Managing Depressive Symptoms in Substance Abuse Clients-Part 2: Administrator's Guide

Chapter 1

Introduction

This Treatment Improvement Protocol (TIP) is designed to assist not only **substance abuse counselors** in working with clients who are experiencing **depressive symptoms** (see Figure. 1.1), but also clinical supervisors and **administrators** who support the work of the counselors. Depressive symptoms are common among clients in substance abuse treatment (Grant, Stinson, Dawson, Chou, Dufour, Compton, et al., 2007). When depressive symptoms occur, they can complicate substance abuse treatment and interfere with recovery.

Figure 1.1

Depressive Symptoms and Related Feelings and Behaviors

The term "depressive symptoms" refers to symptoms experienced by people who, although failing to meet DSM-IV-TR diagnostic criteria for a mood disorder, experience sadness, depressed mood, "the blues," or other related feelings and behaviors:

- Loss of interest in most activities
- Significant unintentional change in weight or appetite
- Sleep disturbances
- Decreased energy, chronic fatigue or tiredness, feeling exhausted
- Feelings of excessive guilt
- Feelings of low self-esteem, low self-confidence, or worthlessness
- Feelings of despair or hopelessness (pervasive pessimism about the future)
- Avoidance of normal familial and social contacts
- Frequent agitation, restlessness
- Psychologically or emotionally detached
- Feelings of irritability or frustration
- Decrease in activity, effectiveness, or productivity
- Difficulty in thinking (poor concentration, poor memory, or indecisiveness)
- Excessive or inappropriate worries
- Being easily moved to tears
- Anticipation of the worst
- Thoughts of suicide

The methods and techniques presented in this TIP are appropriate for clients in all stages of recovery. However, the focus of this TIP is on early recovery—that is, the first few months of treatment, when depressive symptoms are particularly common.

This TIP is *not* about treating any mood disorder that is defined in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, Text Revision (DSM-IV-TR; APA, 2000). Clients with diagnosed mood disorders (e.g., major depression, dysthymia, cyclothymia, bipolar disorder) need specialized treatment from a trained and licensed mental health professional. However, when treating the substance abuse issues of clients who have mood disorders, the substance abuse counselors' role is to (1) address how the depressive symptoms of the mood disorder interact with the substance abuse recovery treatment, and (2) develop a collaborative treatment relationship with the trained and licensed mental health professional who is directing the treatment for the mood disorders.

Why SAMHSA Created an Implementation Guide as Part of This TIP

Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1, provides the tools your counselors need to address depressive symptoms with clients. However, an extensive literature review suggests that without specific attention to implementation issues, these tools are likely to go unused or to be used ineffectively (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). This *Guide* will help you ensure that the ideas in Part 1 are put into practice in your program or agency. Implementation will require the active support of executive administration and the expertise of clinical supervisors.

Consensus Panel Recommendations for Administrators

Substance abuse counselors should be prepared to help clients manage their depressive symptoms because these symptoms can complicate treatment and recovery from substance use disorders. Administrators play an important role in ensuring that their programs incorporate this aspect of treatment. In particular, the Consensus Panel recommends the following:

- All substance abuse treatment programs should integrate screening and management of depressive symptoms into existing substance abuse treatment.
- Programs need to develop the capacity to differentiate clients with depressive symptoms from those with depressive illness and have resources in place to address the needs of both groups.
- Programs have a responsibility to develop a referral network that is capable of evaluating clients with depressive symptoms and receiving clients whose depressive symptoms cannot be managed in the substance abuse treatment setting.
- Adequate policies and procedures should be in place to serve clients with suicidal thoughts or behaviors.
- In clinical supervision, an emphasis should be placed on improving counselors' ability to recognize and manage clients' depressive symptoms.

Why Address Depressive Symptoms?

The Effects of Depressive Symptoms on Recovery

Clients with depressive symptoms may experience challenges to successful treatment above and beyond those experienced by clients who are not depressed (Conner, Sorensen, & Leonard, 2005; Curran, Flynn, Kirchner, & Booth, 2000; Dodge, Sindelar, & Sinha, 2005; Greenfield, Weiss, Muenz, Vagge, Kelly, Bello, et al., 1998; Strowig, 2000).

The client with depressive symptoms may have difficulty in any or all of the following areas:

- Ability to learn program rules or to follow instructions.
- Ability to keep appointments.
- Energy to participate in or maintain interest in program activities.
- Motivation for change.
- Ability to make appropriate decisions about treatment needs and goals.
- Belief that he or she can be helped.
- Responsiveness to reinforcements.
- Ability to handle feelings.
- Ability to handle relations with other clients.
- Ability to attend to (and not disrupt) group activities.
- Ability to stay substance-free after treatment is completed.

In summary, depressive symptoms may pose significant impediments to recovery. Addressing these symptoms is a necessary part of treating the whole person and may be a concern for meeting the client's recovery goals.

Depressive symptoms may easily be mistaken for resistance to treatment. It is essential that staff be able to discriminate between depression and treatment resistance. Depressed clients may well wish to be in recovery but lack the motivation and energy to take on the challenging tasks posed by participation in recovery programs.

The Benefits to Your Program of Addressing Depressive Symptoms

Research clearly demonstrates that depressive symptoms can be reduced through treatment. Addressing these symptoms may improve substance abuse treatment outcomes and long-term abstinence outcomes (Brown, Evans, Miller, Burgess, & Mueller, 1997; Ramsey, Brown, Stuart, Burgess, & Miller, 2002).

Treating the symptoms of depression:
- Enhances the treatment experience for both the person with depressive symptoms and those around him or her.
- Increases retention rates.
- Leads to greater reductions in substance use.

- Reduces the probability of relapse.
- Increases engagement rates in aftercare services.

In addition to these benefits for the client, addressing depressive symptoms as part of your agency or program may lead to:
- Increased clinical competence of staff.
- Increase in appropriate referrals for psychological and psychiatric evaluations for depression and depressive symptoms.
- Increased staff retention, higher levels of staff satisfaction, reduced risk of burnout, decreased staff stress, and reduced turnover.
- Improved risk management (e.g., less suicidal ideation and suicidal behavior) and reduced liability.
- Access to new revenue streams.

Addressing co-occurring substance use and mental disorders is a key priority for the Federal government, State governments, insurance companies, credentialing boards, and accrediting organizations. By starting now to address depressive symptoms in your agency or programs, you will be better positioned in the future to compete in the substance abuse treatment marketplace.

Ideally, your agency can become part of the larger community of research-practitioners who seek the best ways to help clients more quickly experience a higher quality of recovery. By joining with other agencies in your network, you can coordinate treatment practices and perhaps collaboratively obtain research grants. Some of the best practices are unresearched because agencies do not appreciate the value of their unique treatment approach.

Thinking About Organizational Change

If you have decided to implement some or all of the recommendations in *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1,* you, your staff, your clients, and the other agencies and organizations with which you interact may require the development of new treatment protocols and policies, as well as new clinical knowledge, attitudes, and skills. These changes can be rewarding and/or frustrating, but will be beneficial to client well-being in the long run.

Every organization is a social system with its own unique culture. There are actually two cultures to each organization—the formal and the informal—that involve separate communication channels. The ideal is to have these cultures as congruent as possible. They affect decisions, relationships, and common (or conflicting) values and beliefs. Any change in services or approaches to clients will call for a significant change in the organization's culture.

Change in the corporate culture calls for leadership. Management at all levels and in all departments—not just clinical services—must be involved. Ancillary and support personnel also will be affected and need to be part of the process.

The similarities between recovery in an individual and change in an organization are rather striking. In fact, the organizational change process is highly analogous to the clinical processes of assessment, client-centered treatment planning, treatment delivery, and continuing care.

As with recovery, careful assessment is central to organizational change. About half of Part 2, chapter 2 of this TIP concerns assessment issues. As you will see in that discussion, the current status of the organization relative to targeted change goals needs to be assessed. Current practices, staff and administrator competencies, policies and procedures, facilities, and so on will need to be evaluated (see the section "Maximizing the Fit," p. 106). These are similar to client assessments that determine the nature and scope of a client's issues and challenges as well as their strengths and assets.

A program's readiness for change needs to be examined. Sometimes, the best decision is to delay attempting any change and work only on organizational climate and readiness. Introducing change before the groundwork has been laid can foreclose or impede later change opportunities when the climate improves. An excellent resource for organizational assessment for change is the Program Change Model (Simpson, 2002) and its accompanying survey, the Organizational Readiness for Change (Texas Christian University, Institute of Behavioral

Research, 2002). This model addresses strategies and tools for assessing institutional and personal readiness and outlines the stages of the transfer process that administrators may find helpful.

The four stages are:
1. Exposure through training
2. Adoption through leadership decision making
3. Implementation through exploratory use
4. Practice through routine use.

In addition, your assessment should consider your organization's past experiences with change initiatives (i.e., whether they were positive or negative). Just as a bad experience in a previous treatment program may color a client's perception of a new program, old experiences with organizational change may affect attitudes toward new efforts. Thus, a thorough review of organizational history of change is critical to planning new organizational change. The response to change of staff members is equally important to predicting successful outcome of implementation.

As in treatment, assessment is not a one-time activity. Rather, it is an ongoing process that includes regular feedback and adjustment of your plans for organizational change and your approaches to facilitating change. A plan for organizational change is similar to a client-centered treatment plan. First, your plan must be tailored to the specific needs of your organization. Your assessment information helps you determine where your organization needs to go, how to get there, and the pace at which change can occur. Simply following the plan used by another organization makes no more sense than having the identical treatment plan for all of your clients. The choice to implement a component on depressive symptoms presumably is part of a larger mission and vision to provide treatment for a wider range of affective symptoms (such as anger, anxiety, shame, guilt) that undermine progress toward personal and social well-being.

In as many ways as possible, the change plan should be linked to your best understanding of what key stakeholders (e.g., boards, staff, funders, clients, communities, 12-Step groups) want and value. If, for example, your staff desires professional growth opportunities, change aimed at addressing the needs of clients with depressive symptoms can be linked to

expanding staff capabilities in mental health issues. Similarly, your board's concern with expansion might be tied to the need for increased capacity if the organization is to address the depressive symptoms of its clients.

The development of the change plan should involve as many clients, stakeholders, and community resources as possible. There are a number of reasons this is the case. First and obviously, clients, staff, and other stakeholders function best when they feel involved in shaping their worlds. They feel that they have a measure of control and understand what is going to happen and what is expected of them. Equally important, stakeholders (especially staff) have a key role in determining how to make the recommendations in *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1* work best in your agency or program.

Finally, no stakeholder is more important than the clinical supervisor who is commissioned to implement the clinical mission and vision of the administrators. The clinical supervisor is challenged to help counselors maintain a high level of best-practices, to oversee the application of these practices, and to conduct process and program evaluation for quality control. Below is a discussion of how clinical supervisors serve as the critical link between direct service staff and administration, and the role of clinical supervisors in implementing organizational change.

Principles for implementing the change plan are directly analogous to principles of treatment and recovery in that both are achieved in steps, making it a process rather than an outcome. The following principles of managing change are directly adapted from principles of care presented in chapter 1 of *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1*:

1. *There is no single model or approach to implementing a program of organizational change.* A preconception about how change should occur or inflexibility during the change process is all but certain to be counterproductive, if not fatal, to meeting a client's treatment goals or a program's change goals. Constant vigilance and course corrections will be needed. Corrections should be made in consultation with the same stakeholders who developed the original change plan.

2. *A belief in your organization's ability to accomplish the change plan is fundamental.* As with counselors, an administrator's belief that change can happen (and the ability to communicate that belief) is a central component of the change process.

3. *The change program should be individualized to accommodate the specific needs, goals, culture, and readiness to change of your organization.* **It is critical to adapt and "personalize" the plan to fit specific organizational needs and culture.**

At least in the first few years after the implementation of an organizational change plan, maintenance of these changes cannot be assumed. Continuing care of your organization's new accomplishments is critical to their long-term survival. Like treatment and recovery, this is often neglected and can lead to relapse.

Continuing care is needed for several reasons. First, newly learned practices and procedures are fragile and will tend to drift. Organizational change almost always brings about some degree of personnel change. Planning for the selection and integration of new employees, the factors that need to be considered, and the method by which integration will be accomplished all need to be part of the developmental process. Equally important, new and unforeseen barriers may arise that need to be addressed. As time passes, more and more of these challenges will have been encountered and overcome. In the early stages, however, there will be some unanticipated challenges. Regular supervision and training boosters are the best insurance that behavior change will last over time.

Eventually, the changes you implement will become a regular feature of your agency's operation. This process is called institutionalization; it will have occurred when no one seems to really remember what things were like before the change took place. Rather, the new practices you introduced have become the everyday practices of your agency. Even when institutionalization occurs, however, a commitment to continuous quality improvement will help ensure your program's ability to respond to ongoing changes in the needs of your client population and community.

The Challenge of Implementing New Clinical Practices

It is sometimes assumed that good ideas are self-implementing. After all, you may pride yourself on being a rational person who does not need to be persuaded to adopt a good idea when you see one. This is all the more true in your role as a helping professional. You want the best for your clients and actively seek new ideas that will help you help them. However, recognizing a good idea and implementing it in practice are two very different things. In fact, many good ideas for practice improvement are never widely implemented (e.g., Woolf, DiGuiseppi, Atkins, & Kamerow, 1996).

Some of the usual challenges you may hear are:
- "This is not what worked for me."
- "This is not how I was taught to do it."
- "Depression is part of withdrawal; it will go away on its own after a while."
- "We need to stick to basics."
- "I'm doing it just fine, thank you very much."
- "You keep adding things to do. What are you going to take away?"
- "You're the expert: tell me what to do."
- "This won't work for this client."
- "I couldn't make supervision because I had to see a client."

As a general rule, failure to implement new clinical practices has little to do with resistance to change on the part of counselors or administrators. Failure to implement can be a result of issues such as inadequate modeling from administration, lack of follow-through, inadequate training, and many others. Even the best counselors and administrators are highly constrained by the contexts in which they work.

Accordingly, implementation success requires administrators to:
- Be proactive in making the new practice fit the context.
- Create an organizational climate that encourages and supports implementation.

These two tasks are related, and accomplishing one requires accomplishing the other. For example, fitting new practices to your context requires a thorough review of your agency's current operations. Such self-examination, in turn, helps create an organizational climate of openness to new ideas and experimentation. Before implementation begins, it is important to create positive expectations among staff. Investing the time to educate and express support for the specific implementations can go a long way in staff acceptance of change, especially in the early stages.

So often, executive staff face more immediate resistance or ambivalence because the initial groundwork was not done. Moreover, administrators have likely considered the change ideas for some time and expect staff to be at a similar level of enthusiasm and commitment to the proposal.

Change is easier to make when those involved:
- Understand why the change is needed and the benefits they will realize.
- See how the new ways will integrate into and honor what has been done previously.
- Are given motivation strategies for providing ideas and offers of assistance in implementation.

Maximizing the Fit

For a clinical innovation to take hold, it must fit with: (1) key characteristics of your target population and community (e.g., values, expectations); (2) the skills, licensures, certifications, and team structures of your staff; (3) your program or agency's facilities and resources; (4) your policies and practices; (5) local, State, and Federal regulations; (6) available interagency networks (e.g., needed outside resources, memoranda of understanding); and (7) your reimbursement procedures. Certain kinds of mismatches will be fatal to implementing change. For example, no one would expect successful implementation of an innovation when staff lack the skills to perform it. However, a lack of appropriate space or needed audiovisual equipment can stall an innovation in its tracks. As with many endeavors, the details are critical.

It is likely that adjustments will be needed both in your agency's or program's context and in the ways that the recommendations presented in Part 1 are implemented. Part 2, chapter 2 of this TIP provides procedures, checklists, and other tools for assessing the fit between the recommendations provided in Part 1 and your program or agency's current context, procedures, and so on. Useful though these materials are, your ultimate success in "maximizing the fit" will depend on your creativity, problem solving skills, and patience in applying them.

In the early stages of implementing the recommendations in Part 1, organizations will profit from a climate that promotes:
- A willingness to take risks and try unconventional approaches.

- A willingness to tolerate some ambiguity as the fit between new practices and context evolves.
- An ability to recognize false starts and to abandon approaches that are not working.
- Appreciation and reward for ideas and implementation.

As noted earlier, the later stages of implementation will be facilitated by:
- A commitment to continuous quality improvement.
- The development of structures that support and reinforce the change (e.g., standardized training for new staff, regular boosters, and supervision for all staff).
- Expressions of organizational pride in accomplishment.
- Institutionalization (in which new practices become everyday practices).

Clinical supervision is the keystone of implementation of new clinical procedures and processes. Supervision should be more instructive and less crisis driven—more proactive and less reactive—by using such strategies and resources as:
- Innovative supervision methods, including live, in-session supervision, role playing, taping, and group and peer supervision.
- Regularly scheduled, ongoing clinical supervision
- Checklists and fidelity scales.
- Quality skills training.
- Counselor mentoring.

The Role of the Administrator in Introducing and Supporting New Clinical Practices

Chapter 2 of this *Guide* presents the tasks you will need to accomplish in order to implement the changes elaborated in *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1*. Important as these tasks are, they cannot themselves ensure the successful implementation of the Part 1 recommendations. Rather, successful implementation will ultimately depend on the leadership you provide.

Leadership is critical for implementing an organizational change. First and foremost, leadership means *commitment*. If you and your administrative colleagues are not fully committed to improving services for clients with depressive symptoms, meaningful and lasting change is unlikely to take hold. In many ways, attempting change without the commitment of organizational leaders can be worse than no attempt to change at all. The perception that leaders are only giving lip-service to a new idea will eventually become clear to staff. This perception will undermine the current attempts at innovation and may lead to a staff that is reluctant to try new ideas.

Second, leadership means having a *vision* of how the organization will change. This vision should include explicit goals and a clear statement of how conflicts with other organizational goals will be resolved. However, a vision is more than a list of goals. It is a picture of how the organization will look when change has been accomplished—a picture you must paint with words in vivid detail for your staff. Developing this vision and the means to communicate it throughout the organization requires considerable effort.

Leadership should include highly skilled and competent clinicians trained in mental health and substance use disorder treatment who can direct and supervise services for clients with co-occurring depressive symptoms and substance use disorders. These clinicians should know and appreciate the specific roles that can be played by licensed or certified addiction counselors, licensed social workers, psychologists, physicians, and other mental health and substance abuse professionals. They should also have an appreciation for the role depressive symptoms can play in interfering with substance abuse treatment. When such resources are not available on staff, a clinician should be available on a consultant basis.

Since working with clients with depressive symptoms means that programs must be prepared to address the needs of clients with co-occurring disorders, staff have a right to expect that program leadership will be knowledgeable and conversant on the impact of addressing co-occurring disorders and offer a vision of what this means to the program.

Third, leadership means *inspiring* your organization. Inspirational leaders communicate confidence in the organization's ability to change, enthusiasm for change, optimism about the change process, and an unwillingness to accept failure. This needs to be communicated to all stakeholders including current and potential clients, funders, board members, staff, community leaders, community 12-Step participants and programs, and sister agencies. Inspiration not only is a process of oral and written communication, but also involves modeling the attitudes and values you want staff and other stakeholders to adopt, including those discussed earlier (e.g., risk taking, tolerance of ambiguity, and willingness to start over when approaches are not working). Inspiration also involves getting your hands dirty. Nothing inspires staff members more than seeing their leaders struggle alongside them in the day-to-day tasks of making new ideas work.

Finally, leadership means an ongoing and honest *appraisal* of progress. As noted in *Managing Depressive Symptoms: A Review of the Literature, Part 3* (http://store.samhsa.gov) and discussed further below, implementing the recommendations from Part 1 will require ongoing assessments of progress, including regular formative evaluation of process and outcomes. Periodic reports on how the organization is doing can and should be developed from the assessments and evaluations. These reports should be shared with staff as should plans for corrective action when needed. The most effective leaders frame both good and bad news in a positive light. One way to do this is to emphasize the learning value of challenges and setbacks and to remind staff that it is the organization as a whole, rather than any individual, that is responsible for making change happen. This means that "we succeeded" or "we still have room to improve" is always the preferred way to communicate successes and failures.

Chapter 2

Introduction

There is no simple formula for implementing the clinical recommendations presented in *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1*. Like any tool, the resources presented in this chapter will be effective only when used by people who have a clear vision of what they wish to accomplish and who actively determine and understand the processes by which they will get there.

The resources presented in this chapter have been organized into those related to organizational assessment and those related to planning and implementing organizational change. The change process in your agency or program will require creative and thoughtful adaptation and application of these resources to your specific needs and circumstances. They should be viewed as points of departure only. You should revise or otherwise modify the materials as needed for your organization.

The *Change Book* (Addiction Technology Transfer Center Network [ATTC], 2004), provides the basis for the organizational change process presented in this chapter. Additionally, you may wish to consult *Implementation Research: A Synthesis of the Literature* (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). This is a highly readable and very useful summary of the scientific basis for various implementation practices. Some of the main ideas in chapter 1 derive from this synthesis.

You may also wish to consult with colleagues who have managed organizational change in organizations similar to yours. At this point in the development of implementation strategies for human services, many excellent ideas are still to be found outside the published literature. Your colleagues may have insights or ideas that are equal to or more applicable than those presented in this *Guide*.

Finally, a point made in chapter 1 is worth repeating: Managing organizational change is very similar to working with a client in a clinical setting. Your understanding of the recovery process and of the counselor's attributes and techniques that facilitate recovery is an invaluable resource as you apply the tools presented in this chapter.

Assessment and Planning Before Implementation

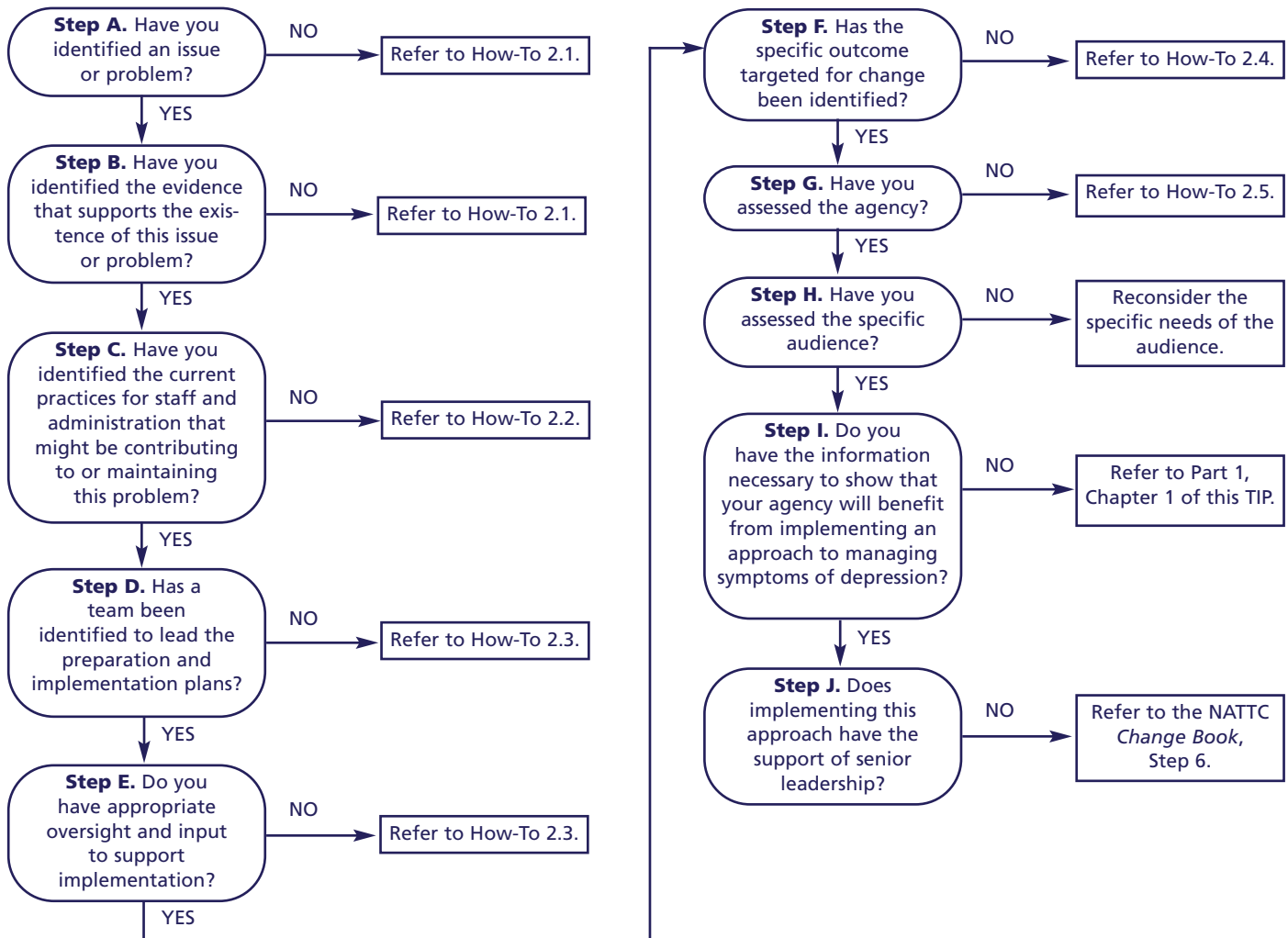### How Do You Decide Whether To Implement a Policy for Managing Depressive Symptoms?

To determine whether it makes sense for your agency to implement the recommendations made in *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1*, refer to Figure 2.1.

How Do You Identify the Issue or Need?

The following How-To components provide ways to operationalize the steps presented in Figure 2.1.

Figure 2.1
Decision Tree
How To Decide Whether To Implement a Policy for Managing Depressive Symptoms

Step A. Have you identified an issue or problem? — NO → Refer to How-To 2.1.

YES ↓

Step B. Have you identified the evidence that supports the existence of this issue or problem? — NO → Refer to How-To 2.1.

YES ↓

Step C. Have you identified the current practices for staff and administration that might be contributing to or maintaining this problem? — NO → Refer to How-To 2.2.

YES ↓

Step D. Has a team been identified to lead the preparation and implementation plans? — NO → Refer to How-To 2.3.

YES ↓

Step E. Do you have appropriate oversight and input to support implementation? — NO → Refer to How-To 2.3.

YES →

Step F. Has the specific outcome targeted for change been identified? — NO → Refer to How-To 2.4.

YES ↓

Step G. Have you assessed the agency? — NO → Refer to How-To 2.5.

YES ↓

Step H. Have you assessed the specific audience? — NO → Reconsider the specific needs of the audience.

YES ↓

Step I. Do you have the information necessary to show that your agency will benefit from implementing an approach to managing symptoms of depression? — NO → Refer to Part 1, Chapter 1 of this TIP.

YES ↓

Step J. Does implementing this approach have the support of senior leadership? — NO → Refer to the NATTC *Change Book*, Step 6.

How-To 2.1: How to Identify the Issue or Need (Figure 2.1, Steps A and B)

Research suggests that the following issues or problems may be relevant to your agency's treatment outcomes. Think about the three levels where change can occur (i.e., program/organizational, practitioner/counselor, and client/patient) when considering the following steps. Also, begin thinking about the part of the agency where you may want to implement changes first (for more information, see also the section How Do You Decide Where To Start?, p. 113).

1. Depressive symptoms are common in clients presenting for substance abuse treatment. Determine whether clients with depressive symptoms are being identified and effectively treated in your agency (see How-To 2.2).

2. People who present with depressive symptoms may take longer to benefit from treatment. Determine whether this is an issue for your agency. Does your program offer the option of longer treatment stays to clients with depressive symptoms? If not, how is this need addressed? What practices may need to be changed?

3. Untreated depressive symptoms result in poorer substance abuse treatment outcomes. Determine whether a goal for your agency is to improve retention rates of clients with depressive symptoms. Determine whether a goal for your agency is to more effectively reduce the number of depressive symptoms experienced by the clients.

One aspect of the identification process is to assess the organizational capability of the agency to implement or augment a program for services to clients with depressive symptoms.

How Do You Assess the Capability of the Agency To Provide Services to Clients with Depressive Symptoms?

People with symptoms of depression may see themselves as worthless, the world as hostile, and their future as hopeless. Is this addressed in your treatment program? For example, are people not making the transition from detoxification to treatment because they are depressed and their depression is not being addressed while they are there? Are people not staying in treatment because they are not confident that their treatment plan will help them manage their symptoms of depression along with their substance use disorders? Assess the current capability of your agency or program to work with people with symptoms of depression (see How-To 2.2 below).

How-To 2.2: How To Assess Current Capability To Manage Depressive Symptoms (Figure 2.1, Step C)

For each program setting consider the following questions:

1. Are the treatment teams (e.g., psychiatrist, nurse, licensed master's level clinicians, certified substance abuse counselors, clinicians, and counselors in training) multidisciplinary?

2. Are symptoms of depression identified and adequately addressed in treatment plans?

3. Are appropriate interventions planned to treat symptoms of depression?

4. Are the interventions already in use effective with the program's clientele?

5. Does the supervisory staff have the knowledge, skills, and attitudes necessary to supervise or coach the line staff applying the interventions?

6. Does the program have referral or consultation relationships with trained and licensed mental health professionals or mental health programs?

Note: For more information on assessing current capability, see Sample Policies 1–6 and Checklists 1–4.

How Do You Organize a Team To Address the Problem?

Once you have identified an issue or problem, you need to create a work group to address the problem (see How-To 2.3).

How-To 2.3: How To Organize a Team To Address the Problem (Figure 2.1, Steps D and E)

1. Identify one person to lead the effort. This person must have the backing of senior administration and the respect of direct treatment staff.

2. Obtain the commitment of the chief executive officer of the agency to articulate the vision for implementation throughout the agency, with all stakeholders, and to the public.

3. Convene an implementation work group consisting of key leaders from different stakeholder groups: consumer leaders, family leaders, team leaders, clinical leaders, and program and administrative leaders. Some stakeholders will serve as ongoing members of the work group while information from others may be solicited through focus groups. If your program has a residential or inpatient component, be sure to include an individual from the night staff (i.e. aide, tech, night nurse). This staff will actually have more conversations with patients than most clinical staff and are in a position to support this program through their observations and understanding.

4. Identify the program oversight committee to which the work group will report. For example, if your agency has a quality improvement committee, the work group may report its findings, recommendations, strategic plans, and modifications to that committee. This is one way to initiate and sustain implementation.

How Do You Identify a Specific Outcome To Target for Change?

Once you've identified a work group to address the problem, you need to identify a specific outcome to be targeted for change (see How-To 2.4).

How-To 2.4: How To Identify a Specific Outcome To Target for Change (Figure 2.1, Step F)

1. Begin with the issue or problem identified in Step A of Figure 2.1, and determine a specific variable that can be measured that is directly related to improving the management of depressive symptoms. For example, "decrease client experience of depressive symptoms."

2. Identify a way to measure "client experience of depressive symptoms." For example, the Center for Epidemiologic Studies Depression Scale (see Part 1) could be administered to agency clients to determine the prevalence of depressive symptoms.

3. Measure a baseline prior to implementing the intervention. For example, determine how many clients experience depressive symptoms while in

treatment at your agency. How many clients are still experiencing depressive symptoms when they leave treatment? Do the clients who experience depressive symptoms tend to leave treatment earlier than the clients who do not report depressive symptoms? Do they tend to have more difficulty maintaining abstinence?

4. Identify which outcome you are most interested in measuring to determine whether implementing the intervention is working.

How Do You Decide Where To Start?

Once you've identified a specific outcome to target for change, you will want the work group to assess the agency and the staff (both frontline and supervisory) to be targeted by the implementation. You will have an easier time implementing your plan if you start with a small program where staff members already work well with one another and believe in the new techniques. Staff members on closely knit teams work with one another's strengths and will have an easier time assigning responsibilities when it comes time to implement the practice. Alternatively, you may choose a small, core group of staff members who are ready to try the new techniques and are prepared to be part of the implementation process (i.e., target early adopters across programs). These will be the first staff members trained and coached in using these techniques.

Other advantages to starting small include:
1. It is easier to track the success of the implementation.
2. It is easier to identify and make any modifications to the techniques that may be necessary to accommodate the agency's clientele.
3. The core group members will talk about the success they are having with the techniques and get other staff interested in learning and using the techniques.

For more information on assessing your agency's readiness for implementation, see How-To 2.5.

How Do You Assess the Agency's Organizational Readiness for Implementation?

How-To 2.5: How To Assess the Agency's Organizational Readiness for Implementation (Figure 2.1, Step G)

1. The committee assesses the agency's organizational readiness by first determining whether implementing practices to improve the management of depressive symptoms in the agency's clientele are consistent with the agency's mission statement. (See also the section Modifying Existing Policies, p 114).

2. The committee determines the obstacles to implementation:

   a. Rate of staff turnover in the agency including average longevity of clinical and support staff.

   b. Inadequate funding for training, technical assistance, and outcome measurement.

   c. Policies and procedures that would have to be changed (see Sample Policies 1–6, pp. 115–119).

d. Agency facilities and resources.

    e. Federal, State, and local regulations that affect the decision to implement this intervention (see the section Addressing Relevant Regulations).

3. The committee determines the opportunities created by implementing this intervention:

    a. Increased funding.

    b. Increased collaboration with other agencies.

    c. Improved community relations and marketing opportunities.

4. The committee determines the organization's stage of change (see also the ATTC Change Book, pp. 33–34).

5. The committee determines where the resources will come from to provide support for the change initiative (ATTC Change Book, p. 29).

6. The committee determines what adoption of this change will mean at all levels of the organization and what the benefits are for administrators, supervisors, and counselors (ATTC Change Book, p. 29).

7. The committee determines what is already happening that might lay the foundation for the desired change (ATTC Change Book, p. 29).

Addressing Policies and Procedures

Planning and implementing a new program component almost always impacts existing policy and procedure. These items need to be reviewed and adapted to be sure they are in conformance with the new program.

Implementing organizational change requires a multilayered approach to establishing communication and commitment across departments and program areas. As described in earlier sections, the commitment of the organizational leader is of utmost importance. Nonetheless, this leadership commitment alone is not adequate to ensure that changes are adopted and sustained over time. Mechanisms to institutionalize these changes must be established. Policies and procedures constitute one of the most common approaches to institutionalizing organizational practices. Although varying in format and structure as a result of regulatory and organizational diversity, policies and procedures serve as the foundation of organizational practice.

This section provides six samples of the critical policies and procedures related to addressing depressive symptoms within substance abuse treatment agencies. In each topic area, a policy statement and set of procedures related to the topic are presented. These sample policies can be used as presented, combined into one or more comprehensive policies, or integrated into the organization's existing policies.

Modifying Existing Policies

In addition to adopting policies on managing depressive symptoms, provider agencies might consider modifying other policies and program descriptions to provide continuity of care for individuals experiencing depressive symptoms.

For example, each substance abuse treatment program will develop its own approach to screening and monitoring the depressive symptoms of its clients based on (a) the characteristics of its clientele, (b) its resources, espe-

cially its staff training and background, (c) legal and reimbursement considerations, and (d) a host of possible idiosyncratic factors (e.g., specific arrangements worked out with referral resources or consultants, participation in clinical trials, or other external influences). Your professional input into developing the necessary policies and procedures is essential, and at a minimum there should be a protocol that stipulates:

- What standard questions a client is asked.
- When these questions are asked (by interview and/or self-report mechanisms) and when repeated (especially what observations or events might trigger rescreening).
- Who can ask these questions and what training is provided or needed regarding the questions and the overall process, procedures, and policies.
- Exactly how scoring or assessment of the clients' responses will be done, including exact guidelines for the follow up triggered by different levels of severity or acuity indicated by various responses.
- Where these policies and procedures fit within the agency's policies and procedures and what chain of command and communication exist, especially for emergency situations that might arise.

The Mission Statement

Descriptions of the mission or treatment philosophy should be modified to include a description of the importance of addressing co-occurring problems (including depressive symptoms) during the course of treatment, the importance of client-centered care, and the need to educate the client about the relationship between substance abuse and depressive symptoms.

Program Descriptions

In addition, program descriptions should have welcoming statements for clients who have co-occurring substance abuse and depressive symptoms and identify client-focused treatment planning that is responsive to individuals who have substance abuse and depressive symptoms. An example of such an approach might be that alternative and/or complementary individualized activities are available in addition to group activities for individuals who may benefit from them. Each program should include a vehicle for communicating with all clients about the relationship between substance abuse and depressive symptoms.

Sample Policy 1
Topic: Clinical staff training and competency.
Policy Statement: All clinical staff will demonstrate basic competency in screening clients with substance use disorders for depressive symptoms.
Procedures: 1. All clinical and support staff will participate in a 3–5 hour training session covering depressive symptoms, their impact on substance abuse treatment retention and outcomes, and criteria and procedures for referring individuals to services aimed at managing depressive symptoms. 2. The clinical supervisor of new employees will provide site-specific information on the procedures for screening and referring individuals who are experiencing depressive symptoms. 3. Clinical competency checklists completed at hire and annually thereafter will ensure that all clinical staff members have a basic knowledge of the benefits of managing depressive symptoms, an understanding of strategies for assessing the significance of depressive symptoms, and an awareness of appropriate referral procedures.

Sample Policy 2

Topic: Recruitment, training, and supervision of clinical staff treating depressive symptoms in clients.

Policy Statement: Counselors interested in providing services for managing depressive symptoms and who possess the relevant basic counseling skills, knowledge, and attitudes (see Checklist 2, p. 122) will be recruited, trained, and supervised to deliver these interventions.

Procedures:
1. At least one clinical position in each program or modality of care will be designated to provide services to manage depressive symptoms.
2. Individuals exhibiting the attitudes, knowledge, skills, and job performance required to provide interventions to manage depressive symptoms will be identified by their clinical supervisor and designated to provide these services.
3. The counselors identified to provide interventions to manage depressive symptoms will receive 2 weeks of initial training and 1 week of additional training each year in the following areas:
   - Screening and assessment of depressive symptoms.
   - Managing depression in the context of cultural diversity.
   - Client-centered care.
   - Motivational interviewing.
   - Building self-efficacy.
   - Cognitive–behavioral approaches.
   - Therapeutic alliance.
   - Personal boundaries and professional ethics.
   - Termination and discharge planning.
4. Counselors managing depressive symptoms will receive clinical supervision twice monthly that includes direct observation or review of tapes of individual sessions with clients with depressive symptoms.
5. Counselors managing depressive symptoms will meet quarterly to provide peer support, supervision, and share resources related to the management of clients with depressive symptoms.

Sample Policy 3

Topic: Screening and referral of clients with substance use disorders and depressive symptoms.

Policy Statement: All clients will be screened for depressive symptoms and referred as needed.

Procedures:
1. During the intake process, all clients will be screened for the following nine depressive symptoms:
   - Loss of interest in most activities.
   - Significant unintentional change in weight or appetite.
   - Sleep disturbances.
   - Decreased energy, chronic fatigue or tiredness, feeling exhausted.
   - Feelings of excessive guilt.
   - Feelings of low self-esteem, low self-confidence, or worthlessness.
   - Feelings of despair or hopelessness (pervasive pessimism about the future).
   - Avoidance of normal familial and social contacts.
   - Frequent agitation, restlessness.
   - Psychologically or emotionally detached.
   - Feelings of irritability or frustration.
   - Decrease in activity, effectiveness, or productivity.
   - Difficulty in thinking (poor concentration, poor memory, or indecisiveness).
   - Excessive or inappropriate worries.
   - Being easily moved to tears.
   - Anticipation of the worst.
   - Thoughts of suicide.
2. Staff will be trained in using specific depression screening tools such as the CES-D scale.
3. Individuals demonstrating depressive symptoms will be referred for assessment by a State-qualified mental health professional (QMHP) or substance abuse specialist.
4. Clients who are determined by a QMHP to have a DSM-IV-TR mental health diagnosis will be referred for mental health treatment to be delivered by a QMHP. Collaborative relationships with mental health treatment providers will be developed.
5. If no current mental health diagnosis is identified by the QMHP but depressive symptoms exist, the client will be referred to a counselor competent in managing depressive symptoms (see Sample Policy 2).
6. The counselor managing depressive symptoms will screen for changes in the symptoms of depression at each session and, if the client is exhibiting more than two symptoms or current suicidal ideations, the counselor will immediately contact his or her clinical supervisor to determine whether the individual should be reassessed by a QMHP.
7. All screening results, consultation sessions with the clinical supervisor, and referrals (and ongoing communications) to a QMHP will be documented in the client's record.
8. The counselor providing services for depressive symptoms will provide the client with an emergency contact list that includes agency personnel and emergency mental health providers. The client can refer to this list if his or her symptoms worsen outside business hours or when substance abuse counselors are not available.

Sample Policy 4

Topic: Treatment planning, service recording, discharge planning, and continuity of care.

Policy Statement: Management of depressive symptoms will be integrated with substance abuse services, be properly documented, and include appropriate discharge and transfer planning related to depressive symptoms.

Procedures:
1. Screening for depressive symptoms and strategies for managing depressive symptoms will be included in the client's treatment plan.
2. Treatment plans for depressive symptoms, along with other substance use problems, will be jointly developed by the multidisciplinary team and the client within and/or across programs.
3. To minimize client confusion, the client will be provided with information about the roles and responsibilities of those delivering care.
4. If the counselor providing services for depressive symptoms is not the client's primary substance abuse counselor, the counselor providing services for depressive symptoms will attend all treatment planning sessions for the client along with the other members of the multidisciplinary team.
5. Treatment plans will include referral to other community resources and peer support activities that may increase the client's self-efficacy and reduce depressive symptoms.
6. Multidisciplinary treatment update sessions that include all professionals involved with the client's care will be held every 7 days for short-term residential treatment and every 30 days for long-term residential treatment and outpatient settings. (The frequency of treatment plan updates should be consistent with State and organizational standards and will vary by modality of care and regulatory agency.)
7. Services delivered by the counselor treating depressive symptoms will be recorded in the client's record at each contact and will be available to other members of the treatment team.
8. Major changes in the client's condition will be communicated between the substance abuse counselor and the multidisciplinary team providing services for depressive symptoms.
9. The checklist of depressive symptoms (see Sample Policy 3) will be completed at the last session before termination to assist in developing the discharge plan and to be used by the quality assurance department for outcome monitoring.
10. Discharge and transfer planning will include recommendations for the client about self-care and professional care for depression.

Sample Policy 5

Topic: Counselor performance appraisal..

Policy Statement: Counselors capable of providing services for depressive symptoms will have job descriptions that include a high level of specific performance expectations related to provision of services for these clients.

Procedures:
1. Job descriptions for counselors providing services for depressive symptoms will include modified caseload and productivity expectations for the modality of care in which the counselor works.
2. Performance appraisal of counselors providing services for depressive symptoms will include demonstration of core competencies related to managing depressive symptoms.
3. Annual training requirements will be outlined in the job descriptions of counselors identified to provide services for depressive symptoms.
4. Client satisfaction surveys and outcome reports will be discussed in annual performance evaluations with counselors managing depression symptoms.

Sample Policy 6
Topic: Evaluation of service effectiveness and quality assurance.
Policy Statement: Services for managing depressive symptoms will be reported annually through the agency's quality assurance system along with indicators of effectiveness based on client outcomes.

Procedures:
1. The agency's quality assurance program will include monitoring the implementation of policies related to screening and assessment of depressive symptoms, QMHP referral procedures, documentation and treatment planning, and supervision of counselors providing services for depressive symptoms.
2. Data from admission and discharge screening of clients with depressive symptoms (see Sample Policy 3) will be aggregated by the quality assurance coordinator for annual reporting to the agency.
3. The following overall agency performance outcomes will be reviewed annually by the management team:
   a. The proportion of clients dropping out of treatment before the third session (it will be important to have information on the dropout rate before implementation of services for depressive symptoms to assess the impact of these services on treatment engagement and retention).
   b. The proportion of clients evidencing two or more depressive symptoms at admission and discharge.
   c. The proportion of clients referred to a QMHP.
   d. The number of clients receiving services for depressive symptoms.
   e. The proportion of all clients experiencing a relapse during treatment and for the subgroup of those with depressive symptoms.

Addressing Relevant Regulations

Another aspect of assessing the agency is to determine whether implementing the intervention will conflict with existing governmental or accreditation regulations and standards. For example, you will want to review the licensing regulations for the substance abuse treatment counselors and the Federal, State, and local regulations that apply to the agency's operation.

The assessment of the agency includes ensuring that the agency, program, and staff are licensed to provide the interventions in *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1*. Before implementing any intervention, ensure that all appropriate policies and procedures are in place and that these interventions fall within the scope of acceptable practice for the applicable Federal, State, and local regulations for your agency, program, and staff. It is also important to note that more and more often, licensed and certified substance abuse counselors have advanced degrees in professions (such as social work, counseling, and psychology) that do allow them to diagnose and treat mental disorders concomitant with the client's substance abuse treatment. Rules and regulations governing the practices of substance abuse counselors are evolving and subject to change by State legislatures (see Part 1 Chapter 1 of this TIP).

Addressing Staff Competence

Where Is the Clinical Expertise in Your Agency?

Change in clinical practice is best facilitated by assessing the skills of well-trained and experienced clinicians and targeting them for training and/or enlisting them in helping less skilled counselors facilitate change. Two clinical management structures are described here—multidisciplinary teams and traditional clinical supervisors.

Multidisciplinary teams are one effective way to ensure that the expertise for providing treatment for co-occurring substance use and mental disorders is available in your agency. If you have multidisciplinary teams in your program, the teams assume the responsibility of tailoring interventions to an individual client's needs in a way that addresses co-occurring disorders seamlessly. The multidisciplinary teams provide ongoing support, education, and treatment planning assistance for all staff. Teamwork creates an enriched environment for implementing techniques for managing co-occurring disorders. An advanced level of capability for managing depressive symptoms in clients with substance use disorders occurs when the more experienced and skilled members of the team have the knowledge, skills, and attitudes required to apply an intervention and to supervise and coach application of an intervention for other counselors.

Many substance abuse treatment agencies do not have multidisciplinary teams and instead rely on the expertise of *clinical supervisors* to evaluate and support the work of line staff. Clinical supervisors must have the knowledge, skills, and abilities required to apply an intervention and be able to demonstrate the intervention before they can coach others to perform it. The supervisors must also have the time to supervise and coach the staff. If this describes the supervisors in the setting where you work, you have an intermediate capability to manage depressive symptoms. If the supervisors have not yet reached this level, then you have a beginning capability for working with co-occurring disorders and must develop a plan to build the resources necessary to increase capacity.

The Frontline Staff and Clinical Supervisors

Once you've assessed the agency, you may want to assess the staff who will actually implement the change (see How-To 2.6).

How-To 2.6: How To Assess the Frontline Staff and Clinical Supervisors To Be Targeted (Figure 2.1, Step H)

The committee determines the specific program and staff members who will be the first to implement change.

1. Are there incentives to change (ATTC Change Book, p. 29)?

2. What are the barriers to change (ATTC Change Book, p. 29)?

3. At what stage of change is the program staff (ATTC Change Book, p. 29)?

4. How will staff practice be affected (ATTC Change Book, p. 29)?

5. What additional support will staff need (ATTC Change Book, p. 29)?

6. Does staff have the prerequisite knowledge, attitudes, and skills?

7. What training and continuing resources are necessary to provide the core intervention components?

See also Sample Policies 1–6 (pp. 115–119) and Checklists 1–4 (pp. 121–124) for additional information to be used in assessing staff readiness.

Staff Qualifications and Competencies

As a part of implementation, a number of process-oriented tasks should be completed, including an assessment of initial staff competence, education and training, development of skills and resources, and supervision. These considerations are relevant not only to the counselors' ability to deliver the services but also to clinical supervisors, other clinical staff, and support staff responsible for recording and billing services. These more peripherally involved staff are often critical to the success of the program and can help shape the public image of the program and sustainability of the service.

Compared with those providing support services, however, the required level of knowledge and skill is significantly different for those directly involved in clinical care. For this reason, the attitudes, knowledge, and skills required to manage depressive symptoms are separated into four categories: administrative and support staff, all clinical staff, counselors designated to manage depressive symptoms, and their clinical supervisors. The four checklists that follow (pp. 121–124) serve two purposes. First, they can be used to assess staff and organizational readiness to implement or sustain the specialized services for managing depressive symptoms. Second, they can be used to identify gaps in training and supervision to be addressed with individuals or groups. See also TAP 21-A, *Competencies for Substance Abuse Treatment Clinical Supervisors* (CSAT, 2007).

Checklist 1: Characteristics and Competencies of Administrative and Support Staff

Attitudes

____ Integration of substance abuse and management of depressive symptoms is important for promotion of the agency mission.

____ Depressive symptoms constitute valid and important experiences of clients with substance use disorders that deserve and require specialized attention.

Knowledge

____ Understands the relationship between depressive symptoms and substance abuse treatment effectiveness.

____ Understands how provision of services for depressive symptoms fits in the mission and goals of the organization.

____ Is familiar with the policies and procedures related to recording and billing services for depressive symptoms.

____ Understands the distinction between DSM-IV-TR diagnoses and the depressive symptoms treatable by substance abuse counselors.

____ Knows the agency's policies and procedures on treating depressive symptoms as they relate to the specific position (e.g., administrative staff in clinical records are familiar with documentation requirements for these services, and the finance staff are knowledgeable about how services are defined for billing purposes).

____ Understands the role of self-help groups in recovery and how those groups can support the goals of the program in working with substance abuse clients with depressive symptoms.

Skills

____ Communicates to the public the role of specialized services for managing depressive symptoms in clients with substance use disorders. Individuals answering telephones or preparing written materials describing agency services can describe the services accurately to outside agencies and to clients. They understand and can communicate the distinction between the mental health diagnosis of depression and depressive symptoms treated by substance abuse counselors.

____ Is able to conduct essential aspects of job duties related to service delivery. Individuals billing for services understand the distinction between mental health diagnoses and depressive symptoms to ensure clear communication with funding agencies.

Checklist 2: Characteristics and Competencies of All Clinical Staff

Attitudes
____ Integration of services for substance abuse and depressive symptoms is important for promotion of the agency mission.
____ Depressive symptoms constitute valid and important experiences of clients with substance use disorders that deserve and require specialized attention.
____ Integration of services for clients with substance use disorders and depressive symptoms is important.
____ Clients have a central role in creating and shaping their treatment goals.
____ Substance abuse and depressive symptoms can be both interrelated and independent; resolving one set of concerns may not lead to resolution of the other set of concerns without specialized treatment.
____ There is no one "right" approach to managing depressive symptoms in clients with substance use disorders.
____ Individual sessions can be particularly valuable for clients with depressive symptoms and can provide an effective adjunct to group treatment.

Knowledge
____ Understands the relationship between depressive symptoms and substance abuse treatment effectiveness.
____ Understands how provision of services for depressive symptoms fits in the mission and goals of the organization.
____ Understands the distinction between DSM-IV-TR diagnoses and the depressive symptoms managed by substance abuse counselors.
____ Knows the agency's policies and procedures on managing depressive symptoms.
____ Understands the interrelationship between depressive symptoms and substance abuse.

Skills
____ Communicates to the public the role of managing depressive symptoms of clients with substance use disorders.
____ Identifies the depressive symptoms listed in the screening policy and procedure (see Sample Policy 3).
____ Properly administers a depression symptom screening measure.
____ Conducts basic client education session on the relationship between depressive symptoms and substance abuse.
____ Collaborates with other team members on treatment and discharge planning.
____ Conducts a suicide risk screening.

Checklist 3: Characteristics and Competencies of Counselors Identified To Manage Depressive Symptoms

Attitudes
____ Integration of services for substance abuse and depressive symptoms is important for promotion of the agency mission.
____ Depressive symptoms constitute valid and important experiences of clients with substance use disorders that deserve and require specialized attention.
____ Integration of services for clients with substance use disorders and depressive symptoms is important.
____ Clients have a central role in creating and shaping their treatment goals.
____ Substance abuse and depressive symptoms can be both interrelated and independent; resolving one set of concerns may not lead to resolution of the other set of concerns without specialized treatment.
____ There is no one "right" approach to managing depressive symptoms in clients with substance use disorders.
____ Individual sessions can be particularly valuable for clients with depressive symptoms and can provide an effective adjunct to group treatment.
____ Resistance to change from clients is surmountable within the influence of the counseling relationship.
____ The client is an integrated whole rather than one or more diagnoses or sets of symptoms.
____ A desire exists to deliver services to clients with substance use disorders experiencing depressive symptoms.

Checklist 3: Characteristics and Competencies of Counselors Identified To Manage Depressive Symptoms (continued)

Knowledge

____ Understands the relationship between depressive symptoms and substance abuse treatment effectiveness.

____ Understands how provision of services for depressive symptoms fits into the mission and goals of the organization.

____ Understands the distinction between DSM-IV-TR depression diagnoses and the depressive symptoms treated by substance abuse counselors.

____ Demonstrates a nuanced understanding of the relationship between substance abuse and depressive symptoms.

____ Understands the distinctions among screening, assessment, and diagnosis of mental health problems.

____ Knows the common approaches to the management of depressive symptoms in substance abuse treatment settings including motivational interviewing, cognitive–behavioral, and supportive-expressive approaches.

____ Understands how substance abuse and depression present in ethnic and other cultural groups encountered in the agency.

____ Knows community resources (particularly mental health and peer support).

____ Understands how 12-Step and other mutual-help support programs can support resolution of depressive symptoms.

____ Is aware of the role of transference and countertransference in the counseling relationship.

____ Understands the role of religion and spirituality in promoting recovery for some clients.

Skills

____ Communicates to the public the role of managing depressive symptoms of clients with substance use disorders.

____ Identifies the depressive symptoms listed in the screening policy and procedure (see Sample Policy 3).

____ Properly administers a depression symptom screening measure.

____ Conducts basic client education session on the relationship between depressive symptoms and substance abuse.

____ Collaborates with other team members on treatment and discharge planning.

____ Conducts a suicide risk screening.

____ Communicates to the public the role of services for depressive symptoms of clients with substance use disorders.

____ Identifies the depressive symptoms listed in the screening policy and procedure (see Sample Policy 3).

____ Properly administers a depression symptom screening measure.

____ Conducts a client education session on the relationship between substance abuse and depressive symptoms.

____ Collaborates with other team members on treatment and discharge planning.

____ Conducts a suicide risk screening.

____ Exhibits evidence-based thinking (tailoring approach to service based on clinical experience, client characteristics, knowledge of field, consultation with supervisor, constraints, and resources available).

____ Effectively uses clinical supervision.

____ Demonstrates empathic listening skills and reflection.

____ Demonstrates competency in at least two of the common approaches to managing depressive symptoms (motivational interviewing, cognitive–behavioral, supportive-expressive approaches).

____ Displays confidence in ability to provide services for depressive symptoms.

____ Acts as a role model for a balanced, healthy lifestyle.

____ Exhibits advanced skills in dealing with resistance to change through nonconfrontational approaches.

____ Identifies and responds to variations in learning styles among clients.

____ Demonstrates the ability to quickly establish a therapeutic alliance with the client: treating the client with respect, communicating a nonjudgmental attitude, listening reflectively, setting appropriate limits, being sensitive to culture and value contexts, and acting as a role model.

____ Is comfortable with and able to resolve conflict.

____ Is able to prepare clients for termination from the program.

Checklist 4: Characteristics and Competencies of Clinical Supervisors

Attitudes

____ Substance abuse counselors have the basic characteristics needed to provide services to manage depressive symptoms.

____ Clinical supervision extends beyond talking about treatment to observing and coaching counselors directly.

Knowledge

____ Possesses all of the knowledge areas listed on Checklist 3.

____ Is knowledgeable of the role of clinical supervision.

____ Recognizes the limits and opportunities related to the role of substance abuse counselors with specialized training in the management of depressive symptoms and supports training about depression for counselors as needed.

____ Can determine when a client with depressive symptoms needs additional skills and services beyond the qualifications of substance abuse counselors.

____ Is trained to use screening instruments for depressive symptoms.

____ Is aware of the role of transference and countertransference in the counseling and supervisory relationship.

____ Recognizes resistance to change among clinical staff and is knowledgeable of strategies to address resistance.

____ Is aware of change processes, process steps and strategies for supporting them.

Counseling Skills

____ Possesses all of the skills listed on Checklist 3.

Supervisory Skills

____ Articulates his or her approach and philosophy to clinical supervision as it relates to clinical supervision approaches described in the literature.

____ Identifies and responds to variations in learning styles among counselors.

____ Is comfortable with and able to resolve conflict among team members.

____ Models advanced counseling skills including development of therapeutic alliance, termination, and dealing with client resistance.

____ Uses direct observation or taping to conduct supervisory sessions.

____ Is able to teach and model skills in motivational interviewing, cognitive–behavioral, and supportive–expressive approaches for managing depressive symptoms.

____ Is able to determine when referral to a QMHP for a mental health assessment is required.

____ Facilitates referrals to QMHP both within and outside the treating agency.

____ Provides incentives through encouragement and support for counselors to enhance skills in treating clients with depressive symptoms.

____ Conducts competency assessment of counselors' skills in treating depressive symptoms.

Addressing Gaps in Staff Capacity To Deliver Services

Not all clinical staff are ready, willing, or able to address co-occurring symptoms. The clinical supervisor is charged with helping staff and administration differentiate the level of new knowledge, attitudes, and skills needed to help counselors and support staff address co-occurring substance use disorders and depressive symptoms. The characteristics and competencies checklists presented above outline the qualifications needed at various levels or in agencies wishing to provide services for managing depressive symptoms in clients with substance use disorders. However, gaps may exist; staff may be lacking in various areas and require additional training and support. In this instance, the implementation work group described in earlier sections may be commissioned to identify these gaps and to develop plans to provide specific training and support to individual staff members on an as-needed basis.

In addition to developing individualized plans to develop attitudes, skills, and knowledge, a number of organizational approaches can be used both to reinforce the change and to overcome resistance to change. *The Change Book* (ATTC, 2004) offers valuable suggestions on addressing resistance to change. These include such strategies as openly discussing staff feelings related to the change, celebrating victories, promoting feedback about the change as a vehicle to improve the process, being realistic about goals, identifying and using the change leaders in promoting the change, and providing training related to the change.

Approaches to Staff Training

It is recommended that training aimed at developing the basic attitudes, knowledge, and skills for managing depressive symptoms be provided to all agency staff as part of implementation. It is important for clinical staff to see the link between the change and organizational leadership. Thus, administrators need to attend these sessions to personally provide the vision of the organization. In addition to training current staff, it is important to consider the ways in which the organization can communicate the vision to new staff. This may be most efficiently accomplished by using existing vehicles, such as new staff orientation and training sessions and worksite orientation procedures.

Training of all clinical staff members on attitudes, knowledge, and skills specific to their positions can be conducted by administrative or clinical supervisors. Again, it is important to communicate the commitment of leadership to integrating services for depressive symptoms. In addition, it is recommended that training sessions provide practice in the skill areas outlined in Checklist 3. To reinforce the importance of the need to provide services to individuals with depressive symptoms, clinical and administrative supervisors are advised to incorporate didactic education, identification of incompatible attitudes, and coaching on the skills needed to implement the policies within existing supervision sessions and team meetings. In short, the agency's vision and commitment to addressing depressive symptoms must infiltrate all clinical interactions between supervisors and counselors.

Formal training of the clinical supervisors and counselors providing services for managing depressive symptoms is also required. It is recommended that the trainer (either internal or external to the organization, and, ideally, a combination of both) identified to conduct the training have advanced education in counseling, social work, or psychology; significant work experience in the substance abuse field; and an understanding of the importance of and commitment to the process of preparing substance abuse counselors to deliver services to clients with depressive symptoms. In addition, the individual must be versed in conducting and teaching others to conduct clinical sessions using motivational interviewing, cognitive–behavioral, and supportive-expressive approaches to symptom management and to meet all of the qualifications and competencies for clinical supervisors. See Figure 2.2 for a list of recommended credentials for trainers. See also How-To 2.7 for how to select a trainer and How-To 2.8 for how to continue the learning after the initial training is completed.

Figure 2.2
Recommended Credentials for Individuals Providing Training in
Management of Depressive Symptoms

- Advanced education in counseling, social work, or psychology
- Minimum of 5 years' experience delivering substance abuse treatment
- Understanding of commitment to preparing substance abuse counselors to manage depressive symptoms
- Being a skilled teacher and clinical supervisor
- Possessing skills and experience in using motivational interviewing, cognitive–behavioral, and supportive-expressive approaches to managing depressive symptoms
- Meeting all certification or licensure qualifications and competencies for clinical supervisors

How-To 2.7: How To Select a Trainer

Qualifications to look for in a trainer include:

1. Experience working with the clientele being served.

2. Ability to demonstrate the techniques as needed in role play with staff or in vivo (if possible).

3. Ability to address the types of challenging cases frontline staff encounter and how to work with challenging clients.

4. Understanding of the obstacles and challenges with which the frontline staff and the clinical supervisors are dealing.

5. Respectful attitude toward the clinical staff.

6. Models the principles and strategies of the intervention with the participants.

7. Ability to maintain and modify the technique for the treatment setting, willingness to review transcripts or tapes of actual sessions, and willingness to consult on the phone.

8. Willingness to accept specific training objectives to target specific staff skill sets in a case review format.

How-To 2.8: How To Continue the Learning After the Initial Training Is Completed

1. Assess the staff's knowledge, abilities, and skills with the core components of the techniques (see Fidelity Checklists 1–5 in Appendix C).

2. Emphasize mastery of the underlying principles of the interventions. Always give feedback on how well staff members are doing with interventions and provide advice on simple ways to improve practice.

3. Emphasize mastery of the common techniques across approaches (e.g., reflective listening, affirmations, increasing self-efficacy).

4. When staff members have the basics, let them choose the approach they want to focus on next (e.g., behavioral, cognitive, beliefs, affective).

Addressing Community Relationships

How Do You Develop Referral Relationships?

Access to a range of mental health and other health and social resources is essential to quality care, particularly for clients with depressive symptoms. Agencies to which staff might refer can be screened using the following variables:

- Sensitivity to substance abuse treatment issues.
- Ability and willingness to work with agencies such as ours.
- No or low funding impediments to working collaboratively.
- Good professional reputation in the community.
- Sufficient funding to address the needs of clients we are referring.
- Willing to cross-train with our staff.
- Willing to accept referral of clients at increased risk of suicide.

How Do You Develop Relationships With the 12-Step Community?

It is useful to have the program's policy and procedures manual reflect an understanding of the essential role that 12-Step programs play in the treatment of clients with substance abuse complicated by depressive symptoms. Mental health personnel need to be sensitive and competent in integrating the principles and practices of self-help programs into the clinical process. This requires knowledge of the underlying philosophy of the 12-Step model, and an understanding of how the programs function and are structured. In like manner, counselors practicing from a 12-Step facilitation model need to appreciate how principles and practices are linked to sound counseling. For example, the use of slogans as a form of cognitive restructuring and disputation is helpful to most clients. The use of structured practices like daily meetings, sponsor contact, and reading self-help group literature can help create alternate forms of reward, relief, and life-management. The policy should recognize barriers to individuals with depressive symptoms accessing and using 12-Step programs.

How Do You Find and Use Mental Health Resources in the Community?

Most substance abuse programs can benefit from positive ad hoc consulting relationships with physicians, psychologists, social workers, and other community medical, rehabilitation, social service, and mental health providers who have specialized knowledge and resources in addressing the needs of clients with depressive symptoms. These resources can provide an adjunct resource for such issues as difficult assessments and differential diagnosis, placement in appropriate treatment programs, medical management of co-occurring chronic medical conditions (such as HIV or tuberculosis), clients with special physical rehabilitation needs, specialized psychopharmacological services for clients with specific medication needs, discharge planning, and family services. Finding and using these resources may be different from finding and using referral resources. Understanding the services that can be provided, fees for service, whether the service can be provided in the treatment program or whether the client must travel to a remote site, and the processes for reporting results of evaluations are some of the issues that need to be considered in using community resources. Generally, unlike referral resources, community resources will not have a formalized contract or agreement with the treatment program. Therefore, issues of confidentiality and information reporting will need to be explored.

Addressing Financial Considerations

Billing

Integration of services for depressive symptoms is intended to enhance substance abuse treatment outcomes and because these services are delivered by substance abuse counselors, such services are likely to be reimbursable under the client's substance abuse diagnosis. In this case, individual sessions aimed at managing depressive symptoms may be billed as individual counseling or psychotherapy associated with the substance abuse or dependence diagnosis. Organizations are advised to clarify this with State and private funding agencies and to identify the specific procedures required to facilitate billing. Financial considerations also reinforce the need for support staff responsible for billing to understand how these services are delivered and their relationship to the primary diagnosis of substance abuse or dependence.

For organizations reimbursed based on case or capitated rates, reimbursement is not likely to change. Services for depressive symptoms are likely to be viewed by managed care organizations or funding agencies as value-added or optional services and thus included in established rates of reimbursement. Although incorporating services for depressive symptoms is not likely to increase reimbursement rates, it may improve performance on contractually mandated outcomes such as treatment engagement, retention, and effectiveness.

Sources of Funding

Most of the costs of implementing services for managing depressive symptoms occur early in the process of implementation, so local foundations are potential sources of funding. A one-time cost of training and knowledge dissemination to staff offers a discrete, relatively low-cost, and attractive opportunity for local foundations to contribute to improving substance abuse treatment outcomes. Other potential sources of funding include traditional State and Federal grants and contracts, direct charges for services from third-party payors, and client fees for service. Additionally, if the services provided are innovative, agencies should consider partnering with social and psychological researchers at a local university to obtain research funds to support clinical efforts. Such research efforts can have many beneficial secondary effects for agency status in the community, such as developing alternative sources of funding, partnering with new groups interested in substance abuse in the community, as well as providing funds for the identified project.

Addressing Continuity and Fidelity

For services for management of depressive symptoms to be fully adopted, the importance of these services will need to be consistently communicated. Policies, mission statements, program descriptions, clinical and administrative training, team meetings, and clinical supervision sessions are all useful avenues for communicating the organization's commitment to delivering service for depressive symptoms (see Figure 2.3).

Implementing the Intervention With Fidelity

When implementing any intervention, it is important to identify the active elements that distinguish the new intervention from other activities. Distinguishing the new intervention from standard practice allows administrators to more easily determine whether the new intervention can be attributed to the changes in expected outcomes. One strategy used by researchers and program implementers is the fidelity checklist. Fidelity checklists clearly describe the active elements of an intervention and define them in behavioral terms so that the degree of implementation can be assessed. Examples of fidelity checklists for measuring interventions for clients with depressive symptoms are presented in Appendix C.

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Figure 2.3
Avenues for Communicating Organizational Commitment to Delivering Services
To Manage Depressive Symptoms

- Mission and vision statements
- Strategic plans
- Annual goals
- Program descriptions
- Treatment philosophy statements
- Policies and procedures
- Training sessions
- Team meetings
- Clinical supervision
- Management meetings
- Quality assurance plans
- Employee newsletters
- Electronic communication vehicles including e-mail and Intranet

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Some of the dimensions of these fidelity checklists include:

- General behaviors that underlie all the interventions.
- Behavioral interventions.
- Cognitive interventions.
- Beliefs interventions.
- Affective interventions.

Some of the issues of implementing fidelity checklists that have to be addressed include:

- Who measures which parts of the checklist?
- How are the results conveyed to the staff?
- How does a program define an acceptable score?
- How does one reward positive results of the efforts measured by the checklist?
- What actions need to be taken if there is poor fidelity to program elements and goals?
- How do elements of the checklist get updated over time and with program changes?

Summary

This TIP is intended to provide guidance in implementing services for managing depressive symptoms in clients with substance use disorders and to identify issues that should be considered in implementing these services. Implementing any major change in organizational practices is a deliberate strategic process, requiring a committed leader and a talented and hardworking team. The outcome of this hard work and commitment has the potential to positively affect the lives of clients with substance use disorders, their families, agency staff, and other stakeholders.

Appendix — Center for Epidemiologic Studies Depression Scale (CES-D)

Instructions: Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the past week by checking the appropriate space.

During the past week	Rarely or none of the time (less than 1 day)	Some or a little of the time (1–2 days)	Occasionally or a moderate amount of the time (3–4 days)	Most or all of the time (5–7 days)
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating; my appetite was poor.				
3. I felt that I could not shake off the blues even with help from my family or friends.				
4. I felt that I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt depressed.				
7. I felt that everything I did was an effort.				
8. I felt hopeful about the future.				
9. I thought my life had been a failure.				
10. I felt fearful.				
11. My sleep was restless.				
12. I was happy.				
13. I talked less than usual.				
14. I felt lonely.				
15. People were unfriendly.				
16. I enjoyed life.				
17. I had crying spells.				
18. I felt sad.				
19. I felt that people disliked me.				
20. I could not get "going."				
Total Score:				

Center for Epidemiologic Studies Depression Scale (CES-D)

Scoresheet

During the past week	Rarely or none of the time (less than 1 day)	Some or a little of the time (1–2 days)	Occasionally or a moder-ate amount of the time (3–4 days)	Most or all of the time (5–7 days)
1. I was bothered by things that usually don't bother me.	0	1	2	3
2. I did not feel like eating; my appetite was poor.	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	3
4. I felt that I was just as good as other people.	3	2	1	0
5. I had trouble keeping my mind on what I was doing.	0	1	2	3
6. I felt depressed.	0	1	2	3
7. I felt that everything I did was an effort.	0	1	2	3
8. I felt hopeful about the future.	3	2	1	0
9. I thought my life had been a failure.	0	1	2	3
10. I felt fearful.	0	1	2	3
11. My sleep was restless.	0	1	2	3
12. I was happy.	3	2	1	0
13. I talked less than usual.	0	1	2	3
14. I felt lonely.	0	1	2	3
15. People were unfriendly.	0	1	2	3
16. I enjoyed life.	3	2	1	0
17. I had crying spells.	0	1	2	3
18. I felt sad.	0	1	2	3
19. I felt that people disliked me.	0	1	2	3
20. I could not get "going."	0	1	2	3
Total Score:				

Appendix — Fidelity Checklists

Fidelity Checklist 1: General Underlying Principles

Adherent Behaviors

____Respect is apparent when the counselor (1) shows respect for a variety of plans about how change can occur and (2) can accept differences between the ideal plan and the plan the client is willing to endorse. Counselors high in respect can negotiate with the client and avoid an authoritarian stance.

____Understanding is apparent when counselors have a stance that is curious and patient and emphasizes drawing out clients' ideas rather than educating clients or giving opinions without being asked.

____ Accepting counselors accept that a client may choose not to change. They are invested in specific behavior changes, but they convey an understanding that the critical variables for change are within the client and cannot be imposed by others.

____Strengths-based counselors focus on identifying, enhancing, and using the client's strengths as the foundation for the client's plan to create positive change. The counselor understands that the client must believe he or she is able to make a change to maintain motivation to make the change.

____Commitment to follow up on the planned activities between sessions is elicited by the counselor by summarizing the client's stance on the issue, framing the next steps, asking the client whether the plan is acceptable, and making any necessary changes to the plan.

Nonadherent Behaviors

____Low respect is evident when the counselor's stance is rigid and authoritarian and little effort is made to include the client's ideas about how change might be accomplished. It includes attempts to persuade clients about the need for change and occasions when clinicians confront clients with their point of view.

____Low understanding is evident when the counselor neglects the task of eliciting the client's verbalizations about need for change. The counselor might convey cynicism about the client's desire for change or focus on giving information or educating the client.

____Low accepting counselors convey a sense of urgency about the need for change. They have difficulty accepting that clients might choose to avoid or delay change or decide to proceed with change in an unconventional manner.

____Low strengths-based counselors neglect to elicit and incorporate client strengths in the plan for change. Counselors base the plan for change on client weaknesses instead of strengths.

____Low commitment to follow up on the planned activities is evident when the counselor assigns homework without eliciting and summarizing the client's stance on the issue and making any necessary changes to the plan.

Fidelity Checklist 2: Behavioral Techniques

Adherent Behaviors

____Identifies specific behaviors that the client identifies as wanting to change. Helps the client identify what to do instead of what not to do. Understands the value of collaborating with the client to find alternative behaviors that are reinforcing to the client.

____Helps the client set achievable goals for behavioral change. Helps the client to take big changes and break them down into smaller changes that can be more easily accomplished and maintained. Understands that the client will continue a behavior until there is good reason to believe that another behavior will be equally satisfying or reduce anxiety.

____Helps the client find the support needed to plan for, initiate, and maintain behavioral changes. Helps the client find internal and environmental resources that will help him or her develop and maintain the motivation necessary to sustain behavioral changes.

____Collaborates with the client on specific behavioral interventions (e.g., mild or moderate physical exercise, getting adequate rest, managing stress).

Nonadherent Behaviors

____Neglects to identify specific behaviors for change. Focuses on what the client is feeling or thinking instead of identifying specific behaviors. Or, chooses to focus on changing a behavior the client does not identify as important to change. Does not understand the role of reinforcement in the role of behavior change.

____Neglects to break big changes down into manageable goals. The counselor expects the client to take on more than the client feels able to take on. Or, the counselor expects the client to replace a reinforcing behavior with a behavior that is less reinforcing or is aversive.

____ Neglects to help the client find the support he or she needs to initiate and maintain behavioral changes. Does not understand the role of aversive experiences in causing clients to avoid making change.

____ Neglects to identify specific behavioral interventions. Instead offers other types of interventions (e.g., cognitive, affective).

Fidelity Checklist 3: Cognitive Interventions

Adherent Behaviors

____Identifies automatic thoughts that are evoked by unpleasant events. Specifically, negative thoughts about self (e.g., worthlessness), the world (e.g., negative interpretation of experiences), and the future (e.g., expectation of failure).

____ Collaborates with the client to determine whether the client's negative thinking is inaccurate.

____Elicits from the client the link between negative thoughts and increased feelings of depression and less functional behaviors. Increases client's objectivity about his or her thoughts and helps the client differentiate between unrealistic and realistic meanings of events.

____Uses cognitive techniques such as searching for alternative explanations or assessing for negative self-talk, and offers reasonable responses to decrease the client's distress.

____ Discusses homework, including understanding obstacles to completing homework.

Nonadherent Behaviors

____Focuses on feelings or behaviors instead of identifying automatic thoughts, or identifies automatic thoughts that are not connected to the unpleasant event or feeling.

____Tells the client that his or her negative thinking is inaccurate instead of collaborating with the client to come to this conclusion.

____Tells the client about the link between negative thoughts and increased feelings of depression/less functional behaviors, instead of eliciting an understanding of the link from the client. Does not increase the client's objectivity about his or her thoughts, and does not help the client differentiate between unrealistic and realistic meanings of events.

____ Uses techniques other than cognitive techniques (e.g., affective techniques).

____ Assigns homework but does not review it.

Fidelity Checklist 4: Beliefs Interventions

Adherent Behaviors

_____ Listens carefully to identify the underlying meaning of what the client is saying.

_____ Elicits the meaning the client attaches to negative events.

_____ Identifies core beliefs (e.g., extreme, negative, categorical, absolute, and judgmental meanings are attached to negative events) that lead to the conclusion that the client can't take care of the problem.

_____ Facilitates the client's objective assessment of his or her core beliefs.

_____ Elicits from the client alternative beliefs or solutions.

_____ Elicits from the client the link between the client's behavior and feelings and the client's underlying beliefs about self.

_____ Elicits from the client possible experiments with new solutions to the problem and ways to test out beliefs.

_____ Discusses homework, including understanding obstacles to completing homework.

Nonadherent Behaviors

_____ Does not identify the underlying meaning of what the client is saying.

_____ Tells the client how to interpret negative events.

_____ Does not identify the core beliefs leading to the client's conclusion that the client won't be able to take care of the problem.

_____ Tells the client that his or her core beliefs are irrational.

_____ Tells the client what the client should believe.

_____ Tells the client that the client's behavior and feelings are linked to underlying beliefs about self instead of eliciting this from the client.

_____ Tells the client what experiments or new solutions to the problem to test out.

_____ Assigns homework but does not review it.

Fidelity Checklist 5: Affective Interventions

Adherent Behaviors

____Identifies the feelings that the client finds too painful, overwhelming, or unmanageable to express.

____Conceptualizes the client's behaviors (e.g., avoidance, controlling, substance use, difficulty asking for help) as arising from the need to avoid these feelings.

____Assists the client in creating a safe enough environment in the counseling session to explore these feelings without having to resort to the use of defenses (e.g., isolating, projecting, drinking).

____Addresses defenses when the client feels comfortable enough to examine them without needing to become more defensive.

____Works at the client's pace toward the goal of helping the client become comfortable with expressing the feelings that are being avoided.

____Demonstrates the ability to help the client pull back from intense feelings and helps the client experience and resolve grief.

Nonadherent Behaviors

____Does not identify the feelings that the client finds too painful, overwhelming, or unmanageable to express.

____Conceptualizes the client's behaviors (e.g., avoidance, controlling, substance use, difficulty asking for help) as arising from reasons other than the need to avoid these feelings.

____Rather than facilitate the client's creation of a safe place to explore these feelings, takes responsibility for creating this environment without regard for the client's concerns.

____Addresses defenses at times when the client is not comfortable enough to examine them.

____Works toward a different goal than the goal of helping the client become comfortable with experiencing the feelings that are being avoided.

____Does not appear to know how to help the client pull back from intense feelings or experience and resolve grief.

Appendix   — DSM-IV-TR Mood Disorders

In substance abuse treatment settings, you are likely to encounter clients with a variety of diagnoses of depressive illnesses. Most of these diagnoses fall in the category of Mood Disorders, as specified in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR; APA, 2000). You can, however, also work with people who have a diagnosis of Adjustment Disorder with Depressed Mood. Additionally, people with a variety of other psychiatric illnesses are susceptible to depression, and some of those illnesses are described in this appendix.

The descriptions of depressive disorders and their primary symptoms are taken from DSM-IV-TR. Please refer to the source document for a more complete description of these disorders.

1. Major Depressive Episode and Major Depressive Disorder

Major Depressive Disorder requires two or more major depressive episodes.

Diagnostic criteria:

Depressed mood and/or loss of interest or pleasure in life activities for at least 2 weeks and at least five of the following symptoms that cause clinically significant impairment in social, work, or other important areas of functioning almost every day

1. Depressed mood most of the day.

2. Diminished interest or pleasure in all or most activities.

3. Significant unintentional weight loss or gain.

4. Insomnia or sleeping too much.

5. Agitation or psychomotor retardation noticed by others.

6. Fatigue or loss of energy.

7. Feelings of worthlessness or excessive guilt.

8. Diminished ability to think or concentrate, or indecisiveness.

9. Recurrent thoughts of death (APA, 2000, p. 356).

2. Dsythymic Disorder

Diagnostic criteria:

Depressed mood most of the day for more days than not, for at least 2 years, and the presence of two or more of the following symptoms that cause clinically significant impairment in social, work, or other important areas of functioning:

1. Poor appetite or overeating.

2. Insomnia or sleeping too much.

3. Low energy or fatigue.

4. Low self-esteem.

5. Poor concentration or difficulty making decisions.

6. Feelings of hopelessness (APA, 2000, p. 380).

3. Bipolar Episode and Bipolar Disorder

Bipolar disorder is characterized by more than one bipolar episode.

There are three types of bipolar disorder:

1. Bipolar 1 Disorder, in which the primary symptom presentation is manic, or rapid (daily) cycling episodes of mania and depression.

2. Bipolar 2 Disorder, in which the primary symptom presentation is recurrent depression accompanied by hypomanic episodes (a milder state of mania in which the symptoms are not severe enough to cause marked impairment in social or occupational functioning or need for hospitalization, but are sufficient to be observable by others).

3. Cyclothymic Disorder, a chronic state of cycling between hypomanic and depressive episodes that do not reach the diagnostic standard for bipolar disorder (APA, 2000, pp. 388–392).

Manic episodes are characterized by:

"A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary)

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (4 if the mood is only irritable) and have been present to a significant degree:

    (1) increased self-esteem or grandiosity

    (2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)

    (3) more talkative than usual or pressure to keep talking

    (4) flight of ideas or subjective experience that thoughts are racing

    (5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

    (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

    (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)" (APA, 2000, p. 362).

Depressive episodes are characterized by symptoms described above for Major Depressive Episode.

4. Substance-Induced Mood Disorder

Substance-Induced Mood Disorder is a common depressive illness of clients in substance abuse treatment. It is defined in DSM-IV-TR as "a prominent and persistent disturbance of mood . . . that is judged to be due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or somatic treatment for depression, or toxin exposure)" (APA, 2000, p. 405). The mood can manifest as manic (expansive, grandiose, irritable), depressed, or a mixture of mania and depression.

Generally, substance-induced mood disorders will only present either during intoxication from the substance or on withdrawal from the substance and therefore do not have as lengthy a course as other depressive illnesses.

5. Mood Disorder Due to a General Medical Condition

It is not as common to find depression due to a general medical condition in substance-abuse treatment settings, but it is important to note that depression can be a result of a medical condition, such as hypothyroidism or Parkinson's disease. The criteria for diagnosis are similar to Major Depressive Episode or a manic episode; however, the full criteria for these diagnoses need not be met. It is important in diagnosis to establish that the depressive symptoms are a direct physiological result of the medical condition, not just a psychological response to a medical problem.

6. Adjustment Disorder With Depressed Mood

Adjustment disorder is a psychological reaction to overwhelming emotional or psychological stress, resulting in depression or other symptoms. Some situations in which an adjustment disorder can occur include divorce, imprisonment of self or a significant other, business or employment failures, or a significant family disturbance. The stressor may be a one-time event or a recurring situation. Because of the turmoil that often occurs around a crisis in substance use patterns, clients in substance abuse treatment may be particularly susceptible to Adjustment Disorders. Some of the common depressive symptoms of an adjustment disorder include tearfulness, depressed mood, and feelings of hopelessness. The symptoms of an adjustment disorder normally do not reach the proportions of a Major Depressive Disorder, nor do they last as long as a Dysthymic Disorder. An acute adjustment disorder normally lasts only a few months, while a chronic adjustment disorder may be ongoing after the termination of the stressor.

7. Other Psychiatric Conditions in Which Depression Can Be a Primary Symptom

Sometimes depression is symptomatic of another mental disorder. This is particularly true when the nature of the mental disorder causes excessive distress to the individual. While, in this context, the depression is a symptom, it is still important to recognize its impact on the person and his or her ability to respond to substance abuse treatment.

Some of the psychiatric disorders in which depression can play a major role include:

A. Posttraumatic Stress Disorder (PTSD)

   Symptoms include episodes of reexperiencing the traumatic event or reexperiencing the emotions attached to the event; nightmares, exaggerated startle responses; and social, interpersonal, and psychological withdrawal. Chronic symptoms may include anxiety and depression. PTSD is categorized as an anxiety disorder.

B. Anxiety Disorders, including Panic Disorder, Agoraphobia (fear of public places), Social Phobias, and Generalized Anxiety Disorder

   Symptoms of anxiety disorders are most often on the anxiety spectrum, but the chronic stress faced by individuals with anxiety disorders can produce depressive symptoms including irritability, hopelessness, despair, emptiness, and chronic fatigue.

C. Schizoaffective Disorder and Schizophrenia

Individuals with schizoaffective disorder have, in addition to many of the symptoms of schizophrenia, a chronic depression with most of the features of Major Depressive Disorder. Because of the difficulty individuals with schizophrenia have in coping with the daily demands of living, depression is often a symptom. With both schizoaffective disorder and schizophrenia, the depression adds an additional dimension to treatment, specifically in helping the person mobilize in the face of their depression to cope with their illness.

D. Personality Disorders

People with personality disorders are particularly susceptible to depression. These individuals are at high risk for substance use disorders. As a result, it is not uncommon to find clients in substance abuse treatment with all three diagnoses. Because personality disorders are categorized in DSM-IV-TR as Axis 2 disorders (see DSM-IV-TR for a description of multiaxial assessment), it is common to find their depression diagnosed separately (from the personality disorder) as an adjustment disorder, dysthymia, or major depressive disorder.

SAMHSA TIPs and Publications Based on TIPs

What Is a TIP?

Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under the Substance Abuse and Mental Health Services Administration's (SAMHSA's) KnowledgeApplication Program (KAP) to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

What Is a Quick Guide?

A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

What Are KAP Keys?

Also based on TIPs, KAP Keys are handy, durable tools. Keys may include assessment or screening in-struments, checklists, and summaries of treatment phases. Printed on coated paper, each KAP Keys set is fastened together with a key ring and can be kept within a treatment provider's reach and consulted fre-quently. The Keys allow you, the busy clinician or program administrator, to locate information easily and to use this information to enhance treatment services.

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