THE CARLAT REPORT
ADDICTION TREATMENT

A CE/CME Publication

CURRENT COVERAGE OF TOPICS IN ADDICTION MEDICINE

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Editor-in-Chief

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Learning Objectives
After reading these articles, you should be able to:

1. Identify best practices in assessing patients with co-occurring disorders.

2. Describe treatment options for patients with co-occurring disorders who are actively using substances.

3. Summarize some of the current findings in the literature regarding psychiatric treatment.

Helping People With Co-Occurring Mental Health and Substance Use Disorders

Kenneth Minkoff, MD.
Senior system consultant, ZiaPartners, Inc, which provides consulting services for co-occurring disorders. Part-time assistant professor of psychiatry at Harvard Medical School.

Dr. Minkoff has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Summary

- Patients with co-occurring disorders are challenging to treat and typically have poorer outcomes than those with a disorder in isolation.
- Steps toward establishing a co-occurring disorder diagnosis include initiating an immediate and integrated assessment.
- The stages of change approach can help measure progress in treatment, as well as manage clinical expectations.

Patients with co-occurring disorders (COD, also known as "dual diagnosis") are often regarded as among the most challenging patients to treat. You need to track two conditions that interact in unpredictable ways, with patients who may not be inclined to follow your recommendations. It's no surprise that such patients typically have poorer outcomes than those with either disorder in isolation. And

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Q&A With the Expert

When Dual Diagnosis Patients Request Addictive Medications: What to Do?

Charles Atkins, MD. Chief medical officer, Community Mental Health Affiliates, CT.

Dr. Atkins has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Despite an increased awareness of co-occurring disorders, there remains a fair amount of confusion about how to treat a mental health issue and a substance abuse issue at the same time without causing more harm. To further complicate the issue, when patients first walk in you often don't know whether they are dealing with two conditions concurrently. Charles Atkins' book, Co-Occurring Disorders: Integrated Assessment and Treatment of Substance Use and Mental Disorders, *addresses these problems. We turned to him for some practical guidance.*

CATR: A common dual diagnosis scenario is that we are treating a patient for depression or anxiety, the patient is on an SSRI and a benzodiazepine, and then suddenly we find out the patient is also on methadone maintenance or has been using medical marijuana regularly. Then we have to decide what to do. For example, should we continue to prescribe the benzo?

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these patients are far from rare. For example, approximately 30% of people with unipolar mood disorder—and at least 60% of those with bipolar disorder—have lifetime substance use disorder (Regier DA, *JAMA* 1990;264(19):2511–2518). Based on this, many years ago I coined the phrase: "Co-occurring disorders are an expectation, not an exception."

After over 30 years of treating patients with COD and teaching clinicians about best practices in COD treatment, I've developed a system of steps you might find helpful. If you learn to do this work well, not only will you begin to master the challenge these individuals present, but you may actually have more fun helping these interesting patients toward dual recovery.

Three assessment steps

Step 1: Welcome your co-occurring patients.

According to the intake form, your next patient just got out of alcohol detox and wants treatment for depression and anxiety. Inwardly, you might groan. You worry this will be a complicated and time-consuming evaluation, possibly including one of your least favorite situations: a person with addiction requesting benzodiazepines or other addictive drugs.

My first message is to relax. Treating people with COD is a slow process in which patients make small steps of progress for each condition. It's important for psychiatrists to adjust their expectations accordingly. We don't have to "fix" anything in the first meeting; we just have to begin a relationship that will be helpful over time. Welcoming is a key step.

Whenever I see a new COD patient, I start with a simple mantra: "The people I work with are going to be exactly who they are, no matter how much I might hope they are someone else." It makes me less prone to frustration, and the work more successful, if I welcome the patient with that in mind.

Here's a basic welcoming "script" that I often use: "I know you're having a hard time. Thank you for coming. You are in the right place. I know my job is not to 'fix' you but rather to get to know you, inspire you with hope, and help you figure out how to get connected to me (and members of my team) so we can help you address all your issues to make progress step-by-step toward a happy, hopeful, and meaningful life."

