Co-Occurring State Incentive Grant (COSIG):

LESSONS LEARNED AT THE CONNECTICUT MENTAL HEALTH CENTER / HISPANIC CLINIC

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Introduction

The Hispanic Clinic (La Clínica Hispana), since its inception in 1972, provides culturally appropriate and recovery-oriented mental health and addiction services to the Latina/o communities of New Haven and surrounding towns. The Hispanic Clinic is part of the Department of Mental Health and Addiction Services' (DMHAS) Connecticut Mental Health Center (CMHC) and a collaborative endeavor with the Department of Psychiatry of the Yale University School of Medicine.

The Hispanic Clinic accomplishes its goal by offering mental health, substance use, co-occurring disorders, and peer/consumer services in an outpatient and community-based setting. The clinic also serves as a training and research site for the Yale University School of Medicine. The training programs encompass the fields of psychiatry, psychology, social work, and nursing. The Clinic is committed to fostering an environment of wellness, empowerment, professionalism, and collaboration.

The target population served by the Clinic is composed of uninsured (except for Medicare, Medicaid and State Administered General Assistance) or low income, Latina/o men and women, 18 years of age and older, monolingual Spanish speaking who are experiencing a variety of behavioral health issues.

The Clinic provides a wide range of outpatient clinical services, including individual and group psychotherapy, psychiatric and psychological evaluations, medication management, vocational rehabilitation and case management. These services are funded by DMHAS and are provided by a multidisciplinary team of DMHAS and Yale employees.

COSIG at the Hispanic Clinic

The Co-Occurring State Incentive Grant (COSIG) was awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to the State of Connecticut with the Hispanic Clinic as one of two treatment pilot sites. The COSIG program at the Hispanic Clinic offers services that include individual and group therapy, intensive case management and vocational rehabilitation, and is the venue by which we are studying the impact of Integrated Dual Disorders Treatment (IDDT) in the context of monolingual Latino clients in a community mental health setting. As treatment for this population can be complex, attention is given to simultaneously addressing mental health and substance use issues in a biopsychosocial model, while also addressing cultural issues, including migration, adherence to cultural values, language, and level of acculturation. Clients also receive medication, psycho-education, relapse prevention, and symptom management treatment. One of the hallmarks of the implementation of IDDT within the Clinic has been the work of the staff as a multidisciplinary team. Additionally, clinicians receive ongoing training and clinical supervision addressing the complexities of helping individuals with co-occurring disorders.

Integration of Latino Cultural Constructs within IDDT

Secondary to the shared language, but no less important, are cultural elements that bind some Hispanic groups together. Though not necessarily unique to Hispanics, these cultural elements or constructs are believed to play a critical role in the life of people of Hispanic origin. The literature cites several such constructs, including *confianza* (trust and intimacy in a relationship), *respeto* (respect; mutual and reciprocal deference), *personalismo* (personal rather than institutional relationship), and *familismo* (familial orientation), to name a few. Given their significance in Hispanic culture, researchers have strongly emphasized the importance of understanding and using these constructs in the treatment of Latina/o clients.

The development of culturally sensitive behavioral health interventions has the potential to reduce bias in diagnosis and treatment and increase treatment efficacy. These interventions have the potential to not only increase the effectiveness of treatment, but also greatly reduce the distress that some Hispanic clients may experience when they first seek services. Since acculturation is a complex, dynamic, and evolving process, the utilization and/or applicability of these constructs may vary from individual to individual and/or within an individual over time. It appears that the cultural constructs discussed above are more salient for individuals who are first-generation Hispanic-American, since they may rely heavily on these constructs to help them develop meaningful friendships and negotiate the many challenges involved in establishing roots in a new and often unfamiliar environment.

The clinical aspect of the implementation of COSIG at the Hispanic Clinic is a replication of the *Dame la Mano Project* which was based on the inclusion, whenever clinically appropriate, of Latino cultural constructs. Within this context, the COSIG pilot at the Clinic is exploring the impact of these constructs as it relates to clients experiencing co-occurring disorders. To this effect, clinicians first evaluate clients for adherence to each construct. If adherence is determined to be present, then the clinician and client will collaboratively integrate the construct(s) into the treatment plan and subsequent therapeutic process. Assessment for their presence is based upon motivational interviewing principles that include the use of open-ended questions, affirmations, reflections (content and affect), and summary statements. The following paragraphs describe this process in more detail:

Confianza (trust): Refers to the element of trust and intimacy in a relationship. When present, it plays a critical role in the development of interpersonal relationships and is an essential component to psychotherapeutic success. If an individual adheres to *confianza*, and it is not established in treatment, the client is not likely to engage in more than superficial work, and is at risk of dropping out of treatment. On the other hand, when *confianza* is adhered to and properly developed, the client and clinician can work well together, even under the most challenging situations. To determine adherence to *confianza,* the clinician is encouraged to ask questions that tap into this construct, such as:

- How important is ***confianza*** to you when you are first getting to know someone?
- Please describe "***una persona de confianza"*** (a person of *confianza*) in your life.

