A Life in the Community for Everyone
U.S. Department of Health and Human Services

COD Research and Resources Monthly Review

Vol. 2, No. 2 February 2007

Homelessness, Co-Occurring Disorders and HIV-Risk

Two recent articles look specifically at the effect substance use and psychiatric disorders have on HIV-risk behaviors in homeless adults. One of the articles also provides some solid estimates concerning rates of COD, substance use disorders (SUD), and mental disorders in people who are homeless in urban areas.

Forney, J. C., Lombardo, S., & Toro, P. A. (2007). Diagnostic and other correlates of HIV risk behaviors in a probability sample of homeless adults. *Psychiatric Services, 58*(1), 92–99.
Forney and colleagues selected 218 individuals who were homeless, from food programs and shelters, assessed them for mental and substance use disorders using a validated instrument (the Diagnostic Interview Schedule [Version 3A]), and used trained interviewers to enhance the accuracy of their estimates. The study authors went to considerable effort to develop a probability sample so that their results could be taken as representative estimates for the entire homeless population of this large Midwestern city.

Forney and colleagues found a definite correlation between SUDs in this population and an increased risk of contracting HIV (using a risk behaviors scale to assess sexual behaviors in the prior 6 months) but (contrary to previous research) found no such correlation between increased HIV risk and mood disorders and/or schizophrenia. The authors found that 4 percent of the 161 men and 5 percent of the 57 women in their sample were already HIV positive.

The authors were also able to provide estimates of SUDs, mood disorders (including mania), schizophrenia, and COD in this homeless population. They found that 77 percent of the men in their sample had a SUD (121 of 161), 27 percent had a mental disorder (44 of 161), and 23 percent had COD (37 of 161). Among women, 55 percent had a SUD (31 of 57), 55 percent had a mental disorder (31 of 57), and 34 percent had COD (19 of 57). Men in their sample were more likely to rate substance abuse treatment services as more important than mental health services, while for women the converse was true.

Earlier (2000) rigorous, epidemiologic research by North and colleagues found similar rates of COD and SUDs in the homeless population of St. Louis, MO. They estimated that 84 percent of the men and 58 percent of the women had a SUD and that 32.2 percent of the men and 36.7 percent of the women had both a SUD and another Axis I disorder. (See: North, C. S., Eyrich, K. M., Pollio, D. E., & Spitznagel, E. L. [2004]. Are rates of psychiatric disorders in the homeless population changing? *American Journal of Public Health*, *94*(1), 103–108, and additional data from a paper presented at American Public Health Association Annual Meeting in Atlanta, GA, 2001, “Are Rates of Psychiatric Disorders Changing Over Time in the Homeless Population?”)

Reback, C. J., Kamien, J. B., & Amass, L. (2007). Characteristics and HIV risk behaviors of homeless, substance-using men who have sex with men. *Addictive Behaviors, 32*(3), 647–654.
This other recent article concerns HIV risk among men who have sex with men, are diagnosed with a substance dependence disorder, and are homeless. However, it has a much smaller, convenience sample (N = 20) selected from men who were seeking services at a treatment program. The authors found that 75 percent of their sample met criteria for a diagnosis of a mood disorder, 33 percent for a major depressive disorder, and 43 percent for an antisocial personality disorder. Twenty-one percent self-reported as being HIV positive.

This Review contains revisions of abstracts and is not generally the product of an original analysis of the actual articles cited. Readers interested in finding out more about COCE should visit the Web site: http://coce.samhsa.gov/

COD Research

Epidemiology

Boyd-Ball, A. J., Manson, S. M., Noonan, C., & Beals, J. (2006) Traumatic events and alcohol use disorders among American Indian adolescents and young adults. *Journal of Traumatic Stress, 19*(6), 937–947.
The authors looked at the relationship between alcohol use disorders and a history of severe trauma in a group of American Indian young adults and adolescents who were living on or near one of two closely related reservations (*N* = 432). They found that a history of trauma increased the chances an individual from this population would have an alcohol use disorder.