Step 2: Identify your patient's goals.

The next step in the process is to identify the person's goals, which helps to instill hope. This helps shift the discussion from an immediate focus on symptom relief to the critical question of how any interventions contribute to helping the person experience meaning and purpose.

"Can you tell me what your vision of a successful life looks like?" I ask the patient. "What kind of help would you most like to achieve that vision?"

With this approach, you create a context in the first 10 minutes of your evaluation that will make the rest of the information gathering go more smoothly, in addition to creating a platform for ongoing partnership.

Step 3: Follow four rules in establishing a diagnosis in COD:

a. The assessment begins immediately.

Some readers may remember being taught to wait several weeks or months to see whether a patient's depression, anxiety, or psychosis "clears up" once the patient has stopped using a substance. However, the current standard of care is that treatment of mood and anxiety symptoms should begin immediately, even when the person is currently using or has recently used substances. An integrated, longitudinal assessment will help clarify the course of both the mental illness and the substance use disorder, delineate how they intersect, and lead to better treatment decisions. (You can find a good review of the evidence for this type of treatment from SAMHSA at https://store.samhsa.gov/shin/content/SMA08-4367/TheEvidence-ITC.pdf.)

For example, I once evaluated a 52-year-old man with heroin addiction who was admitted to the hospital for treatment of severe depression. I learned during the history that—remarkably—he had functioned with heroin addiction for decades, holding a job and maintaining family relationships. Recently, however, his brother had died, and he had been laid off. His heroin use continued as before, but over the past several months, for the first time, he developed classic symptoms of major depression, severe enough to lead to psychiatric admission.

The "traditional" approach would be to insist on heroin detox and a "drug-free" period before initiating antidepressants. Instead, I viewed this patient as having a diagnosis of long-standing opioid addiction, lately with an additional diagnosis of major depression—not different from someone with cardiac disease who might develop depression unrelated to that illness. I started him immediately on antidepressants, at the same time beginning to explore his willingness to consider opioid maintenance treatment for his addiction. He responded to antidepressants, and agreed to an evaluation for opioid maintenance after discharge from the hospital.

b. Diagnoses are established by history, not by symptoms alone.

If someone comes into your office

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drunk, you can't conclude that the person has alcoholism—you can only diagnose alcohol intoxication. In order to diagnose substance use disorder, you need to get a history of substance use over time. Similarly, if a person comes in without drinking for five years, but reports undergoing many prior detoxification admissions and now attends AA daily, that history allows you to diagnose alcohol use disorder in remission, and you need to take that into account while addressing any comorbid psychiatric conditions. The same thing applies if the person presents with current symptoms of hearing voices or anxiety attacks, with or without recent substance use. The only way to make a diagnosis is to get a good history, discover whether or not there is a long-standing established disorder that needs continuing care, and proceed accordingly.

c. If a patient has a long-standing established psychiatric diagnosis by history, that patient likely still has it, even with current or recent substance use.

When patients present with both psychiatric issues and active substance abuse, it may seem as if the substances are causing or aggravating the symptoms. In such cases, it may be tempting to assume that the cure for the psychiatric symptoms is simply to stop the substance use. That's not necessarily the case.

Consider the following: A young man came in to see me with significant panic and daily cannabis use. A detailed history revealed that he had been treating his anxiety with cannabis for many years. While this strategy seemed helpful for a while, recently he had been having more anxiety, and using more cannabis, which in turn was interfering with his work and relationships. I pointed out that while cannabis apparently eased his anxiety initially, there is a well-known phenomenon in which increasing use can actually worsen anxiety. We initiated an SSRI for his panic disorder, and then worked on helping him taper off the cannabis. I warned him that even though his anxiety would initially be exacerbated as he tapered the cannabis, in the long run, this approach was his best shot at treating his long-standing anxiety disorder successfully. The patient was compliant with this approach, and over time, it worked to reduce his use and assist with his anxiety.

d. Do an INTEGRATED assessment—don't artificially divide mental health and substance use history.

