, K.M.; Kosten, T.R.; Rounsaville, B.J.; Pakes, J.A.; and Schottenfeld, R.S. A randomized trial of buprenorphine maintenance for heroin dependence in a primary care clinic for substance users versus a methadone

clinic. *American Journal of Medicine* 105:100–105, 1998.

O'Farrell, T.J.; Choquette, K.A.; and Cutter, H.S.G. Couples relapse prevention sessions after behavioral marital therapy for male alcoholics: Outcomes during the three years after starting treatment. *Journal of Studies on Alcohol* 59(4):357–370, 1998.

O'Farrell, T.J., and Fals-Stewart, W. Family-involved alcoholism treatment: An update. *Recent Developments in Alcoholism* 15:329–356, 2001.

O'Farrell, T.J., and Fals-Stewart, W. Behavioral couples therapy for alcoholism and drug abuse. *Journal of Substance Abuse Treatment* 18:51–54, 2002.

O'Farrell, T.J., and Fals-Stewart, W.A. Alcohol abuse. *Journal of Marital and Family Therapy* 29(1):121–146, 2003.

Office of Applied Studies. *Summary of Findings From the 2000 National Household Survey on Drug Abuse.* NHSDA Series H–13. DHHS Publication No. (SMA) 01–3549. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001. www.samhsa.gov/oas/NHSDA/2kNHSDA/2kNHSDA.htm [accessed February 11, 2004].

Office of Applied Studies. *Treatment Episode Data Set (TEDS): 1992–2000, National Admissions to Substance Abuse Treatment Services.* DASIS Series: S-17, DHHS Publication No. (SMA) 02–3727. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2002. wwwdasis.samhsa.gov/teds00/TEDS_2k_index.htm [accessed February 11, 2004].

Office of Applied Studies. *The DASIS Report: Admissions of Persons With Co-Occurring Disorders, 2000.* Rockville, MD: Substance Abuse and Mental Health Services Administration, April 2003*a*. www.samhsa.gov/oas/2k3/dualTX/dualTX.htm [accessed February 11, 2004].

Office of Applied Studies. *The DASIS Report: Characteristics of Homeless Admissions to Substance Abuse Treatment, 2000.* Rockville, MD: Substance Abuse and Mental Health Services Administration, August 8, 2003*b*. www.samhsa.gov/oas/2k3/homelessTX/homelessTX.htm [accessed February 11, 2004].

Ogunwole, S.U. The American Indian and Alaska Native population: 2000. *Census 2000 Brief.* C2KBR/01–15. Washington, DC: U.S. Census Bureau, 2002.

O'Malley, S.S.; Jaffe, A.J.; Chang, G.; Schottenfeld, R.S.; Meyer, R.E.; and Rounsaville, B. Naltrexone and coping skills therapy for alcohol dependence: A controlled study. *Archives of General Psychiatry* 49(11):881–887, 1992.

Osgood, N.J.; Wood, H.E.; and Parham, I.A., eds. *Alcoholism and Aging: An Annotated Bibliography and Review.* Westport, CT: Greenwood, 1995.

Osher, F.C., and Kofoed, L.L. Treatment of patients with psychiatric and psychoactive substance abuse disorders. *Hospital and Community Psychiatry* 40(10):1025–1030, 1989.

Oslin, D.W.; Pettinati, H.; and Volpicelli, J.R. Older age predicts better adherence and drinking outcomes. *American Journal of Geriatric Psychiatry* 10:740–747, 2002.

Ouimette, P.C.; Kimerling, R.; Shaw, J.; and Moos, R.H. Physical and sexual abuse among women and men with substance use disorders. *Alcoholism Treatment Quarterly* 18(3):7–17, 2000.

Owen, P. Minnesota model: Description of a counseling approach. In: Carroll, K.M., ed. *Approaches to Drug Abuse Counseling.* NIH Publication No. 00–4151. Rockville, MD: National Institute on Drug Abuse, 2000, pp. 117–125.

