

KAP KEYS Based on TIP 42

Substance Abuse Treatment for
Persons With Co-Occurring Disorders

Knowledge Application Program

KAP Keys

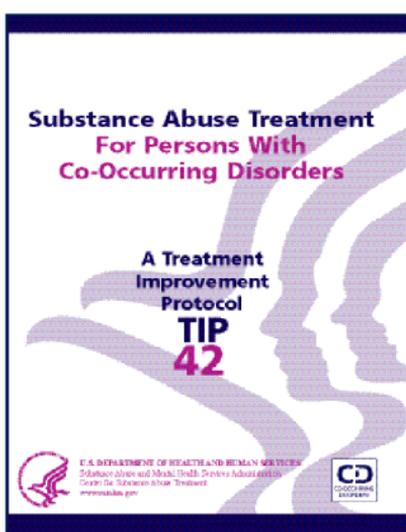
For Clinicians

Based on TIP 42

Substance Abuse

Treatment for Persons With

*Co-Occurring
Disorders*



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

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Introduction

KAP Keys were developed to accompany the Treatment Improvement Protocol (TIP) Series published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA). These KAP Keys are based entirely on TIP 42 and are designed to meet the needs of the busy clinician for concise, easily accessed “how-to” information.

For more information on the topics in these KAP Keys, readers are referred to TIP 42.

Other Treatment Improvement Protocols (TIPs) that are relevant to these KAP Keys:

TIP 27: *Comprehensive Case Management for Substance Abuse Treatment* **BKD251**

TIP 36: *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* **BKD343**

TIP: *Substance Abuse Treatment for Adults in the Criminal Justice System* (Expected publication date 2005)

TIP: *Substance Abuse Treatment: Addressing the Specific Needs of Women* (Expected publication date 2005)

TIP: *Substance Abuse Treatment and Trauma* (Expected publication date 2005)

Assessment for Co-Occurring Disorders

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Twelve Steps in the Assessment Process

Step 1: Engage the client.

Step 2: Identify and contact collaterals (family, friends, other treatment providers) to gather additional information.

Step 3: Screen for and detect COD.

Step 4: Determine quadrant and locus of responsibility.

Step 5: Determine level of care.

Step 6: Determine diagnosis.

Step 7: Determine disability and functional impairment.

Step 8: Identify strengths and supports.

Step 9: Identify cultural and linguistic needs and supports.

Step 10: Identify problem domains.

Step 11: Determine stage of change.

Step 12: Plan treatment.

Do's and Don'ts

1. *Do* keep in mind that assessment is about getting to know a person with complex and individual needs. *Do not* rely on tools alone for a comprehensive assessment.
2. *Do* always make every effort to contact all involved parties, including family members, persons who have treated the client previously, other mental health and substance abuse treatment providers, friends, significant others, and probation officers as quickly as possible in the assessment process.
3. *Don't* allow preconceptions about addiction to interfere with learning about what the client really needs (e.g., "All mental health symptoms tend to be caused by addiction unless proven otherwise"). Co-occurring disorders are as likely to be under-recognized as over-recognized. Assume initially that an established diagnosis and treatment regimen for mental illness is correct, and advise clients to continue with those recommendations until careful reevaluation has taken place.

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4. *Do* become familiar with the diagnostic criteria for common mental disorders, including personality disorders, and with the names and indications of common psychiatric medications. Also become familiar with the criteria in your own State for determining who is a mental health priority client. Know the process for referring clients for mental health case management services or for collaborating with mental health treatment providers.
5. *Don't* assume that there is one correct treatment approach or program for any type of COD. The purpose of assessment is to collect information about multiple variables that will permit individualized treatment matching. It is particularly important to assess stage of change for each problem and the client's level of ability to follow treatment recommendations.
6. *Do* become familiar with the specific role that your program or setting plays in delivering services related to COD in the wider context of the system of care. This will clarify which clients your program will best serve, and will help you to facilitate access to other settings for clients who might be better served elsewhere.
7. *Don't* be afraid to admit when you don't know, either to the client or yourself. If you do not understand what is going on with a client, acknowledge that to the client, indicate that you will work with the client to find the answers, and then ask for help. Identify at least one supervisor who is knowledgeable about COD who can answer your questions.
8. *Do* remember that empathy and hope are the most valuable components of your work with a client. When in doubt about how to manage a client with COD, stay connected, be empathic and hopeful, and work with the client and the treatment team to try to figure out the best approach over time.

