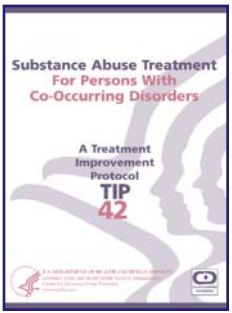
Quick Guide

For Mental Health Professionals

Based on TIP 42

Substance Abuse Treatment for Persons With Co-Occurring Disorders



CO-OCCURRING DISORDERS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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Quick Guide

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This Quick Guide is based on TIP 42, published in 2005, and updated information.

Contents

WHY A QUICK GUIDE?

This Quick Guide accompanies the comprehensive manual, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Number 42 in the Treatment Improvement Protocol (TIP) series. It summarizes the how-to information in TIP 42 pertinent to the mental health professional, focusing on tools and techniques for addressing substance use disorders in mental health settings.

Users of this Quick Guide are invited to consult the primary source, TIP 42, for more information and a complete list of resources for co-occurring disorders. To order a copy or access it online, see the inside back cover of this Guide.

DISCLAIMER

The opinions expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of CSAT, SAMHSA, or HHS. No official support of or endorsement by CSAT, SAMHSA, or HHS for these opinions or for the instruments or resources described are intended or should be inferred. The guidelines presented should not be considered substitutes for individualized client care and treatment decisions.

WHAT IS A TIP?

The Treatment Improvement Protocol (TIP) series provides professionals in the substance abuse treatment and related fields with consensus-based, field-reviewed guidelines on substance abuse treatment topics of vital current interest. TIPs are published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA). The TIP series has been in production since 1991.

TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*

- Provides information about the field of co-occurring substance use and mental disorders
- Focuses on the information that treatment professionals need to know and provides that information in an accessible manner
- Synthesizes knowledge and grounds it in the practical realities of clinical cases and real situations so that the reader will come away with increased knowledge, encouragement, and resourcefulness in working with clients with co-occurring disorders (COD)

The multidisciplinary consensus panel that developed TIP 42 supports and encourages the development of a unified substance abuse and mental

health approach to COD. Recognizing that system integration is difficult and the need for improved COD services is urgent, the panel recommends that, at this stage, the emphasis be on assisting mental health and substance abuse treatment systems in developing increased internal capability to treat individuals with COD effectively, with the two systems continuing to work cooperatively on services to individual clients.

Other TIPs of interest to readers include:

TIP 48: Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery

TIP 47: Substance Abuse: Clinical Issues in Intensive Outpatient Treatment

TIP 45: Detoxification and Substance Abuse Treatment

TIP 41: Substance Abuse Treatment: Group Therapy

TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment

Note: These TIPs are available for download free of charge through the following Web site:
http://www.ncbi.nlm.nih.gov/books/bv.fcgi?call=bv.View..ShowSection&rid=hstat5.part.22441

INTRODUCTION

In this Guide, co-occurring disorder (COD) refers to substance abuse or dependence and a mental disorder. COD is diagnosed when at least one disorder of each type exists independent of the other and is not simply a cluster of symptoms resulting from one disorder. (For this Quick Guide, nicotine dependence is not included among the substance use disorders considered. See TIP 42 sections at pages 216 and 333.) Prior to the modern understanding of addictive disorders, the symptoms of substance use disorders were often seen as "secondary" to a "primary" mental disorder. A major impetus giving rise to the field of co-occurring disorders was the recognition that both disorders need to be considered as "primary" and in need of direct attention.

In the late 1970s, practitioners began to recognize that the presence of substance abuse in combination with mental disorders had profound implications for treatment outcomes. This growing awareness led to today's emphasis on recognizing and addressing both disorders and understanding how they interact with one another.

Between 20 and 50 percent of clients in mental health settings have a co-occurring substance use

disorder. Also, research has clearly shown that substance abuse treatment for clients with co-occurring mental disorders can be beneficial, and its absence deleterious.

Because this Guide is intended for mental heath professionals, the diagnosis and treatment of mental illness is not discussed. The steps and tools provided here are meant to help mental health professionals address the substance use issues of their clients, supplement mental health diagnosis and treatment procedures already in place, and unify the treatment of both disorders.

Many may think of a person with COD as having a serious mental illness (SMI) combined with a substance use disorder. SMI and substance use disorders are the focus of SAMHSA's Center for Mental Health Services (CMHS) Co-Occurring Disorders Toolkit, available for free download at: http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/default.asp

The toolkit addresses severe mental health and substance use disorders; this Guide focuses on the types of clients that counselors working in mental health agencies are more likely to see: persons with mild-to-moderate mental disorders combined with some degree of substance abuse

or dependence. The information in this Guide is meant for clients receiving mental health treatment whose co-occurring substance use disorders also need to be addressed.

Substance abuse practitioners often divide treatment into phases, usually including engagement, stabilization, primary treatment, and continuing care (also called aftercare). Use of phases enables the clinician to apply coherent, stepwise approaches to treatment that promote a recovery-focused orientation. Both substance use and mental disorders are frequently long-term conditions, so treatment for COD and recovery may take place over a long period of time.

Basic assessment of a client's substance use includes gathering information concerning age of first use, primary drugs used, patterns of drug use, and past or current treatment. It is important to identify periods of abstinence of 30 days or longer to understand the nature of the mental health symptoms, treatment, and disability expressed during these abstinent periods. Basic assessment also includes evaluating the client's readiness for change in related areas of his or her life. The assessment section of this Guide expands on these considerations.