- What does it take for you to develop ***confianza*** with someone?
- What would have to happen for ***confianza*** to be broken?

A positive response to the first question may be indicative of adherence and should be followed by further questions. If adherence to *confianza* is determined to exist, the clinician is encouraged to utilize the ruler technique which is commonly used in motivational interviewing to further assess how much *confianza* exists in the relationship and/or how ready the client may be to develop *confianza* with his/her clinician. For example, if a client demonstrates adherence to *confianza*, the clinician is encouraged to ask him/her "On a scale from 0 to 10, with 0 being none to 10 being a lot, how much *confianza* do we currently have?" or "How ready are you to develop *confianza* with me in this treatment?" Once the client responds, the clinician further explores and evokes a conversation through the use of open ended questions and reflections to elicit elaboration. As with the ruler technique in motivational interviewing, the client would be asked: "Why not a lower number?" to elicit a conversation about the elements that are contributing to the existing level of *confianza*. Once this is determined and there is an agreement that a certain level of *confianza* exists in the relationship, the clinician can ask the client "What would it take to go from the existing number to a higher number?" The steps identified to increase *confianza* in the therapeutic relationship are then made concrete and turned into treatment objectives that can be incorporated into the treatment plan and reviewed periodically.

Respeto (respect): Refers to an adherence to a strict hierarchical structure where individuals within the family or community defer to authority, and openly recognize those individuals with more seniority or status. It is often manifested through the use of titles (e.g., Señor, Señora, Don, Doña) and mediated by age and gender. *Respeto* is an intricate aspect of interpersonal relationships within the Hispanic culture and its recognition can aide in the establishment of a productive therapeutic alliance. If the clinician does not consider this construct and there is adherence to it, there is a risk that the client and/or family may feel offended, which may negatively impact the therapeutic relationship. A *falta de respeto* (act of disrespect) is considered offensive and can lead to a negative outcome. We encourage the use of *formalismo* (e.g., the use of titles, such as Señora/Señor) early in the treatment process, as a demonstration of *respeto* for the client and when applicable, their family members. In order to assess for *respeto*, we suggest that the clinician ask questions such as:

- How important is ***respeto*** to you?
- How would you like me to address you? Señor? Señora? How do others address you?
- In what ways can a person demonstrate ***respeto*** for another person?
- Thinking back, how often do you think, ***por respeto*** (out of respect), did you allow your doctor to make treatment decisions for you without your opinion or input?
- Tell me about a time when you felt ***que te faltaron el respeto*** (that you were disrespected/experienced an act of disrespect).

A positive response to the first question provides an indication of possible adherence and it should be explored with further questions. If adherence to *respeto* is determined, the clinician is encouraged to utilize the ruler technique to determine how much *respeto* is present in the current therapeutic relationship. Furthermore, if the client's response indicates a sense of *respeto* that is either too low, or not present, it provides an opportunity for the clinician to inquire what needs to happen for *respeto* to increase.

Personalismo (interpersonal friendliness): Refers to placing a value on interpersonal harmony and relating to others on a personal level. As it applies to clinical settings, *personalismo* suggests that those who adhere to it prefer interpersonal contact that promotes getting to know the provider as a person, and are more likely to avoid expressing disagreement with a provider's suggestions. Clients who adhere are thus likely to view organizational channels with mistrust and dislike if not given the opportunity to establish personal connections with their providers. Examples of *personalismo* in a community mental health setting include small talk, appropriate self-disclosure related to hobbies, country of origin, and favorite foods, as well as face-to-face interaction and active involvement in case management tasks. In clinical practice, the use of *personalismo* should begin from the moment the clinician initiates his/her interaction with the client. Though this type of interaction has not been traditionally viewed as standard practice, we believe that it is conducive to a good therapeutic alliance when properly implemented. Otherwise, the clinician runs the risk of being perceived as *frio* (cold) and/or *antipatico* (unpleasant), which in turn may result in the client prematurely dropping out of treatment. The use of *dichos* or *refranes* (sayings or proverbs) is another excellent way of applying *personalismo*. For example, a client may use it to express possible discomfort, perceptions, and/or world view (e.g., *Esta enfermedad es una prueba de Dios* [this problem is a test from God]). The clinician may use it to highlight potential discrepancies, to give feedback, engage, and to empower (*Ayudate que Dios te ayudara* [Help yourself and God will help you]). We encourage the utilization of questions such as:

- Many people often use the term *buena gente* or simpatica/o to describe a likeable and friendly person. How important is it to you to be considered *buena gente or simpatica/o*? Or to be around *buena gente*?