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This dimension of the assessment considers a person's potential to cause significant harm to self or others. While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to care adequately for oneself, or from altered states of consciousness due to use of intoxicating substances.

Note: Staff without the appropriate training should not attempt to make determinations related to potential risk of harm. Properly trained staff should be called upon to conduct such an interview; if necessary, call 911 or implement the emergency procedures followed by your agency.

Risk of harm may be rated according to the following criteria:

Minimal Risk of Harm

- (a) No indication of suicidal or homicidal thoughts or impulses, no history of suicidal or homicidal ideation, and no indication of significant distress.
- (b) Clear ability to care for self now and in the past.

Low Risk of Harm

- (a) No current suicidal or homicidal ideation, plan, intentions or serious distress, but may have had transient or passive thoughts recently or in the past.
- (b) Substance use without significant episodes of potentially harmful behaviors.
- (c) Periods in the past of self-neglect without current evidence of such behavior.

Moderate Risk of Harm

- (a) Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.
- (b) No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.
- (c) History of chronic impulsive suicidal/homicidal behavior or threats and current expressions do not represent significant change from baseline.
- (d) Binge or excessive use of substances resulting in potentially harmful behaviors without current involvement in such behavior.
- (e) Some evidence of self neglect and/or compromise in ability to care for oneself in current environment.

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Serious Risk of Harm

- (a) Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.
- (b) History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from baseline.
- (c) Recent pattern of excessive substance use resulting in disinhibition and clearly harmful behaviors with no demonstrated ability to abstain from use.
- (d) Clear compromise of ability to care adequately for oneself or to be aware adequately of environment.

Extreme Risk of Harm

- (a) Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior...
 - without expressed ambivalence or significant barriers to doing so, or
 - with a history of serious past attempts which are not of a chronic, impulsive, or consistent nature, or
 - in presence of command hallucinations or delusions which threaten to override usual impulse control.
- (b) Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.
- (c) Extreme compromise of ability to care for oneself or to monitor adequately the environment with evidence of deterioration in physical condition or injury related to these deficits.

Source: American Association of Community Psychiatrists. *LOCUS-Level of Care Utilization System, Psychiatric and Addiction Services. Adult Version. 2000.*
www.wpic.pitt.edu/aacp/finds/LOCUS2000.pdf [Accessed 1/1/05].

Motivational Enhancement Approaches

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Stage of Readiness	Motivational Enhancement Approaches
Precontemplation	<ul style="list-style-type: none">• Express concern about the client’s substance use, or the client’s mood, anxiety, or other symptoms of mental disorder.• State nonjudgmentally that substance use (or mood, anxiety, self-destructiveness) is a problem.• Agree to disagree about the severity of either the substance use or the psychological issues.• Consider a trial of abstinence to clarify the issue, after which psychological evaluation can be reconsidered.• Suggest bringing a family member to an appointment.• Explore the client’s perception of a substance use or psychiatric problem.• Emphasize the importance of seeing the client again and that you will try to help.
Contemplation	<ul style="list-style-type: none">• Elicit positive and negative aspects of substance use or psychological symptoms.• Ask about positive and negative aspects of past periods of abstinence and substance use, as well as periods of depression, hypomania, etc.• Summarize the client’s comments on substance use, abstinence, and psychological issues.• Make explicit discrepancies between values and actions.• Consider a trial of abstinence and/or psychological evaluation.
Preparation	<ul style="list-style-type: none">• Acknowledge the significance of the decision to seek treatment for one or more disorders.• Support self-efficacy with regard to each of the COD.• Affirm the client’s ability to seek treatment successfully for each of the COD.

