Chapter 7—Treatment Models and Settings for People With Co-Occurring Disorders

KEY MESSAGES

- Co-occurring disorders (CODs) are undertreated conditions that exact a serious toll on both the individuals living with them as well as on their families, caregivers, and society as a whole. Early and effective treatments offer people the opportunity to live fulfilling, healthy, productive lives.
- Available treatment models work by leveraging education, support, resources, and other services drawn from multiple sources, such as healthcare professionals collaborating across primary care service, mental health services, and substance use disorder (SUD) treatment; mutual-support programs; professionals in the recovery community; and peer recovery support specialists.
- Treatment providers should not operate in silos nor should they use treatments in isolation. The best way to serve people with CODs is to offer services and programs that are integrated, comprehensive, person centered, and recovery oriented in their structure, milieu, and practice.
- Counselors and programs need to provide effective interventions across multiple settings because people with mental disorders and SUDs often move among across levels of care, and this should not be a barrier to receiving needed evidence-based services.
- Although psychosocial services are often a cornerstone of interventions for CODs, counselors working with this population should be familiar with medication treatment, as many effective pharmacotherapies are available to help people reduce at least some of their symptoms and make appreciable gains in functioning.

Of the 9.2 million adults who had CODs in 2018, approximately half received no treatment at all, and only 8 percent received care for both conditions (Center for Behavioral Health Statistics and Quality, 2019). What happens to people with CODs who enter traditional SUD treatment settings? What can counselors, other providers, supervisors, and administrators do to help people with CODs more successfully access needed services? How can programs provide the best possible services to clients? What treatment options are available, and to what extent are they supported by science? This chapter is addressed to counselors, other treatment/service providers, supervisors, and administrators and seeks to answer these and other important questions about the management of co-occurring mental illness and addiction.

This chapter examines treatment models (e.g., integrated care, assertive community treatment [ACT], intensive case management [ICM], mutual-support and peer-based programs) and treatment settings (e.g., therapeutic communities [TCs], outpatient and residential care, acute care and other medical settings) for clients with CODs. It opens with an overview of general COD treatment considerations, including types of programs, levels of service (and matching clients to appropriate levels), episodes of treatment, integrated versus nonintegrated treatment, culturally competent services, and barriers to care. The bulk of the material then focuses on three areas: treatment models, treatment settings, and pharmacotherapy. Specific interventions, like cognitive–behavioral therapy (CBT), behavioral therapy, multidimensional family therapy, and dialectical behavior therapy, are beyond the scope of this Treatment Improvement Protocol (TIP). Readers should already possess a basic understanding of and working familiarity with these commonly used SUD treatments. Rather, the material is focused on describing the models and settings in which such interventions are provided.

Regarding pharmacotherapy, the chapter is not intended to offer exhaustive guidance on medication for CODs, and prescribers are not the intended primary audience of this chapter. However, counselors and other providers working with people who have CODs will encounter people taking medication and thus need to become familiar with medication names, side effects, and warnings about harmful interactions (especially with alcohol) and other adverse consequences.

Several examples of program models designed to serve COD populations are included throughout this chapter, as are "Advice to the Counselor" boxes to provide readers who have basic backgrounds with the most immediate practical guidance for implementing various program models in different treatment settings. To an extent, this chapter works hand in hand with the programmatic perspectives of Chapter 8 by discussing how to design and implement programs in various settings. Administrators will benefit from reviewing this information but should also be sure to read Chapter 8 for additional information about workforce hiring, training, and retention.

Treatment Overview

Treatment Programs

A mental health program offers an organized array of services and interventions focused on treating mental disorders, providing acute stabilization or ongoing treatment. These programs exist in various settings, like traditional outpatient mental health centers (e.g., psychosocial rehabilitation programs, outpatient clinics) or more intensive inpatient treatment units. Many such programs treat significant numbers of individuals with CODs. Programs more advanced in treating people with CODs may offer various interventions for SUDs (e.g., motivational interviewing, SUD counseling, skills training) in the context of the ongoing mental health services.

An SUD treatment program offers an organized array of services and interventions focused on treating SUDs, providing both stabilization and ongoing treatment. SUD treatment programs more advanced in treating people with CODs may offer a variety of interventions for mental disorders (e.g., symptom management training, psychopharmacology,) in the context of the ongoing SUD treatment.

Program Types

The American Society of Addiction Medicine (ASAM; Mee-Lee et al., 2013) describes three types of service programs for people with CODs:

- Co-occurring–capable (COC) programs are SUD treatment programs that mainly focus on SUDs but can also treat patients with subthreshold or diagnosable but stable mental disorders (Mee-Lee et al., 2013). These programs may offer mental health services onsite or by referral. COC programs in mental health focus mainly on mental disorders but can treat patients with subthreshold or diagnosable but stable SUDs (Mee-Lee et al., 2013). COC programs have addiction counselors onsite or available through referral.
- Co-occurring–enhanced programs have a higher level of integration of SUD treatment and mental health services, staff trained to recognize the signs and symptoms of both disorders, and competence in providing integrated treatment for mental disorders and SUDs at the same time.
- Complexity-capable programs are designed to meet the needs of individuals (and their families) with multiple complex conditions that extend beyond just CODs. Physical and psychosocial conditions and treatment areas of focus often include chronic medical illnesses (e.g., HIV and other infectious diseases), trauma, legal matters, housing difficulties, criminal justice system involvement, unemployment, education difficulties, childcare or parenting difficulties, and cognitive dysfunctions.

Levels of Service

Because mental disorders and SUDs are complex and vary in their severity and consequences, a wide range of levels of service are needed, from high-intensity inpatient medical service to periodic outpatient treatment. **Not all people with CODs will require the full continuum of services, and not all clients will move through levels of care in a linear fashion.** Clients can transition to and from greater and lower intensity services and

should be offered services based on clinical need (e.g., symptom severity, functional ability, person's overall level of stability) and stage of change.

The Level of Care Utilization System (LOCUS; American Association of Community Psychiatrists, 2016) describes six major domains of service levels for people with CODs:

1. Recovery Maintenance/Health Management
2. Low Intensity Community Based Services
3. High Intensity Community Based Services
4. Medically Monitored Non-Residential Services
5. Medically Monitored Residential Services
6. Medically Managed Residential Services

Chapter 3 further addresses levels of care, including services/populations associated with each.

Treatment Matching to Levels of Service Using the Quadrants of Care

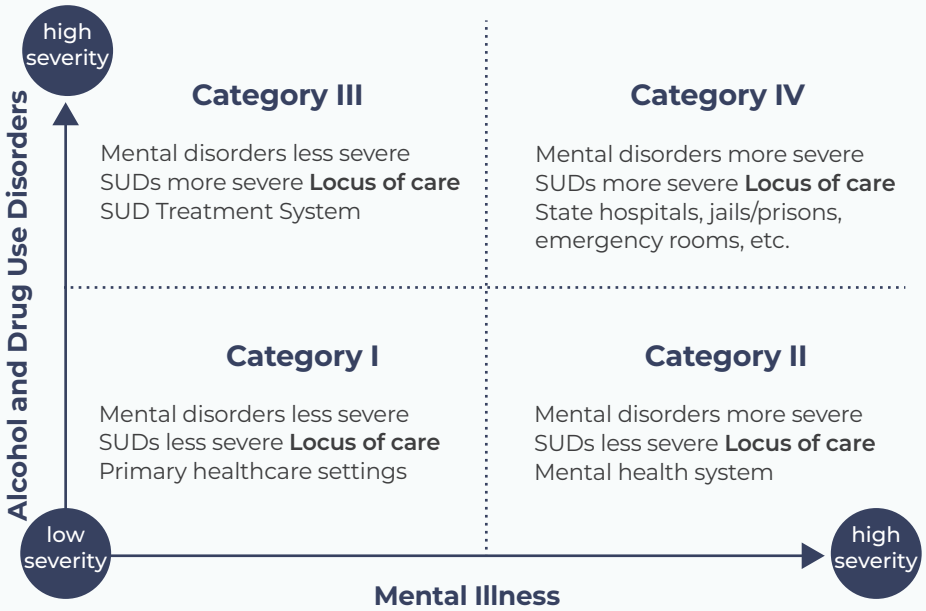
Effective treatment matching is an essential component of quality care for people with CODs that benefits the healthcare system as a whole. Treatment matching not only ensures clients receive the appropriate type and dose of service needed, it can help reduce unnecessary lengths of stay for residential treatment and helps reserve use of costly healthcare resources for those who truly require complex interventions. The widely used Four Quadrant Model (Ries, 1993; Exhibit 7.1) provides a framework for treatment decision making and prioritizing service needs for clients with CODs based on symptom/disorder severity. It has good concurrent and predictive validity (McDonell et al., 2012).

Under this conceptualization, clients are categorized accordingly:

- Category I: Less severe mental disorder/less severe SUD
- Category II: More severe mental disorder/less severe SUD
- Category III: Less severe mental disorder/more severe SUD
- Category IV: More severe mental disorder/more severe SUD

For a more detailed description of each quadrant and how to integrate treatment matching into the assessment process using the Four Quadrant Model, see Chapter 3.

EXHIBIT 7.1. The Four Quadrants of Care



Episodes of Treatment

An individual with CODs can participate in recurrent episodes of treatment involving acute stabilization (e.g., crisis intervention, detoxification, psychiatric hospitalization) and specific ongoing treatment (e.g., mental health–supported housing, day treatment for mental illness, or residential treatment for SUDs). Counselors should recognize the reality that clients engage in a series of treatment episodes, as many individuals with CODs progress gradually through repeated involvement in treatment.

Integrated Versus Nonintegrated Treatment

Providers generally treat CODs in one of three ways (Morisano, Babor, & Robaina, 2014):

1. **Sequential** or **serial treatment,** in which the client is treated for one disorder at a time. This has been the historic approach, but its effectiveness is dubious and may lead to worse outcomes given that, in some conditions, treatment of one disorder can worsen symptoms of the other (e.g., exposure therapy for a client with posttraumatic stress disorder [PTSD] might lead to anxiety and distress and subsequent alcohol use as a form of coping).
2. **Simultaneous** or **parallel treatment,** wherein the client is treated for both disorders but by separate providers and in separate systems. Although an improvement over sequential treatment, this approach does not lead to collaborative, comprehensive care.
3. **Integrated treatment,** which is the preferred method because it addresses all of a client's diagnoses and symptoms within one service system/agency/program and through a single team of providers working closely together. Integrated treatment is a means of actively combining interventions intended to address SUDs and mental disorders in order to treat both disorders, related problems, and the whole person more effectively.