Paluska, S.A., and Schwenk, T.L. Physical activity and mental health: Current concepts. *Sports Medicine* 29(3):167–180, 2000.

Perry, M.J., and Mackun, P.J. Population change and distribution: 1990 to 2000. *Census 2000 Brief*. C2KBR/01-2. Washington, DC: U.S. Census Bureau, 2001.

Peters, R.H.; Greenbaun, P.E.; Steinberg, M.L.; Carter, C.R.; Ortiz, M.M.; Fry, B.C.; and Valle, S.K. Effectiveness of screening instruments in detecting substance use disorders among prisoners. *Journal of Substance Abuse Treatment* 18:349–358, 2000.

Petrakis, I.L.; Gonzalez, G.; Rosenheck, R.; and Krystal, J.H. *Comorbidity of Alcoholism and Psychiatric Disorders: An Overview*. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, November 2002. www.niaaa.nih.gov/publications/arh26-2/81-89.htm [accessed February 11, 2004].

Petry, N.M. A comprehensive guide to the application of contingency management procedures in standard clinic settings. *Drug and Alcohol Dependence* 58:9–25, 2000.

Physicians' Desk Reference (PDR), 53d Edition. Montvale, NJ: Medical Economics, 2003.

Pickens, R.W.; Battjes, R.; Svikis, D.S.; and Gupman, A.E. Substance use risk factors for HIV infection. *Psychiatric Clinics of North America* 16:119–125, 1993.

Preston, K.L.; Silverman, K.; and Cone, E.J. Monitoring cocaine use during contingency management interventions. In: Higgins, S.T., and Silverman, K., eds. *Motivating Behavior Change Among Illicit Drug Abusers*. Washington, DC: American Psychological Association, 1999, pp. 283–308.

Prochaska, J.O., and DiClemente, C.C. *The Transtheoretical Approach: Crossing Traditional Boundaries of Therapy*. Homewood, IL: Dow Jones and Irwin, 1984.

Prochaska, J.O., and DiClemente, C.C. Toward a comprehensive model of change. In: Miller, W.R., and Heather, N., eds. *Treating Addictive Behaviors: Processes of Change*. New York: Plenum Press, 1986, pp. 3–27.

Prochaska, J.O., and DiClemente, C.C. Stages of change in the modification of problem behavior. In: Hersen, M.; Eisler, R.; and Miller, P.M., eds. *Progress in Behavior Modification*. Sycamore, IL: Sycamore Publishing, 1992.

Prochaska, J.O.; Norcross, J.C.; and DiClemente, C.C. *Changing for Good*. New York: William Morrow, 1994.

Project MATCH Research Group. Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol* 58:7–29, 1997.

Project MATCH Research Group. Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism, Clinical and Experimental Research* 22:1300–1311, 1998.

Ramirez, R.R., and de la Cruz, G.P. The Hispanic population in the United States: March 2002. *Current Population Reports*, P20–545. Washington, DC: U.S. Census Bureau, 2003.

Rawson, R.A. Welcome to the ISAP news. *ISAP News* 1(1):1, 2003. www.uclaisap.org/newsletter/documents/May-2003-ISAP-News.pdf [accessed February 11, 2004].

Rawson, R.A.; Huber, A.; Brethen, P.; Obert, J.; Gulati, V.; Shoptaw, S.; and Ling, W. Status of methamphetamine users 2–5

years after outpatient treatment. *Journal of Addictive Diseases* 21:107–119, 2002.

Rawson, R.A.; Obert, J.L.; McCann, M.J.; and Mann, A.J. Cocaine treatment outcome: Cocaine use following inpatient, outpatient, and no treatment. In: Harris, L.S., ed. *Problems of Drug Dependence, 1985: Proceedings of the 47th Annual Scientific Meeting, the Committee on Problems of Drug Dependence, Inc.* NIDA Research Monograph 67. Rockville, MD: National Institute on Drug Abuse, 1986, pp. 271–277.