Button, T. M. M., Rhee, S. H., Hewitt, J. K., Young, S. E., Corley, R. P., & Stallings, M. C. (2007). The role of conduct disorder in explaining the comorbidity between alcohol and illicit drug dependence in adolescence. *Drug and Alcohol Dependence, 87*(1), 46–53.
The authors investigated the extent to which etiological factors common to conduct disorders could explain the development of substance dependence in adolescents. They used community-sampling to select 645 pairs of identical twins, 702 pairs of fraternal twins, 439 pairs of non-twin biological siblings, and 96 pairs of adopted siblings all between the ages of 12 and 18. They found the variance heritability estimates for conduct disorder (58 percent), alcohol dependence (66 percent), and drug dependence (36 percent). In addition, they found that the genetic contribution between alcohol dependence and drug dependence could be partially explained by their shared genetic risk for conduct disorder. This suggests that conduct disorder explains in part the co-occurrence of alcohol and illicit drug dependence in adolescents.

Cable, N., & Sacker, A. (2007). The role of adolescent social disinhibition expectancies in moderating the relationship between psychological distress and alcohol use and misuse. *Addictive Behaviors, 32*(2), 282–295.
The authors used data from a 1970 British Cohort Study to determine the effects of alcohol expectations and psychological distress on alcohol use and misuse. They found that social expectations regarding alcohol's disinhibition effects that were acquired during adolescence predicted later heavy use of alcohol and misuse of alcohol and an absence of adolescent expectancies for social disinhibition had a protective factor against alcohol use and misuse. People experiencing psychological distress at age 30 were more likely than those who did not experience distress to misuse alcohol. Men (but not women) who experienced psychological distress at age 30 were also more likely to be heavy alcohol users but only if they also had expectancies for alcohol to provide social disinhibition when they were adolescents.

Dawson, D. A., Grant, B. F., & Li, T.-K. (2007). Impact of age at first drink on stress-reactive drinking. *Alcoholism: Clinical and Experimental Research, 31*(1), 69–77.
The authors used data from the 2001 to 2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) to investigate the impact of the age when a person had their first drink on drinking as a reaction to stress. They took data from a large (*N* = 26,946) sample of people who had a drink during the past year. After adjusting for sociodemographic characteristics, family history of alcoholism, co-occurring psychological disorders, both adolescent and past-year tobacco and illicit drug use, and other significant interactions with numbers of stressors, they found that beginning drinking at age 14 or younger increased the association between the number of stressors (from a range of 12 possible stressors) experienced and level of alcohol consumption. The association between stress and alcohol consumption was only significant for those who began drinking at age 14 or younger.

Gau, S. S., Chong, M. Y., Yang, P., Yen, C. F., Liang, K. Y., & Cheng, A. T. (2007). Psychiatric and psychosocial predictors of substance use disorders among adolescents: Longitudinal study. *British Journal of Psychiatry, 190*(1), 42–48.
The authors sought to determine psychosocial and psychiatric factors that predicted substance use disorders in adolescents. They looked at a group of British school children who were in grade 7 (aged 12) and free of substance use disorders (*n* = 428) and reassessed them annually for 3 consecutive years. Male gender, attention-deficit hyperactivity

disorder, conduct disorder, and sibling use of tobacco were all significant predictors of developing a substance use disorder. Living with two parents, having good grades in grade 7, and having objections to the use of substances were all significant protective factors.

Gonzalez, V. M., Bradizza, C. M., Vincent, P. C., Stasiewicz, P. R., & Paas, N. D. (2007). Do individuals with a severe mental illness experience greater alcohol and drug-related problems? A test of the supersensitivity hypothesis. *Addictive Behaviors, 32*(3), 477–490.