Integrated treatments for people with CODs have demonstrated superiority to nonintegrated approaches and help improve substance use, mental illness symptoms, treatment retention, cost effectiveness, and client satisfaction (Kelly & Daley, 2013; Morisano et al., 2014). For an indepth discussion, see the section "Integrated Care" later in this chapter.

Culturally Responsive Treatment

One definition of cultural competence refers to "effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs" (Office of Minority Health, 2018). Treatment providers should view clients with CODs and their treatment in the context of their language, culture, ethnicity, geographic area, socioeconomic status, gender, age, sexual orientation, religion, spirituality, and physical/cognitive disabilities.

Cultural factors that may have an impact on treatment include heritage, history and experience, beliefs, traditions, values, customs, behaviors, institutions, and ways of communicating. The client's culture may include distinctive ways of understanding disease or disorder, including mental disorders and SUDs, which the provider needs to understand. Referencing a model of disease that is familiar to the client can help communication and enhance treatment. Counselors should educate themselves about the cultural factors that are important to racial/ethnic groups that their clients represent.

Clients, not counselors, define what is culturally relevant to them. Making assumptions, however well intentioned, about the client's cultural identity can damage the relationship with a client. For example, a client of Hispanic origin may be a third-generation U.S. citizen, fully acculturated, who feels little or no connection with her Hispanic heritage. A counselor who assumes this client shares the beliefs and values of many Hispanic cultures would be making an erroneous generalization. Similarly, it is helpful to remember that all of us represent multiple cultures. Clients are more than their racial/ethnic identities. A 20-year-old African-American man from the rural south may identify, to some extent, with youth, rural south, or African-American cultural elements—or might, instead, identify more strongly with another cultural

element that is not readily apparent, such as his faith. Counselors are advised to open a respectful dialog with clients around the cultural elements that have significance to them.

For discussion of cultural competence in SUD treatment, see TIP 59, *Improving Cultural Competence* (SAMHSA, 2014a). Chapter 6 addresses cultural competency for counselors whose clients have CODs.

Barriers to Treatment

People with CODs usually have extensive treatment needs, which unfortunately often go unmet. Among the approximately 8.5 million U.S. adults ages 18 and older with a past-year SUD and any mental illness in 2018, less than 10 percent received treatment for both disorders (Center for Behavioral Health Statistics and Quality, 2019). Similarly, from 2008 to 2014, 52 percent of people with CODs received neither mental health

REDUCING BARRIERS TO CARE: WHAT CAN COUNSELORS AND ADMINISTRATORS DO?

- **Use person-centered approaches** in assessing and treating clients with CODs. Consider factors such as:
  - The client's gender, age, race/ethnicity, or other demographic characteristic that could affect how the client experiences his or her illnesses and treatment.
  - The client's cultural background, including birth status (i.e., native born vs. immigrant).
  - The client's degree of acculturation and acculturation stress.
  - The client's history of trauma.
  - The client's current functional status (including housing and educational/vocational status).
  - Whether the client is experiencing any cognitive disabilities because of her or her diagnoses (particularly if the person has a psychotic disorder).
  - The interaction style to which the person best responds (e.g., Direct? Nonconfrontational?).
- Consider offering **harm-reduction treatments in addition to abstinence-based services.** Programs that limit themselves to abstinence-only treatments may fail to engage and retain clients who are not ready to stop substance use altogether but are otherwise amenable to treatment.
- Offer informal **pretreatment services** for people who are awaiting intake/appointments.
- **Adapt services to the logistical demands facing clients.** For instance:
  - When possible, offer appointments throughout the week and at various times (including before and after normal business hours to accommodate people who work or attend school full time).
  - Use remote services (e.g., telehealth) to reach and engage clients who are immobile or live at a distance.
- **Make integrated care a priority.** Programs that offer comprehensive services that work to simultaneously address all of a client's needs, using the same set of providers, are more likely to keep clients engaged and participating in treatment than ones that are fragmented. Treating substance use and mental disorders in isolation hinders counselors' ability to help clients address all aspects of functioning and disability, including their housing status, medication needs, and family relationships. These factors require attention because they can become reasons for clients to drop out.
- **Use a staged approach to interventions** (i.e., engagement, persuasion, active treatment, relapse prevention) that is tailored to clients' readiness to change and is flexible, as clients often move through stages in a nonlinear fashion. Motivational interviewing can help determine clients' readiness for interventions and aids in the creation of personally meaningful and realistic treatment goals.
- **Use assertive community outreach,** such as ICM and ACT services, as these foster therapeutic alliance and reduce practical/logistical barriers to treatment access and adherence (e.g., providing in-home services).
- **Emphasize COD leadership within programs.** Programs need to have a director on staff whose primary job is to oversee COD programming, services, fidelity, and staff competency/training.

Sources: Priester et al. (2016); SAMHSA (2009a).

RESOURCE ALERT: FINDING QUALITY TREATMENT FOR SUBSTANCE USE DISORDERS

SAMHSA's fact sheet helps people with SUDs make decisions about quality services and learn where to locate SUD treatment facilities and providers (https://store.samhsa.gov/system/files/pep18-treatment-loc.pdf).

services nor SUD treatment in the prior year (Han, Compton, Blanco, & Colpe, 2017). People might avoid pursuing treatment given lack of affordability, lack of knowledge about where to access treatment, and low perceived treatment need (e.g., not feeling ready to stop using substances, feeling like they could handle mental illness on their own) (Han, Compton, et al., 2017). Other common obstacles to accessing and benefiting from COD treatment include (Priester et al., 2016):

- Attitudinal and motivational barriers.
- Personal beliefs about and cultural conceptions of mental illness, addiction, and treatment.
- A lack of culturally sensitive/responsive assessments and treatments.
- Gender-specific factors. (e.g., a history of violence/abuse/trauma among women).
- Racial/ethnic factors. (e.g., lower rates of diagnosis and treatment referral for minorities than for Whites.)
- Stigma.
- Impaired cognition and insight (particularly among people with serious mental illness [SMI]).
- Logistical barriers (e.g., lack of transportation, childcare needs, limited access to resources).
- Limited social support.
- High levels of distress.
- Providers' inability to identify CODs because of inadequate training, lack of comprehensive screening and assessment procedures, or both.
- A dearth of COD-specialized services across inpatient and outpatient settings.
- Social, political, systemic, and legal barriers (e.g., poor service availability, insurance barriers).
- Socioeconomic factors, like low income, relying on public assistance, being uninsured, or Medicaid restrictions affecting program reimbursement.
- Organizational "red tape" leading to delays in care and lack of service provision.

Some populations, such as women, diverse racial/ethnic groups , people involved in the criminal justice system, and individuals experiencing homelessness, are especially vulnerable to treatment access challenges and poor outcomes. Learn more about these groups and how to adapt services to meet their needs in Chapter 6.

Treatment Models

Integrated Care

Integrated interventions are specific treatment strategies or techniques in which interventions for CODs are combined in a single session/interaction or in a series of interactions/multiple sessions. Integrated interventions can include a wide range of techniques. Some examples include:

- Integrated screening and assessment processes.
- Dual recovery mutual-support group meetings.
- Dual recovery groups (in which recovery skills for both disorders are discussed).
- Motivational enhancement interventions (individual or group) that address both mental and substance use problems.
- Group interventions for people with the triple diagnosis of mental disorder, SUD, and another problem, such as a chronic medical condition (e.g., HIV), trauma, homelessness, or criminality.
- Combined psychopharmacological interventions, in which a person receives medication designed to reduce addiction to or cravings for substances as well as medication for a mental disorder.

Integrated interventions can be part of a single program or can be used in multiple program settings.

INTEGRATED CARE: PARTNERSHIPS FOR PHARMACOTHERAPY

Recovery-oriented systems of care foster both integrated care for the simultaneous treatment of mental illness and SUDs but also foster critical processes, like active linkages, warm handoffs, and ongoing follow-up from one stage or environment of care to the next. This is particularly important for people with SMI because these diagnoses tend to require lifelong monitoring and management of potentially debilitating symptoms. If a client is not responding to a nonpharmacological treatment, consider whether:

- An alternative treatment or service (e.g., a different psychotherapeutic approach, medication, mutual support) is needed.
- The treatment is a good match the client's level of service need.
- The treatment is a good match for the client's readiness for change.

Given that medication often plays a role in helping people with SMI achieve and sustain recovery, it may be worth considering whether referral of clients with CODs (and especially SMI) to a provider qualified to assess for pharmacologic options is needed.

Behavioral health programs should encourage the provider making that referral to do a warm handoff and follow up with the client in 2 to 4 weeks to determine how well the medication is working and whether the client has any concerns. If pharmacotherapy is being provided offsite (e.g., to a methadone clinic), the provider will need to obtain the client's written consent to discuss with the prescribing provider how the client is faring, whether medication seems to be effective, and whether any nonpharmacologic treatments or services need to be tailored in any way as a result of the client taking medication.

For more guidance about medication treatments for CODs, see the section "Pharmacotherapy" at the end of this chapter. Also see the text box "Knowing When To Refer for Medication Management" within that section.

Empirical Evidence of Integrated Care for CODs

The integrated model of care is considered a best practice for serving people with CODs. (See "Resource Alert: Implementing Integrated Care for People With CODs.") It has been linked to many desirable substance-, psychiatric-, functional-, and service-related outcomes, including decreased substance use and abstinence (Drake, Bond, et al., 2016; Flanagan et al., 2016; Kelly & Daley, 2013; McGovern et al., 2015; Ruglass et al., 2017; Schumm & Gore, 2016; Sterling, Chi, & Hinman, 2011); improved mental functioning (Alterman, Xie, & Meier, 2011; Drake, Bond, et al., 2016; Flanagan et al., 2016; Kelly & Daley, 2013; McGovern, Lambert-Harris, Ruglass, et al., 2017); decreased emergency department (ED) visits, inpatient hospitalizations, and healthcare costs (Morse & Bride, 2017); gains in independent housing and competitive employment (Drake, Bond, et al., 2016); improved life satisfaction or quality of life (Drake, Bond, et al., 2016); and greater client satisfaction (Schulte, Meier, & Stirling, 2011).