Key models and techniques used in working with clients with substance use disorders are the stages of change model (which substance abuse counselors use to conceptualize a client's position on the treatment and recovery continuum) and motivational interviewing. Other treatment techniques for clients with COD include contingency management (CM), cognitive–behavioral therapy (CBT), relapse prevention (RP), and medications. Two outpatient models already in use in the mental health field (higher intensity service models typically reserved for persons with more severe mental illnesses)—assertive community treatment (ACT) and intensive case management (ICM)—are valuable for clients with COD. These techniques are discussed briefly to enable you to begin addressing substance use in your clients and to help prevent these clients from falling through the cracks of the treatment system because of their co-occurring substance use disorders.

The hallmark of a unified approach to clients with COD is a welcoming environment where clients experience a seamless delivery of the services they need and desire. Recovery is common and treatment is best delivered in an atmosphere of hopeful expectation. As always, good treatment depends on empathic and well-trained staff. Acquisition of new skills and continued profession-

al development will enable you to better treat clients with co-occurring substance use disorders. Clinical supervision and ongoing training are essential aspects of learning new skills. Thus, this Guide ends with a list of resources for counselors, supervisors, and administrators.

This Guide will achieve its purpose if it assists you in screening your clients for alcohol, drugs, and/or other substance use disorders; in assessing the overall status and needs of clients with COD; and in developing the initial skills needed to address client substance use disorders, especially through the use of the stages of change model and motivational interviewing techniques.

SCREENING AND INTAKE

Because of the high prevalence of COD in treatment settings, and because treatment outcomes for individuals with multiple problems improve if each problem is addressed specifically, it is recommended that all individuals presenting for treatment for a mental disorder also be routinely screened for substance use disorders.

No Wrong Door

"No wrong door" refers to recognition by a service system that individuals with COD may enter the system at a range of community service sites. The Substance Abuse and Mental Health Services Administration (SAMHSA) has adopted a "no wrong door" policy, which states that effective systems must ensure that an individual needing treatment will be identified, assessed, and receive treatment, either directly or through appropriate referral, no matter where he or she enters the realm of services.

The "no wrong door" policy also stresses that all clients are received in an empathic, welcoming manner. The attitude "you have come to the right place" helps build rapport and facilitates open disclosure of information regarding mental health

problems, substance use disorders, and related issues. Proactive efforts are often necessary to design a welcoming environment—from forms and decorations that fit with the community, to sensitivity to the shame or self-doubts that people with substance use disorders often cover with demanding or evasive behaviors.

The Screening Process

It is relatively easy to incorporate screening of clients for co-occurring substance use disorders into the intake procedures already used in mental health settings. Many screening instruments are available to detect the need for a full evaluation of a substance use disorder, including the Simple Screening Instrument for Substance Abuse (SSI-SA) and the Alcohol Use Disorders Identification Test (AUDIT). Both are presented in Appendix B, and are available for free and unrestricted use.

During the screening process, clients may seem to be hesitant or guarded in their response to questions concerning their alcohol or other drug use, including the misuse of prescription medications. Initially, it is typically best to concentrate on building rapport by not challenging the client, while at the same time recording in detail (in a matter-of-fact way) what the client is currently describing as his/her alcohol and/or other drug use. As informa-

tion from others and signs or symptoms of use are encountered, you can return to questions about the extent of your client's use. Cultural issues may need to be sensitively addressed throughout the screening and assessment process so that you can learn how drinking or drug use and having such problems are viewed by the client and in the client's racial or ethnic community.

Information from family, friends, and other providers is valuable as a supplement to the client's own report. Such information regarding drug and alcohol use can help the counselor gauge how similar or at variance the client's account is to that of others.

Safety Issues for Clients Who Are Abusing Substances

Clinicians should not underestimate any threats of self-harm a client may make because the client is actively using substances. Although people who are intoxicated might only seem to be making threats of self-harm (e.g., "I'm just going to go home and blow my head off if nobody around here can help me"), **all statements about harming oneself or others must be taken seriously**. Individuals who have suicidal or aggressive impulses when intoxicated may act on those impulses.

Remember, alcohol and drug abuse are among the highest predictors of dangerousness to self or others—even without any co-occurring mental disorder. Determining which intoxicated suicidal client is "serious" and which one is not requires a skilled mental health assessment, plus information from collaterals who know the client. In addition, it is important to remember that the vast majority of people who are abusing or dependent on substances will experience at least transient symptoms of depression.

As clients sometimes report that they are experiencing withdrawal, or are exhibiting signs of withdrawal, it is helpful to be familiar with the types of withdrawal phenomena. Medically trained personnel can determine if, when, and what interventions are required. Withdrawal scales include the Clinical Institute Withdrawal Assessment (CIWA-Ar) for alcohol withdrawal and the Clinical Institute Narcotic Assessment (CINA) for opioid withdrawal. The CIWA-AR and the CINA are for use by medically trained personnel but are dscussed in Appendix C for informational purposes.

Mental health clinicians need to be aware that not all drugs provoke a significant physiological withdrawal, and it should not be assumed that withdrawal from a drug of abuse will require medical

intervention. Only in the case of alcohol, opioids, sedative-hypnotics, or benzodiazepines is medical intervention likely to be required (see Table 1). Withdrawal from cocaine, marijuana, stimulants, or hallucinogens typically does not require medical intervention; however, medical attention may be warranted for associated conditions (such as dehydration, the danger of harm during hallucinations, overdose, etc.).

It is important to note that withdrawal can cause or exacerbate emotional, psychological, or mental problems. Staff members' ability to respond to a patient's needs in a compassionate manner can make the difference between a return to substance abuse and the beginning of a new, more positive way of life.