- What helps to make you feel comfortable when you are first getting to know someone?

- I've asked you many questions today. I'm wondering what questions you may have for me?

- How do you handle conflict/express disagreement?

A positive response to the first question suggests that adherence to *personalismo* may exist and should be followed by further inquiry.

Familismo (familial orientation): Refers to the strong emphasis placed upon the importance of the family as the center of one's experience and the greater good of the collective over the individual. Family loyalty, reciprocity and solidarity characterize *familismo*. Family members becoming intrinsically involved in each other's affairs and assuming active roles in the lives of

their kinship are examples of *familismo*. A particular characteristic of this construct is that it goes beyond nuclear and extended family, often including friendships, which are seen as having the same significance. When adhered to, *familismo* may exert a strong influence on how individuals choose to seek and utilize mental health and/or addiction services, and may significantly influence the course of treatment. As mainstream values tend to generally be more individualistic, a therapeutic alliance between a provider and the client's identified family members often facilitates treatment by not only enhancing support, but also clarifying the goals of treatment for all parties involved. If successfully established, *familismo* can be a strong mediator of the therapeutic alliance. We encourage the utilization of questions such as:

- How important is family to you?
- What constitutes a family to you?
- What other people would you like involved in your treatment?
- How important is your family's opinion when you make a decision?
- What is the difference between your current support system and the one you had in your home country?
- What does your family think about you being in treatment?

A positive response to the first question suggests that there may be adherence to *familismo* and should be explored with further questions. For each question asked, the clinician should follow up with motivational interviewing interventions such as open ended questions and reflections of both content and affect. Such interventions are helpful in determining how *familismo* manifests itself and the clinical information obtained should be summarized to the client. If it is determined that a client adheres to *familismo*, then the client and clinician collaboratively develop a measurable and concrete treatment plan that includes family-based interventions as part of the treatment.

Implementation of IDDT at the Hispanic Clinic

A. Leadership

The transformation of services from solely mental heath and substance use to co-occurring disorders is an ongoing process that requires a shift in both the content and process of how business is conducted. It often begins with the administration, and therefore to facilitate these changes at the Hispanic Clinic, an administrative leadership structure had to be created to specifically oversee the implementation of COSIG.

B. Clinicians

1. Most outpatient clinicians who worked primarily with clients with mental health disorders did not feel confident in their ability to adequately treat individuals with co-

occurring disorders. Specifically, many felt that the cases were too complex for their level of expertise. They also felt that team support and a cohesive multidisciplinary effort was a necessary requirement.

2. Though trainings specifically on the IDDT model were offered, they were not sufficient to sustain the necessary long-term systemic changes. The need for ongoing consultation and support became critical. Therefore an infrastructure had to be created to meet the ongoing supervisory needs of the clinical staff.

C. Clients

1. Clients presented with multiple basic needs that included issues around housing, medical, vocational and transportation services. In addition to their regular therapy contact (group or individual), a substantial number of clients required crisis intervention and outreach, taxing the clinician's ability to handle a large caseload. Many clients presented with the following:

    a. Frequent use of the local hospital emergency rooms and psychiatric hospitalizations.

    b. Significant outpatient psychiatric time; this presented a difficult challenge as psychiatric time is always limited.

    c. Difficulty in engagement and sporadic attendance to treatment, as a result of the significant psychosocial stressors.

    d. Critical need for primary care and dental services. Primary care services are typically easier to obtain than dental services.

Additionally, clients presented with enormous needs for case management services with priority in the following areas:

    a. Housing (not enough to meet the population demands); even among those clients who have housing, it is frequently in unsafe sections of town that are often centers of illicit activity, such as drug dealings.

    b. Assistance with the completion of disability and entitlement applications.

    c. Transportation to and from the clinic. Most clients require some transportation assistance.

2. Although the intention was to provide group treatment for all clients, this was not possible. In some instances, issues such as conflicting work schedules would not allow for group participation. In other cases, clients were hesitant to participate in the group process. For some, once trust was established on a one to one basis, the transition to group became easier.

