

CONDENSED CLINICAL PRACTICE GUIDELINE

TREATMENT OF CLIENTS WITH SUBSTANCE USE DISORDERS (SUD)

Substance Abuse and Mental Health Services Administration. *Substance Abuse Treatment For Persons With Co-Occurring Disorders: A Treatment Improvement Protocol (TIP) 42*

- I. General definitions, terms, and classification systems.
 - A. In TIP 42, co-occurring disorders (COD) refers to co-occurring SUD (both alcohol and psychoactive substance abuse and dependence) and mental disorders. Clients with COD have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders. A diagnosis of COD occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder.
 - B. Many think of the typical person with COD as having a severe mental disorder combined with a severe substance use disorder, such as schizophrenia combined with alcohol dependence. However, addictions counselors are more likely to see persons with severe addiction combined with mild- to moderate-severity mental disorders.
 - C. Efforts to provide treatment that will meet the unique needs of people with COD have gained momentum over the past two decades in both substance abuse treatment and mental health services settings.
 - D. The combination of SUD and COD has troubling implications for treatment outcomes. Currently the emphasis is on recognizing and addressing the interrelationship of these disorders through new approaches and adaptations of traditional treatment.
 - E. Findings show that many substance abuse treatment clients with less serious mental disorders do well with traditional substance abuse treatment methods, while those with more serious mental disorders need intervention modifications and additions to enhance treatment effectiveness.
 - F. Quadrants of care, developed by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD):
 - 1. Quadrants of care is a classification of *service coordination by severity* in the context of substance abuse and mental health settings. The NASADAD-NASMHPD four-quadrant framework provides a structure for fostering consultation, collaboration and integration among drug abuse and mental health treatment systems and providers to deliver appropriate care to clients with COD. TIP 42 is designed primarily to provide guidance for counselors working in quadrants II and III.
 - 2. Quadrant I: less severe mental disorder/less severe SUD.
 - 3. Quadrant II: more severe mental disorder/less severe SUD.
 - 4. Quadrant III: less severe mental disorder/more severe SUD.
 - 5. Quadrant IV: more severe mental disorder/more severe SUD.
 - G. ASAM Client Placement Criteria (ASAM PPC-2R) describe three types of substance abuse programs for people with COD: *addiction only services, dual diagnosis capable and dual diagnosis enhanced*. TIP 42 employs a related system

that classifies both substance abuse and mental health programs as basic, intermediate and advanced in terms of their progress toward providing more integrated care.

- H. Continuity of care refers to coordination of care as clients move across different service systems and is characterized by three features:
 1. *Consistency* among primary treatment activities and ancillary services; *seamless transitions* across levels of care; and *coordination* of present with past treatment episodes
 2. Because both substance use and mental disorders typically are long-term chronic disorders, continuity of care is critical. Any system of care needs mechanisms to ensure that all clients with COD benefit from continuity of care.

II. Integrated treatment model.

- A. Integration of SUD treatment and mental health services for COD has become a major treatment initiative. System integration is difficult to achieve and the need for improved COD services in substance abuse treatment agencies is urgent. TIP 42 recommends that emphasis be placed on assisting the substance abuse treatment system in the development of increased internal capability to treat individuals with COD effectively. A parallel effort should be undertaken in the mental health system, with the two systems continuing to work cooperatively on services to individual clients.
- B. TIP 42 recommends that program design and development activities of agencies serving clients with COD continue to incorporate consumer and advocacy groups.
- C. Integrated treatment coordinates substance abuse and mental health interventions to treat the whole person more effectively; the term refers broadly to any mechanism by which treatment interventions for COD are combined within a primary treatment relationship or service setting. This approach recognizes the importance of ensuring that entry into any one system can provide access to all needed systems.

III. Recovery perspective.

- A. Recovery perspective acknowledges that recovery is a long-term process of internal change in which progress occurs in stages.
- B. In preparing a treatment plan, the clinician should recognize that treatment takes place in different settings over time, and that much of the recovery process typically occurs outside of, or following, treatment.
- C. Practitioners often divide treatment into phases including engagement, stabilization, primary treatment and continuing care/aftercare.