As you know, sometimes clients with COD arrive at your facility intoxicated. Of course, every agency will need to establish its own guidelines for the treatment of such clients, but policies that exclude intoxicated persons from contact are inappropriate. For example, if the client is with someone else and is cooperative, some engagement and intake can proceed. If the intoxicated individual is not cooperative, he or she can be taken directly to an appropriate treatment setting (such as a residential program or a hospital) without

Table 1. Symptoms and Signs of Withdrawal or Intoxication That May Require Immediate Medical Attention

- Marked changes in mental status
- Increasing anxiety and panic
- Hallucinations
- Seizures
- Temperature greater than 100.4° F (these patients should also be considered potentially infectious)
- Significant increases and/or decreases in blood pressure or heart rate
- Marked insomnia
- Abdominal pain
- Upper and lower gastrointestinal bleeding
- Changes in responsiveness of pupils
- Heightened deep tendon reflexes and ankle clonus, a reflex beating of the foot when pressed rostrally (i.e., toward the mouth of the patient), indicating profound central nervous system irritability and the potential for seizures

From: TIP 45, *Detoxification and Substance Abuse Treatment*, p. 26.

being left alone. Too often, referrals elsewhere or transportation difficulties result in the client falling through the cracks and the possibility for initiating treatment being wasted.

Administration of the Simple Screening Instrument for Substance Abuse (SSI-SA)

The SSI-SA requires minimal staff training and covers a broad spectrum of signs and symptoms of substance use disorders. It is designed for use in a clinical setting for clients receiving or seeking treatment and under the conditions found in most mental health clinics. It has clear face validity as well as research and expert opinion supporting its use, and is easy to incorporte into treatment services. A score of 4 or higher indicates the need for a full assessment.

Use of the SSI-SA should be accompanied by careful discussion of confidentiality. The interviewer should also be clear about the instrument's purpose and should make clear that the information elicited will be used to benefit the individual, not to punish or deny treatment.

The SSI-SA (see page 19) begins with a question about the person's consumption of substances. This question helps the interviewer decide

whether to continue the interview. If the response to question 1 is no, continuing may be unnecessary.

Questions 2 through 4 are problem recognition items to elicit a person's assessment of whether too much of a substance is being used, whether attempts have been made to stop or control substance use, and whether previous treatment has been sought. Answers may help you understand how the person thinks and feels about his or her substance use. People who later report negative consequences of their substance use but who answer "no" to these questions may have poor insight about their substance abuse or deny the severity of their problem.

Questions 5 through 12 determine whether a person has experienced any adverse consequences of substance abuse. These include medical, psychological, social, and legal problems often caused by substance abuse and addiction. Questions elicit symptoms of aggression (question 9), physical tolerance (question 10), preoccupation (question 11), and loss of control (question 12). Question 13 taps feelings of guilt, which may indicate some awareness or recognition of a substance problem; questions 14 and 16 measure the respondent's awareness of a past or present

problem; and question 15 elicits the individual's family history of substance abuse problems.

The SSI-SA form for use by a counselor is presented below. A self-administration form that the client can fill out independently appears in Appendix B.

Simple Screening Instrument for Substance Abuse (Interview Form) (SSI-SA)

Note: **Boldfaced questions** constitute a short version of the screening instrument that can be administered in situations that are not conducive to administering the entire test. Such situations may occur because of time limitations (e.g., a street outreach community worker who has little time with an individual) or other conditions.

Introductory statement:
"I'm going to ask you a few questions about your use of alcohol and other drugs during the past 6 months. Your answers will be kept private. Based on your answers to these questions, we may advise you to get a more complete assessment. It is your choice whether to have an additional assessment or not."

During the past 6 months...

1. **Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opioids, uppers, downers, hallucinogens, inhalants, or nonmedical prescription use.)** (yes/no)
2. **Have you felt that you use too much alcohol or other drugs?** (yes/no)
3. **Have you tried to cut down or quit drinking or using drugs? (yes/no)**

4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.) (yes/no)
5. Have you had any of the following?
   - Blackouts or other periods of memory loss
   - Injury to your head after drinking or using drugs
   - Convulsions, or delirium tremens ("DTs")
   - Hepatitis or other liver problems
   - Feeling sick, shaky, or depressed when you stopped drinking or using drugs
   - Feeling "coke bugs," or a crawling feeling under the skin, after you stopped using drugs
   - Injury after drinking or using drugs
   - Using needles to shoot drugs
6. Has drinking or other drug use caused problems between you and your family or friends? (yes/no)
7. Has your drinking or other drug use caused problems at school or at work? (yes/no)
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.) (yes/no)

9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? (yes/no)
10. Are you needing to drink or use drugs more and more to get the effect you want? (yes/no)
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? (yes/no)
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? (yes/no)
13. Do you feel bad or guilty about your drinking or drug use? (yes/no)

Now I have some questions that are not limited to the past 6 months.

14. Have you ever had a drinking or other drug problem? (yes/no)
15. Have any of your family members ever had a drinking or drug problem? (yes/no)
16. **Do you feel that you have a drinking or drug problem now? (yes/no)**

Thanks for answering these questions.
Do you have any questions for me?
Is there something I can do to help you?

Notes:

_____

_____

_____

_____

Observation Checklist

The following signs and symptoms may indicate a substance abuse problem in the individual being screened:

- Needle track marks
- Skin abscesses, cigarette burns, or nicotine stains
- Tremors (shaking and twitching of hands and eyelids)
- Unclear speech: slurred, incoherent, or too rapid
- Unsteady gait: staggering, off balance
- Dilated (enlarged) or constricted (pinpoint) pupils
- Scratching
- Swollen hands or feet
- Smell of alcohol or marijuana on breath
- Drug paraphernalia such as pipes, paper, needles, or roach clips
- "Nodding out" (dozing or falling asleep)
- Agitation
- Inability to focus
- Burns on the inside of the lips (from freebasing cocaine)

ASSESSMENT

There is no gold standard assessment tool for COD. Assessment of substance use disorders, like mental disorders, may include administration of assessment instruments, as well as an in-depth clinical interview, a social history, a treatment history, interviews with friends and family after receipt of appropriate client authorization(s), a review of medical and psychiatric records, a physical examination, and laboratory tests.