The authors tested whether people with serious mental illness (SMI; defined as schizophrenia or bipolar disorder) and substance-related problems were more likely than others with substance-related problems to receive a diagnosis of substance abuse rather than substance dependence and to experience more negative consequences from substance use at lower levels of consumption than other substance users (known as the *supersensitivity hypothesis*). They compared a group of individuals with a substance use disorder (SUD) but no co-occurring psychiatric disorder (n = 42) to a group with COD (n = 53) and to a group who had SMI but no SUD (n = 35). They did not find significant differences between the group with COD and the group that had SUD alone on measures of substance use, negative consequences, outcome expectancies related to substance use, motivation for change, or severity substance dependence. They did find significantly higher levels of psychological symptoms in the COD group compared to the other two. The authors conclude that their research study does not support the supersensitivity hypothesis.

Hammerbacher, M. & Lyvers, M. (2006). Factors associated with relapse among clients in Australian substance disorder treatment facilities. *Journal of Substance Use, 11*(6), 387–394.

The authors studied 104 clients in Australian substance abuse treatment programs to determine what factors were most associated with relapse. The most common reasons cited for relapse were (in order) negative mood, external pressures to use, desire for a positive mood, and social and/or family difficulties. These reasons for relapse were regardless of primary substance used (i.e., heroin, methamphetamine, or alcohol). COD were most common in those whose primary substance was alcohol. Those who primarily used methamphetamine had the fewest relapses.

Huang, D. B., Kamat, P. P., & Wang, J. (2006). Demographic characteristics and antisocial personality disorder of early and late onset alcoholics identified in a primary care clinic. *American Journal on Addictions, 15*(6), 478–482.

The authors screened individuals (N = 1,734) who sought services at a primary care clinic to determine the relation of antisocial personality disorder (ASPD) to age of onset for alcoholism (i.e., early versus late). They found 76 individuals with early onset alcoholism and 80 with late onset alcoholism. Those with early onset alcoholism were more likely to be single and were younger, had lower socioeconomic status, were more likely to be raised by non-biological parents, and had higher rates of ASPD.

Karch, D., Crosby, A., & Simon, T. (2006). Toxicology testing and results for suicide victims—13 states, 2004. *Morbidity and Mortality Weekly Report, 55*(46), 1245–1248. Available online at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5546a1.htm

In 2003, suicide was the fourth leading cause of death among persons aged 10–64 years and the second and third leading causes of death among persons aged 25–34 and 10–24 years, respectively. Few studies have attempted to determine the contribution of substance use to suicide. To assess toxicology testing practices and to determine the prevalence of positive results for alcohol or other drugs, CDC analyzed test results of suicide victims in the 13 States that collected data for the National Violent Death Reporting System (NVDRS) in 2004. This report summarizes the results of that analysis, which determined that (1) the percentage of suicide victims tested varied among States, ranging from 25.9 percent to 97.7 percent; (2) of those victims tested, 33.3% were positive for alcohol and 16.4% were positive for opiates; and (3) similar percentages of poisoning suicide (i.e., suspected intentional overdose) and nonpoisoning suicide victims tested positive for alcohol or other drugs, with the exception of opiates.

Parks, J., Svendsen, D., Singer, P., & Foti, M. E. (Eds.). (2006). *Morbidity and mortality in people with serious mental illness*. Alexandria, VA: National Association of State Mental Health Program Directors. Available online at http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortaility%20-%20Final%2011-06.pdf

This report reviews recent data concerning the increased rates of morbidity and mortality among people with serious mental illness that suggest that these rates are accelerating and that people in this population are now dying 25 years earlier than those in the general population. The report notes that these high rates of morbidity and mortality are mainly the result of treatable conditions that are themselves caused by modifiable risk factors (e.g., substance abuse, smoking, obesity). The report also makes recommendations for improving care for this population.

Piran, N., & Gadalla, T. (2007). Eating disorders and substance abuse in Canadian women: A national study. *Addiction, 102*(1), 105–113.

The authors examined co-occurring eating disorders and substance abuse/dependence in nationally representative sample of Canadian women. They found that alcohol dependence, illicit drug abuse, and illicit drug dependence were all significantly associated with eating disorders in this population.