Integrated COD care can be effective across different settings and in diverse populations, including:

- **In residential facilities** (McKee, Harris, & Cormier, 2013). Here, integrated care has been associated with significant reductions in mental illness symptoms, improvements in COD-related knowledge and skills, increased self-esteem, and good client satisfaction—even among clients with complex, challenging clinical and psychosocial histories (e.g., presence of PTSD, polysubstance misuse, childhood maltreatment, adolescent substance misuse, unstable housing, reliance on public assistance, being unemployed or out of school).
- **In a variety of criminal justice–related settings,** such as prebooking diversion programs, drug or mental health courts, in jails or prisons, and as a part of community release (Peters et al., 2017; Rojas & Peters, 2015). Integrated COD care has been linked to desirable outcomes such as improved psychiatric symptoms, reduced substance use, and decreased rates of reoffending and recidivism.

RESOURCE ALERT: IMPLEMENTING INTEGRATED CARE FOR PEOPLE WITH CODs

- SAMHSA's Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices KIT (https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4366)
- Case Western Reserve's Center for Evidence-Based Practices. Integrated Dual Disorder Treatment Clinical Guide (www.centerforebp.case.edu/client-files/pdf/iddtclinicalguide.pdf)

- **With people experiencing homelessness** (Polcin, 2016; Smelson et al., 2016). In these populations, integrated COD treatment can help reduce substance use and mental illness symptoms while, depending on the housing service model used, also increasing housing stability and retention.

Assertive Community Treatment

Developed in the 1970s by Stein and Test (Stein & Test, 1980; Test, 1992) for clients with SMI, the ACT model was designed as an intensive, long-term approach to providing services for those who were reluctant to engage in traditional treatment approaches and who required significant outreach and engagement activities. ACT has evolved and been modified to address the needs of individuals with mental disorders (especially SMI) and co-occurring SUDs (De Witte et al., 2014; Fries & Rosen, 2011; Manuel, Covell, Jackson, & Essock, 2011; Young, Barrett, Engelhardt, & Moore, 2014).

Program Model

ACT programs typically use intensive outreach activities, active and continued engagement with clients, and a high intensity of services. Multidisciplinary teams, including specialists in key areas of treatment, provide a range of services to clients. Members typically include mental health and SUD treatment counselors, case managers, nursing staff, and psychiatric consultants. The ACT team provides the client with practical assistance in life management as well as direct treatment, often within the client's home environment, and remains responsible and available 24 hours a day (SAMHSA, 2008). The team has the capacity to intensify services as needed and may make several visits each week (or even per day) to a client. Caseloads are kept smaller than other community-based treatment models to accommodate the intensity of service provision (a 1:10 staff-to-client ratio is typical).

ACT Activities and Interventions

Examples of ACT interventions include (Bond & Drake, 2015; SAMHSA, 2008):

- Outreach/engagement. To involve and sustain clients in treatment, counselors and administrators must develop multiple ways to attract, engage, and reengage clients. Expectations for clients are often minimal to nonexistent, especially in programs serving very resistant or hard-to-reach clients.
- Practical assistance in life management. This feature incorporates case management activities that facilitate linkages with support services in the community, including employment services. Whereas the role of a counselor in the ACT approach includes standard counseling, in many instances substantial time also is spent on life management and behavioral management matters.
- Tangible support. For some clients, especially with SMI, help with logistical and everyday functional needs is critical to ensuring treatment access, engagement, participation, and retention. Supportive care can include assistance with housing, benefits/insurance, transportation, and child care.
- Counseling. The nature of the counseling activity is matched to the client's motivation and readiness for treatment. Interventions may also involve family and other support networks as appropriate.

NINE ESSENTIAL FEATURES OF ACT

1. Services that are provided in the community rather than in clinic offices
2. Assertive engagement with active outreach
3. Holistic approaches that address clients' symptoms, medication needs, housing difficulties, financial needs, and other areas of daily living (e.g., transportation)
4. A multidisciplinary team of mental health service and SUD treatment professionals (e.g., counselors, psychiatrists, social workers, psychiatric and mental health nurses [specialty practice registered nurses], case managers)
5. Providing clients with services directly rather than utilizing referrals to other professionals
6. Integrated services that are tailored to comprehensively and simultaneously address a client's full range of clinical, functional, vocational, social, and everyday living needs
7. A low client–provider ratio (usually about 10 clients per provider)
8. Continuous care, including 24/7 emergency services
9. Focus on helping to support long-term rather than acute recovery

Source: Bond & Drake (2015).

- Crisis assessment and intervention. This is provided during extended service hours (24 hours a day, ideally through a system of on-call rotation).

Key Modifications for Integrating COD Treatment

As applied to CODs, the goals of the ACT model are to engage the client in a helping relationship, to assist in meeting basic needs (e.g., housing), to stabilize the client in the community, and to provide direct and integrated SUD treatment and mental health services. The standard ACT model as developed by Test (1992) has been modified to include treatment for people who have SUD as well as SMI (Bond & Drake, 2015) and to address common needs within the COD community (e.g., housing needs, criminal justice–related needs). Key elements in this evolution have been (Neumiller et al., 2009):

- Offering direct SUD interventions for clients with CODs (often through the inclusion of an addiction counselor on the multidisciplinary team) or, if not possible, referral to SUD treatment.
- Using a COD-based model of care that focuses on specialized services, a nonconfrontational and supportive milieu, and recovery-oriented stages of care.
- Providing higher intensity of services via "mini-teams" of case managers, mental health service and SUD treatment providers, and consumer advocates.
- Adapting ACT to support housing placement, such as:
  - Integrating a Housing First (HF) model of supportive permanent housing.
  - Including outreach workers and assistants to give providers more time with clients.
  - Placing time limits on services to encourage client engagement in interventions that support independent living (like employment and vocational training).
  - Monitoring psychiatric symptoms and medication response.
  - Offering SUD treatment/education.
  - Adding residential housing as a temporary solution for clients in the process of obtaining independent stable housing.
- Modifying for criminal justice settings/populations (Lamberti et al., 2017; Landess & Holoyda, 2017; Marquant, Sabbe, Van Nuffel, & Goethals, 2016) by collaborating with and including criminal justice agencies and professionals (e.g., probation officers) in the ACT team; using court sanctions or other legal leverage to increase motivation and treatment participation/retention; applying forensic rehabilitation strategies to target factors associated with reoffending and recidivism; and educating and training providers in unique aspects of criminal justice–mental health collaboration.

SUD treatment strategies are related to the client's motivation and readiness for treatment and include:

- Enhancing motivation (for example, through use of motivational interviewing).
- Cognitive–behavioral skills for relapse prevention.
- Mutual-support programming, including peer recovery supports to strengthen recovery.
- Psychoeducational instruction about addictive disorders.

For clients uninterested in abstinence, motivational approaches to ACT can highlight the detrimental effects of substance use on their lives and those of the people around them. Therapeutic interventions are then modified to meet the client's current stage of change and receptivity. Learn more in Chapter 5 and in TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* (SAMHSA, 2019c).

Populations Served

When modified as described previously for CODs, the ACT model is capable of including clients with greater mental and functional disabilities who do not fit well into many traditional treatment approaches. The characteristics of those served by ACT programs for CODs include people with an SUD and mental illness, SMI (e.g., intractable depression, bipolar disorder, schizophrenia and other psychotic disorders), serious functional impairments, avoidance of or poor response to traditional outpatient mental health services and SUD treatment, homelessness, criminal justice involvement, or some combination thereof. Consequently, clients targeted for ACT often are high users of expensive service delivery systems (EDs and hospitals) as immediate resources for mental health and SUD services.

Empirical Evidence for ACT

The ACT model has been researched widely as a means of providing community-based services to people with chronic mental illness. The low caseload ratio and delivery of community-based services, combined with intensive attention, structure, monitoring, and outreach, are beneficial for people with SMI, because SMI is typically unstable and highly disabling. For instance, a randomized trial of integrated ACT versus standard case management found ACT significantly improved medication adherence among people with psychotic disorders and SUDs over a 3-year period (Manuel et al., 2011).

Research on ACT for individuals with CODs has been somewhat limited compared with research on ACT for mental illness alone, and findings to date have been mixed. ACT demonstrated superiority to standard clinical case management in reducing alcohol use and incarcerations among people with CODs plus antisocial personality disorder (PD) but not people with CODs without antisocial PD (ASPD; Frisman et al., 2009). However, this study used a small sample size and lacks generalizability. ACT combined with integrated dual disorder treatment (including from an addiction specialist) for people with SMI and SUD (Morse, York, Dell, Blanco, & Birchmier, 2017) improved symptoms of SUDs and mental illness, including decreasing alcohol use but not drug use or overall substance use. In a SAMHSA grant-funded program that provided ACT and integrated COD treatment services to people experiencing chronic homelessness (Young et al., 2014), ACT was associated with improved housing stability, global mental health, past-month depression and anxiety, client self-esteem and decision-making abilities, treatment satisfaction, and treatment

RESOURCE ALERT: IMPLEMENTING ACT FOR PEOPLE WITH CODs

- SAMHSA's ACT for Co-Occurring Disorders Evidence-Based Practices KIT (https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/sma08-4344)
- Georgia Department of Behavioral Health & Developmental Disabilities Program Tool Kit for ACT (https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/document/Georgia%20Toolkit%20for%20ACT%20Teams%20docxfinal%202015.pdf)

engagement but not self-reported alcohol or illicit drug use. In a review of outpatient treatments for schizophrenia and SUD (De Witte et al., 2014), integrated ACT outperformed treatment as usual in terms of substance use, hospitalizations, stable housing, and negative and disorganized symptoms of psychosis but was no better than integrated case management at reducing substance use and improving psychiatric symptom severity.