It is common practice to obtain mental health history and substance use history separately; in fact, these are often split into different categories on standard evaluation forms. In my experience, this approach often results in disjointed and unhelpful information. Instead, I recommend you try obtaining an integrated history to get a more accurate understanding of the problem. A good technique is to use the history of present illness method we all learned in medical school, in which we start by asking when the patient was last doing well, and then find out when and how the current illness episode began.

In order to keep my information gathering efficient and quick, I have learned not to focus on the details of what led to each admission or relapse. Instead, I am most interested in looking for the last time the patient did *well*. This type of assessment focuses on multiple issues that occur during a period of success. Therefore, I have come to call this approach "integrated, longitudinal, and strength-based." (See the Zia Tools link at http://www.ziapartners.com for more information on how to document such an assessment.)

For example, I might start with, "Lately it seems like you've been going through a chaotic period, but before that there was a period when you were doing well. Please give me a picture of what was going on. Where did you live, who were you living with, and how were you supporting yourself? What kind of treatment were you receiving for your bipolar disorder? What were you doing to stay sober?" I'm trying to get an integrated view of one brief "good" period. Granted, in someone with a persistent and disabling mental illness, this period might not be wonderful, but it does represent a baseline period when the person was managing life's challenges relatively well.

Next, I ask, "So how did things start to unravel? What were you doing differently?" In response, I typically hear about the person stopping medication, skipping AA meetings or therapy sessions, spending time with friends who were using, etc. In response, I say something like, "I'm glad you're here; you did the right thing to come for help. The good news is we know from your history exactly what helps you manage both your mental health and substance use conditions. You've gotten a little off track, and now that we know what works, let's get you back on track as quickly as possible and help you learn some skills so things go even better in the future."

Two treatment tips

SAMHSA has published treatment guidelines for COD, which are freely accessible at https://store.samhsa.gov/shin/content/SMA12-4689/SMA12-4689.pdf. Here are two tips that many clinicians find helpful:

Tip 1: Use the stages of change approach to help measure treatment progress and manage your expectations.

The stages of change (pre-contemplation, contemplation, preparation, action, and maintenance) have been covered in the January 2014 issue of *CATR* (I like to divide the action stage into "early" and "late"). These stages describe the process everyone goes through to make improvements in their lives, including health, nutrition, and relationships—as well as mental health and substance use. The staging language helps us understand that the pace of change is incremental and slow.

Here are two useful facts about stages of change:

—Stages of change are problem-specific, not person-specific. Each person has many issues and may be in different stages of change for each one. For example, a patient in the late action stage for mental illness treatment (receiving medication and therapy) may still be in the pre-contemplation stage for substance abuse (using drugs and not wanting to discuss even the possibility of change).

—Interventions and outcomes have to be stage-matched. Your intervention should be tailored to your patient's stage of change. For example, don't skip ahead and discuss a prescription for naltrexone with someone who is in "contemplation" about a drinking problem—that is, a patient who is willing to discuss the problem

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Dr. Atkins: The first thing is to make sure that you do have access to this information. It's better to learn it ahead of time, rather than the patient springing it on you. The best way to do this is to follow your state's prescription monitoring program (Editor's note: See *CATR,* Nov/Dec 2016 on PDMPs). In most cases, the database will include stimulants, opiates, benzodiazepines, and in some cases medical marijuana. Prior to the intake, pull up the database. But regardless of how you find out—whether from the patient or the prescription monitoring program—the first thing to do is educate the patient about the risk. The fact is, the majority of lethal overdoses involve a combination of opioids with benzodiazepines, and patients are putting themselves at risk with the combination. Some will have an "aha" moment and say, "I didn't realize that!" and will want to stop it, but others will be too attached to their Klonopin, Xanax, or Ativan.