D. Staff Recruitment

The Hispanic Clinic operates within a multidisciplinary team concept made up of substance abuse counselors, social workers, psychologists, psychiatrists, case managers, and a nurse. To meet the demands associated with an increased number of clients experiencing co-occurring disorders, we recruited a full time case manager, a vocational rehabilitation specialist, two clinicians, and a nurse. These additional positions were critical in the provision of services for clients with co-occurring disorders.

The challenges in recruiting bilingual/bicultural personnel were not only specific to the limited number of individuals qualified for these various positions, but also to a limited workforce fluent in Spanish and well versed in understanding the nuances of Latino culture. We were able to hire the individuals we needed, but each position presented with its unique challenges. For example, the vocational rehabilitation specialist had to be trained as we could not find someone with the requisite background that had previous experience in working with Latina/o clients in employment issues. An even bigger challenge was the recruitment of a bilingual/bicultural nurse. The pool of nurses is very limited. Fortunately, we were able to recruit from within CMHC. By the end of the COSIG project, individuals with co-occurring disorders were redistributed to all the existing clinical and case management staff, as part of a sustainability plan and consistent with the overall COSIG goal to transform all Hispanic Clinic services to be co-occurring capable and ultimately co-occurring enhanced. Due to the training and on-going supervision the Clinic staff receives, they are able to effectively treat their clients within the IDDT framework.

E. Stage-Wise Interventions

The implementation of stage wise interventions was accomplished via trainings and ongoing supervision. Fortunately, we were able to recruit supervisors with expertise in stage-wise interventions and motivational interviewing to work with the COSIG staff. In addition to designing a supervision experience for the COSIG team, a series of trainings were conducted for all clinic staff to aide in the provision of IDDT. Clinic supervisors began to implement IDDT supervision with guidance from the COSIG leadership. Emphasis was also placed on assisting clinicians in the proper documentation, taking into account the integration of the cultural constructs.

F. Motivational Interviewing

We implemented Motivational Interviewing (MI) by introducing trainings with ongoing consultations. Initially, we only conducted trainings; however, the results were not satisfactory. With the introduction of ongoing consultations, clinicians were able to more effectively learn and implement MI in their sessions. To this effect, we made strategic changes at the administrative level and allocated faculty resources to provide ongoing clinical MI supervision. This, of course, would not have been possible without the support and resources provided by the Yale Department of Psychiatry.

G. Substance Abuse Counseling

Traditionally, substance abuse counseling at the Clinic had been provided by clinicians certified in substance abuse. Thus, the main challenge became to modify substance abuse counseling to reflect the MI philosophy where the clinician works collaboratively with the client to increase motivation and adherence to treatment. Presently, all clinicians provide substance abuse treatment.

H. Group Treatment

For many years, the Hispanic Clinic has been providing group treatment as a primary therapeutic modality. In order to structure the groups in a manner consistent with IDDT, several new groups were created to match clients' particular stage of motivation. This proved challenging as some clinicians did not have clients representing each stage. In order to address this issue, two groups were created: one made up of clients in the pre-contemplation and contemplation stages, and another made up of clients in the action and maintenance stages. Thus far, this format has worked extremely well, as evidenced by client attendance and clinical outcomes, such as symptom reduction. In terms of the curricula used for the COD groups, we utilize elements from *Group Treatment for Substance Abuse: A Stages-of-Change Therapy Manual* and the *NIDA Counseling for Cocaine Addiction: Manual 4.* Both of these manuals required an additional adaptation in order to take into account cultural nuances.

I. Family Psycho-education

A particular challenge had been the inclusion of family psycho-education into the overall treatment interventions offered at the Hispanic Clinic. Following the Clinic's relocation to the main CMHC site and due to the expanded space and central location of the Clinic, we are better able to host family events every quarter. Additionally, monthly family psychoeduational sessions open to all clients and family members are coordinated by the staff nurse and held at the Clinic on a variety of topics, including, HIV, diabetes, heart disease, gender issues, substance abuse, and mental health, to name a few. The family psychoeducation component is of particular salience for those clients who adhere to the cultural construct of *familismo.* Consequently, particular emphasis is placed on integrating the family into all aspects of the therapeutic experience which are deemed clinically appropriate.

J. AA/NA Community Groups

Many of the clients at the Hispanic Clinic do not attend NA or AA groups and therefore this IDDT component proved highly challenging. Most often, clients report obtaining their community support from groups provided in their churches. Moreover, another factor has been the limited availability of Spanish language AA and NA groups in the community. Fortunately, for those clients who want to attend AA and NA groups, we identified groups in the community that are Spanish speaking and easily accessible.