Reeves, T., and Bennett, C. The Asian and Pacific Islander population in the United States: March 2002. *Current Population Reports*, P20–540. Washington, DC: U.S. Census Bureau, 2003.

Reoux, J.P., and Miller, K. Routine hospital alcohol detoxification practice compared to symptom triggered management with an objective withdrawal scale (CIWA-Ar). *American Journal on Addictions* 9(2):135–144, 2000.

Richard, A.J.; Montoya, I.D.; Nelson, R.; and Spence, R.T. Effectiveness of adjunct therapies in crack cocaine treatment. *Journal of Substance Abuse Treatment* 12(6):401–413, 1995.

Richmond, R., and Zwar, N. Review of bupropion for smoking cessation. *Drug and Alcohol Review* 22:203–220, 2003.

Ries, R.K.; Russo, J.; Wingerson, D.; Snowden, M.; Comtois, K.A.; Srebnik, D.; and Roy-Byrne, P. Shorter hospital stays and more rapid improvement among patients with schizophrenia and substance disorders. *Psychiatric Services* 51:210–215, 2000.

Ritsher, J.B.; Moos, R.H.; and Finney, J.W. Relationship of treatment orientation and continuing care to remission among substance abuse patients. *Psychiatric Services* 53(5):595–601, 2002.

Robertson, E.B.; Sloboda, Z.; Boyd, G.M.; Beatty, L.; and Kozel, N.J. *Rural Substance Abuse: State of Knowledge and Issues.* NIDA Research Monograph 168. NIH Publication No. 97–4177. Rockville, MD: National Institute on Drug Abuse, 1997.

Rosenheck, R.; Harkness, L.; and Johnson, B. Intensive community-focused treatment of veterans with dual diagnoses. *American Journal of Psychiatry* 155(10):1429–1433, 1998.

Rounsaville, B.J.; Tims, F.M.; Horton, A.M.; and Sowder, B.J., eds. *Diagnostic Source Book on Drug Abuse Research and Treatment.* DHHS Publication No. (ADM) 93–3508. Rockville, MD: National Institute on Drug Abuse, 1993.

Rowe, C.L., and Liddle, H.A. Substance abuse. *Journal of Marital and Family Therapy* 29:97–120, 2003.

Rubin, A.; Stout, R.L.; and Longabaugh, R. Gender differences in relapse situations. *Addiction* 91(Suppl):S111–S120, 1996.

Sampl, S., and Kadden, R. *Motivational Enhancement Therapy and Cognitive-Behavioral Therapy for Adolescent Cannabis Users: 5 Sessions.* Cannabis Youth Treatment Series, Volume 1. DHHS Publication No. (SMA) 01–3486. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2001.

Schmidley, D. The foreign-born population in the United States: March 2002. *Current Population Reports*, P20–539. Washington, DC: U.S. Census Bureau, 2003.

Schmitz, J.M.; Henningfield, J.E.; and Jarvik, M.E. Pharmacologic therapies for nicotine dependence. In: Graham, A.W.; Schultz, T.K.; and Wilford, B.B., eds. *Principles of Addiction Medicine*, Second Edition. Chevy Chase, MD: American

Society of Addiction Medicine, 1998, pp. 571–582.

Schmitz, J.M.; Oswald, L.M.; Jacks, S.D.; Rustin, T.; Rhoades, H.M.; and Grabowski, J. Relapse prevention treatment for cocaine dependence: Group versus individual format. *Addictive Behaviors* 22(3):405–418, 1997.

Schneider, R.; Mittelmeier, C.; and Gadish, D. Day versus inpatient treatment for cocaine dependence: An experimental comparison. *Journal of Mental Health Administration* 23(2):234–245, 1996.

Schottenfeld, R.S., and Pantalon, M.V. Assessment of the patient. In: Galanter, M., and Kleber, H.D., eds. *The American Psychiatric Press Textbook of Substance Abuse Treatment*, Second Edition. Washington, DC: American Psychiatric Press, 1999, pp. 109–119.