IV. Assessment.

- A. Screening.
 1. Screening identifies clients seeking substance abuse treatment who show signs of mental health problems that warrant further attention.
 2. Easy-to-use screening instruments will accomplish this purpose and can be administered by counseling staff with minimal preparation.
- B. Basic assessment.
 1. *Basic assessment* consists of gathering information that will give evidence of COD and mental and substance use disorder diagnoses; assessing

problem areas, disabilities and strengths; assessing readiness for change; and gathering data to guide decisions regarding the necessary level of care. Intake information consists of the following categories and items:

- *Background* is described by obtaining data on family; relevant cultural, linguistic, gender and sexual orientation issues; trauma history; marital status; legal involvement and financial situation; health; education; housing status; strengths and resources; and employment.
- *Substance use* is established by age of first use, primary drugs used, patterns of drug use (including information related to diagnostic criteria for abuse or dependence), and past or current treatment. It is important to identify periods of abstinence of 30 days or longer to isolate the mental health symptoms, treatment and disability expressed during these abstinent periods.
- *Psychiatric problems* include family and client histories of psychiatric problems (including diagnosis, hospitalization and other treatments), current diagnoses and symptoms, and medications and medication adherence. It is important to identify past periods of mental health stability, determine past successful treatment for mental disorders and discover the nature of substance use disorder issues arising during these stable periods.

2. *Integrated assessment* identifies interactions among the symptoms of mental disorders and substance use, as well as the interactions of the symptoms of SUD and mental health symptoms. Integrated assessment seeks to relate interactions to treatment experiences, especially stages of change, periods of stability and periods of crisis.

C. Diagnosis.

1. TIP 42 discusses mental disorders selected from the DSM-IV-TR and the diagnostic criteria for each disorder. Key information about substance abuse and particular mental disorders is distilled, and appropriate counselor actions and approaches are recommended for the SUD client who displays symptoms of one or more mental disorders.
2. The limited aims of providing this material are to increase substance abuse treatment counselors' familiarity with mental disorder terminology and criteria and to provide advice on how to proceed with clients who demonstrate the symptoms of these disorders.

V. Treatment strategies.

A. Medication.

1. Proper medication is an essential program element, helping clients to stabilize and control their symptoms, thereby increasing their receptivity to other treatment. Pharmacological advances over the past few decades have produced more effective psychiatric medications with fewer side effects. Many people with serious mental disorders who once would have been institutionalized, or who would have been too unstable for substance abuse treatment, have been able to participate in treatment and make progress.

2. The substance abuse treatment counselor needs good understanding of the signs and symptoms of mental disorders and access to medical support. The counselor's role is first to provide the prescribing physician with an accurate description of the client's behavior and symptoms, which ensures that proper medication is chosen, and then to assist the client in adhering to the medication regimen.
 3. The counselor and program can employ peers or the peer community to support individual efforts to follow prescription instructions.
- B. Staffing and cultural competence.
1. TIP 42 recommends enhanced staffing that incorporates professional mental health specialists, psychiatric consultation or onsite psychiatrist for assessment, diagnosis and medication. TIP 42 underscores the importance of creating a supportive environment for staff and encouraging continued professional development, including skills acquisition, values clarification and competency attainment.
 2. Staffs are advised to view clients with COD and their treatment in the context of their culture, ethnicity, geographic area, socioeconomic status, gender, age, sexual orientation, religion, spirituality, and any physical or cognitive disabilities
 3. Staffs need to appreciate the distinctive ways in which a client's culture may view disease or disorder, including COD. Using a model familiar and culturally relevant to the client can help communication and facilitate treatment.
- C. TIP 42 recommends psychoeducational classes that provide increased awareness about the disorders and their symptoms. These groups can include groups designed to discuss the interrelated problems of mental and substance use disorders and to identify triggers for relapse.
- D. TIP 42 recommends participation in community-based dual recovery mutual self-help groups.
- E. Additional treatment strategies.
1. Motivational interviewing (MI). MI is a client-centered, directive method for enhancing intrinsic motivation to change that has proven effective in helping clients clarify goals and commit to change. MI has been modified to meet the special circumstances of clients with COD, with promising results from initial studies to improve client engagement in treatment.
 2. Contingency management (CM). CM maintains that the form/frequency of behavior can be altered through the introduction of a planned and organized system of positive and negative consequences. CM principles can be utilized informally (rewarding behaviors) or formally (attainment of a level/privilege is contingent on meeting certain behavioral criteria). Evidence of the efficacy of CM for clients with COD is still needed.
 3. Cognitive Behavioral Therapy is a general therapeutic approach that seeks to modify negative or self-defeating thoughts and behaviors and is aimed at achieving change in both. Distortions in thinking are likely to be more severe with COD clients who are, by definition, in need of increased