Conclusion

Results of the preliminary evaluation, of 103 Hispanic Clinic clients with co-occurring disorders, conducted by the Yale Program for Recovery and Community Health (PRCH), demonstrate several encouraging findings. Clients at the Clinic have reported an increase in days abstaining from alcohol use and fewer drinks, and an increase in days abstaining from drug use. There has also been a commensurate decrease in maladaptive coping, and arrests have decreased from a rate of 5% to 0%. In terms of type of treatment accessed, inpatient admission for an addiction disorder also decreased from 5% to 0%, fewer days have been spent in a psychiatric hospital, less use of outpatient services for physical complaints, and fewer suicide attempts. Overall, it has been our experience working in a large Latino community mental health clinic that systematically integrating substance use services and Hispanic oriented constructs into existing psychotherapy models can be a viable and effective way to enhance treatment. This is particularly the case with individuals who are first generation and/or less acculturated. These results highlight the importance of providing evidence based practices in a culturally and linguistically appropriate manner in order to enhance engagement and to increase the overall well-being of the clients we serve. For further information, please email Luis Añez (luis.aneznava@yale.edu) or Manuel Paris (manuel.paris@yale.edu).

Suggested Readings

Alegria, M., Canino, G., Rios, R., Vera, M., Calderon, J., Rusch, D., et al. (2002). Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino Whites. *Psychiatric Services, 53*, 1547-1555.

Alegria, M., Mulvaney-Day, N., Torres, M., Polo, A., Cao, Z., & Canino, G. (2007). Prevalence of psychiatric disorders across Latino subgroups in the United States. *American Journal of Public Health, 97*, 68-75.

Alegria, M., Mulvaney-Day, N., Woo, M., Torres, M., Gao, S., & Oddo, V. (2007). Correlates of past-year mental health service use among Latinos: Results from the national Latino and Asian American Study. *American Journal of Public Health, 97*, 76-83.

Amaro, H., Nieves, R., Johannes, S. W., & Cabeza, N. M. L. (1999). Substance abuse treatment: Critical issues and challenges in the treatment of Latina women. *Hispanic Journal of Behavioral Sciences, 21*, 266-282.

Amaro, H., Larson, M.J., Gampel, J., Richardson, E., Savage, A., & Wagler, D. (2005). Racial/ethnic differences in social vulnerability among women with co-occurring mental health and substance abuse disorders: Implications for treatment services. *Journal of Community Psychology, 33*, 495-511.

Amodeo, M., Chassler, D., Oettinger, C., Labiosa, W., & Lundgren, L. (2008). Client retention in residential drug treatment for Latinos. *Evaluation and Program Planning, 31*, 102-112.

Andrés-Hyman, R. C., Ortiz, J., Añez, L. M., Paris, M., & Davidson, L. (2006). Culture and clinical practice: Recommendations for working with Puerto Ricans and other Latinas(os) in the United States. *Professional Psychology: Research and Practice, 37*, 694-701.

Ansell, E. B., Pinto, A., Crosby, R. D., Becker, D. F., Añez, L. M., Paris, M., & Grilo, C. M. (in press). The prevalence and structure of obsessive-compulsive personality disorder in Hispanic psychiatric outpatients. *Journal of Behavior Therapy and Experimental Psychiatry.*

Añez, L. M., Paris, M., Bedregal, L. E., Davidson, L., & Grilo, C. (2005). Application of cultural constructs in the care of first generation Latino clients in a community mental health setting. *Journal of Psychiatric Practice, 11*, 221-230.

Añez, L., Silva, M., Paris, M., & Bedregal, L. (2008). Engaging Latinos through the integration of cultural values and motivational interviewing principles. *Professional Psychology: Research and Practice, 39*, 153-159.

Antshel, K. M. (2002). Integrating culture as a means of improving treatment adherence in the Latino population. *Psychology, Health, and Medicine, 7*, 435-449.

Becker, D. F., Añez, L. M., Paris, M., Bedregal, L., & Grilo, C. M. (2009). Factor structure and diagnostic efficiency of the DSM-IV criteria for Avoidant Personality Disorder in Hispanic men and women with substance use disorders. *Comprehensive Psychiatry, 50,* 463-470.

Becker, D. F., Añez, L. M., Paris, M., & Grilo, C. M. (in press). Exploratory factor analysis of Borderline Personality Disorder criteria in monolingual Hispanic outpatients with substance use disorders. *Psychiatry Research.*

Berdahl, T. A., & Stone, R. A. T. (2009). Examining Latino differences in mental healthcare use: The roles of acculturation and attitudes towards healthcare. *Community Mental Health Journal, 45,* 393-403

Bernal, G. & Scharron-Del-Rio, M. R. (2001). Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. *Cultural Diversity and Ethnic Minority Psychology, 7,* 328-342.

