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

COD Research and Resources Monthly Review

Vol. 2, No. 3 March 2007

SAMHSA Launches Revised NREPP Database

This month SAMHSA launched its revised online National Registry of Evidence-based Programs and Practices (NREPP) database at http://nrepp.samhsa.gov/. SAMHSA has not only revised the presentation of information in NREPP but is also using a new system to evaluate the evidence supporting practices and programs that have sought review.

Instead of quantifying different levels of evidential support in order to classify interventions as model, effective, or promising, the new NREPP provides two ratings: one based on the quality of supporting research and the other on availability of materials to support implementation and training. NREPP now uses two independent experts who apply six specific criteria to assess outcomes and two others who use three criteria to assess readiness for dissemination. NREPP does not attempt to offer a single, authoritative definition of what makes a practice evidence-based but allows readers to look at a range programs with different types of evidential support.

The registry can be searched by topic (including COD), areas of interest (e.g., homelessness, HIV/AIDS, criminal justice, suicide prevention), population (by age, gender, race/ethnicity, and setting), evaluation/study design, by whether it is a proprietary or public intervention, or by entering a keyword.

Currently there are 25 interventions addressing substance abuse and mental health prevention and treatment in the registry, with SAMHSA planning to add 5 to 10 additional ones each month. Programs that were previously accepted by NREPP need to be resubmitted. Over 200 interventions are currently under review. A search in the registry for COD will bring up three interventions, which are described below:

Seeking Safety is an integrated treatment intervention for people with histories of trauma and substance abuse. The Seeking Safety manual includes psychoeducation and coping skills training techniques centered around two dozen treatment topics for both substance abuse and mental health counselors and has been demonstrated to improve outcomes related to trauma symptoms, substance use, program retention, and psychopathology. See: Najavits, L. (2002). *Seeking Safety: A treatment manual for PTSD and substance abuse*. New York: Guilford Press.

Trauma Recovery and Empowerment Model (TREM) was originally developed for women with histories of exposure to sexual and physical abuse. TREM acknowledges the need for direct substance abuse interventions and their importance for recovery. TREM emphasizes a group format but recommends that each client also has a case manager or counselor/therapist. See: Harris, M. & Community Connections Trauma Work Group (1998). *Trauma recovery and empowerment: A clinician's guide for working with women in groups*. New York: Simon & Schuster.

Dialectical Behavior Therapy is a complex therapeutic system developed for clients with multiple problems. It includes skills training, motivational strategies, participation of family and others, integrated team activities, and a structured environment, within a framework that examines and uses the interplay of various internal/emotional and interactive/structural factors. See: Dimeff, L., Koerner, K., & Linehan, M. (2002). *Summary of research on dialectical behavior therapy*. Seattle, WA: Behavioral Tech, LLC.

NREPP will have regular submission periods (which will be announced on the Web site and in a Federal Register Notice). The expected time frame for the next submission period is Fall 2007. For more information, contact NREPP at NREPP@samhsa.hhs.gov or 1-866-436-7377.

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

COD Research

Epidemiology

Caton, C.L.M., Hasin, D.S., Shrout, P.E., Drake, R.E., Dominguez, B., First, M.B., Samet, S., & Schanzer, B. (2007). Stability of early-phase primary psychotic disorders with concurrent substance use and substance-induced psychosis. *The British Journal of Psychiatry*, 190(2), 105–111.

The authors sought to determine the degree to which a DSM-IV diagnosis of substance-induced psychosis may actually reflect a primary psychotic disorder co-occurring with a substance use disorder. They performed a 1-year followup evaluation of 319 individuals who has been admitted to an emergency department with psychosis and found that 25 percent of those who had been diagnosed with a substance-induced psychosis were diagnosed as having a primary psychosis at that later date. When compared to those who did not have an underlying psychosis but were correctly diagnosed as having a substance-induced psychosis this group had poorer level of functioning before the onset of the psychotic episode, had a greater family history of mental illness, and had less insight into their psychosis.

Chen, E.Y., Brown, M.Z., Lo, T.T.Y., & Linehan, M.M. (2007). Sexually transmitted disease rates and high-risk sexual behaviors in borderline personality disorder versus borderline personality disorder with substance use disorder. *Journal of Nervous & Mental Disease*, 195(2), 125–129.