Comment [ES1]: Please define, as this is the first use of this acronym.

coping skills. CBT has proven useful in developing these coping skills in a variety of clients with COD.

4. Relapse prevention (RP). RP has proven to be a particularly useful SUD treatment strategy and it is adaptable to clients with COD. RP seeks to develop the client's ability to recognize cues and to intervene in the relapse process, so lapses occur less frequently and with less severity. RP trains clients to anticipate likely problems and apply various tactics for avoiding lapses to substance use. One form of RP treatment, Relapse Prevention Therapy, has been specifically adapted to provide integrated treatment of COD, with promising results from some initial studies.

VI. Outpatient models.

A. Assertive Community Treatment (ACT).

1. ACT programs, historically designed for clients with serious mental illness, employ extensive outreach activities, active and continuing engagement with clients, and a high intensity of services. ACT emphasizes multidisciplinary teams and shared decision-making.
2. Goals of the ACT model with COD clients are to engage them in helping relationships, assist them in meeting basic needs, stabilize them in the community, and ensure that they receive direct and integrated substance abuse treatment and mental health services.
3. Randomized trials with clients having serious mental and SUD have shown better outcomes on many variables for ACT compared to standard case management programs.

B. Intensive Case Management (ICM).

1. Goals of ICM are to engage individuals in a trusting relationship, assist in meeting their basic needs and help them use community services.
2. The fundamental element of ICM is a low caseload per case manager, which translates into more intensive and consistent services for each client.
3. ICM has proven useful for clients with serious mental illness and SUD. However, TIP 42 notes that direct translation of ACT and ICM models from the mental health settings in which they were developed to substance abuse settings is not self-evident. These programs must be modified and evaluated for application in such settings.

VII. Residential models.

A. Residential treatment for substance abuse occurs in a variety of settings, including long- (12 months or more) and short-term residential treatment facilities, criminal justice institutions, and halfway houses

B. In many substance abuse treatment settings, psychological disturbances have been observed in an increasing proportion of clients over time; as a result, important initiatives have been developed to meet their needs.

C. Modified Therapeutic Community (MTC) is a promising residential model from the substance abuse field for those with SUD and COD.

1. MTC adapts the principles and methods of the therapeutic community to the circumstances of the client, making three key alterations: increased flexibility, more individualized treatment and reduced intensity.

2. Reduced intensity refers to the conversion of the traditional encounter group to a conflict resolution group, which is highly structured, guided, of very low emotional intensity and geared toward achieving self-understanding and behavior change.
3. MTC retains the central feature of TC treatment: a culture is established in which clients learn through mutual self-help and affiliation with the peer community to foster change in themselves and others.
4. A series of studies has established better outcomes and benefit cost of the MTC model compared to standard services. A need for more verification of the MTC approach remains.

D. Discharge planning.

1. Returning to life in the community after residential placement is a major undertaking for clients with COD, and relapse is an ever-present danger.
2. Discharge planning is important to maintain gains achieved through residential or outpatient treatment. Continuing care options include mutual self-help groups, relapse prevention groups, continued individual counseling, psychiatric services and ICM for monitoring and support.

