

Chapter 6—Co-Occurring Disorders Among Special Populations

KEY MESSAGES

- The recovery community is diverse. Assessment, diagnosis, and treatment of substance use disorders (SUDs), mental disorders, or both (co-occurring disorders [CODs]) should be inclusive of all people who need services.
- People experiencing homelessness, those involved in the criminal justice system, women, and people who identify with diverse racial/ethnic groups have historically been underserved, often have unique needs and presenting symptoms, and face certain barriers to care (and thus to recovery) that counselors can help address.
- Counselors may need to adapt treatment approaches to clients with CODs to ensure the most beneficial outcomes for these groups. Adaptations are possible across a wide spectrum, involving basic to increasingly complex modifications. Regardless of complexity, all population-specific adaptations should aim to improve the therapeutic alliance, increase clients' engagement in services, and give people with CODs the best chances for long-term recovery.
- Ample resources are available to help counselors tailor SUD treatment and mental health services to the needs of special populations with CODs.

Some people with CODs are especially vulnerable to treatment challenges and poor outcomes—namely, women, people from diverse racial/ethnic backgrounds, people experiencing homelessness, and people involved in the criminal justice system. This chapter describes proven and emerging COD treatment strategies that can effectively address substance misuse in these populations

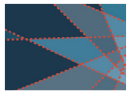
and is intended for counselors, other treatment/service providers, supervisors, and administrators. It describes unique aspects of CODs among specific populations and offers recommendations to SUD treatment providers, other behavioral health service providers, program supervisors/administrators, and primary care providers who may encounter clients with CODs in their practice.

A complete description of the demographic, socio-cultural, and other aspects of the noted populations and related treatment programs and models is beyond the scope of this Treatment Improvement Protocol (TIP). However, readers can find more detailed information about population-specific behavioral health services in other TIPs, including:

- TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* (Center for Substance Abuse Treatment, 2005b).
- TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009b).

MILITARY PERSONNEL

Active duty military members and veterans are a unique, complex population at risk for CODs, trauma, posttraumatic stress disorder (PTSD), and suicidal ideation. They often lack access to sufficient behavioral health services. Providers will need to make special considerations regarding military culture (especially surrounding stigma toward mental illness) and circumstances, such as deployments and family stress, to provide behavioral health services that are responsive to this population's needs. See the "Trauma" section in Chapter 4 for more information on military personnel. Chapter 4 also lists resources that address some of the specific behavioral health needs of the military population and how counselors can best meet those needs.



- TIP 55, *Behavioral Health Services for People Who Are Homeless* (SAMHSA, 2013).
- TIP 57, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA, 2014b).
- TIP 59, *Improving Cultural Competence* (SAMHSA, 2014a).

People Experiencing Homelessness

Homelessness continues to be one of the United States' most intractable and complex social problems, although homelessness affects only about 0.2 percent of the U.S. population (Willison, 2017). The Department of Housing and Urban Development (Henry et al., 2020) reported that approximately 568,000 people experienced homelessness in the United States on any given night in 2019. Moreover, the prevalence of homelessness is rising. From 2018 to 2019, the number of individuals experiencing homelessness rose by 3 percent and the number living in unsheltered locations increased by 9 percent; the number experiencing chronic homelessness increased by 9 percent (Henry et al., 2020).

Among more than 36,000 U.S. adults who participated in the 2012–2013 Wave 3 of the National Epidemiologic Survey on Alcohol and Related Conditions (Tsai, 2018), lifetime homelessness was about 4 percent and past-year homelessness was 1.5 percent. Risk of homelessness was associated with a history of mental illness (including serious mental illness [SMI]), lifetime tobacco use, and lifetime suicide attempt, among other demographic and social variables (Tsai, 2018).

Homelessness, Mental Health, and Substance Misuse

The prevalence of substance misuse and mental illness among people experiencing homelessness is high. Solari and colleagues (2017) found that about 37 percent of adults in permanent supportive housing programs had a mental disorder; 10 percent, substance abuse; and 29 percent, CODs.

Further statistics paint a similar picture:

- Stringfellow et al. (2016) reported that 3-month substance use among individuals experiencing homelessness was 50 percent for alcohol, 19 percent for cannabis, 16 percent for cocaine, 7.5 percent for opioids, and 6.5 percent for sedatives. Furthermore, 59 percent of individuals who took the Alcohol, Smoking, and Substance Involvement Screening Test had moderate or high risk for substance misuse.
- In a study of more than 870,000 veterans with SMI, 7 percent experienced homelessness (Hermes & Rosenheck, 2016).
- Among a sample of women experiencing homelessness who were seeking treatment in primary care settings (Upshur, Jenkins, Weinreb, Gelberg, & Orvek, 2017), self-reported rates of SUDs or mental disorders greatly exceeded those in the general population. Specifically, women reported rates higher than the general population for:
 - SMI (4 times higher).
 - Major depressive disorder (MDD; 5 times higher).
 - Alcohol use disorder (AUD; 4 times higher).
 - Any drug use disorder (12 times higher).
- A study of people 50 and older experiencing homelessness (Spinelli et al., 2017) found that:
 - 38 percent had current symptoms of MDD.
 - 33 percent had current symptoms of PTSD.
 - 19 percent had at least one lifetime hospitalization for psychiatric symptoms.
 - 33 percent reported experiencing childhood physical abuse, and 13 percent experienced childhood sexual abuse.
 - 63 percent had used an illicit substance in the previous 6 months; the most commonly used illicit substances were cannabis (48 percent), cocaine (38 percent), opioids (7 percent), and amphetamines (7 percent).
 - 49 percent drank alcohol in the past 6 months, including 26 percent whose alcohol use was of moderate or greater severity and 15 percent whose use was of high severity.
 - 10 percent reported binge drinking.

People experiencing homelessness often have CODs. In 2010, about 17 percent of adults enrolled in permanent supportive housing programs had CODs; this increased to 22 percent in 2014, 25 percent in 2015, and 29 percent in 2016 (Solari et al., 2016; Solari et al., 2017). Among women experiencing homelessness and seeking primary health care, 26 percent reported at least one mental disorder and one SUD (Upshur et al., 2017). In a sample of veterans experiencing homelessness, 77 percent had at least one previous mental disorder diagnosis; 47 percent, a substance-related diagnosis; and 37 percent, a COD diagnosis (Ding, Slate, & Yang, 2017).

The Importance of Housing

Housing is more than just physical shelter. It is a social determinant of health and is essential for individual physical, emotional, and socioeconomic wellbeing. Housing affects communities, governments, and nations through its impact on the economy, healthcare system, workforce, and more.

Housing for veterans and civilians with mental disorders, SUDs, or CODs is particularly important. Homelessness in these populations is associated with negative treatment-system factors, including

- Increased emergency department (ED) usage (Cox, Malte, & Saxon, 2017; Moulin, Evans, Xing, & Melnikow, 2018).
- Higher ED costs (Mitchell, Leon, Byrne, Lin, & Bharel, 2017).
- Greater usage of inpatient services (Cox et al., 2017).
- Higher risk of incarceration/criminal justice involvement (Cusack & Montgomery, 2017; Polcin, 2016).