In regard to COD, one goal of the assessment process is to understand what role alcohol or other drug use plays in the initiation, maintenance, intensification, or diminishment of mental disorders or in the symptoms of mental disorders. Another goal is to understand how, when, or if mental health symptoms influence alcohol or drug use initiation, maintenance, relapse, and/or recovery. For example, sleep disturbances regularly begin to occur after years of heavy drinking, and sleep-related symptoms are also a common part of the symptom picture in depressive disorders. An assessment would aim to clarify the interplay among a client's sleep disturbances, alcohol consumption, and depression.

Assessment should be client-centered and fully motivate and engage the client in the assessment and treatment process. Client-centered means that the client's perceptions of his or her problems and the goal he or she wishes to accomplish are central to the assessment and to the resulting recommendations.

Assessment of the client with COD is an ongoing process that should be repeated over time to capture the changing nature of the client's status, and to give the client additional disclosure opportunities as the therapeutic alliance strengthens.

Clinicians in both mental health services and substance abuse treatment settings recognize that it can be impossible to establish a firm diagnosis when confronted with the mixed presentation of mental symptoms and ongoing substance abuse. Substance abuse contributes to the emergence or severity of mental symptoms and therefore confounds the diagnostic picture. Therefore, assessment often includes dealing with confusing diagnostic presentations. It can be helpful to adhere to three principles:

- ***Principle 1:*** Diagnosis of a substance use disorder and/or a mental disorder is established more by history than by current symptom presentation.

- ***Principle 2***: It is important to document prior diagnoses and gather information related to current diagnoses.
- ***Principle 3***: For diagnostic purposes, it is almost always helpful to tie mental symptoms to specific periods of time in the client's history, in particular those times when active substance use disorder was not present. Likewise, detailed information is needed concerning periods of time when the client was actively using substances and mental symptoms were absent.

Symptoms of substance-induced disorders run the gamut from mild anxiety and depression (most common across all substances) to full-blown manic and other psychotic reactions (much less common). The "teeter-totter principle"—i.e., what goes up must come down—is useful in predicting the kind of syndrome or symptoms that might be caused by different substances. For example, those who "crash" from stimulants are tired, withdrawn, and depressed. On the other hand, acute withdrawal symptoms from physiological depressants (such as alcohol and benzodiazepines) are hyperactivity, elevated blood pressure, agitation, and anxiety. Virtually any substance taken in sufficient quantities over a long enough period of time can lead to a psychotic state.

Consequently, a provider should determine whether any mental symptoms or treatments identified in the screening process were present during periods of 30 or more days of abstinence, or were present before the onset of significant substance use. Ask:

- "Did this symptom or episode occur during a period when you were clean and sober for at least 30 days?"
- "Before you ever did much drinking or used drugs, had you ever had episodes of [MH symptoms]?"
- "Do you think there is any connection between [MH symptoms] and your alcohol or drug use?"

Using client input, you may be able to define specific time periods during which the substance use disorder was in remission and then get detailed information about mental symptoms, diagnoses, impairments, and successful and unsuccessful treatment efforts by asking:

- "Can you recall a specific period when you were not using?"
- "Did these symptoms [or whatever the client has reported] occur during that period?"

You should also try to determine periods of time when identified mental symptoms were absent and ask about associated alcohol and drug use

during these periods. Counselors should also determine the presence of possible co-occurring trauma or PTSD. Limit questioning to brief and general questions, such as:

- "Have you ever experienced childhood physical abuse? Sexual abuse? A serious accident? Violence or the threat of it?"
- "Have there been experiences in your life that were very traumatic?"

Be careful to obtain information about trauma with sensitivity; don't press for details, as clients can be retraumatized by revealing details before a solid therapeutic alliance is built.

Determining the Stage of Change

Assessment should include determining the stage of change for *each* disorder or problem. For each problem, select the statement that most closely fits the client's view of that problem:

- No problem and/or no interest in change (Precontemplation).
- Might be a problem; might consider change (Contemplation).
- Definitely a problem; getting ready to change (Preparation).
- Actively working on changing, even if slowly (Action).

- Has achieved stability, and is trying to maintain (Maintenance).

In planning treatment, interventions have to be matched not only to specific diagnosis, but to the stage of change for each disorder. The use of the stages of change model is applicable to both mental health and substance use diagnoses. The model acknowledges that clients can be at one stage of recovery or change for mental disorders and another for substance use disorders.

Another technique, motivational interviewing (MI)--a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence--has also proven effective in helping clients clarify goals and commit to change (see models and techniques section, page 45), particularly when coupled with the stages of change model.

Rather than causing anger or resentment in a client while trying to build engagement and a therapeutic alliance, the stages of change model combined with MI helps the counselor reframe issues for the client. The model helps determine the client's attitudes toward his or her drug and alcohol use, while also reframing it in a way that supports considering the possibility of change.

Treatment Planning

Treatment planning should be client centered, addressing the client's goals and using treatment strategies that are acceptable to them. A client-centered treatment plan is the joint responsibility of the clinician or clinical team and the client.

Treatment planning for individuals with COD should be designed according to the principle of dual (or multiple) primary treatment, in which each disorder or problem has a specific intervention that is matched to a problem or diagnosis, as well as stage of change and external contingencies. Treatment plans and interventions for clients with COD can be quite complex, depending on what might be discovered in each domain.