These mixed findings are likely due in part to ACT's unproven ability to ameliorate SUDs. A review of randomized clinical trials of ACT for substance misuse (Fries & Rosen, 2011) found that it helped reduce alcohol and drug use over time **when supplemented with SUD treatment.** But effects were small, and reductions in substance use were typically no better than those from other treatment approaches (e.g., case management). This suggests that traditional ACT is likely not an effective addiction management tool on its own but when used with adjunctive SUD treatment (e.g., inclusion of addiction counselors, use of contingency management for abstinence) may be as effective as case management at improving substance-related outcomes. Nevertheless, based on the weight of evidence, **ACT is a recommended treatment model for clients with CODs, especially when used as an integrated treatment with adjunct substance use services.**

Examples of ACT Programs

The University of Washington Program for ACT

The University of Washington's Program for ACT (PACT) was established to provide outreach-based services to clients with mental and addiction needs, particularly people with SMI and SUDs. Washington PACT teams carry a low caseload (1:10 provider–client ratio) and use high-intensity, multidisciplinary services (e.g., 24/7 care, treatments predominantly offered in the community), including CBT, SUD treatment, family psychoeducation, motivational interviewing, pharmacotherapy, relapse prevention, crisis management, psychiatric rehabilitation, community outreach, social skills training, and supported education/employment services. The program currently has 15 teams located throughout Washington State. Program reports indicate up to 60 percent of Washington PACT team clients have CODs.

RESOURCE ALERT: UNIVERSITY OF WASHINGTON PACT IMPLEMENTATION AND ENGAGEMENT TOOLS

The PACT program website lists resources to help programs implement ACT and improve client engagement (https://depts.washington.edu/ebpa/projects/revised_comprehensive_assessment_r-ca). Resources include:

- A blank weekly client schedule form.
- A sample daily staff schedule.
- A sample client contact log.
- An ACT Transition Assessment Scale to assess client readiness to step down to less intensive services.
- The PACT Comprehensive Assessment Scale, used to help programs assess the client/family needs and determine which program services would best serve the client.
- A sample case study.
- Putting It Together Worksheet, used to summarize content from assessment and develop a treatment plan.
- Checklist of areas for further assessment and tools for follow-up assessment.
- Links to specific assessment tools for:
  - PTSD.
  - Suicide risk.
  - Alcohol use disorder (AUD).
  - SUD.
  - Client ambivalence to change.
  - Recovery assessment.
  - Strengths assessment.
  - Nicotine use.
  - Psychiatric rehabilitation.

Mercy Maricopa ACT Program

Mercy Maricopa, an integrated physical and behavioral health Medicaid managed care plan, offers an ACT program of 23 ACT teams

(including 3 forensic ACT programs) specifically focused on people with SMI. ACT teams provide comprehensive, multidisciplinary wraparound care including psychiatric and SUD treatment, medication management, case management, social services, vocational rehabilitation, housing and vocational assistance, and peer support.

A healthcare analysis from 2018 (NORC, 2018) found that, pre–post enrollment in the ACT program, clients incurred significantly lower overall facility costs ($608 less per member per quarter), overall professional service costs ($485 less), behavioral health service costs ($410 less), and total behavioral health costs ($808 less). Total spending from pre- to postprogram participation decreased by $734 but was not significant. Pharmacy expenditures were significantly higher following ACT program participation ($246 more). ACT clients had significantly less ED utilization and fewer psychiatric hospitalizations from baseline to postprogram participation. Compared to a matched comparison group not participating in the ACT program, ACT clients had significantly lower rates of ED utilization.

Integrated Case Management

The earliest model of case management was primarily a brokerage model. Linkages to services were based on clients' individual needs, but case managers provided no formal clinical services. Over time, it became apparent that providers could provide more effective case management services. Thus, clinical case management largely supplanted the brokerage model. ICM emerged as a strategy in the late 1980s and early 1990s. It was designed as a thorough, long-term service to assist clients with SMI (particularly those with mental and functional disabilities and a history of not adhering to prescribed outpatient treatment) by establishing and maintaining linkages with community-based service providers.

ICM is not a precisely defined term but rather is used in the literature to describe an alternative to both traditional case management and ACT. The goals of the ICM model are to engage individuals in a trusting relationship, assist in meeting their basic needs (e.g., housing), and help them access and use brokered services in the community. The fundamental element of ICM is a low caseload per case manager, which translates into more intensive and consistent services for each client. TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT], 2000b), contains more information on the history of case management, both how it has developed to meet the needs of clients in SUD treatment (including clients with CODs) and specific guidelines about how to implement case management services.

Program Model

ICM programs typically involve outreach and engagement activities, brokering of community-based services, direct provision of some support/counseling services, and a higher intensity of services than standard case management. The integrated case manager assists the client in selecting services, facilitates access to these services, and monitors the client's progress through services provided by others (inside or outside the program structure or by a team). Client roles in this model include serving as a partner in selecting treatment components.

In some instances, the ICM model uses multidisciplinary teams similar to ACT. The composition of the ICM team is determined by the resources available in the agency implementing the programs. The team often includes a cluster-set of case managers rather than the specialists prescribed as standard components of the treatment model. The ICM team may offer services provided by ACT teams, including practical assistance in life management (e.g., housing) and some direct counseling or other forms of treatment. Caseloads are kept smaller than those in other community-based treatment models (typically, the client–counselor ratio ranges from 15:1 to 25:1) but larger than those in the ACT model. Because the case management responsibilities are so wide ranging and require a broad knowledge of local treatment services and systems, a typically trained counselor may require some retraining or close, instructive supervision in order to serve effectively as a case manager.

ADVICE TO ADMINISTRATORS: TREATMENT PRINCIPLES FROM ICM

- Select clients with more mental/functional disabilities who are resistant to traditional outpatient treatment.
- Use a low caseload per case manager to accommodate more intensive services.
- Assist in meeting basic needs (e.g., housing).
- Facilitate access to and utilization of brokered community-based services.
- Provide long-term support, such as counseling services.
- Monitor the client's progress through services provided by others.
- Use multidisciplinary teams.

Treatment Activities and Interventions

Examples of ICM activities and interventions include:

- Engaging the client in an alliance to facilitate the process and connecting the client with community-based treatment programs.
- Assessing needs, identifying barriers to treatment, and facilitating access to treatment.
- Offering practical help with life management; facilitating linkages with community support services.
- Making referrals to treatment programs offered by others in the community; see also TIP 27 (CSAT, 2000b) for guidance on establishing linkages for service provision and interagency cooperation.
- Advocating for the client with treatment providers and service delivery systems.
- Monitoring progress.
- Providing counseling and support to help the client maintain stability in the community.
- Crisis intervention.
- Assisting in integrating treatment services by facilitating communication between service providers.

Key Modifications of ICM for CODs

Key ICM modifications from basic case management for clients with CODs include:

- Using direct interventions for clients with CODs, such as enhancing motivation for treatment and discussing the interactive effects of mental disorders and SUDs.
- Making referrals to providers of integrated SUD treatment and mental health services or, if integrated services are not available or accessible, facilitating communication between separate brokered mental health service and SUD treatment providers.
- Coordinating with community-based services to support the client's involvement in mutual-support groups and outpatient treatment activities.

Empirical Evidence

Most published literature on ICM has focused on mental illness, with fewer U.S. studies examining SUD or CODs. ICM may help people with SMI reduce hospitalizations, stay in treatment longer, and improve social functioning. But many of these studies are considered to be of low quality (e.g., small sample sizes, flawed methodology or study design), and findings are not consistently better than those from standard care or other non-ICM approaches (Dieterich et al., 2017). Some researchers have reported positive effects of ICM for SMI in terms of:

- Increasing social integration among people in supported housing and acquisition of Section 8 housing vouchers (Tsai & Rosenheck, 2012).
- Improving physical health (e.g., weight, blood pressure) among veterans (Harrold et al., 2018).
- Reducing mental illness hospitalizations (by 70 percent); average number of days hospitalized for mental illness (by 75 percent); and average 30-day inpatient psychiatric service costs, outpatient psychiatric service costs, and outpatient medical service costs (Kolbasovsky, 2009).

Studies of ICM and substance use in U.S. populations are tentatively positive, but the research is limited in number and generalizability. In women with substance misuse receiving Temporary Assistance for Needy Families (Morgenstern et al.,

2009), ICM was associated with greater rates of short-term and long-term abstinence and a greater likelihood of being employed full time than was usual care (i.e., screening and referral). In a related study, Kuerbis, Neighbors, and Morgenstern (2011) observed paradoxical moderating effects of depression on ICM substance use outcomes such that women with substance misuse and higher scores of depression who participated in the ICM program had better SUD treatment engagement and fewer drinks per drinking days than women in the program with lower scores of depression. Women with higher depression also exhibited higher or equal rates of SUD treatment attendance and percentage of days abstinent than less-depressed women. Hence, the ICM program was effective at improving addiction outcomes and may be especially so among women with comorbid high depression.

Regarding CODs, ICM appears effective in specific populations (e.g., veterans, people with housing needs, individuals in the criminal justice system), although the magnitude of effect of these programs is unclear, as is whether they are superior to ACT or other approaches. A rural-based ICM for people with and without CODs (Mohamed, 2013) helped more military veterans with CODs engage in rehabilitation, housing, vocational, and addiction services than it did veterans without CODs. The ICM program was associated with improvements in mental disorder symptoms, distress, quality of life, treatment satisfaction, income, and days employed; however, there were no differences in any of these variables between veterans with and without CODs.

Malte, Cox, and Saxon (2017) also examined veterans receiving ICM but with a focus on promoting housing stability and addiction recovery. Almost 60 percent of program participants had a comorbid depressive disorder, 43 percent PTSD, 31 percent an anxiety disorder, 21 percent a psychotic disorder, and 19 percent a bipolar disorder. Over time, participants increased their percentage of days spent in their own home or in transitional housing; decreased days spent homeless or living with others; increased rates of 30-day abstinence; and improved their Addiction Severity Index (ASI) scores (legal, drug, and psychiatric composite scales). However, none of these improvements were significantly different from those observed in the control condition (a housing support group). Nevertheless, the addiction/housing ICM program was associated with more days spent in SUD treatment (almost 53 days longer than controls), greater treatment participation, and higher treatment satisfaction.

