



### Connecticut Issues Guidelines on Recovery-Oriented Care

The Connecticut Department of Mental Health and Addiction Services and the Yale University Program for Recovery and Community Health have issued guidelines on providing recovery-oriented behavioral health care to people with substance use and/or other mental disorders as part of the State's larger recovery initiative (see: <http://www.dmhas.state.ct.us/recovery.htm>). Many providers now recognize the importance of providing care that focuses on resilience and recovery, but most guidelines on how to provide that care have been difficult to access and/or less than comprehensive.

The Guidelines define *recovery* as the "ways in which a person with a mental illness and/or addiction experiences and manages his or her disorder in the process of reclaiming his or her life in the community," and *recovery-oriented care* as "what psychiatric and addiction treatment and rehabilitation practitioners offer in support of the person's recovery" (p. 6). It describes eight domains of recovery-oriented service systems and for each of these lists a number of specific practices. The eight domains, with examples of the accompanying practices, are presented below.

- 1. Primacy of Participation** (e.g., People in recovery are routinely invited to share their stories with current service recipients and/or to provide training to staff.)
- 2. Promoting Access and Engagement** (e.g., The service system has the capacity to go where the potential client is rather than always insisting that the client come to the service.)
- 3. Ensuring Continuity of Care** (e.g., Individuals are not expected or required to progress through a pre-determined continuum of care in a linear or sequential manner.)

- 4. Employing Strengths-Based Assessment** (e.g., A discussion of strengths is a central focus of every assessment, care plan, and case summary.)
- 5. Offering Individualized Recovery Planning** (e.g., Community inclusion is valued as a commonly identified and desired outcome.)
- 6. Functioning as a Recovery Guide** (e.g., Interventions are aimed at assisting people in gaining autonomy, power, and connections with others.)
- 7. Community Mapping and Development** (e.g., People in recovery are viewed primarily as citizens and not as clients and are recognized for the gifts, strengths, skills, interests, and resources they have to contribute to community life.)
- 8. Identifying and Addressing Barriers to Recovery** (e.g., There is a commitment at the local level to embrace the values and principles of recovery-oriented care and to move away from the dominant illness-based paradigm.)

Each of these domains and practices is discussed in depth in the publication. The Guidelines also provide a thorough glossary and a multi-page table showing how a deficit-based perspective on disorders can be made into an asset-based perspective.

**Tondora, L. & Davidson, J. (2006). *Practice guidelines for recovery-oriented behavioral health care*. Hartford, CT: Connecticut Department of Mental Health and Addiction Services. Available online at <http://www.dmhas.state.ct.us/documents/practiceguidelines.pdf>**

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## COD Research

### Epidemiology

**Grunebaum, M. F., Galfalvy, H. C., Nichols, C. M., Caldeira, N. A., Sher, L., Dervic, K., Burke, A. K., Mann, J. J., & Oquendo, M. A. (2006). Aggression and substance abuse in bipolar disorder. *Bipolar Disorders*, 8(5p1), 496-502.**

The authors investigated factors that appeared to distinguish people with bipolar disorder ( $N = 136$ ) who have a co-occurring substance use disorder from those who do not have one. Co-occurring substance use disorders were associated with being impulsive, aggressive, male, and having a co-occurring conduct and/or Cluster B personality disorder. Co-occurring substance use disorders in this population were also associated with an increased number of suicide attempts and an earlier age of onset for first mood disorder. The first mood disorder tended to precede the development of a substance use disorder.

**James, D. J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates* (NCJ 213600). Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics. Available online at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf>**

The authors provide estimates of the prevalence of mental health problems among prison and jail inmates using self-reported data on recent history and symptoms of mental disorders. They compare the characteristics of offenders with a mental health problem to those without, including current offense, criminal record, sentence length, time expected to be served, co-occurring substance dependence or abuse, family background, and facility conduct since current admission. They present measures of mental health problems by gender, race, Hispanic origin, and age. They also describe mental health problems and mental health treatment among inmates since admission to jail or prison. Findings are based on the Survey of Inmates in State and Federal Correctional Facilities, 2004, and the Survey of Inmates in Local Jails, 2002.