Individuals with COD may not fit into existing treatment cultures. Specific considerations to explore with the client include:

- Whether the client feels more comfortable in an alcohol and drug treatment environment or a mental health clinic setting.
- What the client thinks the counselor should be doing to help the situation.
- What cultural situations or concerns the client can identify that might relate to effective treatment.

FIVE GUIDING PRINCIPLES FOR WORKING WITH CLIENTS WITH COD

The following guiding principles can help agencies with limited resources improve existing efforts for clients with COD.

1. Employ a Recovery Perspective

Recovery is a long-term process of internal change, including steps forward and sometimes steps backward. Recovery recognizes that internal changes proceed through various stages.

- *Develop a treatment plan that provides for continuity of care over time*. Recognize that treatment may occur in different settings over time (e.g., residential, outpatient) and that much of the recovery process occurs outside of or following treatment.
- *Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the co-occurring disorder recovery process.* Use sensible, step-wise approaches in developing and using treatment protocols. Consider markers unique to the individual's culture.

2. Adopt a Multiproblem Viewpoint

- People with COD generally have an array of mental health, medical, substance abuse, family, housing, and social problems.
- Services should be comprehensive to address these problems.
- Engagement, stabilization, treatment, and continuing care are treatment phases that can enable the clinician to offer stage-appropriate treatment protocols.

3. Address Specific Personal and Social Problems Early in Treatment

- Approaches may incorporate case management and intensive case management to help clients find housing or handle legal and family matters.
- Often, solving such problems is an important first step toward achieving client engagement in continuing treatment.

4. Plan for the Client's Cognitive and Functional Impairments

- In relatively short, highly structured treatment sessions that focus on practical life problems, present interventions compatible with the client's cognitive and functional impairments.

- Careful assessment of such impairments and a treatment plan consistent with the assessment are essential.

5. Use Support Systems

The mutual self-help movement, the family, the faith community, and other resources that exist within the client's community can play an invaluable role in recovery. This can be particularly true for clients with COD, as many have not enjoyed a consistently supportive environment.

- Based on the Alcoholics Anonymous model, the mutual self-help movement has grown to encompass a wide variety of addictions and mental illnesses. These include Dual Recovery Anonymous (DRA) and Double Trouble in Recovery (DTR).
- Personal responsibility, self-management, and helping one another are the basic tenets of mutual self-help approaches.
- Mutual self-help principles, highly valued in the substance abuse treatment field, are now widely recognized as important components in the treatment of COD.

The therapeutic community (TC), modified mutual self-help programs for COD (e.g., Double Trouble in Recovery), and the client consumer movement all

reflect an understanding of the critical role clients play in their own recovery, as well as the recognition that support from other clients with similar problems promotes and sustains change.

The client with COD who successfully completes treatment must face the fragility of recovery, the toxicity of the past environment, and the negative impact of previous associates who may encourage drug or alcohol use and illicit or maladaptive behaviors. There is a need for groups and activities that support change. In this context, it is important that these clients receive support from families and significant others. There is also the need to help the client reintegrate into the community through such resources as religion, recreation, and social organizations.

MODELS AND TECHNIQUES FOR WORKING WITH CLIENTS WITH COD

The following section reviews techniques, mainly from the substance abuse field, that have been found to be particularly helpful in treating clients with substance abuse and that are being adapted for work with clients with COD.

1. Provide Motivational Interviewing Consistent With the Client's Specific Stage of Change

MI[1] is a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence. MI has proven effective in helping clients clarify goals and commit to change. MI involves *accepting* a client's level of motivation, whatever it is, as the only possible starting point for change.

To date, MI strategies have been applied successfully in treating clients with COD, especially by:

- Assessing the client's perception of the problem
- Exploring the client's understanding of his or her clinical condition.
- Examining the client's desire to continue treatment.

[1]Miller, W. R. & Rollnick, S. (2002). Motivational Interviewing: Preparing People for Change (2nd ed.). New York: Guilford Press.

MI is not just a set of techniques for doing counseling, but an actual, personal process of interacting with a client. The clinician practices MI with five general principles in mind:

1. *Express empathy*. The counselor refrains from judging the client and projects acceptance of the client's perspective within the client's framework.
2. *Develop discrepancy* between the client's goals or values and his or her current behavior.
3. *Avoid argument* and direct confrontation. This avoids evoking resistance.
4. *Roll with resistance*. When resistance is encountered, the counselor may offer new information and perspective, and respectfully invites the client to "take what you want and leave the rest," or the counselor may simply reflect the client's feelings and point of view.
5. *Support self-efficacy* and optimism.

- Fostering client attendance at initial sessions.
- Expanding the client's assumption of responsibility for change.

As noted, the stages of change model is particularly effective when coupled with MI. The five stages of change and motivational approaches for each are defined below.

Precontemplation Stage

In this stage, the client has no intention of changing in the foreseeable future; he or she may be unaware or underaware of problems. At this stage, a clinician should:

- Express concern about the client's substance use, or the client's mood, anxiety, or other symptoms of mental disorder.
- Make clear that the substance use (or mood, anxiety, self-destructiveness) is a problem, but do so in a nonjudgmental way.
- Agree to disagree about the severity of either the substance use or the psychological issues.
- Consider a trial of abstinence to clarify the issue, after which psychological evaluation can be reconsidered.
- Suggest bringing a family member to an appointment when appropriate.
- Explore the client's perception of a substance use or psychiatric problem.
- Emphasize the importance of seeing the client again. Emphasize that you want to help.

Contemplation Stage

At this stage, the client is aware that a problem exists and is thinking seriously about overcoming it but has not yet made a commitment to take action. At this stage, a clinician should:

- Elicit positive and negative aspects of substance

use or psychological symptoms.
- Ask about positive and negative aspects of past periods of abstinence and substance use, as well as periods of depression, hypomania, etc.
- Summarize the client's comments on substance use, abstinence, and psychological issues.
- Identify discrepancies between values and actions.
- Consider a trial of abstinence and/or psychological evaluation.

