Response: The Path to Double Recovery

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Screening

Edward Nuñes: The authors' recommendation that programs screen patients for potential mental health problems on intake is sensible. I'm convinced, as they are, that line clinicians in substance abuse programs can develop the clinical sophistication necessary to recognize mood disorders and make appropriate referrals.

Clinicians should monitor for mood symptoms at all times.

Patricia Penn: I agree. We also need to keep in mind that symptoms often emerge during the treatment process. Clinicians should monitor the client for symptoms at all times, not just during the initial screening.

Nuñes: The SCL-90 symptom checklist is a good instrument for making the initial assessment, although it only assesses symptom levels—it doesn't point to diagnoses.

Penn: There is a real need for more clinician-friendly screening tools. In one of our programs, the counselors have combined the most effective and efficient parts of several instruments into our own hybrid screener. We also have tried CAAPE, the Comprehensive Addictions and Psychological Evaluation developed by Dr. Norman Hoffman, which is designed specifically to diagnose co-occurring disorders, and it looks promising. Dr. Hoffman's screens, which also include one for adolescents, are available at *www.evinceassessment.com.*

William Haning, III: In my hospital, we screen patients with the SCID [Structured Clinical Interview for DSM-IV-TR] at the very outset, then follow up with some of the faster, cheaper screeners. In the community facility where I work, we use a variety of cheap, fast screens. Interestingly, the results in terms of patient profile turn out to be similar in both places. The more comprehensive SCID does not lead to a greater number of diagnoses. I wonder sometimes if its results warrant the extra effort it requires. The computerized version of the SCID is quicker, and we're satisfied that personnel at a bachelor's level or even below can manage it nicely.

Nuñes: I would also advocate for the CAAPE or the Hopkins Symptom Checklist.

The makers of SCID, Drs. Bob Spitzer, Janet Williams, and Michael Frist, have also developed a couple of simplified versions for use in primary care. One is called PRIME-MD, which is clinician-administered and brief. The other is called PHQ, Patient's Health Questionnaire, which the patient fills out. A colleague here at Columbia, Dr. Carlos Blanco, is adding modules on attention deficit disorder and gambling, concerns which aren't present in the primary care versions but are important to substance abuse providers.

Diagnosis

Haning: Unfortunately, a fair number of people are still convinced that all mood disorders in substance abusers derive from the substance use and/or some character pathology that will resolve after a few years of progressive work. It isn't so. There is a considerable comorbidity that really does need to get treated.

Penn: Some patients feel relieved when they receive a mood disorder diagnosis, because it helps explain why they have felt bad for so long. Others, of course, find the diagnosis difficult to accept and resist it.

Haning: Some understand that having a mood disorder is going to complicate their prognosis and give them a harder time in life. They will contest the diagnosis with you.

Nuñes: Patients also resist because plenty of stigma still surrounds mood disorders. A line I hear occasionally is, "I'm not crazy, I'm a drug addict. I don't need to see any shrink."

Haning: The biggest risk in discussing a potential mood disorder diagnosis with a patient is that for some, it provides a rationale for not acknowledging drug dependence. That's not a reason to withhold the information, but it does mean we need to educate the patient about the implications of having two interactive illnesses simultaneously.

Theoretical models and treatment

Haning: I was taken with the authors' discussion of the kindling model, because it could explain a pattern we observe clinically. When methamphetamine users begin treatment, they typically are psychotic or hypomanic and subsequently become depressed. They feel low for a long time, but after somewhere between 10 and 14 months, they perk up, their affect comes alive, and they begin to have less difficulty paying attention and concentrating. The kindling theory, along with imaging studies by Drs. Linda Chang and Nora Volkow [Chang et al., 2002; Volkow et al., 2001], suggest to me that the temporal pattern of recovery might reflect the gradual resolution of methamphetamine-induced brain inflammation.

Penn: Our patients abuse an average of three and a half drugs each, including amphetamines. We see the same pattern: a long struggle, and then recovery becomes self-reinforcing after a year to 14 months.

Haning: Patients don't need to be completely abstinent the whole year to achieve this watershed, but almost.

Penn: The authors' discussion of the theories relating to mood and substance abuse disorders is absorbing, and solving that puzzle will lead to better interventions. In clinical settings, however, we should beware of getting caught up in chicken-and-egg debates about which is primary. They can be a distraction from treatment. I like to ask clients, "What do you think is causing this?" or "How does your substance use affect your mood, and vice versa?" The client's impression gives you an idea how to proceed in treatment.

Nuñes: I also ask patients what their experience with the drug has been, and look very hard for evidence that the substance abuse makes the mood syndrome worse. Often it does, not when the patient is taking the drug, but afterwards.

I work in a motivational framework, so I try to steer patients toward connecting their drug abuse and mental health problems for themselves. Some find it difficult. I'm thinking, in particular, about a patient who has bipolar illness and alcoholism. Medication controls his affective disorder reasonably well when he's not drinking, but when he starts to drink, he deteriorates. We have to constantly remind him that he has been down this path before—we know what the outcome will be. If we can get him to see that connection, it'll make a big difference.

"I'm not crazy, I'm a drug addict."

Haning: The trick for therapists is to get somebody who has lived from moment to moment to look a year into the future, have confidence that things will get better, and just hang in there until they do. In my experience, a major rationale for giving medications such as antidepressants and anticonvulsants is to keep patients coming back for their appointments—whether the meds really suppress symptoms or have only a placebo effect.

Penn: At La Frontera, we have noticed that many people come into our intensive program for a month or two or three, go away for a while, come back, go away, and so on. They seem to need that time to test out and practice what they learn in therapy and let it sink in. We try to maintain an open-door policy so clients can come back as needed.

Haning: We compel patients to rewrite their relapse prevention program each time they come back. We also get into long arguments with insurers about what they see as a revolving door and we see as a progressive acclimatization to recovery.

Penn: I was glad the authors mentioned a group CBT model for treating co-occurring disorders. We also need a model that can accommodate rolling enrollment. With nonrolling enrollment models, we must ask people to wait for weeks just to get into group support. This doesn't work—people don't come back.

Mix or match?

Haning: Some treatment programs mix all their patients together; others provide separate groups for patients with mood disorders. I think separation is best. These patients need a safe environment to discuss their medications and the elements of their treat-

ment that are specific to their co-occurring disorders. In mixed groups, they can get the worst of both worlds: not taking full responsibility for their bad decision-making around drug abuse, and not getting their symptoms taken seriously when there is a need to modify the medication regimen or enhance cognitive-behavioral strategies. Also, referring too often to 'my bipolar disorder' or 'my manic depression' is an invitation to be ostracized.

Penn: This issue also comes up in relation to outside support groups. For example, even though a 12-step pamphlet encourages people to take their medications as prescribed, a lot of individual groups don't subscribe to that. These groups often don't know how to deal with people who have a mental illness. Our patients, especially those with serious mental illness, have lots of problems and generally have trouble finding sponsors. They have had happier experiences with Smart Recovery [*www.smartrecovery.org*], which uses cognitive-behavioral treatment methods that apply to both mood and substance abuse disorders. They like the program because it uses a trained facilitator to keep the meetings contained and ensure that everyone is respected.

Haning: I agree. The key to success in these programs is having somebody who is quasi-professional, either on the periphery of the meeting or actually facilitating it to ensure the fundamental needs of the attending population are met.

Penn: We also need more good modules for training counselors in co-occurring disorders. Online sources would be especially helpful. They could reach people everywhere, including rural areas, where there is a big problem finding people who are competent in treating co-occurring disorders. &

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