People experiencing homelessness who screened at highest risk for an SUD had lower scores of social support and higher scores of psychological distress compared with those who screened at low or moderate risk (Stringfellow et al., 2016). Those with highest SUD risk also reported more difficulty paying for food, shelter, and utilities; were less likely to have medical insurance; and experienced more episodic health conditions.

Service Models for People With CODs Who Are Experiencing Homelessness

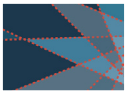
To address substance misuse, mental illness, or both in clients who lack housing, providers can choose among several service models, including:

- **Supportive housing**—housing combined with access to services and supports to address the needs of individuals without housing so that they may live independently in the community. This model is an option for individuals and families who have lived on the street for longer periods of time or whose needs can best be met by services accessed through their housing.
- **Linear housing**—housing that is contingent on completion of treatment for SUDs or mental disorders. Subsidized housing programs participating in this model typically require abstinence as a condition of housing, often through completion of residential treatment.
- **Integrated treatment**—receipt of housing concurrently with addiction/mental health services.

To help clients with CODs address housing needs, treatment programs need to establish ongoing relationships with housing authorities, landlords, and other housing providers. Groups and seminars that discuss housing difficulties may be necessary to help clients with CODs transition from residential treatment to supportive or independent housing. To ease clients' transition, an effective strategy COD treatment programs can use is to coordinate housing tours with supportive housing programs.

Relapse prevention efforts are essential to help clients with CODs maintain housing. Substance misuse may disqualify clients from public housing in the community (Curtis, Garlington, & Schottenfield, 2013).

TIP 55, *Behavioral Health Services for People Who Are Homeless* (SAMHSA, 2013) offers more information on treatment and recovery support approaches specific to people experiencing or at risk for homelessness.



Supportive Housing Model

A systematic literature review (Benston, 2015) found that **permanent supportive housing programs for people experiencing homelessness and mental illness often led to better housing stability** (e.g., percentage of participants housed versus not housed at the end of the study, proportion of time spent in stable housing versus experiencing homelessness, number of days housed versus homeless) compared with control conditions. Although the studies reported mixed results because of variations in design, results, and definitions of “housing,” some, but not all, found that **supportive housing was associated with improvement in psychiatric symptoms and reduced substance use**.

Similarly, an earlier literature review of treatments for people with CODs who were experiencing homelessness recommended use of supportive housing rather than treatment only or linear models (Sun, 2012). Another review (Rog et al., 2014) found that, **among people with CODs, supportive housing was associated with reduced homelessness and improvements in housing tenure, less ED use, fewer hospitalizations, and better client satisfaction** (compared with linear housing models).

Housing First

The Housing First (HF) model provides housing no matter where a person is in recovery from SUDs

or mental disorders. HF is one of the best-known and well-researched approaches to supportive housing. **SAMHSA supports the HF model as a preferred approach for addressing homelessness in individuals with mental illness, SUDs, or both**, as does the U.S. Interagency Council on Homelessness (2014). (See “Resource Alert: Implementing Supportive Housing Programs.”)

HF helps people with CODs (including SMI) establish stable housing and is associated with good housing retention rates (Collins, Malone, & Clifasefi, 2013; Pringle et al., 2017; Watson, Orwat, Wagner, Shuman, & Tolliver, 2013). In some studies, HF is associated with better SUD outcomes than treatment only (Padgett, Stanhope, Henwood, & Stefancic, 2011). However, research on SUD outcomes in HF has generally had mixed results (Paquette & Pannella Winn, 2016). Compared with linear housing models, Kertesz, Crouch, Milby, Cusimano, and Schumacher (2009) found that HF showed better housing stability and retention and, in some cases, favorable reductions in substance misuse severity—but both models benefitted people experiencing homelessness with SMI, SUDs, or both.

The following examples of supportive housing models have successfully reduced homelessness and enhanced outcomes among people with SUDs, mental disorders, or both.

RESOURCE ALERT: IMPLEMENTING SUPPORTIVE HOUSING PROGRAMS

For guidance on implementation of supportive housing programs, see the following resources:

- The National Alliance to End Homelessness's toolkit for adopting an HF approach (<https://endhomelessness.org/wp-content/uploads/2009/08/adopting-a-housing-first-approach.pdf>)
- Pathways to Housing training and consultation (www.pathwayshousingfirst.org/training)
- SAMHSA's Permanent Supportive Housing Evidence-Based Practices toolkit (<https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510>)
- United States Interagency Council on Homelessness's Implementing Housing First in Permanent Supportive Housing fact sheet (www.usich.gov/resources/uploads/asset_library/Implementing_Housing_First_in_Permanent_Supportive_Housing.pdf)

Pathways to Housing

The well-known and heavily researched Pathways to Housing program is an example of HF-based supportive housing. The program was originally designed (Tsemberis & Eisenberg, 2000; Tsemberis, Moran, Shinn, Asmussen, & Shern, 2003) to serve a highly visible and vulnerable segment of New York's population experiencing homelessness: people with CODs who were living in the streets, parks, subway tunnels, and similar places. It has since been expanded to other areas, including Washington, DC, Vermont, Pennsylvania, and Canada. Pathways to Housing reflects a client-centered perspective and offers clients experiencing homelessness the option of moving directly into a furnished apartment of their own. However, clients must agree to receive case management and work with a representative payee to ensure that rent and utilities are paid and resources are well managed (Tsemberis & Eisenberg, 2000). Pathways to Housing uses assertive community treatment (ACT) teams to offer clients an array of support services in twice-monthly sessions. Vocational, medical, behavioral health, and other services are among the options.

Highlights of outcomes reported from Pathways to Housing programs include the following:

- Pathways to Housing DC (2017) reported a 91-percent housing success rate.
- Pathways to Housing PA (2018) supplied 2,992 hours of medical, mental, and SUD treatment services and 2,996 hours of paid transitional employment. Additionally, 100 percent of clients retained housing through the first year, and 65 percent were in SUD treatment after 6 months.
- Over about 3 years, Pathways to Housing VT achieved an 85-percent housing retention rate, and mean number of days spent homeless decreased significantly over the course of a year (11 days at baseline vs. 2 days at 12-month follow-up) (Stefancic et al., 2013).

Linear Housing Model

The linear model provides housing contingent on abstinence from substances. It was once the preferred approach for aiding people with SUDs, mental disorders, or CODs who were experiencing homelessness. Research has since shown this

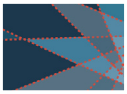
approach to produce less favorable housing retention outcomes than supportive housing (Kertesz et al., 2009; Polcin, 2016). **Linear models often require completion of an SUD treatment program (typically residential treatment) in addition to abstinence before housing is provided, yet SUD treatment completion rates are frequently low.** Often, linear programs also lack access to and control of stable, permanent housing, which contributes to low rates of housing stability compared with permanent supportive housing programs such as HF (Kertesz et al., 2009; Polcin, 2016).

Linear programs do appear effective in helping clients improve substance use outcomes.