Preparation Stage

This stage combines intention and behavior. Action is planned within the next month, and/or action has been taken unsuccessfully in the past year; some reductions have been made in problem behaviors but a criterion for effective action has not been reached. At this stage, a clinician should:
- Acknowledge the significance of the decision to seek treatment for one or more disorders.
- Support self-efficacy with regard to each disorder (i.e., convey to the client legitimate evidence from the client's past or client strengths that promote effective actions).
- Affirm the client's ability to seek treatment successfully for each disorder.
- Help the client decide on appropriate, achiev-

able action for each disorder.
- Caution that the road ahead may be difficult but worth the effort.
- Explain that relapse should not disrupt the client–clinician relationship (i.e., convey to the client that a return to use, if it occurs, should be seen as a bump in the road, not as a failure, and that you need to talk about these bumps).

Action Stage

In this stage, behavior, experience, or environment is modified to overcome the problem; successful alteration of the addictive behavior can be anywhere from 1 day to 6 months (note that action does not equal quick or immediate change). At this stage, a clinician should:
- Be a source of encouragement and support. Remember that the client may be in the action stage with respect to one disorder but only in contemplation with respect to another; adapt your interview approach accordingly.
- Acknowledge the uncomfortable aspects of early abstinence and/or psychological change.
- Reinforce the importance of remaining in recovery from both problems.

Maintenance Stage

This stage is devoted to preventing relapse and consolidating gains attained during the action stage; remaining free from addictive behavior and

engaging consistently in a new incompatible behavior for more than 6 months. At this stage, a clinician should:

- Anticipate and address difficulties as a means of relapse prevention.
- Recognize the client's struggle with either or both problems, working with separate mental health and substance abuse treatment systems, and others.
- Support the client's resolve.
- Reiterate that relapse or psychological symptoms should not disrupt the counseling relationship.

Handling relapse: Relapse is not a stage of change but a setback in a person's attempt to change or modify any particular behavior. Relapse is typically a process in which the resumption of substance use is the last event in a series of maladaptive responses to internal or external stressors or stimuli. At this stage, a clinician should:

- Explore what can be learned from the relapse, whether substance-related or related to the mental disorder.
- Identify the sequence of events and psychological states that preceded actual substance use.
- Express concern about the relapse.
- Emphasize the positive aspect of the effort to seek care.

- Support the client's self-efficacy so that recovery seems achievable.

For more on how MI techniques can improve treatment of COD as well as for a case study, see chapter 5 of TIP 42. For more on MI in general, see TIP 35: *Enhancing Motivation for Change in Substance Abuse Treatment*.

2. Design Contingency Management Techniques to Address Specific Target Behaviors

Contingency Management (CM) maintains that the form or frequency of behavior can be altered through a planned and organized system of timely positive and negative consequences. CM for substance abuse treatment is structured around four central principles:

- The clinician arranges for regular drug testing to ensure the client's use of the targeted substance is detected readily.
- The clinician provides positive reinforcement when abstinence is demonstrated. These positive reinforcers are mutually agreed upon.
- The clinician withholds designated incentives when the substance is detected.
- The clinician helps the client establish alternate and healthier activities.

Checklist for Designing CM Programs
Step 1: Choose a Behavior • One that is objectively quantifiable, occurs frequently, is important, and can be followed quickly by a reinforcer. • Set reasonable expectations.
Step 2: Choose a Reinforcer • Determine available resources (in-house rewards or donations of cash or services from local businesses, such as movie theaters and restaurants). • Identify intangible rewards, such as frequent positive reports to parole officers, flexibility in methadone dosing, and increased freedom (reduce the number of check-ins, passes, etc.).
Step 3: Use Behavioral Principles • Develop a monitoring and reinforcement schedule that is optimized through the application of behavioral principles. • Keep the schedule simple so staff can apply principles consistently and clients can understand what is expected.
Step 4: Prepare a Behavioral Contract • Draw up a contract for the target behavior that considers the monitoring system and reinforcement schedule.

- Be specific and consider alternate interpretations; have others review the contract and comment.
- Include any time limitations.

Step 5: Implement the Contract

- Ensure consistent application of the contract; devise methods of seeing that staff understand and follow procedures.
- Remind the client of behaviors and their consequences (their "account balance" and what is required to obtain a bonus) to increase the probability that the escalating reward system will have the desired effect.

Step 6: Evaluate the Contract

- Periodically assess behavioral changes and the utility of reinforcers.
- Modify the contract based on this assessment.

CM techniques are best applied to specific targeted behaviors, such as:

- Drug abstinence.
- Clinic attendance and group participation.
- Medication adherence.
- Adherence to a treatment plan.
- Goal attainment.

The clinician may use a variety of CM reinforcers:
- Cash.
- Vouchers.
- Prizes.
- Retail items.
- Privileges.

3. Use Cognitive–Behavioral Techniques

Cognitive–behavioral therapy (CBT) is an approach that seeks to modify negative or self-defeating thoughts and behavior. CBT is aimed at both thought and behavior change (i.e., coping by thinking differently and coping by acting differently).

An underlying assumption of CBT is that clients systematically and negatively distort their views of the self, the environment, and the future. A major tenet of CBT is that the person's thinking is the source of difficulty and that this distorted thinking creates behavioral problems.

Distortions in thinking generally are more severe with people with COD than with other substance abuse treatment clients. Clients with COD are, by definition, in need of better coping skills.