Bien, T. H., Miller, W. R., & Boroughs, J. M. (1993). Motivational interviewing with alcohol outpatients. *Behavioural and Cognitive Psychotherapy, 21,* 347-356.

Booth, M. W., Castro, F. G., & Anglin, M. (1990). What do we know about Hispanic substance abuse? A review of the literature. In R. Click & J. Moore (Eds.), *Drugs in Hispanic communities.* New Brunswick, NJ: Rutgers University Press.

Bracero, W. (1998). Intimidades: Confianza, gender, and hierarchy in the construction of Latino-Latina therapeutic relationships. *Cultural Diversity and Mental Health, 4,* 264-277.

Caplan, S., Alvidrez, J., Paris, M., Escobar, J., Dixon, J. K., Desai, M. M., Whittemore, R., & Scahill, L. D. (in press). Subjective versus objective: An exploratory analysis of Latino primary care patients who have self-perceived depression, but do not fulfill PRIME-MD Patient Health Questionnaire (PHQ-9) criteria for depression. *Primary Companion to the Journal of Clinical Psychiatry.*

Caplan, S., Paris, M., Whittemore, R., Desai, M., Dixon, J., Alvidrez, J., Escobar, J., & Scahill, L. (in press). Psychosocial correlates of causal beliefs about depression among Latino immigrants in primary care. *Mental Health, Religion, and Culture.*

Carroll, K., Ball, S., Nich, C., Martino, S., Frankforter, T., Farentinos, C., et al (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence, 81,* 301-312.

Carroll, K. M., Martino, S., Ball, S. A., Nich, C., Frankforter, T., Añez, L. M., Paris, M., Suarez-Morales, L., Szapocznik, J., Miller, W. R., Rosa, C., & Matthews, J. (2009). A multisite randomized effectiveness trial of motivational enhancement therapy for Spanish-Speaking substance users. *Journal of Consulting and Clinical Psychology*, *77*(5), 993-999.

Center for Substance Abuse Treatment. (1994). *Assessment and treatment of patients with co-existing mental illness and alcohol and other drug abuse: Treatment improvement protocol (TIP) series number nine.* DHHS publication No. (SMA) 94-2078. Washington, DC.

Center for Substance Abuse Treatment. (2005). *Substance abuse treatment for persons with co-occurring disorders: Treatment improvement protocol (TIP) series 42.* DHHS publication No. (SMA) 05-3992. Washington, DC.

Clark, H. W., Power, A. K, Le Fauve, C. E., & Lopez, E. I. (2008). Policy and practice implications of epidemiological surveys on co-occurring mental and substance use disorders. *Journal of Substance Abuse Treatment*, *34*, 3-13.

Comas-Diaz, L. (2001). Hispanics, Latinos, or Americanos: The evolution of identity. *Cultural Diversity and Ethnic Minority Psychology, 7*, 115-120.

Comas-Díaz, L. (2006). Latino healing: The integration of ethnic psychology into psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *43*, 436-453.

Conway, K. P., Swendsen, J. D., Dierker, L., Canino, G., & Merikangas, K. R. (2007). Psychiatric comorbidity and acculturation stress among Puerto Rican substance abusers. *American Journal of Preventive Medicine*, *32*, S219-S225.

Cuellar, I., & Paniagua, F. A. (Eds.). (2000). *Handbook of multicultural mental health: Assessment and treatment of diverse populations*. San Diego, CA: Academic Press.

Daley, D. C., Mercer, D. E., & Carpenter, G. (1999). *Counseling for cocaine addiction: The collaborative cocaine treatment study model (manual 4).* Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse.

Dennison, S. J. (2003). *Handbook of the dually diagnosed patient.* Philadelphia: Lippincott Williams & Wilkins.

De Rios, M. D. (2002). *Brief psychotherapy with the Latino immigrant client.* Binghamton, NY: Haworth Press.

Diaz, E., Miskemen, T., Vega, W. A., Gara, M., Wilson, D. R., Lesser, I., Escamilla, M., Neighbors, H. W., & Arndt, S. (2009). Inconsistencies in diagnosis and symptoms among bilingual and English-speaking Latinos and Euro-Americans. *Psychiatric Services, 60*(10), 1379-1382.

Drake, R. E., Mueser, K. T., Clark, R. E., & Wallach, M. A. (1996). The course, treatment, and outcome of substance disorder in persons with severe mental illness. *American Journal of Orthopsychiatry, 66*, 42-51.

Drake, R. E., Yovetich, N. A., Bebout, R. R., Harris, M., & McHugo, G. J. (1997). Integrated treatment for dually diagnosed homeless adults. *The Journal of Nervous and Mental Disease, 185*, 298-305.