VIII. Medical settings.

A. Acute care.

1. Although not substance abuse treatment settings per se, acute care and other medical settings are included in TIP 42 because important substance abuse and mental health treatments do occur in medical units. Acute care refers to short-term care provided in intensive care units, brief hospital stays and emergency rooms.
2. While extensive treatment for substance abuse and COD may not be available in acute care settings, brief assessments, referrals and interventions can be effective in moving a client to the next level of treatment.

B. Primary care clinics.

1. Integration of substance abuse treatment with primary medical care can be effective in reducing both medical problems and levels of substance abuse. More clients can be engaged and retained in substance abuse treatment if treatment is integrated with medical care than if clients are referred to a separate substance abuse treatment program.
2. Because primary care clinics see chronic physical diseases in combination with substance abuse and psychological illness, treatment models appropriate to medical settings are emerging.
3. TIP 42 reviews two programs: the Harborview Medical Center's Crisis Triage Unit in Seattle and The CORE Center (an ambulatory facility for the prevention, care and research of infectious disease) in Chicago. These programs are examples of different medical settings in which COD treatment has been effectively integrated. They have advantages over more typical situations and program features are suggestive of the range of services that can be offered.

C. Course of treatment.

1. Programs that rely on identification and referral have a particular service niche within the treatment system. To be successful, they must have a clear view of their treatment goals and limitations.
 2. Effective linkages with various community-based substance abuse treatment facilities are essential to ensure a strong response to client needs and to ensure access to additional services upon client discharge. TIP 42 details the essential features of providing treatment to clients with COD in acute care and other medical settings, including screening, assessment, accessing services, staffing, treatment components and implementation, transition of care, and program evaluation.
- IX. Dual recovery mutual self-help programs (DTR).
- A. DTR are emerging from two cultures: the 12-Step fellowship recovery movement and the mental health consumer movement. TIP 42 describes both, as well as other, consumer-driven psychoeducational efforts. It provides an overview of emerging self-help fellowships and describes a model self-help psychoeducational group.
 - B. DTR fellowships
 1. DTR fellowships are membership organizations rather than consumer service delivery programs. The fellowships function as autonomous networks, providing a system of support parallel to traditional clinical or psychosocial services.
 2. Meetings are member-led but fellowships may develop informal working relationships or linkages with professional providers and consumer organizations.
 3. Consistent with traditional 12-Step principles, dual recovery 12-Step fellowships do not provide specific clinical or counseling interventions, classes on psychiatric symptoms, or any services similar to case management. DTR maintain a primary purpose of members helping one another achieve and maintain dual recovery, prevent relapse, perform service work, and carry the message of recovery to others who experience dual disorders.
 4. TIP 42 describes access and referral, common features, and models of DTR as well as numerous avenues of access to obtain network and referral information for specific programs around the country.
 5. Empirical evidence suggests that participation in DTR contributes substantially to members' progress in dual recovery. Studies found the following positive outcomes:
 - a. A process analysis indicated that DTR involvement at baseline predicted greater levels of subsequent mutual self-help processes, which were associated with better drug/alcohol abstinence outcomes.
 - b. An examination of the associations between DTR attendance, psychiatric medication adherence and mental health outcomes indicated that consistent DTR attendance was associated with better adherence to medication and lower symptom severity with no psychiatric hospitalization at follow-up.
- X. Special settings and special populations.
- A. Awareness of COD in subpopulations and concern about its implications has been growing.