Sartor, C. E., Lynskey, M. T., & Heath, A. C. (2007). Characterizing dynamic risk in the pathway to alcohol dependence: Reply to commentaries. *Addiction, 102*(2), 189–190.

The authors used data from the Vietnam Era Twin Registry on 1269 offspring of male twins (with a mean age of 20.1) to identify factors that appeared to predict age of first alcohol use and time from first use to alcohol dependence. The average at first alcohol use was 15.7 years and the average age for onset of alcohol dependence was 19.1 years. A Cox proportional hazard regression analysis showed that conduct disorder was the strongest predictor of an early initiation of alcohol use; attention deficit/hyperactivity disorder, parental alcohol dependence (from either parent), male gender, and parental divorce were also associated with early initiation of use. The regression analysis showed that nicotine dependence generalized anxiety disorder and cannabis abuse were strong predictors of a rapid progression to alcohol dependence.

Scott, C. L., Lewis, C. F., & McDermott, B. E. (2006). Dual diagnosis among incarcerated populations: Exception or rule? *Journal of Dual Diagnosis, 3*(1), 33–58.

The authors reviewed the literature concerning rates of mental disorders with co-occurring substance use disorders, mental disorders with co-occurring developmental disabilities, and developmental disabilities with co-occurring substance use disorders among people who are incarcerated. They found high levels of co-occurring disorders in this population.

Zlotnick, C., Johnson, D. M., Stout, R. L., Zywiak, W. H., Johnson, J. E., & Schneider, R. J. (2006). Childhood abuse and intake severity in alcohol disorder patients. *Journal of Traumatic Stress, 19*(6), 949–959.

The authors sought to determine whether a history of childhood sexual abuse (CSA) and/or childhood physical abuse (CPA) lead to more severe alcohol problems than would be found in individuals who did not have such histories. They found that CSA was associated with a greater number of social and psychiatric problems, an earlier age of onset for alcohol use disorders, a greater number of Axis I disorders, and with less frequent drinking. CPA was associated with an increased number of alcohol-related consequence, a greater amount of social and psychiatric dysfunction, a greater number of Axis I disorders, and less frequent drinking than individuals without a childhood history of abuse.

Infrastructure

Staff Development

Price, J. H., Sidani, J. E., & Price, J. A. (2007). Child and adolescent psychiatrists' practices in assisting their adolescent patients who smoke to quit smoking. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(1), 60–67.

The authors contacted by mail a random sample of child and adolescent psychiatrists selected from the membership of the American Academy of Child and Adolescent Psychiatry and asked about practices related to client smoking. They

received responses from 184 doctors. Of these, 48 percent stated they were self-taught regarding smoking cessation techniques, 67 percent considered themselves in the "maintenance stage" in regards to asking their clients about smoking, 19 percent considered themselves consistent in assessing the willingness to quit among clients who smoked, and 30 percent were consistent in urging clients who smoked to quit. Psychiatrists who considered themselves confident and prepared perceived fewer barriers to treating smoking in clients. Respondents estimated that 61 percent of clients with conduct disorders smoked, 46 percent of those with schizophrenia smoked, and 40 percent of those with AD/HD smoked.

Services & Service Systems

Definitions, Terminology & Classification

Graham, K., Massak, A., Demers, A., & Rehm, J. (2007). Does the association between alcohol consumption and depression depend on how they are measured? *Alcoholism: Clinical and Experimental Research, 31*(1), 78–88.

The authors used telephone interviews to perform a general population survey, asking 6,009 men and 8,054 women (aged 18–76) about their alcohol symptoms and mood. They found that the relationship between alcohol consumption and depression remained consistent across gender and across types of depression, but was significantly affected by the type of measure used for alcohol consumption (the strongest relationship was found for measures of heavy episodic drinking and large quantity of consumption per drinking episode). Gender also affected the measurement of the relationship between alcohol consumption and depression. For example, when depression was measured as meeting diagnostic criteria for major depression and alcohol consumption was measured as quantity of consumption per drinking episode or by occurrence of heavy episodic drinking, there was a stronger relationship between alcohol consumption and depression for women than for men. Their major findings are (1) that depression is most related to drinking large quantities during each drinking episode, less related to total alcohol volume consumed, and not related to frequency of consumption and (2) that these relationships are stronger for women than men but only when depression is measured as meeting diagnosis criteria for major depression and not when related to recent depressed affect.