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	<ul style="list-style-type: none">• Help the client decide on appropriate, achievable action for each of the COD.• Caution that the road ahead is tough but very important.• Explain that relapse should not disrupt the client–clinician relationship.
Action	<ul style="list-style-type: none">• Be a source of encouragement and support; remember that the client may be in the action stage with respect to one disorder but only contemplation with respect to another; adapt your interview approach accordingly.• Acknowledge the uncomfortable aspects of withdrawal and/or psychological symptoms.• Reinforce the importance of remaining in recovery from both problems.
Maintenance	<ul style="list-style-type: none">• Anticipate and address difficulties as a means of relapse prevention.• Recognize the client’s struggle with either or both problems, working with separate mental health and substance abuse treatment systems, and so on.• Support the client’s resolve.• Reiterate that relapse or psychological symptoms should not disrupt the counseling relationship.
Relapse	<ul style="list-style-type: none">• Explore what can be learned from the relapse, whether substance-related or related to the mental disorder.• Express concern and even disappointment about the relapse.• Emphasize the positive aspect of the effort to seek care.• Support the client’s self-efficacy so that recovery seems achievable.
<p><i>Source: Samet, J.H., Rollnick, S., and Barnes, H. Beyond CAGE: A brief clinical approach after detection of substance abuse. Archives of Internal Medicine 156(20):2287–2293, 1996 (reproduced with permission).</i></p>	

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Element	Description
Client Assistance Counseling	<ul style="list-style-type: none"> Emphasizes client responsibility, coaching and guiding the client, and using the client’s senior peers to provide assistance.
Medication	<ul style="list-style-type: none"> Begins with psychiatric assessment and medication prescription, then monitors for medication adherence, side effects, and effectiveness.
Active Outreach and Continuous Orientation	<ul style="list-style-type: none"> Builds relationships and enhances program compliance and acceptance through multiple staff contacts.
Token Economy	<ul style="list-style-type: none"> Awards points (redeemable for tangible rewards such as phone cards, candy, toiletries) for positive behaviors including medication adherence, abstinence, attendance at program activities, follow-through on referrals, completing assignments, and various other activities essential to the development of commitment.
Pioneers—Creating a Positive Peer Culture	<ul style="list-style-type: none"> Facilitates program launch by forming a core group of selected residents (pioneers) to transmit the peer mutual self-help culture and to encourage newly admitted clients to make full use of the program.
Client Action Plan	<ul style="list-style-type: none"> Formulated by clients and staff to specify, monitor, and document client short-term goals under the premise that substantial accomplishments are achieved by attaining smaller objectives.
Preparation for Housing	<ul style="list-style-type: none"> Entitlements are obtained—a Section 8 application for housing is filed, available treatment and housing options are explored, work readiness skills are developed, and household management skills are taught.

Source: Adapted from Sacks, S., Skinner, D., Sacks, J., and Peck, A. *Manual for Engaging Homeless MICAs in a Shelter Program*. New York: National Development and Research Institutes, 2002.

Key Questions in a Suicide Risk Review

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Note: Staff without the appropriate training should not attempt to make determinations related to suicide risk. Properly trained staff should be called upon to conduct such an interview; if necessary, call 911 or implement the emergency procedures followed by your agency.

What is wrong?

- Personal narrative about how bad things are and the nature of the problem(s)
- Personal construction of reasons for suicide
- Personal measure of psychological pain and suffering

Why now?

- Elements of the current crisis
- History of real or imagined losses or rejections
- Sudden and unacceptable changes in life circumstances; for example, the client just received a serious or terminal diagnosis, relapse, onset of possible symptoms (e.g., sleeplessness)

With what?

- The means of suicide under consideration
- Access to the means selected

Where and when?

- Possible location and timing of a suicide attempt
- Degree of planning
- Possible anniversary phenomena

When and with what in the past?

- Past history of suicidal behavior
- Past history of intense suicidal ideation and/or planning
- Whether rescue was avoided
- Timing of past attempts
- Social response to past attempts
- Potential protective factors (reasons for living)
- Comparison of current method versus old method

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Who's involved?

- Others who may know or be involved
- Persons who may or may not be helpful in managing the client
- Names of potentially helpful third parties
- Possible presence of a suicide pact or murder-suicide plan

Why not now?

- One or more protective factors (reasons for living)
- Spiritual or religious prohibitions
- Duties to others or pets
- Residual tasks to be completed before the attempt; for example, making out a will

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<i>Community Enhancement</i>	
Morning Meeting	Increase motivation for the day's activities and create a positive family atmosphere.
Concept Seminars	Review the concept of the day.
General Interest Seminars	Provide information in areas of general interest (e.g., current events).
Program-Related Seminars	Address issues of particular relevance (e.g., homelessness, HIV prevention, and psychotropic medication).
Orientation Seminars	Orient new members and introduce all new activities.
Evening Meetings	Review house business for the day, outline plans for the next day, and monitor the emotional tone of the house.
General Meetings	Provide public review of critical events.