1. TIP 42 focuses on three of these subgroups: the homeless, those in criminal justice settings and women
 2. Though a full description of these clients and related programs is beyond the scope of TIP 42, it provides background information on the problem of COD in these specific populations, describes some model programs and Federal initiatives, and offers recommendations for programs and services
- B. Homeless persons with COD.
1. This is a particularly problematic subgroup, one that places unique demands on the mental health and substance abuse treatment systems.
 2. For most homeless clients with COD, the impact of substance abuse and mental illness bears a direct relationship to their homeless status.
 - a. Results from the homelessness prevention cooperative agreement funded by SAMHSA's CMHS and CSAT suggest the importance of providing interventions that address housing.
 - b. TIP 42 reviews several studies that explored the interactions among housing, treatment and outcomes for persons with COD who are homeless. Results were significant and underline the contribution of stable housing to recovery.
 3. Service models.
 - a. The treatment community has developed several models for homeless clients with COD: Supportive housing, housing contingent on treatment, integrated housing and treatment, and MTC approaches.
 - b. Although the evidence base consists of a small number of studies that vary in methodological rigor and population focus, the results indicate that housing with supports in any form is a powerful intervention that improves the housing stability of individuals with substance abuse and mental disorders, including those who have been homeless.
- C. Criminal justice populations.
1. Rationale for providing substance abuse treatment in prisons.
 - a. Rationale is based on the well-established relationship between substance abuse and criminal behavior. Offenders with mental illness were likely to be using substances when they committed their convicting offense and likely to be incarcerated for a violent crime.
 - b. Majority of probationers with mental disorders not involved in violent crime.
 - c. The goal of substance abuse treatment for criminal offenders, especially for those who are violent, is to reduce criminality.
 2. Treatment features and approaches.
 - a. Several features distinguish current programs to treat inmates with COD from other substance abuse treatment programs:
 - Staff are trained and experienced in treating both mental illness and substance abuse.
 - Both disorders are treated as “primary.”

- Treatment services are integrated whenever possible.
Comprehensive treatment is flexible and individualized.
 - Focus of treatment is long-term.
- f. Treatment approaches used with other populations (e.g., TCs, CBT interventions, relapse prevention strategies, support groups) can be adapted to suit the particular needs of offenders with COD. Common modifications described in the literature include smaller caseloads, shorter and simplified meetings, special attention to criminal thinking, education about medication and COD, and minimizing confrontation.
3. Post-release and follow-up.
- a. In the last decade, a number of studies have established the importance of linking institutional services to community services. The initial rationale for providing aftercare subsequent to prison-based treatment was to ease the abrupt transition of the offender from prison to community, thus promoting reintegration while monitoring the offender's behavior in a semi-controlled environment.
 - b. Significant reductions in recidivism were obtained; reductions were larger and sustained for longer periods of time when institutional care was integrated with aftercare programs. Examples are TC work-release or other community-based treatment such as post-prison TC or CBT programs.
 - c. Longer-term follow-up studies of TC in-prison plus aftercare programs have reported findings indicating that treatment effects producing lower rates of return to custody may persist for up to five years.
 - d. Recently, the National Institute on Drug Abuse has established the Criminal Justice Drug Abuse Treatment System. This initiative funds regional research centers that are intended to forge partnerships between substance abuse service providers and the criminal justice system.
4. Empirical evidence
- a. Evaluation of the Personal Reflections program showed that inmates randomized into the MTC group had significantly lower rates of reincarceration compared to those in the mental health services-only group.
 - b. Because of the stigma associated with the combination of SUD/COD and a criminal record, this group of offenders will face barriers to being accepted into an aftercare program. They also will have difficulty locating effective programs for their complex problems that require specialized treatment.
5. Working with criminal justice populations. TIP 42 recommends:
- a. Recognize special service needs.
 - b. Give positive reinforcement for small successes.
 - c. Clarify expectations regarding response to supervision.