To adapt CBT for clients with COD:

- Use visual aids, including illustrations and concept mapping (a visual presentation of concepts that makes patterns evident).
- Practice role preparation and rehearse for unexpected circumstances.
- Provide specific *in vivo* feedback on applying principles and techniques.
- Use outlines for all sessions that list specific, behaviorally anchored learning objectives.
- Test for knowledge acquisition.
- Make use of memory enhancement aids, including notes, tapes, and mnemonic devices.

4. Use Relapse Prevention Techniques

The National Institute on Drug Abuse (NIDA) defines relapse as "any occasion of drug use by recovering addicts that violates their own prior commitment and that often they regret almost immediately."

A variety of relapse prevention models are described in the literature. However, most approaches have many common elements. Generally they focus on the need for clients to:

- Have a broad repertoire of cognitive and behavioral coping strategies to handle high-risk situations and relapse warning signs.

- Make lifestyle changes that decrease the need for alcohol, drugs, or tobacco.
- Increase healthy activities.
- Prepare for interrupting lapses, so that they do not end in full-blown relapse.
- Resume or continue to use relapse prevention skills even when a full-blown relapse occurs by renewing their commitment to abstinence.

Relapse prevention therapy (RPT) is an intervention designed to anticipate and cope with relapse. Use specific aspects of RPT to:

- Explore with clients both the positive and negative consequences of continued drug use.
- Help clients recognize high-risk situations for returning to drug use.
- Help clients develop the skills to avoid those situations or cope effectively with them when they do occur.
- Develop a "relapse emergency plan" to exercise "damage control" and limit the duration and severity of lapses.
- Teach specific skills to identify and cope effectively with drug urges and craving.

The following relapse prevention methods can be used with clients with COD:

- Provide relapse prevention education on both mental disorders and substance abuse and how they can impact one another.

- Teach skills to handle any pressure to discontinue psychotropic medication because of the lack of support or attitudes of others.
- Teach skills to increase medication adherence.
- Encourage attendance at dual recovery groups and teach social skills necessary for participation.
- Use a daily inventory to monitor psychiatric symptoms and/or craving situations.
- If relapse occurs, use it as a learning experience to investigate triggers with the client. Reframe the relapse as an opportunity for self-knowledge and a step toward ultimate success.

For more on RPT as well as a case study and an RPT intervention adapted specifically for clients with COD, see chapter 5 of TIP 42. See also the forthcoming TIP, *Relapse Prevention and Recovery Management in Substance Abuse Treatment Settings.*

5. Use Repetition and Skill Building to Address Deficits in Functioning

Clients with COD often have cognitive limitations, including difficulty concentrating. Sometimes these limitations are transient and improve during the first several weeks of treatment; in other cases, symptoms persist for long periods.

General treatment strategies to address cognitive limitations in clients include:

- Be more concrete and less abstract in communicating ideas.
- Use simpler concepts.
- Have briefer discussions.
- Repeat the core concepts many times.

Individuals often learn and remember better if information is presented in multiple formats (verbally; visually; or affectively through stories, music, and experiential activities).

6. Facilitate Client Participation in Mutual Self-Help Groups

The clinician plays an important role in helping clients with COD access appropriate mutual self-help resources and benefit from them:

- Attend several mutual self-help groups to understand how they are managed and how they help.
- Help the client locate an appropriate group, particularly a dual disorder group, through the Internet, AA helpline, etc.
- Help the client find a sponsor, ideally one who also has COD and is at a late stage of recovery.
- Help the client prepare to participate appropriately in the group.

- Help overcome barriers to group participation.
- Debrief with the client after he or she has attended a meeting to help process his or her reactions and prepare for future attendance.

Providing Essential Services for People With COD

Develop a COD Program with the following components:

- Screening, assessment, and referral for persons with COD.
- Staffing that includes substance abuse treatment professionals, cross-training of staff, and an integrated team approach.
- Physical health consultation.
- Prescribing onsite psychiatrist.
- Medication and medication monitoring, including medications used to treat opioid and alcohol dependence.
- Psychoeducational classes.
- Double trouble groups.
- Dual recovery self-help groups.

Appendix A: DEFINITION OF SUBSTANCE ABUSE VS. SUBSTANCE DEPENDENCE

For people with COD, the question of "abuse" or "dependence" is, in some ways, not as critical or important as when a client has an SUD without any other psychiatric problem. When a person only has an SUD and it is diagnostically substance abuse, there can be an expectation that the client may be able to control the substance use and with some therapeutic help, end the substance abuse and no longer warrant any current SUD diagnosis. Persons diagnosed with an SUD dependency are usually considered "addicted" and the typical expectation is that the person will have seriously diminished ability to abstain and will require considerable help in achieving sobriety.

However, when someone has a COD where they are already having to deal with non-SUD psychiatric concerns, even a co-occurring substance abuse pattern is likely to make treatment difficult, increase relapses for both SUD and psychiatric disorders, decrease quality of life and interpersonal support networks, and in other ways interfere with getting better and increase the odds of getting worse. Thus, for people with COD, all sub-

stance use needs to be addressed as an immediate and critical problem.

Still, it can be important for patient placement considerations, to determine whether a client suffers from a dependence or abuse or in some way warrants a more restrictive treatment setting placement. For example, a client with schizophrenia may only occasionally abuse cocaine, but if such use leads to florid or agitated psychotic states, then the client will need a restricted environment even though the diagnosis is abuse and not dependence. Consequently, for informational purposes, the diagnostic criteria for abuse and dependence[2] are given below.

Criteria for a Diagnosis of Substance Abuse

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
   1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences,

[2]American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders (4th Text Revision ed.). Washington, DC: Author.

suspensions, or expulsions from school; neglect of children or household).