CATR: The latter has been more my experience!

Dr. Atkins: Assuming that they are not moved by the overdose risks, there's another piece of education that applies to a surprisingly large proportion of such patients. If they have sleep issues—and this may be why they want to take benzos—you can tell them that they may well have sleep apnea from the combination of opioids and benzos. I was a busy buprenorphine prescriber for many years, and I was surprised at how many of my young, non-obese, otherwise healthy patients had moderate sleep apnea—I would guess about a third of those I referred for sleep studies had it. This makes sense because both of these drugs are central respiratory depressants. So I recommend referring these patients for sleep studies; if they have apnea, we'll know what they need to do to treat it, and if they don't have apnea, we may feel more comfortable prescribing a sleep aid.

CATR: And if you are going to taper an opioid-using patient off benzos, how would you go about it?

Dr. Atkins: You're going to go slowly, especially if you are treating an anxiety disorder. Decreasing by 10% per week works. Just be aware that we're sometimes fooling ourselves if we think patients are taking meds as prescribed, so even if you write out a lovely tapering strategy, many of them will run out early. So tell them that if they are shaky or tremulous, they need to go to an ER.

CATR: Do you have a policy of never prescribing benzos to opioid users?

Dr. Atkins: No, I don't advocate a flat no-benzo rule because some patients will not accept that and will drop out of treatment, which is not helpful. It's important to adopt a harm-reduction approach and realize that people will engage in risky behavior. If someone refuses to stop benzos, you can try to diminish the risk, document your discussions, keep the dose as low as possible, limit the size of prescriptions, and require regular urine tox screens. I may refer patients to an intensive outpatient program, where staff might be able to convince them to do a medically supervised outpatient taper. And some patients will require inpatient treatment to safely taper off the benzodiazepine.

CATR: What about patients who inform you they have been using cannabis for some time? Is there a danger associated with combining cannabis with opioids?

Dr. Atkins: We don't have a lot of information on marijuana and opioids. However, unlike benzos, cannabis is not a respiratory depressant, and there are some patients who will say, "If you stop my Klonopin, can you let me smoke marijuana?" And indeed, given the choice, I would rather they smoke pot than incur the risk of respiratory depression with benzos. It's not something I would have said five years ago, but in the face of the current fatal overdose epidemic, it seems the lesser of two evils.

"I don't advocate a flat no-benzo rule because some patients will not accept that and will drop out of treatment, which is not helpful. It's important to adopt a harm-reduction approach and realize that people will engage in risky behavior."

Charles Atkins, MD

CATR: Putting aside the issue of combining marijuana with opioids, there are patients who are being treated with antidepressants and anti-anxiety drugs, and who are smoking marijuana every day. They may tell us using marijuana works for them, but we have no way of knowing if that's true, or if they are just using it recreationally. This is especially problematic with patients on disability who are not working, for whom we feel we shouldn't be condoning marijuana use.

Dr. Atkins: Right, so you have patients who are sitting at home smoking marijuana and watching junk TV, and you don't feel that much is being accomplished. At this point, talk to the patients about what they are really working on in treatment—are they moving in the direction of a goal, are they stagnating, or are they moving away from the goal? For disabled patients smoking pot, ask them, "Is this the life that you want?" You might find that they do have goals, like wanting to reunify with their children, doing more fishing, or getting involved in their church or other volunteerism. (See the accompanying article by Dr. Minkoff, which advises using the stages of change model to help patients get on a clear path for reaching their goals.)

CATR: Shifting gears a bit, let's talk about alcoholism. What are your thoughts about treating patients with alcohol use disorder and mood disorders?