- d. Use flexible responses to infractions.
 - e. Give concrete (i.e., not abstract) directions.
 - f. Design highly structured activities.
 - g. Provide ongoing monitoring of symptoms.
- D. Women.
- 1. Gender-specific issues and treatment settings.
 - a. Responsibility for care of dependent children is one of the most important barriers to entering treatment. Women who enter treatment sometimes risk losing public assistance support and custody of their children, making the decision to begin treatment a difficult one.
 - b. Women accompanied by their children into treatment can be successful.
 - c. Women with COD can be served in the same types of mixed-gender co-occurring programs and with the strategies mentioned elsewhere in TIP 42. Specialized programs for women with COD have been developed primarily to address pregnancy and childcare issues as well as certain kinds of trauma, violence and victimization that may best be dealt with in women-only programs.
 - d. Though few women-centered or women-only outpatient co-occurring programs have been described, studies show that gender-specific specialized programming may make very significant differences. It is the responsibility of the program to address the specific needs of women, and mixed-gender programs need to be made more responsive to women's needs. Women in mixed-gender outpatient programs require very careful and appropriate counselor matching and the availability of specialized women-only groups to address sensitive issues such as trauma, parenting, stigma and self-esteem. Strong administrative policies pertaining to sexual harassment, safety and language must be clearly stated and upheld.
 - e. These same issues occur in residential programs designed for women who have multiple and complex needs and require a safe environment for stabilization, intensive treatment and an intensive recovery support structure. Residential treatment for pregnant women with COD should provide integrated co-occurring treatment and primary medical care, as well as attention to other related problems and disorders. The needs of women in residential care depend in part on the severity and complexity of their COD.
 - 2. Gender-specific issues in treatment.
 - a. The rate of substance abuse among young females has become almost equivalent to that of young males.
 - b. Women and men have differing coping mechanisms and symptom profiles. As compared to their male counterparts, women with SUD have more mental disorders, lower self-esteem and more difficulty with emotional problems.

- c. Treatment should emphasize the importance of relationships, the link between relationships and substance abuse, and the importance of relationships with children as a motivator in treatment.
3. Pregnancy and COD.
- a. Pregnancy can aggravate or diminish the symptoms of COD. Worsening symptoms of mental illness can result from hormonal changes that occur during pregnancy; lactation; medications given during pregnancy or delivery; the stresses of pregnancy, labor and delivery; and adjusting to and bonding with a newborn.
 - b. Women with co-occurring disorders sometimes avoid early prenatal care, have difficulty complying with healthcare providers' instructions, and are unable to plan for their babies or care for them when they arrive.
 - c. Many pregnant women with COD are distrustful of substance abuse treatment and mental health service providers, yet they are in need of multiple services. One concern is whether the mother can care adequately for her newborn. For her to do so requires family-centered, coordinated efforts from social workers, child welfare professionals and the foster care system.
 - d. It is important to make careful treatment plans during pregnancy for women with COD that include planning for childbirth and infant care. Treatment programs should work to maintain medical and mental stability during the client's pregnancy and collaborate with other healthcare providers to ensure that treatment is coordinated.
 - e. When women are parenting, it can often retrigger their own childhood traumas. Providers need to balance growth and healing with coping and safety. Treatment should balance focus on building parenting skills with sensitivity to emotional barriers to dealing with these issues.
 - f. Providers also need to allow for evaluation over time for women with COD as they progress through treatment.
4. Post-partum depression: "blues," clinical depression, psychosis.
- a. Postpartum blues affects up to 85 percent of new mothers. Anticipation and preventive reassurance throughout pregnancy can prevent postpartum blues from becoming a problem. Women with sleep deprivation should be assisted in getting proper rest. Follow-up care should ensure that the woman is making sufficient progress to avoid a relapse to substance use.
 - b. Postpartum depression affects 10 percent to 15 percent of new mothers. Risk factors for postpartum depression include prior history of anxiety disorders or personality disorders, nonpostpartum depression or psychological distress during pregnancy, other prepregnancy mental diagnosis, or family history of mental disorder.