The Northern Kentucky Female Offender Reentry Project (McDonald & Arlinghaus, 2014) examined ICM among incarcerated women with SMI, SUDs, or both (78 percent had a COD). Compared with women who only participated in the program while incarcerated, women who participated during imprisonment and after release demonstrated better outcomes in educational attainment (e.g., obtaining a General Equivalency Degree, enrolling in college after release), obtaining part- or full-time work, SUD treatment and mental health service engagement, and recidivism.

Examples of ICM Programs

SAMHSA's Cooperative Agreement to Benefit Homeless Individuals

SAMHSA's Cooperative Agreement to Benefit Homeless Individuals (CABHI) programs use integrated approaches, including ICM, to address addiction, mental illness, and medical, housing, and employment needs. Funding is administered as part of SAMHSA's Recovery Support Strategic Initiative, with the overarching goal of helping people with SUDs, SMI, or CODs reduce the experience of homelessness (e.g., via subsidized and supportive housing). The program was initiated in 2011 to provide funding to public and nonprofit entities and was expanded in 2013 to offer funds to help establish or enhance statewide service infrastructure and planning. It again expanded in 2016 to include more communities (including tribal communities) and nonprofit organizations. Integrated services offered by CABHI programs include community outreach; screening, assessment, and treatment for addictions, mental illness, or both; peer recovery support services; and ICM.

The Extended Hope Project in Yolo County, California, is a CABHI recipient (2016–2019) offering integrated treatments to improve housing stability, behavioral and physical health, and criminal justice status for people in Yolo County with CODs who are experiencing homelessness.

The program includes:

- A screening, assessment, and triage service to link clients with outreach workers to assess clients for needed services and enroll them in case management.
- An ICM and treatment team, including case managers, who responded to crisis needs, worked with clients on shared treatment decision making, and helped develop tailored treatment plans; peer recovery support specialists, who provided mentorship, support, and education; and an employment specialist to aid with job placement.
- Collaboration with a housing navigator to help connect clients with permanent housing placement and teach eviction prevention strategies.

Pathways to Housing, Inc.'s HF Programs

The HF program uses the supportive permanent housing model (see Chapter 6) to help people with CODs obtain stable housing and prevent future homelessness (Tsemberis, 2010). Originally launched in New York City in 1992, programs now also exist in Washington, DC, Vermont, Pennsylvania, and Canada. HF programs do not require clients to achieve abstinence before enrolling and instead integrate SUD and mental disorder treatment with housing support services (e.g., ACT or ICM).

The Tulsa Housing and Recovery Program, a recipient of the SAMHSA Services in Supportive Housing 5-year grant in 2009, is a collaboration between community mental health centers and housing providers that offers SUD treatment, mental health services, and supportive housing (via the HF model) to individuals with CODs who are experiencing homelessness. Integrated services and ICM are key components of the program. From 2009 to 2013, the program reported numerous improved outcomes (Shinn & Brose, 2017), including the following:

- 94 percent of clients retained in housing (i.e., continuously housed for 12 months or longer)
- 72 percent of clients reduced their substance use at 6 months
- 70 percent scored at minimal or no risk for substance misuse at 6 months
- 69 percent reported at least 3 months of abstinence
- 79 percent had a reduction in self-reported trauma symptoms at 6 months
- 81 percent achieved trauma-related treatment gains in 6 months
- 100 percent of clients were successfully linked to healthcare services through peer support and nurse-led assessment and triage

Comparison of ACT and ICM

Both ACT and ICM share the following key activities and interventions:

- Focus on increased treatment participation
- Client management
- Abstinence as a long-term goal, with short-term supports
- Stagewise motivational interventions
- Psychoeducational instruction
- Cognitive–behavioral relapse prevention
- Encouraging participation in mutual-support programs
- Supportive services
- Skills training
- Crisis intervention
- Individual counseling

Differences Between ACT and ICM

ACT is more intensive than most ICM approaches. The ACT emphasis is on developing a therapeutic alliance with the client and delivery of service components in the client's home, on the street, or in program offices (based on the client's preference). ACT services are provided predominantly by the multidisciplinary staff of the ACT team, and the program often is located in the community (Bond & Drake, 2015; Ellenhorn, 2015). Most ACT programs provide services 16 hours a day on weekdays, 8 hours a day on weekends, plus on-call crisis intervention, including visits to the client's home at any time, day or night, with the capacity to make multiple visits to a client on any given day. Caseloads usually are 10:1. ICM programs typically include fewer hours of direct treatment, but they may include 24-hour crisis intervention; the focus of ICM is on brokering community-based services for the client. ICM caseloads range up to 25:1.

The ACT multidisciplinary team shares responsibility for the entire defined caseload of clients and meets frequently (ideally, teams meet daily) to ensure that all members are fully up-to-date on clinical matters. Although team members may play different roles, all are familiar with every client on the caseload. The nature of ICM team functioning is not as defined, and cohesion is not necessarily a focus of team functioning; the ICM team can operate as a loose organization of independent case managers or as a cohesive unit in a manner similar to ACT. Also, the ACT model can include the clients' family within treatment services (White, McGrew, Salyers, & Firmin, 2014), which is not always true for ICM models.

ICM most frequently involves the coordination of services across different systems over extended periods of time, whereas ACT integrates and provides treatment for CODs within the team. As a consequence, advocacy with other providers is a major component of ICM, but advocacy in ACT focuses on ancillary services. The ACT multidisciplinary team approach to treatment emphasizes providing integrated treatment for clients with CODs directly, assuming that the team members include both mental health and SUD treatment counselors and are fully trained in both approaches.

Recommendations for Extending ACT and ICM in SUD Treatment Settings

ACT and ICM models translate easily to SUD treatment. The consensus panel offers five recommendations for successful use of ACT and ICM in SUD treatment with clients who have CODs:

1. **Use ACT and ICM for clients who require considerable supervision and support.** ACT is a treatment alternative for those clients with CODs who have a history of sporadic adherence with continuing care or outpatient services and who require extended monitoring and supervision (e.g., medication monitoring or dispensing) and intensive onsite treatment supports to sustain their tenure in the community (e.g., criminal justice clients). For this subset of the COD population, ACT provides accessible treatment supports without requiring return to a residential setting. The typical ICM program is capable of providing less intense levels of monitoring and supports, but can still provide these services in the client's home on a more limited basis.
2. **Develop ACT programs, ICM programs, or both selectively to address the needs of clients with SMI who have difficulty adhering to treatment regimens most effectively.** ACT, which is a more complex and expensive treatment model to implement than ICM, has been used for clients with SMI who have difficulty adhering to a treatment regimen. Typically, these are among the highest users of expensive (e.g., ED, hospital) services. ICM programs can be used with treatment-resistant clients who are clinically and functionally capable of progressing with much less intensive onsite counseling and less extensive monitoring.
3. **Extend and modify ACT and ICM for other clients with CODs in SUD treatment.** With their strong tradition in the mental health field, particularly for clients with SMI, ACT and ICM are attractive, accessible, and flexible treatment approaches that can be adapted for individuals with CODs. Components of these programs can be integrated into SUD treatment programs.
4. **Add SUD treatment components to existing ACT and ICM programs.** Incorporating methods from the SUD treatment field, such as substance use education, peer mutual support, and greater personal responsibility, can continue to strengthen the ACT approach as applied to clients with CODs. The degree of integration of substance use and mental health components within ACT and ICM depends on the ability of the individual case manager/counselor or the team to provide both services directly or with coordination.
5. **Extend the empirical base of ACT and ICM to further establish their effectiveness for clients with CODs in SUD treatment settings.** The empirical base for ACT derives largely from application among people with SMI and needs to be extended to establish firm support for the use of ACT across the entire COD population. In particular, adding an evaluation component to new ACT programs in SUD treatment can provide documentation currently lacking in

VOCATIONAL SERVICES AND TREATMENT MODELS

Vocational rehabilitation has long been one of the services offered to clients recovering from mental disorders and, to some degree, to those recovering from SUDs. The fact is that many individuals with CODs are not working, including 9 percent who are unemployed and 23 percent not in the labor force for other reasons (e.g., disabled, retired, in school) (Center for Behavioral Health Statistics and Quality, 2019). However, it is unreasonable to expect employers to tolerate employees who are actively using alcohol on the job or who violate their drug-free workplace policies.

Vocational support is vital because steady and unsteady work among people with CODs has been linked to improvement in symptoms, achieving independent housing, and enhanced quality of life (McHugo, Drake, Xie, & Bond, 2012). Vocational programs and supported employment can help clients with CODs gain competitive employment, more work hours, and increased earnings (Frounfelker, Wilkniss, Bond, Devitt, & Drake, 2011; Luciano & Carpenter-Song, 2014; Marshall et al., 2014; Mueser, Campbell, & Drake, 2011). Therefore, if work is to become an achievable goal for individuals with CODs, vocational rehabilitation and supported employment should be integrated into comprehensive COD recovery services.

Vocational services can be incorporated into many treatment models, including ACT and ICM. For more information about incorporating vocational rehabilitation into treatment, see TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* (SAMHSA, 2000).

the field concerning the effectiveness and cost benefit of ACT in treating the person who misuses substances with co-occurring mental disorders in SUD treatment settings. The limitations of ICM have been listed in previous sections. Providers should use ACT or ICM to meet clients' needs as indicated by assessment.

Dual Recovery Mutual-Support Programs

The dual recovery mutual-support movement is emerging from two cultures: the 12-Step recovery movement and, more recently, the culture of the mental health consumer movement. This section describes both, as well as other, consumer-driven psychoeducational efforts.

In the past decade, mutual-support approaches have emerged for people with CODs. Mutual-support programs apply a broad spectrum of personal responsibility and peer support principles, usually including 12-Step programs. These programs are gaining recognition as more meetings are being held in both agency and community settings throughout the United States, Canada, and abroad.

In recent years, dual recovery mutual-support organizations have emerged as a source of support for people in recovery from CODs (Bogenschutz et al., 2014b; Monica, Nikkel, & Drake, 2010; Zweben & Ashbrook, 2012). Mental health advocacy organizations—including the National Alliance for the Mentally Ill and the National Mental Health Association—offer resources to help locate dual recovery mutual-support organizations (see "Resource Alert: Locating Mutual-Support Groups for People With CODs" and Appendix B). At the federal level, SAMHSA also has produced documents identifying dual recovery mutual-support organizations (Center for Mental Health Services, 1998; CSAT, 1994).