Dr. Atkins: Bipolar disorder and alcohol abuse are so commonly paired, I think of them like peanut butter and jelly. My colleague Karen Kangas, EdD, a leader in the advocacy community, says that when you are talking to someone with bipolar disorder, it's not a question of whether the patient does drugs; rather, it's which drugs the patient does. The percentage of patients with bipolar and co-occurring substance use is 60%–90%, depending on the population studied (American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders, 5th ed.* American Psychiatric Press: Washington, DC). Alcohol can put the brakes on when a patient feels manic and agitated, and it makes the patient feel better, at least temporarily, when depressed. I do believe that among substance users,

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but not yet interested in change. Instead, for this individual, you might continue to treat the psychiatric illness, while helping the patient self-examine as follows: "What is the right amount of substance use for me to achieve my most important life goals?" Look for small successes, and work with patients where they are.

In consulting with treatment agencies, I often hear about clinicians' frustration with the pace of clients' improvement. For example, I spoke with one psychiatrist who had treated a young woman for psychosis for two years, yet she was "still using." I asked for more details, and learned that the patient came into the clinic addicted to alcohol and methamphetamine, unwilling to even discuss her substance use. Over the two years, she engaged with her doctor and team, received medication for her psychosis, and gradually progressed. Recently, she had two three-month periods of sobriety, and she had stopped using meth. I pointed out that although this client was still actively drinking, she had moved beyond pre-contemplation and was now in the early action stage. This is real progress, because moving through stages of change normally takes months or years in a person like this.

I suggest memorizing the stages and learning to "stage" your patients for each issue. Your patients may be progressing more than you realize—and if you are stage-matched in what you do, they will progress even faster.

Tip 2: It is a standard of practice to prescribe necessary non-addictive psychotropics for known serious mental illness even if the patient is using substances.

Just like other medications, psychotropic medications for a known illness, taken as prescribed, continue to work—albeit perhaps less effectively—even when the person is using substances.

While combining prescribed medications and substances can be risky, using substances is risky in and of itself, whether or not people are on medication. For most people with severe mental illness, the risk of a bad outcome increases when they are unmedicated, and even more so if they are disconnected from care.

CATR VERDICT: Invest time and energy in connecting with your COD patients and carefully sequencing their histories. Progress will still be slow, as it may be for any single disorder, but it will occur.

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there are more patients with bipolar than many of us realize. I've certainly had the experience of treating a patient for "depression" for years and then having the patient come into the office one day and talk about not sleeping for three days and being overly energetic—at which point I realize the patient is bipolar. I would steer your readers to the Mood Disorder Questionnaire, which is freely available and is a very good screen for bipolar disorder. Other symptom screens I use frequently are the PHQ-9 for depression and the PCL-5 (PTSD Checklist for DSM-5) available from the Veteran's Administration's National Center for PTSD (https://www.ptsd.va.gov).

CATR: One of the treatment issues we see with alcohol users is trying to come up with a non-addictive treatment for anxiety/insomnia.

Dr. Atkins: Yes, and there are some off-label medications that can be helpful, such as gabapentin, antihistamines, and others. I find the most value in non-medication strategies, such as mindfulness meditation and CBT for insomnia. I point out to patients that while medications are helpful, they are essentially rented solutions—in contrast, therapy is something you own forever and always. These therapeutic treatments may not be widely available or affordable for patients, but there are free apps that can be helpful. One is CBT-I Coach, which was developed by the federal government and Stanford. While its emphasis is on improving sleep, it also includes many tools that are great for anxiety, including audio for doing progressive relaxation, guided imagery, and meditative breathing. I also recommend the book *The Miracle of Mindfulness* to teach people about the basics of medication—it is available for free as a PDF (https://tinyurl.com/yd7hytn5).

CATR: How do patients respond to suggestions to try non-medication strategies?

Dr. Atkins: It runs the gamut, from enthusiastic to "I don't have time for that." You really want to match the person to something palatable. Keep in mind that while there is an incredible amount of marketing from drug companies to advocate pharmacologic solutions, no one's putting the same effort into "selling" exercise and meditation. That sometimes leaves not just patients but also psychiatrists unfamiliar with non-medication strategies. Some doctors are getting on board these days, but it can be hard when you're trying to manage

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Research Updates

ALCOHOL

Do Prizes for Abstinence Increase Sobriety in People With Serious Mental Illness?