The authors sought to determine whether and to what degree co-occurring substance use disorders increased rates of sexually transmitted disease (STD) and risk behaviors for contracting STDs among women with borderline personality disorder (BPD) (n=102) and BPD with co-occurring substance use disorders (n=82). They found that the latter group had significantly higher levels of STDs (particularly higher levels of gonorrhea, trichomonas, and human papillomavirus). Mediating factors for the relationship between STDs and co-occurring substance use disorder and BPD were poverty, prostitutions occurring in the prior year, recent unprotected sex with 2 or more people, and having more than 20 sex partners in one's lifetime. The only significant contribution to the relationship between STD and combined co-occurring substance use disorder and BPD was from prostitution.

Cuellar, J. & Curry, T.R. (2007). The prevalence and comorbidity between delinquency, drug abuse, suicide attempts, physical and sexual abuse, and self-mutilation among delinquent Hispanic females. *Hispanic Journal of Behavioral Sciences*, 29(1), 68–82.

Cuellar and Curry assessed drug abuse, delinquency, suicide attempts, self mutilation, and histories of physical and/or sexual abuse in a group of 141 young, female, Hispanic probationers. They found high amounts of delinquency, marijuana abuse, suicide attempts, and self-mutilation. There was extensive correlation between substance abuse and self-mutilation, suicide attempts, and histories of physical and/or sexual abuse

Darke, S., Ross, J., Williamson, A., Mills, K.L., Havard, A., & Teesson, M. (2007). Patterns and correlates of attempted suicide by heroin users over a 3-year period: Findings from the Australian treatment outcome study. *Drug and Alcohol Dependence*, 87 (2–3), 146–152.

This study looks at suicide attempts by a group of 387 Australian heroin users (134 who were entering a detox program, 134 entering opioid substitution therapy, 81 entering a residential treatment program, and 38 who were not entering treatment) over the course of 3 years. While 11.6 percent of subjects attempted suicide during the study, the proportion that attempted suicide declined each year of the study. There were also significant declines in suicide planning, suicidal ideation, and major depression. However, in spite of these declines subjects had higher levels of suicide attempts, suicidal ideation, and major depression than have been found in the general population. Approximately 25 percent of individuals who noted they had suicidal ideation at the start of the study made an attempt during the study, and suicidal ideation expressed in one year correlated with an increased risk of a suicide attempt during the following year. Subjects who had made a prior attempt were five times more likely to make another during the course of the study.

Dom, G., de Wilde, B., Hulstijn, W., & Sabbe, B. (2007). Traumatic experiences and posttraumatic stress disorders: Differences between treatment-seeking early- and late-onset alcoholic patients. *Comprehensive Psychiatry*, 48:(2), 178-185.

Prior research has suggested that trauma experienced in childhood may effect the type, severity, and course of alcohol use disorders. The authors studied 54 individuals with early-onset alcoholism and 65 with late-onset alcoholism who were inpatients at a treatment program. Those who had an early-onset for their alcohol use disorder had a greater number of childhood traumatic experiences and those experiences were more severe when compared to subjects with a late-onset alcohol use disorder. For female but not male subjects, the severity of childhood trauma correlated with the severity of current substance use and use-related problems.

Fein, G., Di Sclafani, V., Finn, P., & Scheiner, D.L. (2007). Sub-diagnostic psychiatric comorbidity in alcoholics. *Drug and Alcohol Dependence*, 87(2–3), 139–145.

The authors looked at sub-diagnostic levels of psychiatric symptoms in a group of 48 people with alcohol use disorders who had long-term abstinence and a control group of 48 people who drank lightly or not at all. Levels of psychiatric pathology and the number of psychiatric symptoms were higher among abstinent alcoholics, and this remained true even after removing subjects who had a psychiatric diagnosis. The majority of the difference in psychiatric symptoms was accounted for by sub-diagnostic levels of psychopathology.

Jackson, C.T., Covell, N.H., Drake, R.E., & Essock, S.M. (2007). Relationship between diabetes and mortality among persons with co-occurring psychotic and substance use disorders. *Psychiatric Services*, 58(2), 270–272.

The authors investigated the relationship between mortality and diabetes among individuals who had both substance use and psychotic disorders. Of the 197 individuals in the study, 21 percent had evidence of diabetes. During the 12 year period for which Medicaid records were reviewed, mortality rates were significantly higher (41 percent) for those subjects who had diabetes than for those who did not)10 percent).