Schuckit, M.S. Goals of treatment. In: Galanter, M., and Kleber, H.D., eds. *The American Psychiatric Press Textbook of Substance Abuse Treatment.* Washington, DC: American Psychiatric Press, 1994, pp. 3–10.

Schumacher, J.E.; Milby, J.B.; Caldwell, E.; Raczynski, J.; Engle, M.; Michael, M.; and Carr, J. Treatment outcome as a function of treatment attendance with homeless persons abusing cocaine. *Journal of Addictive Diseases* 14(4):73–85, 1995.

Schwartz, M.; Baker, G.; Mulvey, K.P.; and Plough, A. Improving publicly funded substance abuse treatment: The value of case management. *American Journal of Public Health* 87:1659–1664, 1997.

Scott, J.; Gilvarry, E.; and Farrell, M. Managing anxiety and depression in alcohol and drug dependence. *Addictive Behaviors* 23(6):919–931, 1998.

Seidner, A.L.; Burling, T.A.; Gaither, D.E.; and Thomas, R.G. Substance-dependent inpatients who accept smoking treatment. *Journal of Substance Abuse* 8(1):33–44, 1996.

Sheehan, D.V.; Lecrubier, Y.; Harnet-Sheehan, K.; Amorim, P.; Janavs, J.; Weiller, E.; Hergueta, T.; Baker, R.; and Dunbar, G. The Mini International Neuropsychiatric Interview (M.I.N.I.): The development and validation of a structured diagnostic psychiatric interview. *Journal of Clinical Psychiatry* (Suppl. 20):22–33, 1998.

Shoptaw, S.; Frosch, D.; Rawson, R.A.; and Ling, W. Cocaine abuse counseling as HIV prevention. *AIDS Education and Prevention* 9(3):15–24, 1997.

Shoptaw, S.; Reback, C.J.; Freese, T.E.; and Rawson, R.A. *Friends Health Center: Behavioral Interventions for Methamphetamine Abusing Gay and Bisexual Men, A Treatment Manual Combining Relapse Prevention and HIV Risk-Reduction Interventions.* Los Angeles: Friends Research Institute, Inc., 1998.

Shoptaw, S.; Rotheram-Fuller, E.; Yang, X.; Frosch, D.; Nahom, D.; Jarvik, M.E.; Rawson, R.A.; and Ling, W. Smoking cessation in methadone maintenance. *Addiction* 97:1317–1328, 2002.

Siegal, H.A.; Fisher, J.A.; Rapp, R.C.; Kelliher, C.W.; Wagner, J.H.; O'Brien, W.F.; and Cole, P.A. Enhancing substance abuse treatment with case management: Its impact on employment. *Journal of Substance Abuse Treatment* 13(2):93–98, 1996.

Siegal, H.A.; Li, L.; and Rapp, R.C. Case management as a therapeutic enhancement: Impact on post-treatment criminality. *Journal of Addictive Diseases* 21:37–46, 2002.

Simpson, T.L., and Miller, W.R. Concomitance between childhood sexual and physical abuse and substance use problems: A review. *Clinical Psychological Review* 22(1):27–77, 2002.

Sloan, K.L., and Rowe, G. Substance abuse and psychiatric illness: Treatment experience. *American Journal of Drug and Alcohol Abuse* 24(4):589–601, 1998.

Spicer, P.; Beals, J.; Croy, C.D.; Mitchell, C.M.; Novins, D.K.; Moore, L.; Manson, S.M.; and the American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project Team. The prevalence of DSM-III-R alcohol dependence in two American Indian populations. *Alcoholism, Clinical and Experimental Research* 27(11):1785–1797, 2003.

Stanton, M.D., and Shadish, W.R. Outcome, attrition, and family—Couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological Bulletin* 122(2):170–191, 1997.