Several areas inform the rationale for establishing dual recovery programs as additions to mutual-support programs (Bogenschutz et al., 2014b; Timko, Sutkowi, & Moos, 2010; Zweben & Ashbrook, 2012):

- **Stigma and prejudice:** Stigma related to both SUDs and mental illness continues to be problematic, despite the efforts of many advocacy organizations. Unfortunately, these negative attitudes may surface within a meeting. When this occurs, people in dual recovery may find it difficult to maintain a level of trust and safety in the group setting.
- **Inappropriate or controversial advice (confused bias):** Many members of addiction

recovery groups recognize the real problem of cross-addiction and are aware that people use certain prescription medications as intoxicating drugs. Confusion about the appropriate role of psychiatric medication exists, and as a result, some members may offer well-intended, but inappropriate, advice by cautioning newcomers against using medications. Clearly, confused bias against medications may create either of two problems. First, newcomers may follow inappropriate advice and stop taking their medications, causing a recurrence of symptoms. Second, newcomers quickly may recognize confused bias against medications within a meeting, feel uncomfortable, and keep a significant aspect of their recovery a secret.

- **Interpersonal connectedness:** Individuals with CODs often experience difficulty establishing and maintaining close personal relationships. The presence of a mental disorder could make establishing rapport and developing an alliance with mutual-support program members and sponsors more difficult, subsequently hindering participation and causing clients to feel reluctant about sharing their stories and struggles with others who are only facing addiction rather than both illnesses.
- **Direction for recovery:** A strength of traditional mutual-support program fellowships is their ability to offer direction for recovery that is based on years of collective experience. The new dual recovery programs offer an opportunity to begin drawing on the experiences that members have encountered during both the progression of their CODs and the process of their dual recovery. In turn, that body of experience can be shared with fellow members and newcomers to provide direction into the pathways to dual recovery.
- **Acceptance:** Mutual-support program fellowships provide meetings that offer settings for recovery. Dual recovery meetings may offer members and newcomers a setting of emotional acceptance, support, and empowerment. This condition provides opportunities to develop a level of group trust in which people can feel safe and able to share their ideas and feelings honestly while focusing on recovery from both illnesses.

Although a dual-focused mutual-support program is clearly preferable, people with CODs can still derive benefit from attending traditional mutual-support groups, such as Alcoholics Anonymous (AA). A meta-analysis of 22 studies examining AA attendance by people with CODs (Tonigan, Pearson, Magill, & Hagler, 2018) found a significant effect of increased alcohol abstinence compared with people with CODs who did not attend AA. Attending and being involved in AA and other non-COD-based mutual-support groups appears to help young adults with CODs improve abstinence, although rates of abstinence may not improve as significantly as in young adults with SUDs alone (Bergman, Greene, Hoeppner, Slaymaker, & Kelly, 2014).

Dual Recovery Mutual-Support Approaches

Dual recovery mutual-support program fellowship groups recognize the unique value of people in recovery sharing their personal experiences, strengths, and hope to help other people in recovery. This section provides an overview of emerging mutual-support fellowships and describes a model mutual-support psychoeducational group.

Mutual-Support Groups

Four dual recovery mutual-support organizations have gained recognition in the field. Each fellowship is an independent and autonomous membership organization with its own principles, steps, and traditions. Dual recovery fellowship members are free to interpret, use, or follow the program in a way that meets their own needs. Members use the program to learn how to manage their addiction and mental disorders together. The following section provides additional information on the mutual-support model. (See also "Resource Alert: Locating Mutual-Support Groups for People With CODs.")

1. **Double Trouble in Recovery (DTR).** This organization provides 12 Steps that are based on a traditional adaptation of the original 12 Steps. For example, the identified problem in Step 1 is changed to CODs, and the population to be assisted is changed in Step 12 accordingly. The organization provides a format for meetings that are chaired by members of the fellowship.

2. **Dual Disorders Anonymous.** This organization follows a similar format to DTR. It provides a meeting format that is used by group members who chair the meetings.
3. **Dual Recovery Anonymous.** This organization provides 12 Steps adapted and expanded from the traditional 12 Steps, similar to DTR and Dual Disorders Anonymous. The terms "assets" and "liabilities" are used instead of the traditional term "character defects." In addition, it incorporates affirmations into 3 of the 12 Steps. Similar to other dual recovery fellowships, this organization provides a suggested meeting format that is used by group members who chair the meetings.
4. **Dual Diagnosis Anonymous.** This organization provides a hybrid approach that uses 5 additional steps in conjunction with the traditional 12 Steps. The five steps differ from those of other dual recovery groups in underscoring the potential need for medical management, clinical interventions, and therapies. Similar to other dual recovery fellowships, this organization provides a meeting format that is used by group members who chair the meetings.

The dual recovery fellowships are membership organizations rather than consumer service delivery programs. The fellowships function as autonomous networks, providing a system of support parallel to traditional clinical or psychosocial services. Meetings are facilitated by members, who are responsible, and take turns "chairing" or "leading" the meetings for fellow members and newcomers. Meetings are not led by professional counselors (unless a member is a professional counselor and takes a turn at leading a meeting), nor are members paid to lead meetings. However, the fellowships may develop informal working relationships or linkages with professional providers and consumer organizations.

Dual recovery mutual-support program fellowships do not provide specific clinical or counseling interventions, classes on psychiatric symptoms, or any services similar to case management. Dual recovery fellowships maintain a primary purpose of members helping one another achieve and maintain dual recovery, prevent relapse, and carry the message of recovery to others who experience dual disorders. Dual recovery mutual-support program members who take turns chairing their meetings are members of their fellowship as a whole. Anonymity of meeting attendees is preserved because group facilitators do not record the names of their fellow members or newcomers. Fellowship members carry out the primary purpose through the service work of their groups and meetings.

Groups provide various types of meetings, such as **step study meetings,** in which the discussion revolves around ways to use the fellowship's 12 Steps for personal recovery. Another type of meeting is a **topic discussion meeting,** in which members present topics related to dual recovery and discuss how they cope with situations by applying the recovery principles and steps of their fellowship. **Hospital and institutional meetings** may be provided by fellowship members to individuals currently in hospitals, treatment programs, or criminal justice settings.

Fellowship members who are experienced in recovery may sponsor newer members. Newcomers may ask a member they view as experienced to help them learn fellowship recovery principles and steps.

Outreach by fellowship members may provide information about their organization to agencies and institutions through inservice programs, workshops, or other types of presentations.

Access and Linkage

The fellowships are independent organizations based on 12-Step principles and traditions that generally develop cooperative and informal relationships with service providers and other organizations. The fellowships can be seen as providing a source of support that is parallel to formal services, that is, participation while receiving treatment and continuing care services.

Referral to dual recovery fellowships is informal:

- An agency may provide a "host setting" for one of the fellowships to hold its meetings. The agency may arrange for its clients to attend the scheduled meeting.
- An agency may provide transportation for its clients to attend a community meeting provided by one of the fellowships.

RESOURCE ALERT: LOCATING MUTUAL-SUPPORT GROUPS FOR PEOPLE WITH CODs

- Dual Recovery Anonymous. Index of Registered Dual Recovery Anonymous 12-Step Meetings (www.draonline.org/meetings.html)
- Faces & Voices of Recovery. Mutual Aid Groups for Co-Occurring Health Conditions, including groups specifically for co-occurring mental disorders and SUDs (https://facesandvoicesofrecovery.org/resources/mutual-aid-resources/)
- SAMHSA. Behavioral Health Treatment Services Locator. Self-Help, Peer Support, and Consumer Groups (https://findtreatment.gov/)

- An agency may offer a schedule of community meetings provided by one of the fellowships as a support to referral for clients.

Common Features of Dual Recovery Mutual-Support Fellowships

Dual recovery fellowships tend to have the following in common:

- A perspective describing CODs and dual recovery
- A series of steps providing a plan to achieve and maintain dual recovery
- Literature describing the program for members and the public
- A structure for conducting meetings in a way that provides a setting of acceptance and support
- Plans for establishing an organizational structure to guide growth of membership, that is, a central office, fellowship network of area intergroups, groups, and meetings. An "intergroup" is an assembly of people made up of delegates from several groups in an area. It functions as a communications link upward to the central office or offices and outward to all the area groups it serves.

Empirical Evidence

Empirical evidence suggests that participation in mutual-support programs contributes substantially to members' progress in dual recovery and should be encouraged. Specifically, studies have found the following positive outcomes:

- Among veterans with an SUD and depression, lower scores of depression and lower future alcohol use (Worley, Tate, & Brown, 2012)
- Fewer days of alcohol and other substance use, better scores of mental health, and fewer self-reported substance-related problems (Rosenblum et al., 2014; Woodhead, Cowden Hindash, & Timko, 2013)
- Greater treatment attendance and possibly increased alcohol abstinence and decreased drinks per drinking day over time (but not necessarily better than usual care) (Bogenschutz et al., 2014b)

Qualitative studies (Hagler et al., 2015; Matusow et al., 2013; Penn, Brooke, Brooks, Gallagher, & Barnard, 2016; Roush, Monica, Carpenter-Song, & Drake, 2015) exploring perspectives of clients with CODs who engage in mutual-support services (e.g., 12-Step and SMART Recovery) also detail numerous perceived benefits from these programs, such as:

- Fellowship building (e.g., meeting others with similar problems).
- Addressing spiritual needs/topics (this may be considered a negative aspect by some clients).
- Building camaraderie, affiliation, and a sense of community.

Dual recovery mutual-support programs recognize the unique value of people in recovery sharing their personal experiences, strengths, and hope to help other people in recovery.

- Having a "safe space" to share experiences without fear of judgment or rejection.
- Increased knowledge/insight about mental illness and SUDs (especially how they interrelate).
- Learning skills and tools that facilitate recovery.
- Feeling empowered.
- Developing a sense of hope for recovery.
- Access to therapy/therapeutic services that would otherwise be inaccessible, given lack of insurance.

Peer Recovery Support Services

The inclusion of peer supports—people who have experienced addiction, mental illness, or both and are in recovery—in SUD and mental illness recovery processes has increased substantially in the past decade. Peer recovery support services can help improve long-term recovery by increasing abstinence, decreasing inpatient services and hospitalization, and improving functioning (Bassuk, Hanson, Greene, Richard, & Laudet, 2016; Chinman et al., 2014; Davidson, Bellamy, Guy, & Miller, 2012; Reif, Braude, et al., 2014).