Drake, R. E., Mc Hugo, G. J., Clark, R. E., Teague, G. B., Xie H., Miles, K., et al. (1998). Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: A clinical trial. *American Journal of Orthopsychiatry, 68*, 201-215.

Drake, R. E., Mercer-McFadden, C., Mueser, K. T., McHugo, G. J., & Bond, G. R. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin, 24*, 589-608.

Drake, R. E., & Wallach, M. A. (2000). Dual diagnosis: 15 years of progress. *Psychiatric Services, 51*, 1126-1129.

Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., et al. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services, 52*, 469-476.

Drake, R. E., Goldman, H. H., Leff, S., Lehman, A. F., Dixon, L., Mueser, K. T., & Torrey, W.C. (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services, 52*, 179-182.

Falicov, C. J. (1998). *Latino families in therapy*. New York: Guilford Press.

Gloria, A. M. & Peregoy, J. J. (1996). Counseling Latino alcohol and other substance users/ abusers: cultural considerations for counselors. *Journal of Substance Abuse Treatment, 62*, 119-126.

Grilo, C. M., Añez, L., & McGlashan, T. H. (2002). DSM-IV axis II co-morbidity with borderline personality disorder in monolingual Hispanic psychiatric outpatients. *The Journal of Nervous and Mental Disease, 190*, 324-330.

Grilo, C. M., Becker, D. F., Añez, L. M., & McGlashan, T. H. (2004). Diagnostic efficiency of DSM-IV criteria for borderline personality disorder: An evaluation in Hispanic men and women with substance use disorders. *Journal of Consulting and Clinical Psychology, 72,* 126-131.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training*, *43*, 531-548.

Harris, K. M., & Edlund, M. J. (2005). Use of mental health care and substance abuse treatment among adults with co-occurring disorders. *Psychiatric Services, 56*, 954-959.

Hendrickson, E. L., Schmal, M. S., & Ekleberry, S. C. (2004). *Treating co-occurring disorders: A handbook for mental health and substance abuse professionals.* New York: Haworth Press.

Jaramillo, J. A. (1996). Tu and usted: Address etiquette in the Mexican American family. *Hispanic Journal of Behavioral Sciences, 18,* 522-532.

Kail, B. L. & Elberth, M. (2003). Engaging and treating the substance-abusing Latina. *Journal of Ethnicity in Substance Abuse, 2,* 19-30.

Kessler, R., Nelson, C., McGonagle, K. (1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry, 66*, 17-31.

Keyser, D. J., Watkins, K. E., Vilamovska, A. M., & Pincus, H. A. (2008). Improving service delivery for individuals with co-occurring disorders: New perspectives on the quadrant model. *Psychiatric Services*, *59*, 1251-1253.

LaRoche, M. (2002). Psychotherapeutic considerations in treating Latinos. *Harvard Review of Psychiatry, 10,* 115-122.

LaRoche, M. J., & Maxie, A. (2003). Ten considerations in addressing cultural differences in psychotherapy. *Professional Psychology: Research and Practice*, *34*, 180-186.

Mangrum, L. F. (2009). Client and service characteristics associated with addiction treatment completion of clients with co-occurring disorders. *Addictive Behaviors*, *34*, 898-904.

Martino, S., Carroll, K., Kostas, D., Perkins, J., & Rounsaville, B. (2002). Dual diagnosis motivational interviewing: A modification of motivational interviewing for substance-abusing patients with psychotic disorders. *Journal of Substance Abuse Treatment, 23*, 297-308.

McGovern, M. P., Xie, H., Segal, S. R., Siembab, L., & Drake, R. E. (2006). Addiction treatment services and co-occurring disorders: Prevalence estimates, treatment practices, and barriers. *Journal of Substance Abuse Treatment, 31*, 267-275.

Mezzich, J. E., Ruiz, P., & Muñoz, R. A. (1999). Mental health care for Hispanic Americans: A current perspective. *Cultural Diversity and Ethnic Minority Psychology, 5*, 91-102.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York, NY: Guilford Press.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York, NY: Guilford Press.

National Council of La Raza. (2005, July). *Critical disparities in Latino mental health: Transforming research into action.* Washington, DC: Author.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report* (DHHS Pub. No. SMA-03-3832). Rockville, MD.

Novas, H. (2003). *Everything you need to know about Latino history*. New York: Plume/Penguin Books.

O'Connell, D.F. (1998). *Dual disorders: Essentials for assessment and treatment.* New York: Haworth Press.