Stasiewicz, P.R., and Stalker, R. A comparison of three "interventions" on pretreatment dropout rates in an outpatient substance abuse clinic. *Addictive Behaviors* 24(4):579–582, 1999.

Stewart, E.C., and Bennett, M.J. *American Cultural Patterns: A Cross-Cultural Perspective*, Second Edition. Yarmouth, ME: Intercultural Press, 1991.

Substance Abuse and Mental Health Services Administration (SAMHSA). *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders.* Rockville, MD: SAMHSA, 2002.

Substance Abuse and Mental Health Services Administration (SAMHSA). *Strategies for Developing Treatment Programs for People With Co-Occurring Substance Abuse and Mental Disorders.* SAMHSA Publication No. 3782. Rockville, MD: SAMHSA, 2003.

Sue, D.W., and Sue, D. *Counseling the Culturally Different: Theory and Practice*, Third Edition. New York: John Wiley and Sons, 1999.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Instrument for Alcohol Scale (CIWA-Ar). *British Journal of the Addictions* 84:1353–1357, 1989.

Szapocznik, J.; Kurtines, W.M.; Foote, F.H.; Perez-Vidal, A.; and Hervis, O. Conjoint versus one-person family therapy: Some evidence for the effectiveness of conducting family therapy through one person. *Journal of Consulting and Clinical Psychology* 51:881–889, 1983.

Szapocznik, J.; Kurtines, W.M.; Foote, F.H.; Perez-Vidal, A.; and Hervis, O. Conjoint versus one-person family therapy: Further evidence for the effectiveness of conducting family therapy through one person with drug-abusing adolescents. *Journal of Consulting and Clinical Psychology* 54:395–397, 1986.

Szapocznik, J., and Williams, R.A. Brief strategic family therapy: Twenty-five years of interplay among theory, research and practice in adolescent behavior problems and drug abuse. *Clinical Child and Family Psychology Review* 3(2):117–134, 2000.

Tempesta, E.; Janiri, L.; Bignamini, A.; Chabac, S.; and Potgieter, A. Acamprosate and relapse prevention in the treatment of alcohol dependence: A placebo-controlled study. *Alcohol and Alcoholism* 35(2):202–209, 2000.

Tolman, R.M. The development of a measure of psychological maltreatment of women by their male partners. *Violence and Victims* 4:159–177, 1989.

Tonigan, J.S. Project MATCH treatment participation and outcome by self-reported ethnicity. *Alcoholism, Clinical and Experimental Research* 27(8):1340–1344, 2003.

Tonigan, J.S.; Miller, W.R.; and Schermer, C. Atheists, agnostics, and Alcoholics

Anonymous. *Journal of Studies on Alcohol* 63:534–541, 2002.

Tracy, E.M., and Whittaker, J.K. The social network map: Assessing social support in clinical practice. *Families in Society: The Journal of Contemporary Human Services* 71:461–470, 1990.

Turner, R.J., and Gil, A.G. Psychiatric substance use disorders in South Florida: Racial/ethnic and gender contrasts in a young adult cohort. *Archives of General Psychiatry* 59(1):43–50, 2002.

Tuten, M., and Jones, H.E. A partner's drug-using status impacts women's drug treatment outcome. *Drug and Alcohol Dependence* 70(3):327–330, 2003.

Urban Institute; Burt, M.R.; Aron, L.Y.; Douglas, T.; Valente, J.; Lee, E.; and Iwen, B. *Homelessness: Programs and the People They Serve–Findings of the National Survey of Homeless Assistance Providers and Clients, Technical Report.* Washington, DC: Interagency Council on the Homeless, 1999. www.huduser.org/publications/homeless/homeless_tech.html [accessed February 11, 2004].

U.S. Census Bureau. Asian Pacific American Heritage Month: May 2003. *Facts for Features.* Washington, DC: U.S. Census Bureau, April 17, 2003. www.census.gov/Press-Release/www/2003/cb03-ff05.html [accessed February 11, 2004].