Research suggests that peer-based services help people with mental disorders and SUDs improve clinical and functional outcomes (Acri, Hooley, Richardson, & Moaba, 2017; Bassuk et al., 2016; Chapman, Blash, Mayer, & Spetz, 2018; Chinman et al., 2014; Reif, Braude, et al., 2014; SAMHSA, 2017). These include:

- Rates of abstinence.
- Number of days abstinent.
- Relapse rates.
- Treatment engagement.
- Treatment retention.
- Residential treatment use.
- Rehospitalization.
- Adherence to treatment plan.
- Treatment completion.
- Treatment satisfaction.
- Relationships with treatment providers.
- Housing stability.
- Probation/parole status.
- Number of criminal justice charges.
- Recovery capital.
- Mental disorder symptoms.
- Knowledge about mental illness and SUDs.
- Family functioning, including parenting abilities.
- Access to social supports.

Little research has examined the use of peer supports for CODs. Given the success of peer services in promoting recovery and wellness in people with either mental illness or addiction, it is reasonable to hypothesize that peer support could also be effective for individuals with both. O'Connell, Flanagan, Delphin-Rittmon, & Davidson (2017) found inclusion of peer supports for people with co-occurring psychosis and substance misuse significantly improved positive (but not negative) symptoms of psychosis, number of days of alcohol use, number of days experiencing alcohol-related problems, self-rated importance of getting treatment for alcohol misuse, feelings of relatedness, social functioning, and inpatient readmissions relative to a treatment as usual condition. Evidence-based interventions for CODs, such as ACT and integrated therapies, were not originally designed to include peer support, but **more and more, peer providers are becoming a formal part of COD treatment teams** (Harrison, Cousins, Spybrook, & Curtis, 2017). Including peers in COD services might improve staff treatment fidelity, which is critical for ensuring that evidence-based services produce intended outcomes (Harrison et al., 2017).

Treatment Settings

Therapeutic Communities

The goals of TCs are to promote abstinence from alcohol and illicit drug use, and to effect a global change in lifestyle, including attitudes and values. The TC views substance misuse as a disorder of the whole person, reflecting problems in conduct, attitudes, moods, values, and emotional management. Treatment focuses on abstinence, coupled with social and psychological change that requires a multidimensional effort, involving intensive mutual support, typically in a residential setting. Residential TC treatment duration is typically 6 to 12 months, although treatment duration has been decreasing under the influence of managed care and other factors.

In a definitive book titled *The Therapeutic Community: Theory, Model, and Method,* De Leon (2000) provided a full description of the TC for SUD treatment to advance research and guide training, practice, and program development. Descriptions of TCs also appear in the National Institute on Drug Abuse (NIDA, 2015) Research Report titled *Therapeutic Communities* (https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/therapueticcomm_rrs_0723.pdf).

TCs have demonstrated positive outcomes in substance misuse and SUD treatment retention (De Leon, 2015; NIDA, 2015). A review of randomized and nonrandomized trials of TCs (Vanderplasschen et al., 2013) found that, compared with control conditions, TCs gave advantages in employment, psychological symptoms, and family/social relationships. SUD outcomes were variable but generally favored the TC condition. Relapse rates among TC clients also varied widely but were relatively high (25 percent to 55 percent returned to substance use within 12 to 18 months), although time to relapse was typically longer in TCs than in control conditions. This is consistent with earlier research from Malivert, Fatséas, Denis, Langlois, & Auriacombe (2012) that associated TCs with decreased substance use but high relapse rates. Clients in TCs with lower relapse rates tended to stay longer in treatment and continuing care than people who relapsed more quickly. Forensic outcomes were consistently positive for recidivism, rearrests, and reincarceration, even over time (3 years and 5 years). Again, TCs plus continuing care were associated with even greater improvements in abstinence and rearrests than TCs only.

Modified TCs for Clients With CODs

The modified TC (MTC) approach adapts the principles and methods of the TC to the circumstances of the client with CODs. The illustrative work in this area has been done with people with CODs, both men and women, providing treatment based on community-as-method—that is, the community is the healing agent. This section focuses on MTCs as a potent residential model for SUD treatment; most of this section applies to both TCs and other residential SUD treatment programs.

WHAT MAKES TCs WORK?

It remains unclear how and why TCs are effective at improving outcomes for people recovering from addiction. Pearce and Pickard (2013) suggest that TCs are effective because of their ability to promote in clients a sense of belongingness, which is associated with better self-esteem and feelings of acceptance and happiness. TCs promote belongingness through high frequency of client contacts that are positive in nature, that exhibit mutual concern for the client's wellbeing, and that occur over a long period of time.

The other key mechanism is the ability of TCs to promote in clients a sense of responsible agency. This includes the ability to: (1) "reflect on one's behavior, make decisions about how one wants to do things differently, form resolutions, and commit to change" as well as (2) "to see this resolution or commitment through: not to waver from the chosen course, or, if one wavers, to find a way to get back on track rather than sink into despair" (Pearce & Pickard, 2013, p. 7). Responsible agency has been linked to greater self-efficacy and ability to change behaviors (and sustain those new behaviors over time). TCs promote responsible agency through motivational interviewing; cognitive interventions like CBT or dialectical behavior therapy; and by helping clients understand the relationships between thoughts, emotions, and behaviors.

Treatment Activities/Interventions

All program activities and interactions, singly and in combination, are designed to produce change. Interventions are grouped into four categories—community enhancement (to promote affiliation with the TC community), therapeutic/educative (to promote expression and instruction), community/clinical management (to maintain personal and physical safety), and vocational (to operate the facility and prepare clients for employment). Implementation of the groups and activities listed in Exhibit 7.2 establishes the TC community. Although each intervention has specific individual functions, all share community, therapeutic, and educational purposes.

EXHIBIT 7.2. TC Activities and Components

- Maintaining highly structured daily regimens that include:
  - Morning and evening house meetings
  - Daily jobs/tasks
  - Individual therapy sessions
  - Group therapy sessions
  - Seminars and education meetings
- Adhering to clearly articulated expectations (accompanied by rewards and punishments to help shape adaptive behaviors)
- Vocation or educational activities, or both
- Social activities to increase bonding among housemates and help client establish healthy, supportive networks, such as:
  - Group discussions, including group therapy, to help change behaviors and cognitions and build new skills
  - Community meetings to review the rules, goals, and procedures of the TC
  - Education meetings (e.g., seminars)
  - Role-playing activities
  - Games and recreational activities

Source: NIDA (2015).

Key Modifications

The MTC alters the traditional TC approach in response to the client's psychiatric and addiction-related symptoms, cognitive impairments, reduced level of functioning, short attention span, and poor urge control. A noteworthy alteration is the change from encounter group to conflict resolution group. Conflict resolution groups have the following features:

- Staff led and staff guided throughout
- Three highly structured and often formalized phases:
  - Feedback on behavior from one participant to another
  - Opportunity for both participants to explain their position
  - Resolution between participants with plans for behavior change
- Substantially reduced emotional intensity; emphasis on instruction and learning of new behaviors
- Persuasive appeal for personal honesty, truthfulness in dealing with others, and responsible behavior to self and others

To create an MTC program for clients with CODs, three fundamental alterations can be applied:

- **Increased flexibility**
- **Decreased intensity**
- **Greater individualization**

More recent adaptations also can include:

- Accepting clients on medication-assisted treatment (MAT) for opioid use disorder (OUD) and, in some cases, incorporating medication into treatment plans (NIDA, 2015).
- Placing greater limits on long-term residential treatment, given rising healthcare costs (NIDA, 2015).
- Teaming with a medical facility that provides integrated healthcare services so that the TC can be considered a federally qualified health center and thus help increase treatment access for vulnerable populations, including people with CODs (NIDA, 2015; Smith, 2012).

Nevertheless, the central TC feature remains; the MTC, like all TC programs, seeks to develop a culture in which clients learn through mutual support and affiliation with the community to foster change in themselves and others. Respect for ethnic, racial, and gender differences is a basic tenet of all TC programs and is part of teaching the general lesson of respect for self and others. Exhibit 7.3 summarizes the key modifications necessary to address the unique needs of clients with CODs.

Role of the Family

Many MTC clients come from highly impaired, disrupted family situations. MTC programs offer them a new frame of reference and support group. Some clients do have available intact families or family members who are supportive. For these clients, MTC programs offer various family-centered activities like special family weekend

EXHIBIT 7.3. TC Modifications for People With CODs

STRUCTURAL MODIFICATIONS	PROCESS MODIFICATIONS	INTERVENTION MODIFICATIONS
There is increased flexibility in program activities.	Sanctions are fewer with greater opportunity for corrective learning experiences.	Orientation and instruction are emphasized in programming/planning.
Meetings and activities are shorter.		Individual counseling is provided more frequently to enable clients to absorb the TC experience.
There is greatly reduced intensity of interpersonal interaction.	Engagement and stabilization receive more time and effort.	Task assignments are individualized.
More explicit affirmation is given for achievements.		Breaks are offered frequently during work tasks.
Greater sensitivity is shown to individual differences.	Progression through the program is paced individually, according to the client's rate of learning.	Individual counseling and instruction are more immediately provided in work-related activities.
Greater responsiveness to the special developmental needs of the individual.		Engagement is emphasized throughout treatment.
More staff guidance is given in the implementation of activities; many activities remain staff assisted for a considerable period of time.	Criteria for moving to the next phase are flexible to allow lower functioning clients to move through the program phase system.	Activities are designed to overlap.
There is greater staff responsibility to act as role models and guides.		Activities proceed at a slower pace.
Smaller units of information are presented gradually and are fully discussed.	Live-out reentry (continuing care) is an essential component of the treatment process.	Individual counseling is used to assist in the effective use of the community.
Greater emphasis is placed on assisting individuals.		The conflict resolution group replaces the encounter group.
Increased emphasis is placed on providing instruction, practice, and assistance.	Clients can return to earlier phases to solidify gains as necessary.	

Source: Sacks & Sacks (2011).