Therapeutic communities (TCs), an example of the linear model, have been shown to reduce substance use and psychiatric symptoms, but according to some research, may not produce robust improvements in housing status (Kertesz et al., 2009). Compared with usual care (e.g., receiving day treatment only), the Birmingham approach to the linear housing model can improve both housing and substance use outcomes. This approach offers referrals for private or public housing only upon completion of a comprehensive, community-based SUD treatment program that includes behavioral interventions, employment training, and community reinforcement and supports (e.g., relapse prevention, goal setting, rewards for achieving objectively defined recovery goals). The Birmingham approach has significantly improved abstinence, housing stability (especially among clients

THE ROLE OF RECOVERY HOUSING FOR PEOPLE WITH CODs

Recovery housing is a critical issue for all clients with CODs—not just those experiencing homelessness. Without stable supportive housing, achieving and maintaining long-term recovery is less likely. The National Alliance for Recovery Residences maintains a resource library on recovery housing to help providers learn about the various types of recovery residences, how recovery housing affects client outcomes, and how to support clients in identifying and obtaining housing that best meets their recovery needs (<https://narronline.org/resources/>).



who achieve longer term abstinence), and employment; program retention has been moderate to high (Kertesz et al., 2009).

Integrated Housing and Treatment Models

People experiencing homelessness often have diverse, complex treatment and support needs. Thus, a multifactorial, flexible, integrated approach to addressing clients' behavioral health and housing needs may be preferable, in some cases, to the more structured housing service models described previously (Polcin, 2016). The Comprehensive, Continuous, Integrated System of Care is an integrated COD treatment approach that has been adapted to include housing and employment supports. In one program using this approach (Harrison, Moore, Young, Flink, & Ochshorn, 2008), homelessness decreased by 90 percent, permanent housing increased by 202 percent, unemployment decreased by 16 percent, and employment increased by 1,215 percent. The program also showed decreases in number of days of past-month illicit substance use, and past-month substance use declined over the course of 6 months. Other significant improvements included (Moore, Young, Barrett, & Ochshorn, 2009):

- Decreased need for SUD treatment and psychological/emotional services.

ADVICE TO THE COUNSELOR: WORKING WITH CLIENTS WHO HAVE CODs AND ARE EXPERIENCING HOMELESSNESS

The consensus panel recommends that providers:

- Address the housing needs of clients.
- Help clients obtain housing.
- Teach clients skills for maintaining housing.
- Collaborate with shelter workers and other providers of services to people experiencing homelessness.
- Address real-life concerns in addition to housing, such as SUD treatment, legal/criminal justice matters, Supplemental Security Insurance/entitlement applications, problems related to children, and health care.

- Increased receipt of needed SUD treatment and psychological/emotional services.
- Reductions in unmet medical needs.
- Decreased self-reported mental disorder symptoms.

People Involved in the Criminal Justice System

Estimated rates of mental disorders and SUDs in prison populations vary but are consistently high, often exceeding general population rates (Fazel, Yoon, & Hayes, 2017; Reingle Gonzalez & Connell, 2014; Marotta, 2017). Among those incarcerated in U.S. state prisons (Prins, 2014), mental disorders of highest prevalence include:

- 9 percent to 29 percent for current MDD.
- 5.5 percent to 16 percent for bipolar disorder.
- 1 percent (women), 5.5 percent (men and women), and 7 percent (men) for panic disorder.
- 2 percent to 6.5 percent for schizophrenia.

In a sample of more than 8,000 U.S. inmates (Al-Rousan et al., 2017), nearly 48 percent had a history of mental illness, 29 percent had an SMI, and 26 percent had an SUD. About 48 percent of those with a mental illness also misused substances. People on probation or parole from 2002 to 2014 had significantly higher rates of *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) SUDs than U.S. adults not on probation or parole (Fearn et al., 2016); 13 percent had alcohol abuse (vs. 4 percent), 15 percent had alcohol dependence (vs. 3 percent), 2 percent had illicit drug abuse (vs. 0.3 percent), and 8 percent had illicit drug dependence (vs. 1 percent).

Rationale for Treatment

Inmates with a history of mental illness or CODs are at higher risk of violence (Peters et al., 2017). They are more likely to be charged with violent crimes before incarceration and to experience or perpetrate prison-related assaults during incarceration (Wood, 2013).

The rationale for providing SUD treatment in the criminal justice system is based on the well-established link between substance misuse and criminal behavior. The overall goal of SUD

Among individuals in the criminal justice system, comorbid SMI and SUDs substantially increase the risk of multiple reincarcerations compared with having either disorder alone (Baillargeon et al., 2010). However, the odds of incarceration are reduced when people engage in SUD treatment (Luciano, Belstock, et al., 2014).

treatment for criminal offenders, especially those who have engaged in violence, is to reduce criminality.

Evidence suggests that people with CODs can be effectively treated while incarcerated (Peters et al., 2017). Unfortunately, despite the high need for services, lifetime treatment rates among offenders with CODs are low: approximately 38 percent have received any type of previous behavioral health services; 27 percent, inpatient or outpatient SUD treatment; 4 percent, inpatient mental health services; 7 percent, both SUD treatment and mental health services; and 16 percent, any type of behavioral health service during the past year (Hunt, Peters, & Kremling, 2015).

Treatment Features, Approaches, and Empirical Evidence

Several features distinguish COD treatment programs currently available in the criminal justice system from other treatment programs:

- Staff are trained and experienced in treating both mental disorders and SUDs.
- Both disorders are treated as “primary.”
- Treatment services are integrated if possible.
- Treatment is comprehensive, flexible, and individualized.
- The focus of the treatment is long term.

Treatment frameworks that yield positive results for incarcerated people with CODs include integrated dual disorder treatment (IDDT), risk-need-responsivity (RNR) models, and CBT (Peters et al., 2017):

- IDDT models integrate SUD treatment and mental health services in a single setting; professionals with training in both sets of disorders address all symptoms concurrently.

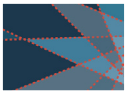
IDDT treatments can be adapted for incarcerated populations to address criminal thinking and reduce risk of recidivism.

- RNR models match service intensity to clients’ risk of recriminalization after release, which tends to be high in people with CODs. RNR programs are often highly focused on reducing substance misuse, which is strongly linked to reincarceration. Additional recidivism risk factors addressed through this framework include reducing antisocial attitudes and beliefs, addressing family and relationship problems, enhancing education and employment skills, and encouraging prosocial activities.
- CBT can be tailored to offenders with CODs by addressing antisocial thoughts and maladaptive behaviors, increasing coping skills to reduce substance use (e.g., urges, cravings) and criminal behavior, and cognitive restructuring to decrease criminal thinking.

These and other COD treatment approaches can be implemented across a range of criminal justice settings and services, including as part of prebooking diversion programs, drug and mental health courts, reentry programs, and probation supervision. Many prison- and jail-based treatments for offenders with CODs have generated positive results for reincarceration (especially for TCs). Certain interventions, including case management via mental health drug courts, motivational interviewing combined with cognitive training, and interpersonal psychotherapy, often show no effect

RESOURCE ALERT: SAMHSA PUBLICATIONS ON SCREENING, ASSESSMENT, AND TREATMENT FOR CRIMINAL JUSTICE POPULATIONS

- TIP 44, Substance Abuse Treatment for Adults in the Criminal Justice System (<https://store.samhsa.gov/system/files/sma13-4056.pdf>)
- SAMHSA’s Screening and Assessment of Co-Occurring Disorders in the Justice System (<https://store.samhsa.gov/system/files/sma15-4930.pdf>)



on criminal activity and drug use—possibly because of small sample sizes and the low quality of studies (Perry et al., 2015; Peters et al., 2017). However, some research does report positive outcomes, suggesting that COD treatment should not be dismissed outright. For instance, a COD wraparound intervention for drug courts resulted in significant reductions in the average number of nights spent in jail, alcohol use, and drug use, and increases in full-time employment (Smelson et al., 2018).