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<i>Therapeutic/Educative</i>	
Individual Counseling	Incorporates both traditional mental health and unique modified TC goals and methods.
Psychoeducational Classes	Are predominant, using a format to facilitate learning among clients with COD; address topics such as entitlements/money management, positive relationship skills training, triple trouble group, and feelings management.
Conflict Resolution Group	Modified encounter groups designed specifically for clients with COD.
Medication/ Medication Monitoring	Begins with psychiatric assessment and medication prescription, continues with psychoeducation classes concerning the use and value of medication, then monitors using counselor observation, the peer community, and group reporting for medication adherence, side effects, and effectiveness.
Gender-Specific Groups	Combine features of “rap groups” and therapy groups focusing on gender-based issues.
Community and Clinical Management Policies	A system of rules and regulations to maintain the physical and psychological safety of the environment, ensuring that resident life is orderly and productive, strengthening the community as a context for social learning.
Social Learning Consequence	A set of required behaviors prescribed as a response to unacceptable behavior, designed to enhance individual and community learning by transforming negative events into learning opportunities.

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<i>Vocational</i>	
Peer Work Hierarchy	A rotating assignment of residents to jobs necessary to the day-to-day functioning of the facility, serving to diversify and develop clients' work skills and experience.
World of Work	A psychoeducational class providing instruction in applications and interviews, time and attendance, relationships with others at work, employers' expectations, discipline, promotion, etc.
Recovery and World of Work	A psychoeducational class that addresses issues of mental disorders, substance abuse, and so on, in a work context.
Peer Advocate Training	A program for suitable clients offering role model, group facilitator, and individual counseling training.
Work Performance Evaluation	Provides regular, systematic feedback on work performance.
Job Selection and Placement	Individual counseling after 6 months to establish direction and to determine future employment.
<p><i>Source: Sacks, S., Sacks, J.Y., and De Leon, G. Treatment for MICAs: Design and implementation of the modified TC. Journal of Psychoactive Drugs 31(1):19–30, 1999.</i></p>	

Borderline Personality Disorder—Step Work Handout

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Step One: “We admitted we were powerless over alcohol, that our lives had become unmanageable.”

- Describe five situations where you suffered negative consequences as a result of drinking or using other drugs.
- List at least five “rules” that you have developed to try to control your use of alcohol or other drugs. (Example: “I never drink alone.”)
- Give one example describing how and when you broke each rule.
- Check the following that apply to you:
 - I sometimes drink or use drugs more than I plan.
 - I sometimes lie about my use of alcohol or drugs.
 - I have hidden or stashed away alcohol or drugs so I could use them alone or at a later time.
 - I have had memory losses when drinking or using drugs.
 - I have tried to hurt myself when drinking or using drugs.
 - I can drink or use more than I used to, without feeling drunk or high.
 - My personality changes when I drink or use drugs.
 - I have school or work problems related to using alcohol or drugs.
 - I have family problems related to my use of alcohol or drugs.
 - I have legal problems related to my use of alcohol or drugs.
- Give two examples for each item that you checked.

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Step Two: “We came to believe that a Power greater than ourselves could restore us to sanity.”

- Give three examples of how your drinking or use of drugs was “insane.” (One definition of insanity is to keep repeating the same mistake and expecting a different outcome.)
- Check which of the following mistakes or thinking errors that you use:
 - Blaming
 - Lying
 - Manipulating
 - Excuse making
 - Beating up yourself with “I should have” statements
 - Self-mutilation (cutting on yourself when angry)
 - Negative self-talk
 - Using angry behavior to control others
 - Thinking “I’m unique”
- Explain how each thinking error you checked above is harmful to you and others.
- Give two examples of something that has happened since you stopped drinking or using drugs that shows you how your situation is improving.
- Who or what is your Higher Power?
- Why do you think your Higher Power can be helpful to you?

Borderline Personality Disorder—Step Work Handout

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Step Three: “We made a decision to turn our will and our lives over to the care of God as we understood Him.”

- Explain how and why you decided to turn your will over to a Higher Power.
- Give two examples of things or situations you have “turned over” in the last week.
- List two current resentments you have, and explain why it is important for you to turn them over to your Higher Power.
- How do you go about “turning over” a resentment?
- What does it mean to turn your will and life over to your Higher Power?
- Explain how and why you have turned your will and life over to a Power greater than yourself.