1. Prognosis of recovery is good with supportive counseling accompanied as needed by pharmacological therapy.
 2. Antidepressants, anxiolytic medications and electroconvulsive therapy have all been successful in treating postpartum depression. Because some medications pass into breast milk and can cause infant sedation, it is best to consult an experienced psychiatrist.
 3. Clients need to be monitored for thoughts of suicide, infanticide and progression of psychosis in addition to their response to treatment.
- c. Postpartum psychosis is a serious mental disorder. Clients may lose touch with reality and experience delusions, hallucinations, and/or disorganized speech or behavior. Risk factors are previous diagnoses of bipolar disorder, schizophrenia, or schizoaffective disorder or major depression in the year preceding the birth; previous depressive illness or postpartum psychosis; first pregnancy; and family history of mental illness.
1. The severity of the symptoms mandates pharmacological treatment in most cases and, sometimes, hospitalization.
 2. The risk of self-harm and/or harm to the baby needs to be assessed, and monitoring of mother-infant pairs by trained personnel can limit these risks.
5. Pharmacological considerations.
- a. Before giving any medications to pregnant women it is important that they understand the risks and benefits of taking these medications. Certain psychoactive medications may be associated with birth defects, especially in the first trimester of pregnancy, and weighing potential risk/benefit is important.
 - b. Since pregnant women often present to treatment in mid to late second trimester and polydrug use is the norm, it is important first to screen clients for dependence on the classes of substances that can produce a life-threatening withdrawal for the mother: alcohol, benzodiazepines and barbiturates. These substances, as well as opioids, can cause a withdrawal syndrome in the baby, who may need treatment.
 - c. Pregnant women should be made aware of any and all wrap-around services to assist them in managing newborn issues, including food, shelter, medical clinics for inoculations, etc., as well as programs that can help with developmental or physical issues the infant may experience as a result of alcohol/drug exposure.
6. Women, trauma and violence.
- a. Trauma, SUD and treatment.
 1. It is estimated that 55 percent to 99 percent of women in substance abuse treatment have had traumatic experiences, typically childhood physical or sexual abuse, domestic violence, or rape. Of these, between 33 percent and 59

- percent typically experience current PTSD; yet, historically, few substance abuse treatment programs assess for, treat or educate clients about trauma.
2. Addiction places women at higher risk of future trauma, through their associations with dangerous people and lowered self-protection when using substances.
- b. Models for women's trauma recovery.
1. A number of models are emerging, many with data demonstrating effective ways of addressing the trauma-specific needs of women with COD.
 2. TIP 42 describes the core elements of a trauma-informed addictions program as follows:
 - a. The program must help clients understand the interaction between trauma and substance use.
 - b. The program should teach self-soothing mechanisms to help trauma survivors deal with symptoms such as flashbacks without resorting to substance use.
 - c. The milieu must promote consumer empowerment and relationship-building as well as healing.
 - d. The program should be strengths-based, providing an opportunity for caring connections through group work and informal sharing, and establishing a supportive milieu.
 - e. Clients must develop crossover skills that are important in recovery from trauma and chemical dependency.
 - f. A program should offer ancillary services to continue recovery once the client leaves the program. These services include legal services, safe housing and health care.
 - g. A program should avoid the use of recovery tactics that are contraindicated for women recovering from physical and sexual violence. For many women, these include shaming, moral inventories, confrontation, emphasis on a higher power and intrusive monitoring.
 - h. Many practitioners find that alternatives to the 12-Step model are helpful for some women. On the other hand, many women have benefited from 12-Step programs.
- c. While a detailed description of trauma recovery model programs is beyond the scope of TIP 42, this guide describes a number of emerging models available for use. Many are supported by published materials, such as workbooks with session guides that aid in implementation. Examples include the following:

1. The *Trauma Recovery and Empowerment Model (TREM)* is a group approach to healing from the effects of trauma. TREM combines the elements of social skills training and psychoeducational and psychodynamic techniques, and emphasizes peer support, which have proven to be highly effective approaches with survivors. A 33-session guide book for clinicians is available.
 2. *Seeking Safety* offers a manual-based CBT model which has been used in a number of studies with women who have substance dependence and co-occurring PTSD.
 3. *Helping Women Recover: A Program for Treating Addiction* is an integrated program with a separate version for women in the criminal justice system. This model integrates theoretical perspectives of substance abuse and dependence, women's psychological development, and trauma.
 4. The *Addiction and Trauma Recovery Integration Model* is designed to assess and intervene at the body, mind and spirit levels to address key issues linked to trauma and substance abuse.
 5. *Trauma Adaptive Recovery Group Education and Therapy (TARGET)* helps clients replace their stress responses with a positive approach to personal and relational empowerment. TARGET has been adapted for deaf clients and for those whose primary language is Spanish or Dutch.
- D. The National Women's Resource Center reviewed the literature on women's programs and found that these models have many basic tenets in common. The overarching principle is that the provision of comprehensive services and treatment needs to be in accord with the context and needs of women's daily lives. Recommendations based on the Center's review include:
1. Identify and build on each woman's strengths.
 2. Avoid confrontational approaches.
 3. Teach coping strategies including individual appraisals of stressful situations.
 4. Meet daily needs of women such as childcare and transportation.
 5. Have a strong female presence on staff.
 6. Promote bonding among women.
 7. Offer program components that help women reduce the stress associated with parenting and teach parenting skills.
 8. Develop programs for both women and children.
 9. Provide interventions that focus on trauma and abuse.
 10. Foster family reintegration and build positive ties with the extended/kinship family as well as healthy support networks.