Evidence in Support of Postrelease Treatment and Follow-Up

In the past decade, several studies have established **the importance of linking institutional services to community services** (of various kinds). Postrelease programs often include reentry courts, ACT, and integrated case management services, all of which should offer comprehensive services to address mental health, SUDs, and housing and employment needs.

Forensic adaptations to continuous care for CODs via ACT can be leveraged to improve criminal justice–related, substance-related, and functional outcomes. Integrated, comprehensive approaches to postrelease treatment and follow-up may help reduce rearrest and reconvictions when adapted for criminal justice populations. Adaptations may include modifications like inclusion of a reentry plan, transportation to and supervision for treatment visits, and acquisition/reinstatement of financial assistance (e.g., Social Security income, Medicaid; Peters et al., 2017).

Smith, Jennings, and Cimino (2010) used a stage progressive recovery model of ACT to help offenders with CODs transition from incarceration on an inpatient forensic unit to community living. Participants were provided stage-specific skills and interventions (e.g., support to improve self-care, medication management, relapse prevention, enhanced socialization). Stages of treatments were tied to behavioral rewards and increased privileges (such as less supervision) and included assessment and orientation, a CBT program, a prerelease stage, and conditional release and community continuing care programming. Ninety percent of individuals who completed the program had “overall success” (e.g., no psychiatric state hospital

readmissions and no rearrests following release), 75 percent maintained substance abstinence, and 82 percent maintained steady housing (i.e., keeping a consistent home without being evicted, ejected, or changing residences more than three times in any year). Interestingly, of the five individuals who were rearrested following release, all had maintained substance abstinence, stable housing, and employment.

Meanwhile, Cusack, Morrissey, Cuddeback, Prins, and Williams (2010) compared forensic adaptations of ACT for criminal justice–involved individuals who had mental illness, SUDs, or CODs with usual treatment. They found reductions in jail bookings and psychiatric hospitalizations, increases in the use of outpatient mental health services, increases in the odds of staying out of jail after release, and decreases in inpatient psychiatric service costs and per-person jail costs.

Women

Women with CODs can be served in mixed-gender COD programs using the same strategies mentioned elsewhere in this TIP. However, specialized COD programs do exist that address

In 2002, the National Institute on Drug Abuse (NIDA) established the Criminal Justice Drug Abuse Treatment Studies Series to fund regional research centers meant to forge partnerships between SUD treatment providers and the criminal justice system. The goal is to foster the design and testing of approaches to better integrate in-prison treatment and postprison services. In 2008, NIDA launched the second wave of studies; these focused specifically on testing interventions in prison settings, including provision of medication-assisted treatment (MAT) and screening and assessment to identify SUDs and co-occurring health conditions and mental disorders.

An archive of related studies and publications is available online (www.icpsr.umich.edu/icpsrweb/NAHDAP/series/244/studies).

Other NIDA justice system research initiatives are also available online (www.drugabuse.gov/researchers/research-resources/criminal-justice-drug-abuse-treatment-studies-cj-dats).

pregnancy and childcare difficulties as well as certain kinds of trauma, violence, and victimization. These issues are sometimes best dealt with in women-only programs.

Substance Misuse and Mental Illness in Women

Although women exhibit lower rates of SUDs than men do, prevalence rates are still high. According to 2018 National Survey on Drug Use and Health (NSDUH) data, about 17 percent of women ages 18 and older reported past-year use of illicit drugs, about 4 percent reported past-month heavy alcohol use, and about 22 percent engaged in past-month binge alcohol use (Center for Behavioral Health Statistics and Quality [CBHSQ], 2019).

In the United States, mental illness prevalence estimates are higher for women than men. The 2018 NSDUH showed that approximately 15 percent of men ages 18 and older reported a past-year mental illness compared with approximately 23 percent of women. However, rates for men and women are very similar for SMI (3.4 percent for men and 5.7 percent for women), CODs (4.0 percent for men and 3.4 for women), and combined SUDs with SMI (1.1 percent for men and 1.4 percent for women). More women than men with any mental illness received mental health services in 2018, whether including or excluding SMI (CBHSQ, 2019).

Treatment Approaches for Women

SUD treatment

Women disproportionately face barriers to treatment related to children and child care. Responsibility for care of dependent children is one of the most significant barriers women face in entering treatment, because many programs will not enroll women who lack child care (Taylor, 2010). Women who enter treatment sometimes risk losing public financial assistance and custody of their children, making the decision to begin treatment a difficult one (Taylor, 2010). However, women accompanied by their children into treatment can achieve successful outcomes. The Iowa Pregnant and Postpartum Women's Residential Treatment

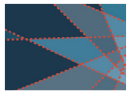
Program (<https://idph.iowa.gov/substance-abuse/programs/ppw>), funded through a SAMHSA grant, reported a 76-percent treatment completion rate and 90.5-percent abstinence rate from drugs and alcohol at 5 to 8 months after admission (Jones & Arndt, 2017).

Other barriers to SUD treatment women face include (McHugh, Votaw, Sugarman, & Greenfield, 2018; Taylor, 2010):

- Fear of stigma, shame, and embarrassment, especially among women with a history of sex work.
- Lack of support from partners, family, or friends.
- Inability to afford the high cost of treatment; women are less likely than men to have health insurance or sufficient funds to cover costs.
- Lack of programs that serve women and children.
- Denial or tendency to attribute substance-related problems to sources other than the addiction itself (like stress or physical health).
- Avoidance of programs including men, particularly if there is a history of physical or sexual abuse.
- Presence of a co-occurring mental illness, especially PTSD, depression, anxiety, or an eating disorder. CODs in women may lead to difficulty initiating, engaging in, and completing treatment.

Women differ from men in their SUD treatment initiation and participation behaviors and needs (Grella, 2008; McHugh et al., 2018; NIDA, 2018d):

- Women are more likely to be referred to or enter treatment via community-based social services, like welfare and child welfare programs, and are less likely to enter via the criminal justice system.
- Women are more likely to require public assistance to pay for treatment.
- Women may be more likely to initiate treatment after fewer years of substance misuse than men, but their clinical profiles are often more severe (e.g., greater psychosocial distress, greater odds of trauma experience, higher childcare burden, worse functional impairment). They also tend to start substance use at a later age but progress from first use to addiction faster than men do.



- Women with SUDs have a higher reported prevalence of mental disorders, particularly internalizing conditions (e.g., depression, anxiety, eating disorders, PTSD) and lower self-esteem, whereas men with SUDs are more likely to exhibit externalizing conditions (e.g., antisocial personality disorder [PD]).
- Whereas women with SUDs report having more difficulty with emotional problems, their male counterparts report having more trouble with functioning (e.g., work, money, legal problems).