REVIEW OF: McDonell MG et al, *Am J Psychiatry* 2017;174(4):370–377. doi:10.1176/appi.ajp.2016.16050627.

Although studies have demonstrated the effectiveness of contingency management (CM) for illicit drug use, there's less evidence for treatment of alcoholism—in part because a standard breathalyzer has a short detection window of 12 hours, meaning patients must only abstain from drinking since the previous night to pass the test.

Over the past few years, however, a more effective alcohol biomarker has been introduced. Ethyl glucuronide (EtG) is an alcohol metabolite that is present in the urine for at least 5 days after a patient's last drink. It can therefore verify longer-term abstinence.

Researchers in Seattle recruited 79 patients who had both alcohol use disorder and serious mental illness such as schizophrenia, bipolar disorder, and recurrent depression. Roughly two-thirds were men, half were white, and the average age was in the mid-40s. All were in outpatient substance use disorder (SUD) treatment. Before being randomly grouped, participants had to complete a 4-week induction period designed to identify those who were most likely to stay in the actual 12-week study. Those who showed up during the induction phase were randomly assigned to a CM group (N = 40) or a noncontingent reinforcement (control) group (N = 39). Participants in both groups provided urine samples 3 times a week.

After the induction phase, participants in the CM group who submitted 3 consecutive urine samples negative for EtG earned "prize draws" from a container of tokens. Half of the tokens simply said "good job," while the other half could be turned in for prizes ranging in value from $1 to $80. Participants also received $10 gift cards for attending SUD groups each week. Those in the control group received prize draws for each urine sample submitted, no matter what the result. Control participants also received gift cards regardless of whether they attended groups.

RESULTS

The CM group had significantly more EtG-negative urine samples (mean of 8.56) than the control group (mean 4.11). This translated to 1.5 weeks of additional continuous abstinence. Moreover, the CM group had significantly fewer drinking days and fewer days of drinking to intoxication throughout the study. These differences persisted into a 3-month follow-up period.

CATR'S TAKE

This well-designed study supports the effectiveness of contingency management for patients dually diagnosed with mental illness and alcohol use disorder. Point-of-care EtG costs money, but the benefits in terms of improved sobriety are likely worth it.

—Daniel Carlat, Publisher, CATR

Dr. Carlat has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

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patients every 15–20 minutes and feel you don't have time to explore these options with them. What I would recommend, if you yourself are not going to become familiar, is to find some competent cognitive behavioral therapists, or dialectical behavior therapists, to whom you can refer patients for these kinds of help. It's a way of increasing your armamentarium.

CATR: Is there any way to put a face on today's patient with co-occurring disorders? Has it morphed from when the condition was first coined?

Dr. Atkins: Co-occurring disorders were first conceptualized when the big state hospitals were closing back in the 1980s. People with serious schizophrenia, mood disorders, and other severe types of mental health problems that caused psychosis were suddenly being released from 24/7 residential settings and almost immediately getting into trouble with alcohol and street drugs. That's when we began to have these very high rates of homelessness and alcoholism in that population. Flash forward to the last decade and what has been happening with the opioid epidemic—a whole new population of people with co-occurring disorders has emerged.

CATR: Can you elaborate?

Dr. Atkins: Today, it's not so much about people who are on society's margins. People have their anxiety disorder, their depression, their PTSD, and they're silently miserable—they take care of it at home as best they can. But then they get hurt during football practice or hurt their back and get put on Oxycontin, and they find that not only is the knee or back injury feeling better, but also suddenly the anxiety is gone. When they finally decide to come see you, it's not for the mental health issue; it's because they've gotten into trouble with opiates and need to do something about it. That's what gets them into treatment—that they're doing something illegal or morally reprehensible to support their addiction. These days, it's more the mental health end that's hidden rather than the substance abuse issue.