James, L.M. & Taylor, J. (2007). Impulsivity and negative emotionality associated with substance use problems and Cluster B personality in college students. Addictive Behaviors, 32:(4), 714-727.

The authors compared the mediating effects of impulsivity and negative emotionality in a group of 617 university students who had substance use problems and Cluster B personality disorder (PD) symptoms. They found that negative emotionality was significantly associated with substance use problems, as well as antisocial PD, borderline PD, and narcissistic PD. They also found that impulsivity was significantly associated with drug use problems, antisocial PD, and histrionic PD. Negative emotionality but not impulsivity was a significant mediator between alcohol related problems and symptoms of Cluster B PDs. However, impulsivity but not negative emotionality was a significant mediator between drug related problems and histrionic PD.

Looby, A. & Earleywine, M. (2007). Negative consequences associated with dependence in daily cannabis users. *Substance Abuse Treatment, Prevention, and Policy*, 2(3).
Available online at http://www.substanceabusepolicy.com/content/pdf/1747-597X-2-3.pdf

The authors gave an Internet survey to 2500 adults who used cannabis on a daily basis and evaluated whether or not they met DSM-IV TR criteria for cannabis dependence. The 1111 who met criteria for cannabis dependence used more cannabis, alcohol, and various other drugs. The cannabis-dependent individuals also had less motivation, satisfaction with life, and happiness. They also had greater levels of depression and respiratory symptoms.

Medina, K.L. & Shear, P.K. (2007). Anxiety, depression, and behavioral symptoms of executive dysfunction in ecstasy users: Contributions of polydrug use. *Drug and Alcohol Dependence*, 87 (2–3), 303–311.

The authors examined the relationship between MDMA use and self-reported levels of executive functioning and psychological symptoms in a group of 48 MDMA users and 17 individuals who use marijuana only (who served as a control group). While many of the MDMA users had elevated levels of psychological symptoms, the frequency of MDMA use did not predict higher levels of psychological symptoms.

Office of Applied Studies (2007). *Co-occurring major depressive episode (MDE) and alcohol use disorder among adults* (The NSDUH Report, February 16, 2007). Rockville, MD: Substance Abuse and Mental Health Services Administration. Available online at http://oas.samhsa.gov/2k7/alcDual/alcDual.pdf

This report analyzes data from SAMHSA's National Survey on Drug Use and Health (NSDUH) from 2004 and 2005. The report estimates that 2.7 million adults (1.2 percent of people age 18 or older) had co-occurring major depressive disorder and an alcohol use disorder in the past year. Men and women had similar rates of these two co-occurring disorders (1.3 and 1.1 percent, respectively). The rates of these two co-occurring disorders decreased with age, with those age 18 to 25 having the highest rate (2.7 percent) and those over the age of 50 having the lowest (0.3 percent). Treatment rates were low with 40.7 percent of those with past-year co-occurring major depressive disorder and an alcohol use disorder not receiving any treatment in the prior year, 48.6 percent receiving treatment for depression only, 1.9 percent receiving treatment for the alcohol use disorder only, and only 8.8 percent receiving treatment for both disorders.

Services & Service Systems

Prevention

Gillham, J.E., Reivich, K.J., Freres, D.R., Chaplin, T.M., Shatté, A.J., Samuels, B., Elkon, A.G.L., Litzinger, S., Lascher, M., Gallop, R., & Seligman, M.E.P. (2007). School-based prevention of depressive symptoms: A randomized controlled study of the effectiveness and specificity of the Penn Resiliency Program. *Journal of Consulting and Clinical Psychology*, 75(1), 9–19.

The authors evaluated the effectiveness of a cognitive-behavioral depression prevention program, the Penn Resiliency Program (PRP), with students at three different middle schools over a 3-year followup period. They compared PRP outcomes with outcomes from the Penn Enhancement Program (a similar intervention that controls for nonspecific intervention elements) and a control group. The results differed according to the school. In two of the three schools, PRP significantly decreased depressive symptoms to a greater extent than was found in the other two comparison groups. In the third school, however, there was no significant decrease in depressive symptoms from the PRP intervention.

Screening & Assessment

Lanyon, R.I. (2007). Utility of the psychological screening inventory: A review. *Journal of Clinical Psychology*, 63(3), 283–307.