Regarding treatment outcomes, large-scale randomized clinical trials have been mixed in their findings but generally find no gender differences.

Over the past two decades, there has been an increase in policy and research supporting the need for gender-sensitive SUD treatments. Compared with mixed-gender approaches (Grella, 2008; McHugh et al., 2018), some women-specific programs have been linked to:

- Better treatment retention and substance use outcomes (including abstinence).
- Better client satisfaction, comfort, and self-reported feelings of safety.
- Reduced risk of criminal activity and incarceration.
- Higher rates of receiving continuity of care.

Positive outcomes are especially likely in programs that include residential treatment with in-house accommodations for children, outpatient treatments that incorporate family therapy, and comprehensive services that address women-specific needs (e.g., case management, pregnancy-related services, parenting training/classes, child care, job training, and continuing care). Gender-specific treatments are effective in several subpopulations of women, including those with children, CODs, trauma history, or criminal justice system involvement (McHugh et al., 2018).

Programs offering COD treatment have a responsibility to address women's specific needs. Mixed-gender programs need to be responsive to women's needs. Women in mixed-gender outpatient programs require careful, appropriate counselor matching and the availability

of specialized women-only groups to address sensitive topics such as trauma, parenting, stigma, and self-esteem. Strong administrative policies pertaining to sexual harassment, safety, and language must be clearly stated and upheld. The same responsibility exists for residential programs designed for women who have multiple and complex needs and require a safe environment for stabilization, intensive treatment, and an intensive recovery support structure. Residential treatment for pregnant women with CODs should provide integrated SUD and mental disorder treatment and primary medical care, as well as attention to related problems and disorders. The needs of women in residential care depend in part on the severity and complexity of their co-occurring mental disorders. Other areas meriting attention include past or present history of domestic violence or sexual abuse, physical health, and pregnancy or parental status.

Exhibit 6.1 lists suggestions for gender-responsive SUD treatment. TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (SAMHSA, 2009c) offers more information on adapting behavioral health services to the needs of women.

COD Treatment

The treatment barriers and socioeconomic burdens facing women with either SUDs or mental illness alone are multiplied for women with both conditions, leading to substantial challenges that make recovery more difficult and relapse more likely. Women with SUDs frequently have comorbid mental disorders, including SMI (Evans, Padwa, Li, Lin, & Hser, 2015). This leads to more severe symptoms, worse functioning, lower quality of life, and more complex treatment needs than for women who only have SUDs. Specifically, women with CODs (particularly involving SMI, like bipolar disorder or psychosis) are more likely than women with only SUDs to (Evans et al., 2015):

- Experience homelessness.
- Be unmarried.
- Have a past history of physical or sexual abuse.
- Receive public assistance.
- Have a longer substance use history.
- Have more severe alcohol use-related problems.

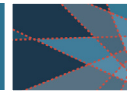


EXHIBIT 6.1. Adapting Treatment Services to Women's Needs

- Use nonconfrontational, strengths-based, trauma-informed treatment approaches.
- Offer evidence-based interventions that have been researched specifically in female populations.
- Ensure staff training and competencies regarding women-specific problems in substance misuse.
- Provide:
 - Prenatal/postnatal services.
 - Women-only groups.
 - Parenting training/counseling.
 - Trauma/abuse counseling and other services.
 - Education about and referral to women's health services.
- Use gender-specific assessments (including assessment of intimate partner violence and trauma).
- Offer services related to child care and children's needs, including:
 - Onsite child care or, for residential settings, live-in accommodations for children.
 - Screening and assessments for children.
 - Child and family counseling (or referral for those services).
 - Coordinated care with child welfare/children's protective services.
- Ensure the physical treatment environment is safe and secure. Being in close proximity to schools, child care, and public transportation is also desirable.

Sources: Grella (2008); Tang, Claus, Orwin, Kissin, & Arieira (2012).

- Have more severe problems related to employment.
- Have more severe medical conditions.
- Have greater family dysfunctions.
- Be on psychiatric medication.

Services for women with CODs should address these disparities. Women with CODs may also lack social support compared with women who have only SUDs; counselors should help women with CODs locate and use supportive services (Brown, Harris, & Fallot, 2013).

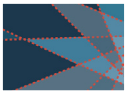
Women receiving treatment for SUDs or CODs often benefit from trauma-informed approaches. Trauma is present in an overwhelming majority of women with CODs (SAMHSA, 2015c), regardless of their age. Most women have a history of at least one adverse childhood experience, often abuse (Choi et al., 2017). However, women with CODs are less likely than women with SUDs only to enter treatment and to receive ongoing care (Bernstein et al., 2015), despite mental disorders and SUDs both being disabling in women and a common cause of inpatient hospitalization (Bennett, Gibson, Rohan, Howland, & Rankin, 2018).

Women with CODs—and particularly with SMI and SUDs—often do not receive services for their conditions.

Of women who entered SUD treatment with a co-occurring mental illness (Evans et al., 2015), almost 30 percent with a comorbid mental disorder received no mental health services over the course of 8 years, including 7 percent with co-occurring psychosis, 13 percent with bipolar disorder, and 20 percent with depressive disorder.

Pregnancy and CODs

Pregnancy can both aggravate and diminish the symptoms of co-occurring mental illness. Women with schizophrenia may experience a worsening of symptoms, whereas women with bipolar disorder have exhibited lower rates of new onset or recurrence of symptoms (Jones, Chandra, Dazzan, & Howard, 2014). Ample research has examined MDD during the prenatal, perinatal, and postnatal periods. Antidepressant discontinuation or untreated depression during pregnancy can exacerbate symptoms, including those related to risk of suicide, and worsen outcomes for both



mother and child (Gentile, 2017; Vigod, Wilson, & Howard, 2016). However, pregnancy has been linked to lower substance use in women, even if abstinence is temporary (Muhuri & Gfroerer, 2009; SAMHSA, 2009c). Compared with women who have a single disorder or no disorder, pregnant women with CODs are at elevated risk for negative perinatal outcomes, including birth complications, premature birth, low infant birthweight, nonadherence to prenatal care, child developmental delays, and poorer psychosocial functioning (Benningfield et al., 2010; Lee King, Duan, & Amaro, 2015).

Topics To Address With Co-Occurring Mental Illness

Careful treatment plans are essential for pregnant women with mental disorders. Plans should address childbirth and infant care. Women often are concerned about the effects of their medication on their fetuses. Treatment programs should aim to maintain medical and mental stability during clients' pregnancies and collaborate with other healthcare providers to ensure coordination of treatment.

Experts recommend a multidisciplinary approach to perinatal COD treatment, including consultation with providers in obstetrics, addiction, mental health, and pediatrics on pharmacotherapy (e.g., selective serotonin-reuptake inhibitors [SSRIs], MAT for opioid use disorder [OUD]), individual counseling (e.g., CBT, exposure, other trauma-based therapies), SUD treatment, prenatal care, maternal education, health promotion, and linkage to social services (Goodman, Milliken, Theiler, Nordstrom, & Akerman, 2015).

Pregnant women with CODs report desiring SUD treatment that includes (Kuo et al., 2013):

- More flexible treatment schedules.
- Longer sessions.
- Assistance with transportation to and from sessions.
- Group treatments.
- Interpersonal support (from partners, friends, family, and counselors).
- Linkage to community resources (like mutual-support programs).