Palacios, W. R., Urmann, C. F., Newel, R., & Hamilton, N. (1999). Developing a sociological framework for dually diagnosed women. *Journal of Substance Abuse Treatment, 17,* 91-102.

Paris, M., Añez, L., Bedregal, L., Andrés-Hyman, R., & Davidson, L. (2005). Help seeking and satisfaction among Latinas: The roles of setting, ethnic identity, and therapeutic alliance. *Journal of Community Psychology, 33,* 299-312.

Passel, J. S., & Cohn, D. (2008). *U.S. Population Projections: 2005-2050*. Washington, DC: Pew Hispanic Center.

RachBeisel, J., Scott, J., & Dixon, L. (1999). Co-occurring severe mental illness and substance use disorders: A review of recent research. *Psychiatric Services, 50,* 1427-1434.

Randolph, W. M., Stroup-Benham, C., Black, S. A., & Markides, K. S. (1998). Alcohol use among Cuban Americans, Mexican Americans, and Puerto Ricans. *Alcohol Health & Research World, 22,* 265-269.

Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy, 23,* 325-334.

Ruiz, P. (1997). Issues in the psychiatric care of Hispanics. *Psychiatric Services, 48,* 539-540.

Ruiz, P. (2002). Hispanic access to health/mental health services. *Psychiatric Quarterly, 73*(2), 85-91.

Santa Ana, E. J., Carroll, K. M., Añez, L., Paris, M., Ball, S. A., Nich, C., Frankforter, T. L., Suarez-Morales, L., Szapocznik, J., & Martino, S. (2009). Evaluating Motivational Enhancement Therapy adherence and competence among Spanish-speaking therapists. *Drug and Alcohol Dependence, 103,* 44-51.

Santiago-Rivera, A., Arredondo, P., & Gallardo-Cooper, M. (2002). *Counseling Latinos and la familia*. Thousand Oaks, CA: Sage Publications.

Suarez-Morales, L., Martino, S., Bedregal, L., McCabe, B. E., Cuzmar, I. Y., Paris, M., Feaster, D. J., Carroll, K. M., & Szapocznik, J. (in pres). Do therapist cultural characteristics influence the outcome of substance abuse treatment for Spanish-speaking adults? *Cultural Diversity and Ethnic Minority Psychology.*

Torrey, W. C., Drake, R. E., Cohen, M., Fox, L. B., Lynde, D., Gorman, P. et al. (2002). The challenge of implementing and sustaining integrated dual disorders treatment programs. *Community Mental Health Journal, 38*, 507-521.

Triandis, H. C., Marín, G., Lisansky, J., & Betancourt, H. (1984). Simpatía as a cultural script of Hispanics. *Journal of Personality and Social Psychology, 47*, 1363-1375.

U.S. Department of Health and Human Services. (1999). *Mental Health: A report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General.* Rockville, MD: DHHS, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

U.S. Department of Health and Human Services. (2003). *Co-occurring Disorders: Integrated Dual Disorders Treatment – Implementation Resource Kit.* Rockville, MD: DHHS, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Available on http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/

Vega, W. A., Sribney, W. M., & Achara-Abrahams, I. (2003). Co-occurring alcohol, drug and other psychiatric disorders among Mexican-origin people in the United States. *American Journal of Public Health, 93*, 1057-1064.

Vega, W. A., Canino, G., Cao, Z., & Alegria, M. (2009). Prevalence and correlates of dual diagnoses in U.S. Latinos. *Drug and Alcohol Dependence, 100*, 32-38.

Vega, W. A., Rodriguez, M. A., & Gruskin, E. (2009). Health disparities in the Latino population. *Epidemiologic Reviews, 10,* 1-14.

Velasquez, M. M., Maurer, G. G., Crouch, C., & DiClemente, C. C. (2001). *Group treatment for substance abuse: A stages-of-change therapy manual.* New York, NY: Guilford Press.

Watkins, K. E., Hunter, S. B., Wenzel, S. L., Tu, W., Paddock, S. M., Griffin, A., et al (2004). Prevalence and characteristics of clients with co-occurring disorders in outpatient substance abuse treatment. *American Journal of Drug and Alcohol Abuse, 30,* 749-764.

Wu, L. T., Ringwalt, C. L., & Williams, C. E. (2003). Use of substance abuse treatment services by persons with mental health and substance use problems. *Psychiatric Services, 54,* 363-369.

Zuniga, M. E. (1991). Dichos as metaphorical tools for resistant Latino clients. *Psychotherapy, 28,* 480-483.

Zweben, J. E. (1996). Psychiatric problems among alcohol and other drug dependent women. *Journal of Psychoactive Drugs, 28,* 345-366.