The author reviews research on the Psychological Screening Inventory (PSI), an instrument designed to identify which individuals require a more complete psychological evaluation. Differerent scales from the PSI show strong effect sizes in distinguishing psychiatric inpatients from non-patients, incarcerated individuals from non-incarcerated, and people with general psychological distress from those without such distress. The author also reviews findings on the use of this inventory with people who have substance abuse problems.

Treatment Planning & Services

Blow, F.C., Serras, A.M., & Barry, K.L. (2007). Late-life depression and alcoholism. *Current Psychiatry Reports*, 9:(1), 14-19.

The authors review knowledge concerning the relationship between depression and alcohol use in older adults. They also make clinical practice recommendations for treating co-occurring alcohol use disorders and depression in this population.

Coffey, S.F., Schumacher, J.A., Brady, K.T., & Cotton, B.D. (2007). Changes in PTSD symptomatology during acute and protracted alcohol and cocaine abstinence. *Drug and Alcohol Dependence*, 87(2–3), 241–248.

The authors investigated whether post-traumatic stress disorder (PTSD) symptoms in people with co-occurring substance use disorders and a self-reported history of trauma would decrease after a period of abstinence from cocaine and/or alcohol. They assessed PTSD symptoms over the course of 28 days of abstinence from cocaine and alcohol. As with earlier research regarding other psychiatric diagnoses, symptoms of PTSD decreased over this period of abstinence with

the majority of the decrease being seen at 2 weeks after commencing abstinence. Symptoms declined both for individuals whose symptoms rose to the level of PTSD diagnosis as well as those who had sub-clinical levels of PTSD symptoms.

Gurpegui, M., Martínez-Ortega, J.M., Jurado, D., Aguilar, M.C., Diaz, F.J., & de Leon, J. (2007). Subjective effects and the main reason for smoking in outpatients with schizophrenia: A case-control study. *Comprehensive Psychiatry*, 48(2), 186–191.

The authors investigated the subjective effects of smoking experienced by people with schizophrenia (n=173) compared to a control group of smokers without such a diagnosis (n=100). People with schizophrenia were more likely to look for a feeling of calmness as their main reason for smoking than were subjects in the control group. Among smokers with schizophrenia, a desire for an effect of cheerfulness from smoking was associated with higher levels of symptoms of depression, a desire for a calming effect was associated with higher levels of symptoms of anxiety, and a desire for an effect of sociability with lower levels of negative schizophrenia symptoms.

Mills, K.L., Teesson, M., Ross, J., & Darke, S. (2007). The impact of post-traumatic stress disorder on treatment outcomes for heroin dependence. *Addiction*, 102(3), 447–454.

The authors sought to determine the effects of PTSD on treatment outcomes for group of 615 people with heroin dependence (predominantly ones seeking treatment). They found that in spite of decreases in substance use, PTSD had a continuing effect of increasing both physical and mental disability and decreasing occupational functioning throughout the 2-year followup period.

Post, P., Perret, Y., Anderson, S., Dalton, M., & Zevin, B. (2007). *Documenting disability for persons with substance use disorders & co-occurring impairments: A guide for clinicians*. Nashville, TN: National Health Care for the Homeless Council. Available online at http://www.nhchc.org/DAAguide.pdf

This guide from Health Care for the Homeless provides detailed information for clinicians seeking to document a level of disability suitable for Supplemental Security Income (SSI) program or the Social Security Disability Insurance (SSDI) program payments for clients who have COD. While the publication was developed for those working with clients who are homeless, it will also be useful with other clients who have COD.

Weinstock, J., Alessi, S.M., & Petry, N.M. (2007). Regardless of psychiatric severity the addition of contingency management to standard treatment improves retention and drug use outcomes. Drug and Alcohol Dependence, 87:(2-3), 288-296.

The authors evaluated the relationship between the severity of psychiatric disorders and substance abuse treatment outcomes in a group of 393 subjects who received contingency management plus standard treatment or standard treatment alone. They found a significant interaction between severity of psychiatric disorders and treatment modality regarding retention in treatment. Subjects who received only the standard treatment were more likely to drop out of treatment early if they had more severe psychiatric disorders, but this was not the case among those who also received the contingency management intervention. Severity of psychiatric disorders was not linked to duration of abstinence achieved or adherence to the contingency management treatment requirements.