- Treatment environments that convey a sense of safety and comfort.

When women are parenting, it can often retrigger their own childhood traumas. Therefore, providers need to balance growth and healing with coping and safety. Focusing on women's desire to be good mothers, the sensitive counselor will be alert to guilt, shame, denial, and resistance related to dealing with these problems, as recovering women gain awareness of effective parenting skills. **Providers should allow for evaluation over time for women with CODs. Reassessments should occur as mothers progress through treatment.**

Pharmacological Considerations

Prescribers should be aware that pregnant women must understand the risks and benefits of taking medications and sign informed consent forms verifying receipt and understanding of the information provided to them. Certain psychoactive medications are associated with birth defects, especially in the first trimester of pregnancy; weighing potential risk/benefit is important. In most cases, a sensible direction can be found through consultation with physicians and pharmacists who have expertise in treating pregnant women with mental disorders. Screen women for dependence on substances that can produce life-threatening withdrawal for the mother: alcohol, benzodiazepines, and barbiturates. These substances, as well as opioids, can also cause a withdrawal syndrome in babies, who may need treatment. Make pregnant women aware of wraparound services to assist them in managing newborns, such as food, shelter, and medical clinics for inoculations. Also ensure that women are informed of programs that can help with developmental or physical problems the infant may experience as a result of alcohol or drug exposure.

Postpartum Depression and Psychosis

The term "postpartum depression" (PPD) in *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013) refers to MDD in which the most recent depressive episode has an onset either during pregnancy or within 4 weeks after delivery. DSM-5 designates such cases through

PREGNANCY AND MAT FOR OUD

The approval of three medications by the Food and Drug Administration to treat OUD—methadone, buprenorphine, and naltrexone—has given the primary care and behavioral health fields powerful new tools to fight the opioid epidemic and save lives.

Considerations for MAT to address OUD in pregnant women include the following:

- MAT is possible for women with OUD who are pregnant and should be actively considered, given the wealth of evidence showing its effectiveness in reducing opioid use and preventing overdose.
- Pregnant women should be considered for methadone or transmucosal buprenorphine treatment.
- Pregnant women treated with methadone or sublingual or buccal buprenorphine have better outcomes than pregnant women not in treatment who continue to misuse opioids.
- Little research has examined the use of naltrexone during pregnancy. It should not be used with women who are pregnant. Instead, they should be referred for an evaluation for methadone or buprenorphine.
- Neonatal abstinence syndrome may occur in newborns of pregnant women who take buprenorphine. Women receiving opioid agonist therapy while pregnant should talk with their healthcare provider about neonatal abstinence syndrome and how to reduce it.
- An obstetrician and an SUD treatment provider should deliver collaborative treatment, and the woman should be offered counseling and other behavioral health services as needed.

Source: SAMHSA (2018c).

the MDD specifier “with peripartum onset.” (See Chapter 4 for DSM-5 diagnostic criteria for MDD.)

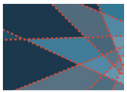
PPD prevalence estimates vary, given differences in timeframes researchers use to define the postpartum period. According to DSM-5 (APA, 2013), 3 percent to 6 percent of women will experience a major depressive episode either during pregnancy or in the weeks and months following childbirth. In a sample of 10,000 mothers screened for depression 4 to 6 weeks following delivery, 14 percent were positive for depression (Wisner et al., 2013). Forty percent had postpartum onset, 33 percent had onset during pregnancy, and 27 percent had onset prior to pregnancy. Thoughts of self-harm occurred in 19 percent.

PPD is considered distinct from postpartum “blues,” which is a mild, transient depression occurring most commonly within 3 to 5 days after delivery in about 30 percent to 80 percent of women after childbirth (Buttner, O’Hara, & Watson, 2012; Jones & Shakespeare, 2014). Prominent in its causes are a woman’s emotional letdown following the excitement and fears of pregnancy and delivery, the discomforts of the period immediately after giving birth, hormonal changes, fatigue from loss of sleep during labor and while hospitalized, energy expenditure at labor, and anxieties about

caring for the newborn at home. Symptoms include weepiness, insomnia, depression, anxiety, poor concentration, moodiness, and irritability. These symptoms tend to be mild and transient, and women usually recover completely with rest and reassurance. Anticipation and preventive reassurance throughout pregnancy can prevent postpartum blues from becoming a problem. Women with sleep deprivation should be assisted in getting proper rest. Follow-up care should ensure that the woman is making sufficient progress and not heading toward a relapse to substance use.

Moderate-to-strong risk factors for PPD include prior history of depression, anxiety, or other mental distress during pregnancy; prepregnancy mental disorder diagnosis (especially depression); presence of postpartum blues; psychosocial stress (e.g., poor marital relationships, lack of social support, child care-related distress); and certain personality traits and features (i.e., neuroticism, low self-esteem) (O’Hara & McCabe, 2013).

Prospects for recovery from PPD are good with supportive mental health counseling (especially for acute cases) accompanied as needed by pharmacotherapy, particularly in severe PPD (Thomson & Sharma, 2017). Various forms of



counseling (e.g., CBT, behavioral activation, interpersonal therapy), pharmacotherapy (e.g., SSRIs, selective norepinephrine reuptake inhibitors), and brain stimulation (e.g., electroconvulsive therapy, repetitive transcranial magnetic stimulation) have all been successful in treating PPD (Guille, Newman, Fryml, Lifton, & Epperson, 2013; O'Hara & Engeldinger, 2018; Thomson & Sharma, 2017). Additionally, the drug brexanolone received FDA approval for treating PPD in 2019. **Because some medications pass into breastmilk and can cause infant sedation, women should consult an experienced psychiatrist or pharmacist for details on pharmacotherapy.**

Patients with PPD need to be monitored for thoughts of suicide, infanticide, and progression of psychosis in addition to their response to treatment. Postpartum psychosis is a serious but rare mental disorder, with first lifetime onset occurring in 0.25 to 0.6 per 1,000 births (Bergink, Rasgon, & Wisner, 2016). Women with this disorder may lose touch with reality and experience delusions, hallucinations, and disorganized speech or behavior. Women most likely to be diagnosed with postpartum psychosis have a previous diagnosis or family history of bipolar disorder or other psychotic disorders (e.g., schizophrenia, schizoaffective disorder) (Davies, 2017). Other studies reviewed by Bergink and colleagues (2016) indicate that physiological factors, such as hormonal, immunological, and circadian rhythm disturbances, can increase the risk of postpartum psychosis in women who are already genetically vulnerable (e.g., those with a personal or family history of bipolar disorder, those with certain variants of the serotonin transporter gene). Typical onset is 3 to 10 days after delivery (Bergink et al., 2016).

Postpartum psychosis is associated with an increased risk of suicide and infanticide (Bergink et al., 2016; Brockington, 2017). **As such, the severity of the symptoms mandates immediate evaluation** (for diagnosis and for safety), which often needs to be performed in an inpatient setting, and treatment with benzodiazepines, lithium, antipsychotics, electroconvulsive therapy, or a combination thereof (Bergink et al., 2016;

Doucet, Jones, Letourneau, Dennis, & Blackmore, 2011). The risk of self-harm or harm to the baby needs to be assessed. Monitoring of mother–infant pairs by trained personnel can limit risks.