2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Criteria for a Diagnosis of Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts

of the substance to achieve intoxication or desired effect.

b. Markedly diminished effect with continued use of the same amount of the substance.

2. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for the substance (refer to the DSM-IV-TR, Criteria A and B of the criteria sets for withdrawal from specific substances).
   b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire or unsuccessful effort to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recur-

rent physical or mental health problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

The term substance abuse has come to be used informally to refer to both abuse and dependence. Substance abuse treatment professionals commonly use the term "substance abuse" to describe any excessive use of addictive substances, whether the substance is alcohol or another drug.

Substance dependence is more serious than abuse. This maladaptive pattern of substance use includes such features as increased tolerance for the substance, resulting in the need for ever-greater amounts of the substance to achieve the intended effect; an obsession with securing the substance and with its use; or persistence in using the substance in the face of serious physical or mental health problems. By and large, the terms "substance dependence" and "addiction" have come to mean the same thing, though there is debate about the interchangeable use of these terms.

Appendix B: SUBSTANCE ABUSE SCREENING INSTRUMENTS

Simple Screening Instrument for Substance Abuse Self-Administered Form (SSI-SA)

Directions: The questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months.

During the last 6 months...

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opioids, uppers, downers, hallucinogens, or inhalants) ___Yes ___No
2. Have you felt that you use too much alcohol or other drugs? ___Yes ___No
3. Have you tried to cut down or quit drinking or using alcohol or other drugs? ___Yes ___No
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.) ___Yes ___No

5. Have you had any health problems? For example, have you:
   - ___Had blackouts or other periods of memory loss?
   - ___Injured your head after drinking or using drugs?
   - ___Had convulsions, delirium tremens ("DTs")?
   - ___Had hepatitis or other liver problems?
   - ___Felt sick, shaky, or depressed when you stopped?
   - ___Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
   - ___Been injured after drinking or using?
   - ___Used needles to shoot drugs?
6. Has drinking or other drug use caused problems between you and your family or friends? ___Yes___No
7. Has your drinking or other drug use caused problems at school or at work? ___Yes ___No
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.) ___Yes ___No
9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs? ___Yes ___No

10. Are you needing to drink or use drugs more and more to get the effect you want?
    ___Yes ___No
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?
    ___Yes ___No
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?
    ___Yes ___No
13. Do you feel bad or guilty about your drinking or drug use? ___Yes ___No

The next questions are about your lifetime experiences.

14. Have you ever had a drinking or other drug problem? ___Yes___ No
15. Have any of your family members ever had a drinking or drug problem? ___ Yes___ No
16. Do you feel that you have a drinking or drug problem now? ___Yes ___No

Thanks for filling out this questionnaire.

ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Less than monthly	2 to 4 times a month	2 to 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking	1 or 2	3 or 4	5 or 6	7 to 9	10 or more

Questions	0	1	2	3	4
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	2 to 4 times a month	2 to 3 times a week	4 or more times a week
4. How often during the last year have you found that you were not able to stop drinking once you started?	Never	Less than monthly	2 to 4 times a month	2 to 3 times a week	4 or more times a week
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	2 to 4 times a month	2 to 3 times a week	4 or more times a week
6. How often during the last year have you needed a drink first thing in the morning to get your-self going after a heavy drinking session?	Never	Less than monthly	2 to 4 times a month	2 to 3 times a week	4 or more times a week

Questions	0	1	2	3	4
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Note: The AUDIT is reprinted with permission from the World Health Organization. To reflect standard drink sizes in the United States, the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at http://www.who.org and at http://www.niaaa.nih.gov/Publications/EduationTrainingMaterials/guide.htm.

APPENDIX C: SCALES FOR ASSESSMENT OF WITHDRAWAL

There are a number of instruments available to assess client withdrawal symptoms. For informational purposes, the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) and the Clinical Institute Narcotic Assessment Scale (CINA) are referenced in this Appendix. Mental health clinicians with clients who use cocaine or opioids may want to access the CSSA, SOWS, or OOWS. These and other instruments are in the public domain and can be downloaded from the University of Washington Alcohol and Drug Abuse Institute (ADAI) Instruments Database, at http://lib.adai.washington.edu/instruments/.

Assessment Instruments for Dependence and Withdrawal From Alcohol and Specific Illicit Drugs			
Drug of Dependence	Instrument	Reference	Notes
Alcohol	CIWA-Ar (see below)	Sullivan et al. 1989	10 items that take 2 to 5 minutes to complete; scores 0–67, with 10 or greater as clinically significant; requires training to administer
Narcotics	CINA (see below)	Peachey & Lei 1988	Measures 11 signs and symptoms commonly seen in patients during narcotic withdrawal
Cocaine	Cocaine Selective Severity Assessment (CSSA)	Kampman et al. 1998	18 items that take 10 minutes to complete; high scores correlated with poor outcome

Assessment Instruments for Dependence and Withdrawal From Alcohol and Specific Illicit Drugs (cont.)			
Drug of Dependence	**Instrument**	**Reference**	**Notes**
Opioids	Subjective Opiate Withdrawal Scale (SOWS)	Handelsman et al. 1987	16-item questionnaire; using a scale of 0–4, respondents rate to what extent they are currently experiencing each of 16 characteristics; higher scores indicate more severe withdrawal
	Objective Opiate Withdrawal Scale (OOWS)	Handelsman et al. 1987	Rater observes patient for about 10 minutes and indicates if any of 13 manifestations of withdrawal are present; scores can range from 0 to 13, with higher scores indicating more severe withdrawal; staff must be familiar with withdrawal signs

Ordering Information

TIP 42

Substance Abuse Treatment for Persons With Co-Occurring Disorders

Special thanks to Fred Osher, MD, Director, Health Systems and Services, Council of State Governments, for his guidance on content.

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