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Step Four: “We made a searching and fearless moral inventory of ourselves.”

- List five things you like about yourself.
- Give five examples of situations where you have been helpful to others.
- Give three examples of sexual behaviors related to your drinking or use of other drugs, which have occurred in the last 5 years, about which you feel bad.
- Describe how beating yourself up for old drinking and drug-using behaviors is not helpful to you now.
- List five current resentments you have, and explain how holding on to these resentments hurts your recovery.
- List all laws you have broken related to your drinking and use of other drugs.
- List three new behaviors you have learned that are helpful to your recovery.
- List all current fears you are experiencing, and discuss how working the first three Steps can help dissolve them.
- Give an example of a current situation you are handling poorly.
- Discuss how you plan to handle this situation differently the next time the situation arises.

Source: Adapted with permission from Evans, K., and Sullivan, J.M. *Step Study Counseling with the Dual Disordered Client*. Center City, MN: Hazelden Educational Materials, 1990.

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The group facilitator presents thinking errors and then asks each group member to identify two thinking-error examples that apply to him or her and to choose one to focus on with the group's help.

1. **Excuse making.** Excuses can be made for anything and everything. Excuses are a way to justify behavior. For example: "I drink because my mother nags me," "My family was poor," "My family was rich."
2. **Blaming.** Blaming is an excuse to avoid solving a problem and is used to excuse behavior and build up resentment toward someone else for "causing" whatever has happened. For example: "They forced me to drink it!"
3. **Justifying.** To justify an antisocial behavior is to find a reason to support it. For example: "If you can, I can," "I deserve to get high, I've been clean for 30 days."
4. **Redefining.** Redefining is shifting the focus on an issue to avoid solving a problem. Redefining is used as a power play to get the focus off the person in question. For example: "I didn't violate my probation. The language is confusing and the order is full of typos."
5. **Superoptimism.** "I think; therefore it is." Example: "I don't have to go to AA. I can stay sober on my own."
6. **Lying.** There are three basic kinds of lies: (1) lies of commission, or making things up that are simply not true; (2) lies of omission, or saying partly what is true but leaving out major sections; and (3) lies of assent, or pretending to agree with other people or approving of their ideas despite disagreement or having no intention of supporting the idea.
7. **"I'm Unique."** Thinking one is special and that rules shouldn't apply to one.
8. **Ingratiating.** Being nice to others, and going out of one's way to act interested in other people, can be used to try to control situations or get the focus off a problem. Also known as "apple polishing."

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9. **Fragmented personality.** Some people may attend church on Sunday, get drunk or loaded on Tuesday, and then attend church again on Wednesday. They rarely consider the inconsistency between these behaviors. They may feel that they have the right to do whatever they want, and that their behaviors are justified.
10. **Minimizing.** Minimizing behavior and action by talking about it in such a way that it seems insignificant. For example: "I only had one beer. Does that count as a relapse?"
11. **Vagueness.** This strategy is to be unclear and nonspecific to avoid being pinned down on any particular issue. Vague words or phrases such as: "I more or less think so," "I guess," "Probably," "Maybe," "I might," "I'm not sure about this," "It possibly was," etc.
12. **Power play.** This strategy is to use power plays whenever one isn't getting one's way in a situation. Examples include walking out of a room during a disagreement, threatening to call an attorney or to report the group facilitator to higher-ups.
13. **Victim playing.** The victim player transacts with others to invite either criticism or rescue from those around him.
14. **Grandiosity.** Grandiosity is minimizing or maximizing the significance of an issue, and it justifies not solving the problem. For example: "I was too scared to do anything else but sit," "I'm the best there is, so no one else can get in my way."
15. **Intellectualizing.** Using an emotionally detached, data-gathering approach to avoid responsibility. For example, when faced with a positive urine drug screen the client states, "When was the last time the laboratory had its equipment calibrated?" or "What is the percentage of error in this testing procedure?"

Source: Adapted with permission from Evans, K., and Sullivan, J.M. *Step Study Counseling with the Dual Disordered Client*. Center City, MN: Hazelden Educational Materials, 1990.



Ordering Information

TIP 42

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2. Visit NCDI'S Web site at **www.ncadi.samhsa.gov**.
3. You can also access TIPs online at:
www.kap.samhsa.gov.

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