PPD and Substance Misuse

Little research has examined the relationship between PPD and substance use. One review of substance use in postpartum women found that problematic alcohol use occurred in 1.5 percent to 8 percent and drug use (cocaine and prescription psychoactive drugs) occurred in 2.5 percent (Chapman & Wu, 2013). Among women who reported using substances postpartum or who had a positive history of substance misuse, PPD was highly prevalent (20 percent to 46 percent). However, the women participating in these studies were likely to have had higher rates of depression than the general population to begin with because of low income and socially marginalized status (e.g., teenage mothers). The review also found that alcohol or illicit drug use was associated with higher scores of depression in postpartum women. These findings are consistent with an earlier review (Ross & Dennis, 2009) that similarly observed an association between substance use and an increased risk of PPD.

Women, Trauma, and Violence

Up to 80 percent of women seeking SUD treatment have a lifetime history of physical or sexual victimization, often traced back to childhood (Cohen, Field, Campbell, & Hien, 2013). **Intimate partner violence is also strongly connected to women's substance misuse and mental illness** (Macy, Renz, & Pelino, 2013; Mason & Dumont, 2015). In addition to SUDs, trauma-exposed individuals in the community who have PTSD are at an increased risk for MDD, dysthymic disorder, bipolar I and II disorders, generalized anxiety disorder, panic disorder, agoraphobia without panic disorder, social and specific phobias, and lifetime suicide attempt (Pietrzak, Goldstein, Southwick, & Grant, 2011).

People seeking SUD treatment who have PTSD are 14 times more likely to have an SUD than people without PTSD (McCauley, Killeen, Gros, Brady, & Back, 2012). In the general public,

lifetime prevalence rates of PTSD (full or partial) are two times higher in women than in men, with 46 percent of people with full PTSD also meeting criteria for an SUD (Pietrzak et al., 2011). Women who are incarcerated have even higher rates of each disorder—88 percent with full or partial PTSD and 87 percent with an SUD (Wolff et al., 2011). Women with trauma/PTSD may misuse substances to avoid intrusive, distressing symptoms (e.g., flashbacks, nightmares) or to numb themselves to emotional pain (Dass-Brailsford & Safilian, 2017).

Few SUD treatment programs assess for, treat, or educate clients about trauma and instead focus on managing the addiction (Macy et al., 2013). This is a serious deficiency, given the many interrelated consequences of failing to address trauma. Greater violence leads to more serious substance misuse and other addictions (e.g., eating disorders, sexual addiction, compulsive exercise), along with higher rates of depression, self-harm, and suicidal impulses. People with PTSD and AUD, for example, are vulnerable to more severe symptoms, greater risk of comorbid mood and PDs, worse physical functioning, and higher risk of suicide attempt than those with either disorder alone (Blanco et al., 2013). SUDs place women at higher risk of future trauma through associations with dangerous people and lowered self-protection when using substances (e.g., going home with a stranger after drinking).

Integrated trauma-informed treatment programs and approaches may be equally or more efficacious or effective than usual care in reducing substance misuse and psychiatric symptoms. Examples include integrated CBT, Seeking Safety, the Treatment Affect Regulation: Guide for Education and Therapy program, the Addictions and Trauma Recovery Integration program, the Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure program, and the Trauma Recovery and Empowerment Model (Dass-Brailsford & Safilian, 2017; Killeen, Back, & Brady, 2015).

For more information about trauma and for guidance on offering trauma-informed care, see Chapter 4.

For more detailed information, including individual and other models of trauma healing, see:

- TIP 51, Substance Abuse Treatment: Addressing the Specific Needs of Women (<https://store.samhsa.gov/system/files/sma15-4426.pdf>).
- TIP 57, Trauma-Informed Care in Behavioral Health Services (<https://store.samhsa.gov/system/files/sma14-4816.pdf>).

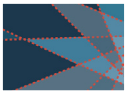
People of Diverse Racial/Ethnic Backgrounds

As racial and ethnic diversity in the United States increases, the need to address cultural differences in mental health and SUD treatment access, provision, and outcomes is becoming more urgent.

Per NSDUH data (CBHSQ, 2019), 2.9 percent of Whites had a past-year illicit drug use disorder in 2018 versus about 3.4 percent of African Americans, 4.0 percent of American Indians and Alaskan Natives, 3 percent of Latinos, and 1.6 percent of Asian Americans. AUD, prevalence was 5.7 percent among Whites, 4.5 percent among African Americans, 7.1 percent among American Indians or Alaskan Natives, 5.3 percent among Latinos, and 3.8 percent among Asian Americans. Approximately 16 percent of African American adults ages 18 and older had any past-year mental illness in 2018; similar rates occurred in other groups, including Latinos (16.9 percent) and Asian Americans (14.7 percent). By comparison, 20.4 percent of Whites and 22.1 percent of American Indians and Alaska Natives reported any past-year mental illness.

Cultural Perceptions of Substance Misuse, Mental Disorders, and Healing

Clients may have culturally determined concepts of what it means to misuse substances or to have a mental disorder, what causes these disorders, and how they may be “cured.” **Providers are encouraged to explore these concepts with people who are familiar with the cultures represented in their client population and with the clients themselves. Counselors should be**



alert to differences in how their role and the healing process are perceived by people who are of cultures other than their own. Whenever appropriate, familiar healing practices meaningful to clients should be integrated into treatment. An example would be the use of acupuncture to calm a Chinese client or help control cravings.

Cultural Perceptions and Diagnosis

Being aware of cultural and ethnic bias in diagnosis is important. For example, in the past some African Americans were stereotyped as having paranoid PDs, whereas women have been diagnosed frequently as being histrionic or borderline. American Indians with spiritual visions have been misdiagnosed as delusional or as having borderline or schizotypal PDs. **Diagnostic criteria should be tempered by sensitivity to cultural differences in behavior and emotional expression and by an awareness of the provider's own biases and stereotyping.**

Treatment Access and Utilization

Compared with Whites, other racial/ethnic populations make up a smaller percentage of the U.S. population with mental disorders, SUDs, or both. Yet concerns remain about treatment access and use, as people of diverse ethnic/racial backgrounds are disproportionately uninsured

(Kaiser Family Foundation, 2017; Sohn, 2017). Racial and ethnic populations have historically faced more financial and nonfinancial barriers to health care in general than Whites, including low cultural competency in their treatment providers (Mitchell, 2015). These barriers lead to worse health outcomes (e.g., increased morbidity, worse quality of care) as well as higher healthcare costs. Similarly, marginalized groups face systemic, organizational, cultural, and attitudinal obstacles to SUD treatment and mental health services (Holden et al., 2014; Keen et al., 2014; Masson et al., 2013; Maura & Weisman de Mamani, 2017; Pinedo, Zemore, & Rogers, 2018), including:

- Fear of stigma and feelings of shame.
- Mistrust of providers.
- Language barriers.
- Logistical obstacles (e.g., lack of transportation, lengthy wait times).
- Fearing the provider will not understand the client's culture, religion, or circumstances (e.g., immigration) or that the services won't be culturally responsive.
- Lack of insurance.
- Not knowing where to go for treatment.
- Not believing treatment is needed.
- Lacking confidence in treatment effectiveness.
- Family factors (e.g., lack of support, pressure