**Knopik, V. S., Heath, A. C., Jacob, T., Slutske, W. S., Bucholz, K. K., Madden, P. A. F., Waldron, M., & Martin, N. G. (2006). Maternal alcohol use disorder and offspring AD/HD: Disentangling genetic and environmental effects using a children-of-twins design. *Psychological Medicine*, 36(10), 1461-1471.**

The authors investigated the effects of both genetic risk associated with maternal alcohol use disorder and prenatal environmental risk factors on the development of attention deficit hyperactivity disorder (AD/HD) in an Australian sample of twins. The children of twins who had a history of alcohol use disorder or of a twin whose co-twin had an alcohol use disorder had a significantly higher rate of AD/HD than the children of twins from the control group (who did not have a history of alcohol use disorder). After adjusting for prenatal maternal cigarette use, the genetic link between maternal alcohol use disorder and children's AD/HD remained significant.

**Nelson, E. C., Heath, A. C., Lynskey, M. T., Bucholz, K. K., Madden, P. A. F., Statham, D. J., & Martin, N. G. (2006). Childhood sexual abuse and risks for licit and illicit drug-related outcomes: A twin study. *Psychological Medicine*, 36(10), 1473-1483.**

Using data from a study of young adult (mean age 29.9) Australian twins ( $N = 6050$ ), the authors investigated links between childhood sexual abuse and substance use and substance use disorders. Respondents who had a history of childhood sexual abuse had a greater risk for becoming regular cigarette smokers and for use of each illicit drug in the survey. For regular users of the substances, a history of childhood sexual abuse was also associated with nicotine and alcohol dependence and with most types of illicit substance use disorders. In same sex discordant pairs of twins, twins who had experience childhood sexual abuse had a greater risk for regular tobacco use, illicit substance use, and illicit substance use disorders when compared to co-twins who did not experience childhood sexual abuse.

**Nunes, E. V., Liu, X., Samet, S., Matseoane, K., & Hasin, D. (2006). Independent versus substance-induced major depressive disorder in substance-dependent patients: Observational study of course during follow-up. *Journal of Clinical Psychiatry, 67*(10), 1561-1567.**

The authors evaluated whether or not baseline and past diagnoses of primary or substance-induced psychiatric disorders predicted future depression in individuals with alcohol, cocaine, and/or opioid dependence. In individuals with substance dependence, both primary and substance-induced major depressive disorder predicted future depression. Also, panic attacks, posttraumatic stress disorder, borderline personality disorder, and antisocial personality disorder predicted depression at the 12-month follow-up.

**Smith, S. M., Stinson, F. S., Dawson, D. A., Goldstein, R., Huang, B., & Grant, B. F. (2006). Race/ethnic differences in the prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Psychological Medicine, 36*(7), 923-930.**

The authors looked at the prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders in different ethnic groups using data from the National Epidemiologic Survey on Alcohol and Related Conditions. They found that 1-year rates of most mood, anxiety, and substance use disorders were highest among Native Americans and lowest among Asian Americans. For most ethnic groups, alcohol and drug dependence (but not alcohol and drug abuse) were significantly associated with mood disorders. Interestingly, alcohol dependence was significantly associated with most anxiety disorders in White, Black, and Asian sub-populations but not for Native Americans, and there were few significant associations between substance abuse disorders and anxiety disorders.

**Stinson, F. S., Ruan, W. J., Pickering, R., & Grant, B. F. (2006). Cannabis use disorders in the USA: Prevalence, correlates and co-morbidity. *Psychological Medicine, 36*(10), 1447-1460.**

The authors used data from a large national survey ( $N = 43093$ ) of adults in the United States to make estimates on the prevalence, sociodemographic correlations, and associations with co-occurring psychiatric disorders for cannabis use disorders. They found a 12-month prevalence rate of 1.1 percent for cannabis abuse and .3 percent for cannabis dependence, and a lifetime prevalence rate of 7.2 percent for cannabis abuse and 1.3 percent for cannabis dependence. Factors that increased the odds for cannabis abuse and/or dependence included being male; Native American; and widowed, separated, or divorced. Having low income increased the odds of cannabis dependence, and residing in the western United States increased the odds of dependence and/or abuse. Factors that decreased the odds of cannabis abuse or dependence included being Black, Asian, or Hispanic. They found high rates of co-occurrence between cannabis use disorders and other psychiatric disorders.