Screening & Assessment

Hides, L., Dawe, S., Young, R. M., & Kavanagh, D. J. (2007). The reliability and validity of the Severity of Dependence Scale for detecting cannabis dependence in psychosis. *Addiction, 102*(1), 35–40.

The authors sought to evaluate the reliability and validity of the Severity of Dependence Scale (SDS) for screening for cannabis dependence in people with a schizophrenia spectrum disorder. They evaluated the scale's performance with 153 inpatients at an Australian hospital. They found that the SDS had a high level of internal consistency and strong construct and concurrent validity. Subjects who scored with a "2" or higher on the scale were almost 30 times more likely to have a diagnosis of cannabis dependence.

Hunt, Y. M., Kyle, T. L., Coffey, S. F., Stasiewicz, P. R., & Schumacher, J. A. (2006). University of Rhode Island Change Assessment-Trauma: Preliminary psychometric properties in an alcohol-dependent PTSD sample. *Journal of Traumatic Stress, 19*(6), 915–921.

The authors investigated the psychometric properties of University of Rhode Island Change Assessment's Trauma scale (URICA-T) in a group of individuals who met diagnostic criteria for both PTSD and alcohol dependence. They found that the URICA-T appears to have acceptable psychometric properties as a continuous measure of motivational readiness in individuals with co-occurring PTSD and alcohol dependence.

McChargue, D. E. & Cook, J. W. (2007). Depression vulnerability within smoking research: How accurate are one-item screening items? *Addictive Behaviors, 32*(2), 404–409.

The authors evaluated the accuracy of single screening questions for diagnosing episodes of major depression with a group of individuals with nicotine dependence (N = 79). The questions were asked as part of a telephone interview and the authors found that they accurately classified a history of major depression diagnosed by a clinician and accurately

predicted the number of depressive episodes, level of self-reported rumination, and level of self-reported proneness to depression.

System Integration

Durbin, J., Goering, P., Streiner, D., & Pink, G. (2006). Does systems integration affect continuity of mental health care? *Administration and Policy in Mental Health, 33*(6), 705–717.

The authors reviewed current research on systems integration with particular attention to outcomes related to continuity of care. They found that research consistently demonstrated that there was a positive association between systems integration and continuity of care. Generally, systems that had stronger management arrangements, fewer different service sectors, centralized access to services, and used intensive case management throughout the entire system showed better results than systems that could not be so characterized.

Treatment Planning & Services

Bellack, A. S., Bennett, M., & Gearon, J. (2006). *Behavioral treatment for substance abuse in people with serious and persistent mental illness: A handbook for mental health professionals*. Oxford, UK: Routledge, Taylor & Francis Group.

This book focuses on the difficulties involved in treating people with co-occurring schizophrenia and substance use disorders. It addresses various treatment components including motivational interviewing, social skills training, problem solving skills, and relapse prevention. The book provides clear guidelines for treatment and uses case studies.

Kleinpeter, C., Deschenes, E. P., Blanks, J., Lepage, C. R., & Knox, M. (2006). Providing recovery services for offenders with co-occurring disorders. *Journal of Dual Diagnosis, 3*(1), 59–85.

The authors performed a process evaluation of a COD court treatment program in Orange County, CA. Individuals with drug offences who were diagnosed with bipolar disorder, schizophrenia, or major depressive disorder entered an 18-month integrated treatment program. Program participants were provided with medication and entered either a residential or outpatient treatment program (depending on their assessment). The majority of the 72 offenders who entered the program in its first 2 years were stabilized on their medications, which increased treatment stay. After 6 months in the program, offenders had improved social functioning, fewer problems resulting from substance use, and were more productive in meeting their goals.

Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2007). Racial and ethnic disparities in SSRI availability in substance abuse treatment. *Psychiatric Services, 58*(1), 55–62.

The authors sought to determine whether (and to what extent) there were racial and ethnic disparities in the availability of selective serotonin reuptake inhibitors (SSRIs) for substance abuse treatment clients with depression. They used 2002–2004 data from the National Treatment Center Study, which had a sample of 326 publicly funded and 339 privately funded substance abuse treatment programs. Data showed that SSRIs were available at 48 percent of these treatment programs. By factoring out organizational and treatment characteristics, the authors found a negative association between the percentage of Latino clients and the availability of SSRIs. They also found that the while African Americans appeared to have less access SSRIs than whites, the association was fully mediated by other factors such as s the presence of a physician on staff or on contract.

Kratochvil, C. J., Wilens, T. E., & Upadhyaya, H. (2006). Pharmacological management of a youth with ADHD, marijuana use, and mood symptoms [invited column]. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*(9), 1138–1141.

The authors present a case study of a 16-year-old male with AD/HD and signs of marijuana abuse. They suggest a course of treatment including medication for AD/HD based on this case.

Levin, F. R., Evans, S. M., Brooks, D. J., & Garawi, F. (2007). Treatment of cocaine dependent treatment seekers with adult ADHD: Double-blind comparison of methylphenidate and placebo. *Drug and Alcohol Dependence, 87*(1), 20–29.

The authors compared the effectiveness of sustained-release methylphenidate (MPH) to a placebo for the treatment of adult AD/HD symptoms in a group of individuals receiving treatment for cocaine dependence. Both groups also received individual cognitive behavioral therapy on a weekly basis. The retention rates were the same for both groups. They found that while the MPH appeared to be no better than a placebo at reducing AD/HD symptoms in this population there was also some evidence that the improvement in AD/HD symptoms (in those receiving MPH) was associated with a reduction in cocaine use.

Min, S.-Y., Whitecraft, J., Rothbard, A. B., & Salzer, M. S. (2007). Peer support for persons with co-occurring disorders and community tenure: A survival analysis. *Psychiatric Rehabilitation Journal, 30*(3), 207–213.

The authors evaluated a peer support program (The Friends Connection) for people with COD. Their analysis showed that clients who participated in the program experienced, over the course of three years, longer periods of living in the community without a return to hospitalization than clients in the control group. Also, clients in the program were less likely to be re-hospitalized during the study period.

Morley, K. C., Teesson, M., Reid, S. C., Sannibale, C., Thomson, C., Phung, N., Weltman, M., Bell, J. R., Richardson, K., & Haber, P. S. (2006). Naltrexone versus acamprosate in the treatment of alcohol dependence: A multi-centre, randomized, double-blind, placebo-controlled trial. *Addiction, 101*(10), 1451–1462.

The authors compared acamprosate and naltrexone for treating alcohol dependence in a sample of 169 clients at three different Australian treatment sites. All subjects also received a manualized intervention on medication compliance. Of the 94 individuals who completed the study, outcomes regarding measures of drinking, alcohol craving, and biochemical markers were not significantly different for the two groups. Subjects who received naltrexone and had low levels of dependence and/or were diagnosed as having “no depression” received a significant beneficial treatment effect from that medication. No effect was found for acamprosate.

Weiss, R. D., Griffin, M. L., Kolodziej, M. E., Greenfield, S. F., Najavits, L. M., Daley, D. C., Doreau, H. R., & Hennen, J. A. (2007). A randomized trial of integrated group therapy versus group drug counseling for patients with bipolar disorder and substance dependence. *American Journal of Psychiatry, 164*(1), 100–107.

The authors compared integrated group therapy and group drug counseling (the latter which focused solely on substance use) in population of patients with co-occurring bipolar disorder and substance dependence ($N = 62$). Patients were randomly and evenly assigned to the two treatment conditions. The patients who received integrated group therapy had significantly fewer days on which they used substances during both the treatment and followup periods. Those who received integrated group therapy also had more depressive and manic symptoms, but there was no significant difference between the groups on the amount time ill with the bipolar disorder.

Samuelson, K. W., Neylan, T. C., Metzler, T. J., Lenoci, M., Rothlind, J., Henn-Haase, C., Choucroun, G., Weiner, M. W., & Marmar, C. R. (2006). Neuropsychological functioning in posttraumatic stress disorder and alcohol abuse. *Neuropsychology, 20*(6), 716–726.

The authors compared neuropsychological tests on four groups of veterans: those with and without posttraumatic stress disorder (PTSD) and with or without an alcohol abuse history. They found (after controlling for alcohol use, education, vocabulary, and depression) that PTSD was associated with lower levels of verbal memory, attention, and processing speed performance. A history of alcohol abuse was associated with poorer visual memory performance.

Schumacher, J. A., Coffey, S. F., & Stasiewicz, P. R. (2006). Symptom severity, alcohol craving, and age of trauma onset in childhood and adolescent trauma survivors with comorbid alcohol dependence and posttraumatic stress disorder. *American Journal on Addictions, 15*(6), 422–425.

The authors examined whether the association between trauma and alcohol abuse symptoms was more pronounced among those who experienced childhood trauma as opposed to trauma during their adult lives. They found that those who

reported childhood trauma also reported greater severity of both trauma and alcohol abuse symptoms and more alcohol craving.

Stahler, G. J., Mazzella, S., Mennis, J., Chakravorty, S., Rengert, G., & Spiga, R. (2007). The effect of individual, program, and neighborhood variables on continuity of treatment among dually diagnosed individuals. ***Drug and Alcohol Dependence, 87*****(1), 54–62.**

The authors reviewed medical charts from 271 people who had been diagnosed with COD and were discharged from an in-patient acute care hospital unit to determine individual, program, and geographic factors that might affect continuation in aftercare. They found that having three or more treatment episodes prior to hospitalization and living in an area that has a concentration of temporary or transitional housing (most likely an area of low-income housing) were associated with greater participation in further treatment after discharge. Returning to a preadmission address after discharge, having a chief complaint of bizarre behavior, living in close proximity to two or more stores that sell alcohol, having a high density of 12-Step meetings in the neighborhood, having a diagnosis of substance-induced mood disorder, and having a urine sample that screened positive for heroin were all associated with lower participation in aftercare.

Strakowski, S. M., DelBello, M. P., Fleck, D. E., Adler, C. M., Anthenelli, R. M., Keck, P. E. J., Arnold, L. M., & Amicone, J. (2007). Effects of co-occurring cannabis use disorders on the course of bipolar disorder after a first hospitalization for mania. ***Archives of General Psychiatry, 64*****(1), 57–64.**

The authors sought to determine how the sequence of onset for cannabis use disorder and bipolar disorder (in individuals who have both) affected the subsequent course for each disorder. They compared a group of patients whose cannabis use disorder preceded their bipolar disorder (n = 33) to one in which bipolar disorder began before the cannabis use disorder (n = 36) but did not find pronounced effects resulting from the sequence of disorders. They did find that cannabis use was associated with a greater amount of time spent in affective episodes and with rapid cycling. Also cannabis use disorders typically remitted after hospitalization but were followed by rapid recurrence after discharge.

Waldrop, A. E., Back, S. E., Verduin, M. L., & Brady, K. T. (2007). Triggers for cocaine and alcohol use in the presence and absence of posttraumatic stress disorder. ***Addictive Behaviors, 32*****(3), 634–639.**

The authors evaluated triggers for cocaine and alcohol use in a group of 72 individuals, some with PTSD, who had been diagnosed with either cocaine dependence or alcohol dependence. They found that those who had co-occurring PTSD were significantly more likely than those who did not to use substances as a response to negative situations (e.g., physical discomfort, uncomfortable emotions). Subjects who were cocaine dependent with co-occurring PTSD also used more cocaine during pleasant times than those without PTSD.