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1999. www.mentalhealth.org/features/surgeongeneralreport/home.asp [accessed February 11, 2004].

U.S. Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity–A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2001. www.mentalhealth.org/cre/default.asp [accessed February 11, 2004].

U.S. Government Office of Technology Assessment. *Technologies for Understanding and Preventing Substance Abuse and Addiction.* Washington, DC: U.S. Government Printing Office, 1994.

U.S. House Committee on the Judiciary, Subcommittee on Crime. *Testimony of Bruce C. Fry, J.D., M.P.P.*, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. 104th Cong., 2d sess., October 2, 2000. www.house.gov/judiciary/fry1002.htm [accessed February 11, 2004].

Vaillant, G.E. *The Natural History of Alcoholism.* Cambridge, MA: Harvard University Press, 1983.

Veach, L.J.; Remley, T.P., Jr.; Kippers, S.M.; and Sorg, J.D. Retention predictors related to intensive outpatient programs for substance use disorders. *American Journal of Drug and Alcohol Abuse* 26(3):417–428, 2000.

Vega, W.A.; Gil, A.G.; and Wagner E. Cultural adjustment and Hispanic adolescents. In: Vega, W.A., and Gil, A.G., eds. *Drug Use and Ethnicity in Early Adolescence.* New York: Plenum, 1998, pp. 125–148.

Vega, W.A.; Gil, A.G.; and Zimmerman, R.S. Patterns of drug use among Cuban-American, African-American, and white non-Hispanic boys. *American Journal of Public Health* 83(2):257–259, 1993.

Volpicelli, J.R.; Alterman, A.I.; Hayashida, M.; and O'Brien, C.P. Naltrexone in the treatment of alcohol dependence. *Archives of General Psychiatry* 49:876–880, 1992.

Volpicelli, J.R.; Markman, I.; Monterosso, J.; Filing, J.; and O'Brien, C.P. Psychosocially enhanced treatment for cocaine-dependent mothers: Evidence of efficacy. *Journal of Substance Abuse Treatment* 18(1):41–49, 2000.

Washton, A.M. Evolution of intensive outpatient treatment (IOP) as a "legitimate" treatment modality. *Journal of Addictive Diseases* 16(2):xxi–xxvii, 1997.

Washton, A.M. A psychotherapeutic and skills-training approach to the treatment of addiction. In: Carroll, K.M., ed. *Approaches to Drug Abuse Counseling.* NIH Publication No. 00–4151. Rockville, MD: National Institute on Drug Abuse, 2000, pp. 139–148.

Watkins, K.E.; Burnam, A.; Kung, F.Y.; and Paddock, S. A national survey of care for persons with co-occurring mental and substance use disorders. *Psychiatric Services* 52(8):1062–1068, 2001.

Webb, C.; Scudder, M.; Kaminer, Y.; and Kadden, R. *The Motivational Enhancement Therapy and Cognitive–Behavioral Therapy Supplement: 7 Sessions of Cognitive–Behavioral Therapy for Adolescent Cannabis Users.* Cannabis Youth Treatment Series, Volume 2. DHHS Publication No. (SMA) 02–3659. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2002.

Weinberg, N.Z.; Rahdert, E.; Colliver, J.D.; and Glantz, M.D. Adolescent substance abuse: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry* 37:252–261, 1998.

Weinstein, S.P.; Gottheil, E.; and Sterling, R.C. Randomized comparison of intensive outpatient vs. individual therapy for cocaine abusers. *Journal of Addictive Diseases* 16(2):41–56, 1997.

Weiss, R.D.; Griffin, M.L.; Greenfield, S.F.; Najavits, L.M.; Wyner, D.; Soto, J.A.; and Hennen, J.A. Group therapy for patients with bipolar disorder and substance dependence: Results of a pilot study. *Journal of Clinical Psychiatry* 61(5):361–367, 2000.