11. Make emotional support programs available for children.

References

- American Psychiatric Association: *Practice guideline for the treatment of clients with substance use disorders*. 2nd Ed. Arlington (VA). (August 2006).
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-V)*. Arlington, VA: American Psychiatric Publishing, Inc.; 2013.
- Mee-Lee, D., Shulman, G.D., Fishman, M., Gastfriend, D.R., Griffith, J.H. (eds): *ASAM Client Placement Criteria for the Treatment of Substance-Related Disorders*, 2nd ed., revised. Chevy Chase, MD, American Society of Addiction Medicine, 2001.
- Substance Abuse and Mental Health Services Administration. *Substance Abuse Treatment For Persons With Co-Occurring Disorders: A Treatment Improvement Protocol 42*. U.S. Department of Health and Human Services (July 2008).
- VA/DoD Clinical Practice Guideline. *Management of Substance Use Disorders*. VA/DoD Evidence Based Practice. Veterans Health Administration/Department of Defense. Version 2.0 (2009).

Other Resources

The full VA/DoD SUD guideline can be accessed at www.healthquality.va.gov/ and <https://www.qmo.amedd.army.mil/substance%20abuse/substance.htm>

National Institute on Alcohol Abuse and Alcoholism (NIAAA)
[www.niaaa.nih.gov/Publications/
EducationTrainingMaterials/Pages/guide.aspx](http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/Pages/guide.aspx)

On the NIAAA website, providers can find resources that include clinical guides and videos on alcohol screening and brief intervention, alcohol use disorder screening instruments and assessment support materials, medication wallet cards and client materials. For additional resources, visit www.RethinkingDrinking.niaaa.nih.gov.

National Institute on Drug Abuse (NIDA)
www.drugabuse.gov/nidamed/

NIDA provides resources that include screening tools, charts of commonly abused drugs, drug abuse reports, multilingual education packets and client-physician conversation posters.

Substance Abuse and Mental Health Services Administration (SAMHSA)

www.dpt.samhsa.gov/providers/providerindex.aspx

SAMHSA provides resources for provider training on substance abuse, addiction, prescribing and risk management, as well as resources on addiction treatment forums, treatment protocols and drug interactions.

Medical and Non-Medical Addiction Specialists

American Academy of Addiction Psychiatry

(www.aaap.org) 401-524-3076

American Psychological Association

(<http://apa.org>) 800-964-2000

American Society of Addiction Medicine

(www.asam.org) 301-656-3920

The Association for Addiction Professionals

(www.naadac.org) 800-548-0497

National Association of Social Workers

(www.socialworkers.org or www.helpstartshere.org)

Alcoholics Anonymous

(www.aa.org) 212-870-3400 or check your local phone directory under “Alcoholism”

Secular Organizations for Sobriety

(www.cfiwest.org/sos/index.htm) 323-666-4295

Al-Anon/Alateen

(www.al-anon.alateen.org) 888-425-2666 for meetings

Adult Children of Alcoholics

(www.adultchildren.org) 310-534-1815

Veterans Crisis Line

(www.mentalhealth.va.gov/suicide_prevention/index.asp)

800-273-8255 and press 1

Substance Abuse Treatment Facility Locator

(www.findtreatment.samhsa.gov) 800-662-HELP

(4357)www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp