2013 EPRESS

WEDNESDAY, October 16th 12ET/11CT

You must RSVP to the reminder email when it comes out if you plan to attend!

Dial the Number **888-670-3525** to participate.

Enter the conference code **2153983597#**

Plan ahead; everyone invited!

November Conference Call
Wednesday, November 20th
@ 12ET/11CT

December Conference Call
Wednesday, December 18th
@ 12ET/11CT

Questions from Directors

A disabled father asked us repeatedly to give his public assistance cards (small plastic cards that act like cash) to his ex-wife so that she could buy food for their young children. We have a rule against using visitation staff to exchange items between the parents in most cases, but here we made an exception because the parents were so concerned about their children. Our staff were trying to do the right thing. The week after our staff gave the card to the mother, she came back to the program and said that when she tried to use the card, there was no money on it. But the father insists that when he gave us the card, it still had money on it. Both parents are now upset with us.

These payments are tracked electronically, so it is unlikely that this issue won't be resolved soon. The recipient (father) of the benefits (card) should be receiving electronic or paper statement summaries monthly. These statements should detail all financial transactions. If the card holder has a question about his balance or a transaction, he should immediately call the Direct Express® card Customer Service Department at 1 (888) 741-1115 to find out how to dispute a transaction. More information can be found here: http://www.usdirectexpress.com/edcfdtclient/docs/faq.html#48

This means that the puzzle will be sorted out soon, and you will find out whether the card had no money on it and when/where that money was spent. The larger issue here is the instinct to help the parents with a transfer, which is a wonderful instinct that unfortunately can backfire. This kind of scenario has had different facts over the years: a parent asks the program to pass along a cashier's check, or cash, or keys, or paperwork, but the other parent tells the staff the transfer is deficient in some way. All programs make their own rules about how much transferring they will do. Your story is yet another warning that offers to transfer items back and forth between parents comes with risks.

I was very concerned on the Director's call last month, because it seems like supervised visitation can have a lot of safety issues. What can I do to make my program safer?

Several directors share your concerns, and I, too, have been alarmed at what seems to be a heightened amount of danger at SV. My first advice would be for you to read the Safety E Book – it presents very basic safety information that explains what some of the risks are at SV. It can be found here: http://familyvio.csw.fsu.edu/wp-content/uploads/2010/05/Safety_eBook.pdf. Then, read the Law Enforcement Guide to Supervised Visitation. It can be found here: http://familyvio.csw.fsu.edu/wp-content/uploads/2010/05/LawEnforcebook.pdf. The Report to the Florida Legislature, produced in 2008 contains best practices related to safety and much more. (The recommended Standards have not yet been authorized by Florida law, so those recommendations are used as Best Practices.) It can be found here: http://familyvio.csw.fsu.edu/clearinghouse/standards-best-practices/.

After you have done your reading, I suggest you think very critically about the kinds of cases that your program will accept. As the Report says, SV programs must be designed, developed, and administered with safety in mind, and programs must only accept cases in which they have considered and can reasonably address the safety needs of parents, children, and program staff. Programs can emphasize, but not guarantee, safety.

That said, I encourage you to consider your cases. If you were given a case that included a parent who had threatened the life of the other parent and child on multiple occasions, do you think your program could reasonably provide for a safe visit? As the Supervised Visitation Standards Committee heard from a judge at their last meeting, judges hear these kinds of allegations quite often. This means that the system does not always consider these threats valid. Still, in those tragedies we've studied, the parent did make threats before carrying out those threats. That's why the Clearinghouse is always waving the banner of safety, and we believe it's always best practice to have security personnel onsite whenever possible. The issue that always stymies us is funding: programs have shrinking dollars and heavy pressure to take cases. It's a treacherous balancing act, and we encourage every program to study each case carefully, getting as much information as you can before the first visit to determine the risks and how to manage them.

We have spent time learning about dual diagnosis. Now my staff and I realize that many of our clients have these problems. Do the CBCs train their workers on dual diagnosis?

I asked this directly of Arlene Carey (DCF), and she advised that training of Child Protective Investigators and Case Managers does address dual diagnosis and how to best work with families affected by substance abuse and mental health issues.

Training in the Protective Factors!

The Clearinghouse is creating training material on the six protective factors. The Introduction to this training is attached to the E-Press. The First E-Book will be delivered (and available online) in October.

Changes in Diagnoses with the new DSM-5

Abby Novak

In May of 2013, the American Psychiatric Association published the most recent Diagnostic and Statistical Manual of Mental Disorders, DSM 5.

Changes have been made to the DSM 5, including changes among the following:

- neurodevelopmental disorders (like autism and intellectual disabilities)
- depression
- anxiety
- trauma and stress related disorders
- substance use issues.

There is a high likelihood that as a supervised visitation staff member, you will encounter a client who has a mental illness. Though you won't be *diagnosing* clinical disorders, keeping up-to-date in your knowledge will help ensure the safety and well-being of children and families.

Neurodevelopmental Disorders

This section replaces a previous chapter- Disorders Typically Diagnosed in Early Childhood

Intellectual Disability (formerly mental retardation)

The name intellectual disability was chosen to replace mental retardation because of new language used in political and medical communities. In order to be diagnosed with an intellectual disability, intellectual abilities (IQ) and adaptive functioning (ability to function in a variety of settings) must be tested and any deficits found must be significant.

Autism Spectrum Disorder

Autism Spectrum Disorder (ASD) combines several separate disorders from the DSM-IV including Autism and Asperger's. In order to be diagnosed with ASD, an individual must show deficits in social communication/interaction (difficulty in social situations) and have restricted and repetitive behaviors, interests and activities (i.e. interest in tapping a pencil and only tapping a pencil, continuously for an long period of time).

Attention-Deficit/Hyperactivity Disorder

Because of ADHD's frequent diagnosis, examples were added to help providers understand ADHD at different ages. Individuals must show several symptoms from each test category before the age of 12 (previously any number of symptoms before the age of 7) to be diagnosed with ADHD. Additionally, DSM 5 allows a dual-diagnosis of ADHD and ASD and adult ADHD diagnoses.

Depressive Disorders

Bereavement Exclusion

In previous editions of the DSM, an individual grieving the loss of a loved one could not be diagnosed as having depressive disorder within 2 months of their loss. This exclusion has been removed, as researchers feel grief presents similarly to major depressive disorder and has real, physical symptoms such as suicidal thoughts, poor health, etc.

Anxiety Disorders

Separation Anxiety Disorder

Because the DSM 5 does not include a chapter on diagnoses typically made during early childhood, separation anxiety disorder is now listed as an anxiety disorder. Additionally, the definition of separation anxiety disorder now extends to adults, as research shows adults experience this disorder as well as children.

Trauma and Stress Related Disorders

This chapter was added to differentiate the characteristics of disorders initiated by/related to trauma and stress from anxiety-based disorders.

Reactive Attachment Disorder

Reactive Attachment Disorder was re-classified with the creation of this chapter. DSM-5 characterizes the two subtypes of this disorder- reactive attachment disorder and disinhibited social engagement disorder- as two separate disorders, both resulting from neglect and insecure attachments. Though similar, the two differ in fundamental ways; reactive attachment disorder is an incomplete attachment to desired adults while disinhibited social engagement disorder is behavioral and can resemble ADHD.

Posttraumatic Stress Disorder

Posttraumatic stress disorder's definition has been changed to reflect differences in development (diagnosis differs for young children, young adults, etc.). Additionally, specific criteria were added for children under six years old.

Substance-Related and Addictive Disorders

Substance Use Disorder

Unlike DSM-IV, DSM 5 does not distinguish between different types of substance use (alcohol, cocaine, inhalant, etc.) but rather places all forms of substance abuse under the "Substance Use Disorder" category. Early sobriety is now defined as 3-12 months without use and sustained sobriety as over 12 months without use.

Focused Training: Autism Diagnosis Changes in the DSM

By Kayla Kirk

Introduction

Autism has been included in the Diagnostic Statistical Manual (DSM) under Pervasive Development Disorders. Autism was previously broken down into several different sub-types in the DSM-IV. They were Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Development Disorder Not Otherwise Specified (PDD-NOS). Recently, the updated DSM-V has changed the criteria to be diagnosed and using one term: **Autism Spectrum Disorder. Many children with a diagnosis are seen at visitation programs. Staff should be aware of the key terms and what they mean.**

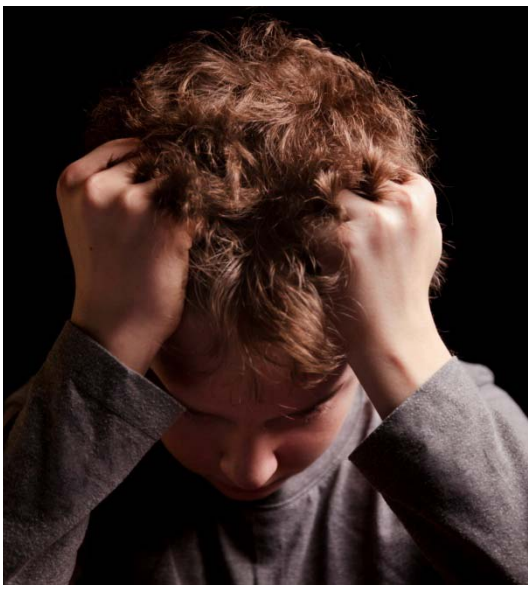
This training will cover:

- What Autism is
- The old diagnostic criteria in the DSM-IV
- The new diagnostic criteria in the DSM-V
- What these changes are in simpler terms
- The rights and benefits of a diagnosed Autistic child
- How Autism may affect children and families

What is Autism?

Autism is a complex disorder of brain development. It is the fastest growing serious developmental disability in the United States. It can be noticed through

delayed development or a regression in development. Children are diagnosed through specially trained physicians and psychologists who administer autism specific behavioral evaluations. There are several key factors that differentiate Autism to other disorders and intellectual disability:



- Difficulties in social interaction
- Verbal and nonverbal communication impairment
- Repetitive behaviors
- Heightened or dulled sensitivity to sensory experiences

Quick Facts about Autism:

- One in 88 children are diagnosed with Autism
- Autism is five times more common in boys than girls
- Normally found in children two to three years old
- Each individual with Autism is unique
- The Autism spectrum has different levels of severity
- Autistic children may have exceptional skills in music, art, and academics.
- Forty percent of autistic children have average or above-average intelligence
- Twenty-five percent of autistic children are nonverbal
- The cause of Autism has not been determined
    - Appears to be caused by a combination of risk genes and environmental factors that influences early brain development
    - *The theory that medical immunizations were the cause of Autism has been discredited*

Old Diagnosis Criteria in DSM-IV

In the DSM-IV, Autism is found in **Chapter One: Disorders Usually First Diagnosed in Infancy, Childhood, and Adolescence**. It is under the Pervasive Development Disorders category. Autism is broken down into Autistic Disorder, Asperger's

Disorder, and Pervasive Development Disorder Not Otherwise Specified. The latter two are given a diagnostic code of 299.80. For diagnosis, a total of six out of twelve symptoms must be recorded from sections one, two, and three. At least two symptoms must come from section one, and one symptom from section two and three.

Section one is associated with impairment in social interaction. This includes:

- Impairment in nonverbal behaviors: Eye contact, facial expressions, body postures
- Failure to develop relationships
- Lack of seeking to share interests or achievements with others
- Lack of social or emotional response

Section two is associated with impairments in communication:

- Delay in or total lack of development of spoken language
- Unable to initiate or sustain a conversation with others
- Repetitive use of language
- Lack of play appropriate to developmental level

Section three is associated with repetitive patterns of behavior, interests, and activities:

- Preoccupation with interest that is abnormal
- Has routines or rituals that must be followed
- Repetitive motor movements
- Preoccupation with specific parts of objects

A delay or abnormal functioning in at least one of the following areas prior to age three is also needed for diagnosis:

- Social interaction
- Language
- Imaginative play

And finally, it cannot be better diagnosed by Rett's or Childhood Disintegrative Disorder.

Current Diagnosis Criteria in DSM-V

In the DSM-V, Autism is now referred to as Autism Spectrum Disorder. Many changes occurred from the old version to the newest one. Autism Spectrum Disorder is the umbrella term for Autistic Disorder, Asperger's Disorder, and PDD-NOS. They are no longer three different diagnoses. ASD can be found under the chapter named Neurodevelopmental Disorders. The diagnostic criteria are broken down into two sections.

Section one is associated with deficits in social communication and social interaction. This includes:

- Abnormal social and emotional responses
- No nonverbal communication
- Problems developing, maintaining, and understanding relationships

Section two is associated with repetitive patterns of behavior, interests, or activities

- Repetitive motor movements, use of objects, or repetitive speech
- Inflexible adherence to routines or patterns
- Fixated interests that are abnormal in intensity
- Hyper or hypo-reactivity to sensory input

Also, symptoms must be present in early development, need to have clinically significant impairment in social, occupational, or other areas of current functioning, and not be better explained by intellectual disability or global developmental delay.

There is now a severity table that is broken down into three levels:

- Level one: requires support.
- Level two: requires substantial support.
- Level three: requires very substantial support.

It is also noted that if a person with a well-established DSM-IV diagnosis of Autism Disorder, Asperger's Disorder, or PDD-NOS should be given the diagnosis of Autism Spectrum Disorder.

What does this mean?

These changes between the DSM-IV and DSM-V can be broken down into simpler terms:

- Autism Disorder, Asperger's Disorder, and PDD-NOS have been put into one diagnosis of Autism Spectrum Disorder
    - All have such similar symptoms that they do not belong in separate categories.
    - Grounded in research and is a more accurate tool for consistent diagnosis
- More specific so that diagnoses from different physicians and psychologists are reliable and valid
- Now characterized by severity rather than different types.
- DSM-IV sections of social interaction and communication have been collapsed into one section referred as Social/Communication Deficits
    - Due to these symptoms almost always appearing together
- Heightened or dulled sensitivity to sensory experiences has been added to the DSM-V
- The requirement of a delay in language development no longer necessary

Rights and Benefits

Children and families who are affected with Autism have many rights and receive many helpful benefits. A child must be diagnosed with Autism first, and then apply for these benefits through the government or school. Below is a list of the services a person who is diagnosed with Autism can receive:

- Early Intervention programs
- Special Education
- Free and appropriate public education that meets the needs of a child (covered under the Individuals with Disabilities and Education Act)
    - Parent is equal partner with school in deciding education plan

    - Placed in least restrictive environment (greatest possible opportunity to interact with children who don't have a disability)
    - One-on-one aid
- Extended School Year Services (may continue school in the summer and can stay in school until the age of twenty-one)
- Social Security Disability Income
- Supplemental Security Income
- Medicaid Home and Community Based Benefits
- Special living arrangements (transitional housing, supported living, supervised living, group home)
- Employment resources and assistance covered by the Department of Vocational Rehabilitation (find a job, provide training, protections against discrimination)

Effects of the new Diagnostic Criteria

The new diagnosis of Autism may affect several programs and funding for those diagnosed with the disorder. First and foremost, it may become more difficult for children and families to be diagnosed. There are stricter guidelines physicians and psychologists must follow to come to a diagnosis. This could mean that higher functioning people will not meet the criteria and have difficulty accessing relevant services. Some services that could be impacted by the changes are below:

- Government services and assistance
- Medicaid
- Supplemental Security Income (SSI)
- Education services
- Early intervention programs
- Insurance coverage

A preliminary study conducted by the National Institute of Health and Autism Speaks researched if an old diagnosis of autism would be renewed based on the new criteria in the DSM-V. They looked at over five thousand case files of children and found that the majority of them would keep their diagnosis. This is a positive sign, but continued research must be conducted to see what these changes are affecting for those with Autism.

Conclusion

In this training we covered Autism Spectrum Disorder. We defined what autism is, the old diagnostic criteria in DSM-IV, the new diagnostic criteria in DSM-V, what changes have been made in simpler terms, the rights of autistic children and families, and what these changes may affect for your family. You should now have a better understanding of how Autism is diagnosed and what services and benefits are available.

Glossary

Autism Disorder: disorder of neural development characterized by impaired social interaction, verbal and non-verbal communication, and by restricted and repetitive behaviors

Autism Spectrum Disorder: typically characterized by social deficits, communication difficulties, and stereotyped or repetitive behaviors and interests

Asperger's Disorder: characterized by significant difficulties in social interaction and nonverbal communication

Childhood Disintegrative Disorder: has normal development, but suddenly regresses to an earlier development period

Department of Vocational Rehabilitation: assists people with disabilities to gain, maintain, and advance in employment

Diagnostic Code: used as a tool to group and identify diseases, disorders, and symptoms

Diagnostic Statistical Manual: published by the American Psychiatric Association and provides

standard criteria for the classification of mental disorders

Individuals with Disabilities and Education Act (IDEA): United States federal law that governs how states and public agencies provide early intervention, special education, and related services to children with disabilities

Medicaid: A program, funded by the federal and state governments, which pays for medical care for those who can't afford it

Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS): severe impairment in the development of reciprocal social interaction or verbal and nonverbal communication skills, or when stereotyped behavior, interests, and activities are present, but the criteria are not met for a specific diagnosis

Rett's Disorder: neurodevelopmental disorder that almost exclusively affects females; features include small hands and feet, a deceleration of the rate of head growth, and repetitive hand movements

Social Security Disability Income: income given when you have been diagnosed with a disability

Supplemental Security Income: Federal income supplement program funded by general tax revenues to help people with disabilities and the elderly

References

http://www.autismspeaks.org/science/science-news/top-ten-lists/2012/field-trials-suggest-new-criteria-diagnosing-autism-reliable

http://www.autismspeaks.org/

http://www.autism.com/index.php/news_dsmV

http://link.springer.com/article/10.1007%2Fs10803-012-1642-5/fulltext.html

http://shine.yahoo.com/team-mom/how-will-the-new-definition-of-autism-in-dsm-5-affect-children--parents--advocates-anxious-over-changes--152353760.html#!iNIUL

http://www.scientificamerican.com/article.cfm?id=autism-new-criteria

http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=06fc9395-e47e-41c1-bf25-f7607a2d4c86%40sessionmgr14&vid=2&hid=1

http://www.mdconsult.com/das/article/body/423824318-2/jorg=journal&source=&sp=26792725&sid=0/N/1176506/s0890856713003067.pdf?issn=0890-8567

http://www.autismspeaks.org/docs/family_services_docs/GP_Legal_Guidelines.pdf

Advanced Training:
Recent Research in the Area of Dual Diagnosis

Introduction

As discussed in last month's e-press, dual diagnosis is when a person suffers from both mental illness and substance abuse. This article is advanced training, covering recent research in the area of dual diagnosis. We reviewed some of this recent research at the last phone conference, and Karen promised to send it all to you.

History of Abuse

Trauma and abuse are strongly associated with dual diagnosis. Child maltreatment is a particularly strong predictor of dual diagnosis in women. Identifying prior abuse and providing social support are common recommendations. The following articles highlight some recent research in the area of history of abuse and family history of abuse in relation to dual diagnosis.

Jan Breckenridge et al., *Use and abuse: understanding the intersections of childhood abuse, alcohol and drug use and mental health*, 5(4) Mental Health and Substance Use 314 (2012).

> This study, like many others, confirmed that childhood abuse is related to dual diagnosis. This article studied client and mental health worker perceptions. One service worker stated that of those asked at her agency,

as many as 70-80% of women with dual diagnosis report having experienced childhood abuse. One interviewed client referred to feeling like luck was involved in getting help, **such as by finding the right worker, at the right time, often in an unlikely place.** It only takes one person, which is why it is important for supervised visitation personnel to know about dual diagnosis.

Suzanne Brown et al., *Impact of dual disorders, trauma, and social support on quality of life among women in treatment for substance dependence*, 9(1) J. Dual Diagnosis 61 (2013).

This study found that women with dual diagnosis were likely to have a lower quality of life. The study also revealed that trauma history was a significant predictor of quality of life. The authors concluded that women with dual diagnosis are likely to have a history of trauma, including childhood trauma. The authors recommend assessing client history and providing strong social support.

Camille S. Wilson et al., *Impact of family history in persons with dual diagnosis*, 9(1) J. Dual Diagnosis 30 (2013).

Survey of 413 people found that having a family history (parents and siblings) of substance abuse and psychiatric problems was a strong predictor of poor family relationships and abuse. The study concludes that **identifying substance abuse and mental illness in a person's family history can help identify someone at risk for dual diagnosis.**

Lena M. Lundgren et al., *Mental health, substance use, and criminal justice characteristics of males with a history of abuse in a Swedish national sample*, 9(1) J. Dual Diagnosis 47 (2013).

Study found that men who reported history of physical, emotional, or sexual abuse in their lifetime were significantly more at risk of developing either substance abuse or mental health issues.

Domestic Violence

Domestic violence is often intertwined with dual diagnosis. The combination of substance abuse, aggressive behavior, and mental illness creates an environment that fosters intimate partner violence. The following articles provide insight into the relationship between dual diagnosis and domestic violence.

Cory A Crane et al., *Sub-clinical trauma in the treatment of partner violent offenders with substance dependence*, 6(1) Advances in Dual Diagnosis 5 (2013).

> Fifty-six people with PTSD and substance abuse that were identified as perpetrators of domestic violence were studied throughout their treatment in one of the following treatment programs: substance abuse, violence, or trauma. The results of the study revealed that **participants with a significant history of trauma were more likely to become repeat domestic violence offenders.** The study built upon the evidence that domestic violence perpetrators often have a history of trauma.

Jennifer Holly & Miranda A.H. Horvath, *A question of commitment – improving practitioner responses to domestic and sexual violence, problematic substance use and mental ill-health*, 5(2) Advances in Dual Diagnosis 59 (2012).

> As studies in a variety of fields have shown, training improves sensitivity and likelihood of assessing tough issues. This study revealed that practitioners were likely to ask about substance abuse or mental illness but were unlikely to inquire about the possibility of domestic violence. **Because domestic violence and dual diagnosis co-occur, the article calls for training of professionals that may come into contact with domestic violence victims.**

Caroline J. Easton, *Co-occurring mental health problems among substance dependent offenders of intimate partner violence*, 5(2) Advances in Dual Diagnosis 86 (2012).

> This study followed 63 people who had been arrested for domestic violence and also had substance abuse issues. About one quarter of the identified participants reported also having prior mental health treatment. The study found that domestic violence perpetrators with both substance abuse problems and mental health issues were more likely to use substances

during treatment and were more prone to aggressive behaviors and anger control problems, than perpetrators with only substance abuse problems. The study concluded that it is important to assess and target any mental health issues for perpetrators with substance abuse problems.

Gail Gilchrist et al., *Exploring the relationship between intimate partner violence, childhood abuse and psychiatric disorders among female drug users in Barcelona*, 5(2) Advances in Dual Diagnosis 46 (2012).

A study of 118 female drug users added to the evidence that experiencing child abuse, having a mental illness, or having a substance abuse problem is associated with domestic violence victimization. These afflictions frequently co-occur in a complex relationship. This study found that the likelihood of **experiencing domestic violence was three times greater for participants who reported any of the following: had attempted suicide, had been abused as a child, had borderline personality disorder, or lived with a substance user.** Because of this increased likelihood, the study called for assessment of these conditions for women in substance abuse treatment programs.

Veterans and Homeless Populations

Certain populations are at risk for dual diagnosis. Veterans and homeless persons are subject to a number of risk factors that can lead to dual diagnosis. The following articles discuss some recent findings affecting these specific populations.

Jessica C. Tripp et al., *Impact of physical health on treatment for co-occurring depression and substance dependence*, 9(3) J. Dual Diagnosis 239 (2013).

Survey of 205 veterans in clinical treatment found that chronic health problems were related to co-occurring depression and substance dependence. However, short term medical problems were related to lower substance abuse. The study concluded that persons with chronic health

problems could benefit from treatment addressing their health concerns as well as substance and depression issues.

Barbara E. Havassy & Amy A. Mericle, *Recent violence among persons entering short-term residential mental health and substance abuse treatment*, 9(3) J. Dual Diagnosis 222 (2013).

Homelessness is a risk factor for becoming a victim of violence. Dual diagnosis is a risk factor for being involved in violence as either a victim or perpetrator. This study examined 419 homeless persons in either mental health or substance abuse treatment. 34% of the participants had been victims of violence, while only 6% had been perpetrators. Dual diagnosis is often associated with aggressive or violent behavior, but this study concluded that **homeless persons with dual diagnosis are more likely to be victims of violence than perpetrators**. The study did note that alcohol use disorder was associated with the increased likelihood of perpetration.

Kathryn O'Connor et al., *Unemployment and co-occurring disorders among homeless veterans*, 9(2) J. Dual Diagnosis 134 (2013).

Homelessness is a barrier to overcoming dual diagnosis. This study found that the economic recession impacted homeless veterans with dual diagnosis at a far rate greater than the general population. Unemployment for homeless veterans reached as high as 66%. The sampled veterans reported unemployment as the top reason for unstable housing, followed by their dual diagnosis issues. The study called for increased support for employment programs for veterans.

Stigma

Stigma is a recurring issue with dual diagnosis. Stigma can cause clients to not seek treatment or not respond well to treatment in the case of self-stigma. Researchers overwhelmingly recommend training to help with fear and stigmatizing attitudes. Below are some recent articles that discuss stigma, self-stigma, and training.

Gail Gilchrist et al., *Reducing depression among perinatal drug users – what is needed? A triangulated study*, 5(4) Advances in Dual Diagnosis 164 (2012).

A study that interviewed twenty-eight perinatal drug users and ten experts found that both the women and the experts agreed on the tools for successful treatment in a number of areas. Both groups agreed that access to resources such as mental health and drug prevention programs was vital to treatment success. Additionally, parenting and housing support were important. As with other afflictions, **helping the afflicted mother secure shelter and her child is a path to a better family. The views of the women interviewed revealed that being judged or stigmatized by staff was a barrier to their recovery.** The women also feared child protective services.

Stephanie Rodrigues et al., *Self-Stigma, self-esteem, and co-occurring disorders*, 9(2) J. Dual Diagnosis 129 (2013).

Self-stigma is when a person agrees with a social stereotype and internalizes the stereotype, which leads to lower self-esteem and difficulty overcoming his or her condition. This study's participants with dual diagnosis experienced self-stigma. The self-stigma was related to a number of bad outcomes, including treatment noncompliance, relapses, and hindered recovery. The study concludes that building self-esteem is important for recovery.

Grenville Rose et al., *Problematic substance use in two mental health NGOs, and staff, client and general public attitudes towards problematic substance use amongst people with mental illness*, 5(4) Mental Health and Substance Use 275 (2012).

This study surveyed multiple perspectives of dual diagnosis persons, including health staff, the general public, and dual diagnosis clients. The study found that staff were most comfortable with contact and held less stigmatizing attitudes. However, the public and the clients held similar stigmatizing attitudes. The public felt less comfortable around dual diagnosed persons and wanted less contact. The dual diagnosis clients reported self-stigma and held more stigmatizing attitudes than health staff.

The study posits that training on the risks associated with dual diagnosis persons may reduce fears and stigmatized attitudes.

Order of Onset

With dual diagnosis, practitioners are often unable to tell which issue appeared first, as mental illness and substance abuse have overlapping characteristics and either condition can lead to the development of the other. However, the following articles provide some insight into order of onset in particular circumstances.

Amy K. Bacon & Suzanne E. Thomas, *Stress reactivity, social anxiety, and alcohol consumption in people with alcoholism: a laboratory study*, 9(2) J. Dual Diagnosis 107 (2013).

This study tested the hypothesis that social anxiety influences drinking for persons with alcohol dependence. The study sought to discover if social anxiety creates a feedback loop for persons with alcohol dependence. The study of forty participants found that once alcohol dependence is reached, social anxiety does not have an effect. However, this study does conform to other research that shows using alcohol to cope with anxiety is a significant risk of developing dependence.

Nicole K. Lee et al., *Examining the temporal relationship between methamphetamine use and mental health comorbidity*, 5(1) Advances in Dual Diagnosis 23 (2012).

This study tracked 126 methamphetamine users. Of the sample that reported having mental health issues (69%), about one quarter indicated having mental health problems before using methamphetamine, while almost three quarters reported that mental health problems developed after using. The study found that mental health problems begin to occur after about a year of use.

Conclusion

As shown through recent research, history of abuse is a warning sign that a person may develop dual diagnosis or experience domestic violence. Most of the studies recommend training on dual diagnosis to alleviate problems with stigma and to help identify dual diagnosis.

Resources for keeping up with dual diagnosis research.

Advances in Dual Diagnosis – http://www.emeraldinsight.com/journals.htm?issn=1757-0972

Journal of Dual Diagnosis – http://www.tandfonline.com/loi/wjdd20

Mental Health and Substance Use – http://www.tandfonline.com/loi/rmhs20