Wells, K.; Klap, R.; Koike, A.; and Sherbourne, C. Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. *American Journal of Psychiatry* 158:2027–2032, 2001.

White, J.M.; Winn, K.I.; and Young, W. Predictors of attrition from an outpatient chemical dependency program. *Substance Abuse* 19(2):49–59, 1998.

White, W.L. *Slaying the Dragon: The History of Addiction Treatment and Recovery in America.* Bloomington, IL: Chestnut Health Systems, 1998.

Whiteside-Mansell, L. The development and evaluation of an alcohol and drug prevention and treatment program for women and children: The AR-CARES Program. *Journal of Substance Abuse Treatment* 16:265–275, 1999.

Williams, R., and Gorski, T.T. *Relapse Prevention Counseling for African Americans: A Culturally Specific Model.* Independence, MO: Herald, 1997.

Williams, R., and Gorski, T.T. *Relapse Prevention Workbook for African Americans: Hope and Healing for the Black Substance Abuser.* Independence, MO: Herald, 1999.

Williams, R.J.; Chang, S.Y.; and Addiction Centre Adolescent Research Group. A comprehensive and comparative review of adolescent substance abuse treatment outcome. *Clinical Psychology: Science and Practice* 7:138–166, 2000.

Willoughby, F.W., and Edens, J.F. Construct validity and predictive utility of the stages of change scale for alcoholics. *Journal of Substance Abuse* 8:275–291, 1996.

Winters, F.; Fals-Stewart, W.; O'Farrell, T.J.; Birchler, G.R.; and Kelley, M.L. Behavioral couple therapy for female substance-abusing patients: Effects on substance abuse and relationship adjustment. *Journal of Consulting and Clinical Psychology* 70:344–355, 2002.

Winzelberg, A., and Humphreys, K. Should patients' religiosity influence clinicians' referral to 12-step self-help groups? Evidence from a study of 3,018 male substance abuse patients. *Journal of Consulting Psychology* 67:790–794, 1999.

Wiseman, E.J.; Henderson, K.L; and Briggs, M.J. Individualized treatment for outpatients withdrawing from alcohol. *Journal of Clinical Psychiatry* 59(6):289–293, 1998.

Woody, G.E.; Donnell, D.; Seage, G.R.; Metzger, D.; Marmor, M.; Koblin, B.A.; Buchbinder, S.; Gross, M.; Stone, B.; and Judson, F.N. Non-injection substance use correlates with risky sex among men having sex with men: Data from HIVNET. *Drug and Alcohol Dependence* 53(3):197–205, 1999.

World Health Organization (WHO). *International Classification of Diseases, 10th Edition (ICD-10) Classification of Mental and Behavioral Disorders: Clinical Descriptions and Diagnostic Guidelines.* Geneva, Switzerland: WHO, 1992.

World Health Organization (WHO). *Composite International Diagnostic Interview (CIDI).* Core Version 2.1. Geneva, Switzerland: WHO, 1997.

Zerger, S. *Substance Abuse Treatment: What Works for Homeless People? A Review of the Literature.* Nashville, TN: National Health Care for the Homeless Council, 2002.

Ziedonis, D.M., and D'Avanzo, K. Schizophrenia and substance abuse. In: Kranzler, H.R., and Rounsaville, B.J., eds. *Dual Diagnosis and Treatment.* New York: Marcel Dekker, 1998, pp. 427–465.

Zilberman, M.L.; Tavares, H.; Blume, S.B.; and el-Guebaly, N. Substance use disorders: Sex differences and psychiatric comorbidities. *Canadian Journal of Psychiatry* 48(1):5–13, 2003.

Zullino, D.F.; Besson, J.; Favrat, B.; Krenz, S.; Zimmerman, G.; Schnyder, C.; and Borgeat, F. Acceptance of an intended smoking ban in an alcohol dependence clinic. *European Psychiatry* 18(5):255–257, 2003.