CATR: What can we do to determine whether there's something going on beside the addiction problem?

Dr. Atkins: Anxiety disorders, PTSD, depression—these are high-volume mental health disorders. So when someone comes in with a drug problem, even someone who came out from behind the picket fence and otherwise seems to have an orderly life, use it as an

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CE/CME Post-Test

This CME test is only available to active subscribers. Tests must be completed within a year from each issue's publication date. If your subscription expires before that date, you will not have access to the test until your subscription is renewed. To earn CME or CE credit, you must read the articles and then take the post-test at www.TheCarlatReport.com. You must answer 75% of the questions correctly to earn credit. You will be given two attempts to pass the test. As a subscriber to *CATR*, you already have a username and password to log onto www.TheCarlatReport.com. To obtain your username and password, please email info@thecarlatreport.com or call 978-499-0583.

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Below are the questions for this month's CE/CME post-test. This page is intended as a study guide. Please complete the test online at www.carlataddictiontreatment.com. Note: Learning objectives are listed on page 1.

1. You are seeing a patient who has recently completed an alcohol detox program, and you suspect he has a co-occurring anxiety disorder. Your assessment should focus on the following: (LO #1)

   [ ] a. Gathering information about what led to the recent alcohol treatment admission
   [ ] b. Procuring mental health history and substance use history separately from one another
   [ ] c. Establishing that the patient has been sober for 30 days before treating any anxiety symptoms
   [ ] d. Obtaining an integrated mental health and substance use history

2. What percentage of patients with bipolar disorder also have co-occurring substance use? (LO #2)

   [ ] a. Under 20%
   [ ] b. 25%–55%
   [ ] c. 60%–90%
   [ ] d. Over 90%

3. According to Dr. Minkoff, which of the following represents an effective "stages of change" approach to treating a patient with a co-occurring disorder? (LO #1)

   [ ] a. Apply a person-specific versus problem-specific strategy
   [ ] b. Encourage a quicker pace at the pre-contemplation stage
   [ ] c. Taper medication when a patient reaches the late action stage of either disorder
   [ ] d. Coordinate the intervention to the patient's current stage of change

4. For patients with substance abuse issues, mindfulness meditation can be an effective treatment for co-occurring insomnia. (LO #2)

   [ ] a. True [ ] b. False

5. In a recent study on the effectiveness of contingency management for patients dually diagnosed with mental illness and alcohol use disorder, the contingency management group had which of the following results? (LO #3)

   [ ] a. Same amount of drinking days but fewer days of drinking to intoxication
   [ ] b. One week of additional continuous abstinence over a 3-month follow-up period
   [ ] c. Two weeks of additional continuous abstinence over a 2-month follow-up period
   [ ] d. Fewer drinking days but same amount of days drinking to intoxication

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This Month's Focus:
Dual Diagnosis

Next month in *The Carlat Addiction Treatment Report:* Detox

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opportunity to screen for these problems. Even if someone's not talking about depression or anxiety, you want to look for it. Remember, people who don't become addicted to opioids are the ones who tend not to have mental health disorders. The people who are much more likely to become dependent—the ones who end up in your office—do have mental health problems. If you screen for the high-ticket items like the anxiety disorders, the mood disorders, the PTSD—there's a lot of that one—you'll probably catch the majority of stuff.

CATR: That's really useful. Anything else?

Dr. Atkins: Yes. Anyone interested in prescribing buprenorphine can get free, online 8-hour training from the Provider Clinical Support System. It's available at https://pcss-o.org.

CATR: Thank you for your time, Dr. Atkins.

Editorial correction to last month's *CATR* issue

In the June/July issue of *CATR* on Alternatives to 12-Step Programs, the second summary bulleted item should read: **"Unlike 12-step programs, SMART views belief in a higher power as a personal matter not necessarily related to recovery, and SMART meetings are highly conversational."**

We apologize for any inconvenience.