**Winiarski, M. G., Greene, L. I., Miller, A. L., Palmer, N. B., Salcedo, J., & Villanueva, M. (2005). Psychiatric diagnoses in a sample of HIV-infected people of color in methadone treatment. *Community Mental Health Journal, 41*(4), 379-391.**

The authors determined rates of psychiatric disorders in a convenience sample of HIV-positive, African American and Latino clients in methadone treatment in New York City ( $N = 139$ ). Of this sample, 99 had psychiatric diagnoses in addition to opioid dependence. The mean number of diagnoses in the sample was 3.84.

### Services & Service Systems

#### Screening & Assessment

**Bennett, M. E., Bellack, A. S., & Gearon, J. S. (2006). Development of a comprehensive measure to assess clinical issues in dual diagnosis patients: The Substance Use Event Survey for Severe Mental Illness. *Addictive Behaviors, 31*(12), 2249-2267.**

The authors describe a brief instrument, The Substance Use Event Survey for Severe Mental Illness (SUESS), designed to assess clinical factors of concern for people with co-occurring substance use disorders and severe mental illness. They

also present data on the performance of the instrument with people with co-occurring disorders from several large studies and provide some initial reliability data on the SUESS.

**Lincoln, A. K., Liebschutz, J. M., Chernoff, M., Nguyen, D., & Amaro, H. (2006). Brief screening for co-occurring disorders among women entering substance abuse treatment. *Substance Abuse Treatment, Prevention, and Policy, 1*(26). Available online at <http://www.substanceabusepolicy.com/content/pdf/1747-597X-1-26.pdf>**

The authors described a brief screening instrument designed to screen for trauma history and symptoms of mental disorders in women entering substance abuse treatment. Based on testing with a diverse population of women in treatment, they believe the 14-question instrument accurately screens for PTSD but not for other mental illnesses. In the sample they screened ( $N = 374$ ), 89 percent of respondents reported a lifetime history of history of interpersonal violence, 70 percent reported a lifetime history of sexual assault, and 88 percent reported symptoms of mental disorders in the prior month.

### *Services Integration*

**Graham, H. L., Copello, A., Birchwood, M., Orford, J., McGovern, D., Mueser, K. T., Clutterbuck, R., Godfrey, E., Maslin, J., Day, E., & Tobin, D. (2006). A preliminary evaluation of integrated treatment for co-existing substance use and severe mental health problems: Impact on teams and service users. *Journal of Mental Health, 15*(5), 577-591.**

The authors attempted to assess the effectiveness of integrating substance abuse treatment into five existing assertive outreach programs in Birmingham, England. They assessed changes in the ways team members discussed substance abuse problems in their clients through observing team meetings and assessed different measures of clients services use (e.g., engagement, levels of substance use, positive substance-related beliefs) as well. They found that after training, substance abuse treatment was integrated to a degree and there were changes in team members' practice. They also observed improvements in client engagement and a reduction in both alcohol use and positive alcohol-related beliefs, although those changes occurred regardless of staff training.

### *Treatment Planning & Services*

**Bender, K., Springer, D. W., & Kim, J. S. (2006). Treatment effectiveness with dually diagnosed adolescents: A systematic review. *Brief Treatment and Crisis Intervention, 6*(3), 177-205.**

The authors reviewed clinical trials of interventions for adolescents with COD. They note that several treatment modalities appear to have success with this population but that behavioral family therapy and cognitive-behavioral problem-solving therapy show the largest effect across externalizing, internalizing, and substance-abuse outcomes. They conclude by suggesting some preliminary guidelines for treating youth with COD based on the most effective treatments available in the literature.

**Hermann, R. C., Chan, J. A., Provost, S. E., & Chiu, W. T. (2006). Statistical benchmarks for process measures of quality of care for mental and substance use disorders. *Psychiatric Services, 57*(10), 1461-1467.**

The authors describe statistical benchmarks for 12 process measures of mental health and substance abuse treatment quality of care, which they developed from using administrative data on care received by patients with Medicaid benefits in 6 States between 1994 and 1995. Of the proposed measures, six concern follow-up treatment visits, three concern treatment with antidepressants, two concern treatment with antipsychotics, and one treatment for bipolar disorder using mood stabilizers.