RACIAL/ETHNIC DISPARITIES AND SMI

Findings from a 2017 review of ethnic/racial disparities in the diagnosis and treatment of SMI suggest that:

- African Americans, Asian Americans, and Latinos offered mental health services in medical settings are more likely than Whites to receive a schizophrenia spectrum diagnosis.
- African Americans are more likely than Whites to be diagnosed with schizophrenia (and in one study were more than four times likely).
- African Americans are more likely than Whites to get higher doses of antipsychotics and are less likely to be prescribed newer generation antipsychotics (which have fewer side effects).
- Mental health service retention is lower for African Americans than for Whites.
- African Americans have worse mental health outcomes following inpatient treatment than Whites.
- Minorities are more likely to drop out of treatment by psychologists, psychiatrists, and general practitioners.
- African Americans are less likely than Whites to receive continuing care (e.g., medication management, outpatient visits/follow-up services) following hospital discharge.
- Diverse racial and ethnic populations in medical settings are more likely to use emergency rather than community services and thus are more likely to be hospitalized than Whites.

Source: Maura & Weisman de Mamani (2017).

to not enter treatment, withdrawal of financial help, not including family in treatment).

The effects of these barriers are reflected in lagging rates of treatment access, utilization, and completion for mental illnesses, SUDs, or CODs by diverse ethnic/racial populations compared with Whites (Cook et al., 2017; Holden et al., 2014; Maura & Weisman de Mamani, 2017; Nam et al., 2017; Saloner & Le Cook, 2013; Sanchez et al., 2016). This inequity may result from underassessment, underdiagnosis, and underreferral (Priester et al., 2016) as well as from cultural barriers.

Rates of SUD treatment provided in criminal justice facilities, in which racial/ethnic populations are overrepresented compared with Whites (Pew Research Center, 2018), also reveal cultural disparities (Nicosia, Macdonald, & Arkes, 2013). Whites who are incarcerated and have an SUD are more likely than African Americans and Latinos to receive SUD treatment and more likely to have SUD treatment and mental health services as a part of their sentencing requirements (Nowotny, 2015).

Reducing Racial/Ethnic Disparities

Recommended approaches to improving disparities in treatment access, utilization, and completion center on implementing healthcare and funding policy changes (e.g., legislation to increase awareness about disparities, expanding state Medicaid funding for treatment programs) and improving workforce cultural responsiveness (Morgan, Kuramoto, Emmet, Stange, & Nobunaga, 2014; Saloner & Le Cook, 2013; Wile & Goodwin, 2018). For instance, culturally responsive organizational practices (e.g., diverse hiring, staff training, linkage with surrounding community) and acceptance of public insurance have reduced gaps in service access and provision for low-income minority racial/ethnic populations by reducing wait time and improving SUD treatment retention (Guerrero, 2013).

Integrated and person-centered care also may help reduce healthcare disparities through strategies such as (Maura & Weisman de Mamani, 2017; Sanchez et al., 2016):

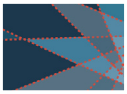
- Using bilingual case managers.
- Maintaining a diverse workforce.
- Ensuring staff are trained in culturally responsive care.
- Using multilingual mutual-support programs.
- Using patient navigators to help clients access community resources and overcome logistical barriers (e.g., keeping appointments).
- Performing assessments that address clients' cultural concepts/understanding of their symptoms.
- Using culturally relevant interpretations and frameworks to describe mental disorders (e.g., depression) rather than solely relying on Western definitions.
- Eliciting client preferences about treatment decisions, including giving the option to forego medication in favor of psychotherapy.
- When appropriate, including family in the treatment process and in education about mental illness.
- Using patient-centered communication to improve client education and reduce stigma, shame, and misunderstanding.
- Using sensitive, empathic, person-centered communication to build trust and enhance rapport.
- Providing culturally adapted evidence-based treatments when possible.

For more information about developing and implementing culturally responsive and competent services, see TIP 59, *Improving Cultural Competence* (SAMHSA, 2014a).

Cultural Differences and Treatment: Empirical Evidence on Effectiveness

Studies of cultural differences in COD treatment are scarce. However, **culturally adapted mental health services have been linked to small-to-moderate benefits compared with nonadapted treatments, placebo, waitlists, and usual care** (Cabassa & Baumann, 2013). For example, a review of culturally responsive mental health services for people with SUDs (Gainsbury, 2017) reported that:

- Culturally tailored psychosocial interventions increase treatment engagement and



ADVICE TO THE COUNSELOR: USING CULTURALLY APPROPRIATE METHODS

The consensus panel recommends these modifications to provide culturally appropriate COD treatment:

- Adapting interventions by altering the content of materials or communications to reflect racial/ethnic or cultural facts, values, imagery, beliefs, and norms. Engage members of the community (such as through focus groups) to ensure content adaptations are appropriate, accurate, and relevant.
- Use translated materials to meet the needs of clients for whom English is not a primary language. Simplified materials (such as those using illustrations, which can be more universally understood) are also desirable.
- Tailor services by culturally matching counselors to clients (if possible) and via culture-specific resources.
- When able, implement programs directly in the community where clients reside.
- Take into account the client's cultural beliefs about mental health, substance use, help-seeking behavior, causes of problems, and approaches to treatment. Similarly, in some cultures, there may be strong beliefs about the role of the family in the treatment of mental illness, substance misuse, or both; those beliefs may need to be accounted for when treatment planning.

Source: Healey et al. (2017).

participation, enhance client–provider alliance, reduce early treatment discontinuation, and improve symptoms.

- Cultural competence training for staff is associated with improved communication, more accurate diagnosis, a positive therapeutic alliance, and greater client satisfaction.
- Providing treatment in a client's native language or dialect can lead to better treatment outcomes and may be more influential than matching the provider's race/ethnicity to that of the client.
- Providers who show greater comfort with openly discussing cultural identities and values with clients may have better client retention rates than those who are uneasy talking about such topics.

Cultural competence should be a goal for programs as well as providers. In a study of more than 350 nationally representative outpatient SUD treatment programs (Guerrero & Andrews, 2011), program cultural competence—namely, managers'

culturally sensitive beliefs—predicted reduced client wait time and increased retention among Latinos and African Americans. Program leadership can influence staff uptake of culturally responsive care, translating to potentially better outcomes for clients.

Conclusion

To effectively fill practice gaps and more comprehensively address the widespread problem of unmet COD treatment needs, behavioral health service providers and programs need to recognize groups who have been historically underserved. The recovery community is diverse, and counselors may need to think outside of the box in adapting traditional techniques and perspectives to better meet the individual needs of all clients. Using a cookie-cutter approach for all clients in all settings increases the likelihood of improper diagnosis and treatment and is inconsistent with expert guidance on providing comprehensive, person-centered, recovery-oriented care.

Substance Use Disorder Treatment for People With Co-Occurring Disorders

UPDATED 2020

TREATMENT IMPROVEMENT PROTOCOL

TIP 42

SAMHSA

Substance Abuse and Mental Health
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