ADVICE TO ADMINISTRATORS: RECOMMENDED TREATMENT AND SERVICES FROM THE MTC MODEL

In addition to the general guidelines for working with people who have CODs described in Chapter 5, the following treatment recommendations are derived from MTC work and are applicable across all models:

- Treat the whole person.
- Provide a highly structured daily regimen.
- Use peers to help one another.
- Rely on a network or community for both support and healing.
- Regard all interactions as opportunities for change.
- Foster positive growth and development.
- Promote change in behavior, attitudes, values, and lifestyle.
- Teach, honor, and respect cultural values, beliefs, and differences.

visiting, family education and counseling sessions, and, if children are involved, classes focused on prevention. All such activities occur later in treatment to facilitate client reintegration into the family and into mainstream living.

Empirical Evidence

A series of studies has established that:

- MTCs affect a wide range of clinical and functional variables, including substance use, mental disorder symptoms, criminal behavior, employment, and housing (Sacks, McKendrick, Sacks, & Cleland, 2010). For instance, a review of TCs and MTCs (Magor-Blatch, Bhullar, Thomson, & Thorsteinsson, 2014) reported reduced substance use (including increased abstinence and reduced risk of relapse), decreased criminal behavior (including rearrests and reincarcerations), and improved psychological functioning among diverse populations, including people with CODs. However, benefits were more consistent from pre–post treatment than when comparing TCs/MTCs with control groups (e.g., no treatment, other treatment).
- Among people involved in the criminal justice system who have CODs, MTCs can effectively reduce SUD and mental illness symptoms, delay relapse, improve social functioning, reduce criminal activity, and decrease recidivism compared with traditional TCs (Magor-Blatch et al., 2014; Peters et al., 2017). MTCs also appear to reduce reincarceration better than parole supervision (Sacks, Chaple, Sacks, McKendrick, & Cleland, 2012).
- People with CODs and HIV receiving MTC continuing care had a greater decrease in SUD and mental illness symptoms at 6 months than people receiving standard continuing care (Sacks, McKendrick, Vazan, Sacks, & Cleland, 2011). Larger improvements were observed in MTC clients who had higher levels of psychosocial functioning and health at the start of treatment.
- MTCs can meet the various needs of pregnant and parenting women with SUDs—many of whom have co-occurring mental disorders, experiences with homelessness, criminal justice involvement, or a combination thereof. One such program (Bromberg, Backman, Krow, & Frankel, 2010) reduced recidivism, promoted long-term abstinence (about 90 percent of clients remained abstinent for 2 years after program completion), and facilitated drug-free births and healthy infant development.

Outpatient SUD Treatment

Treatment for SUDs occurs most frequently in outpatient settings—a term that encompasses a variety of disparate programs (Cohen, Freeborn, & McManus, 2013; NIDA, 2018b; SAMHSA, 2019a).

RESOURCE ALERT: HOW TO IMPLEMENT TC/MTC PROGRAMMING

Guidance on designing and implementing TCs/MTCs is available online through various manuals, reports, and other documentation. Some of the publications in the following list are specific to a particular organization or state. However, they can still serve as useful tools for informing the types of services, structures, and processes needed to make TC/MTC programming successful:

- NIDA's *Therapeutic Communities* Research Report (https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/therapueticcomm_rrs_0723.pdf)
- The Arkansas Department of Human Services' *Therapeutic Communities Certification Manual* (https://humanservices.arkansas.gov/images/uploads/dpsqa/DBHS_Therapuetic_Communities_Certification_-_FINAL.pdf)
- Missouri Department of Corrections and Maryville *Treatment Center's Therapeutic Community Program Handbook* (www.law.umich.edu/special/policyclearinghouse/Documents/MO%20-%20Maryville%20Treatment%20Center%20Therapeutic%20Community%20Program%20Handbook.pdf)
- National Institute of Justice's *Program Profile: Modified Therapeutic Community for Offenders With Mental Illness and Chemical Abuse Disorders* (www.crimesolutions.gov/ProgramDetails.aspx?ID=90)
- University of Delaware Center for Drug and Alcohol Studies. *Therapeutic Community Treatment Methodology: Treating Chemically Dependent Criminal Offenders in Corrections* (www.cdhs.udel.edu/content-sub-site/Documents/CDHS/CTC/Treating%20Chemically%20Dependent%20Criminal%20Offenders%20in%20Corrections.pdf)

Some offer high-intensity services, like several hours of treatment each week, which can include mental health and other support services as well as individual and group counseling for substance misuse; others provide minimal services, such as only one or two brief sessions to give clients information and refer them elsewhere (NIDA, 2018b). Some agencies offer outpatient programs that provide services several hours per day and several days per week, thus meeting the LOCUS criteria for High Intensity Community Based Services.

Typically, treatment includes individual and group counseling, with referrals to appropriate community services. Until recently, there were few specialized approaches for people with CODs in outpatient SUD treatment settings.

Many individuals with CODs have multiple health and social problems that complicate their treatment. Evidence from prior studies indicates that a mental disorder often makes effective SUD treatment harder because of cognitive, psychosocial, and economic barriers that hinder engagement and retention (Priester et al., 2016). Outpatient treatment programs are available widely and serve the most clients (Cohen et al., 2013; SAMHSA, 2019a), so using current best practices from the SUD treatment and mental health fields is vital. Doing so enables these programs to use the best available treatment models to reach the greatest possible number of people with CODs.

Prevalence

Outpatient SUD treatment programs are the most common form of SUD treatment setting in this country. In 2018, 83 percent of SUD treatment facilities in the United States offered outpatient services (SAMHSA, 2019a). Specifically, 77 percent offered regular outpatient services, 46 percent intensive outpatient, 14 percent day treatment or partial hospitalization, 10 percent outpatient detoxification, and 28 percent outpatient methadone/buprenorphine maintenance or naltrexone treatment.

CODs are commonly found in clients who enter SUD treatment. In 2018, 50.2 percent of individuals

in SUD treatment had a COD, and 99.8 percent of SUD treatment facilities reported having clients with CODs (SAMHSA, 2019a). Despite the complexity of CODs, outpatient programs have good capacity (e.g., organization structures and policies) to meet the treatment needs of these populations, perhaps even more so than intensive outpatient programs and residential programs (Lambert-Harris, Saunders, McGovern, & Xie, 2013).

Empirical Evidence of Effectiveness

Outpatient settings can be paired with a variety of treatment approaches to help clients with CODs successfully improve substance-related mental health outcomes and functional outcomes, including frequency of substance use, abstinence, relapse risk, mental illness symptom remission, psychiatric hospitalizations, social functioning, having independent housing, gaining competitive employment, and life satisfaction (Drake, Bond, et al., 2016; Haller, Norman, et al., 2016; McDonell et al., 2013). Most integrated treatments—such as those combining CBT, motivational interviewing, and family services—are offered in outpatient, not residential, settings and have a strong evidence base supporting their effectiveness for CODs (Kelly & Daley, 2013), including SMI with SUDs (Cleary, Hunt, Matheson, & Walter, 2009; De Witte et al., 2014).

Outpatient COD treatment can yield positive outcomes even when treatment is not tailored specifically to CODs. Tiet and Schutte (2012) reviewed the differential benefits of COD treatment at either addiction, mental illness, or COD outpatient treatment programs. All clients improved in 6-month abstinence and suicide attempts compared with baseline, although people attending COD outpatient settings did not fare any better on these outcomes than clients completing outpatient treatment from SUD clinics or mental health service clinics.

Outpatient treatment can also be leveraged as a form of continuing care, such as following discharge from hospitalization or release from jail/prison, to help clients maintain long-term recovery and wellness (Grella & Shi, 2011). Six-month outpatient ACT for men with SMI and SUD (Noel, Woods, Routhier, & Drake, 2016) was effective in sustaining improvements clients experienced during the previous 6 months in residential treatment, including improvements in mental health, substance use, housing, education, employment, family functioning, spirituality, and sleep hygiene. Outpatient mental health services focused on supporting community reintegration following release from jail were associated with 12-month declines in number of arrests and number of days in jail among people with CODs and people with mental disorders only (Alarid & Rubin, 2018).

Evidence suggests that intensive outpatient treatment for people with CODs can improve substance misuse and increase abstinence among a range of populations, including civilians and veterans, women, people from diverse racial/ethnic backgrounds, uninsured individuals, and people experiencing homelessness (McCarty et al., 2014). Intensive outpatient treatment has been associated with decreases in psychological symptoms and distress, decreases in the average number of days per week of substance use, improvements in Global Assessment of Functioning scores, and high client satisfaction (Wise, 2010).

Designing Outpatient Programs for Clients With CODs

People with CODs vary in their motivation for treatment, nature and severity of their SUD (e.g., drug of choice, polysubstance misuse), and nature and severity of their mental disorder. However, most clients with CODs in outpatient treatment have less serious and more stabilized mental and SUD symptoms than those in residential treatment (Mee-Lee et al., 2013).

Outpatient treatment can be the primary treatment or provide continuing care for clients after residential treatment, offering flexibility in activities/interventions and intensity of treatment. Treatment failures occur for people with SMI and those with less serious mental disorders for several reasons, among the most important being that programs lack resources to provide time for mental health services and medications that would likely improve recovery rates and recovery time significantly.

RESOURCE ALERT: OUTPATIENT SUD TREATMENT

- SAMHSA's TIP 47, Substance Abuse: Clinical Issues in Intensive Outpatient Treatment (https://store.samhsa.gov/system/files/sma13-4182.pdf)
- SAMHSA's TIP 46, Substance Abuse: Administrative Issues in Outpatient Treatment (https://store.samhsa.gov/system/files/toc.pdf)

If lack of funding prevents the full integration of mental health assessment and medication services within an SUD treatment agency that provides outpatient services, establishing a collaborative relationship with a mental health agency (through a memorandum of agreement) would ensure that the services for the clients with CODs are adequate and comprehensive. In addition, modifications are needed to both treatment design interventions and staff training to ensure implementation of interventions appropriate to the needs of the client with CODs.

To meet the needs of specific populations among people with CODs, the consensus panel encourages outpatient treatment programs to develop special services for populations that are represented in significant numbers in their programs. Examples include women, women with dependent children, individuals and families experiencing homelessness, and racial/ethnic populations. (Information on how programs can adapt services to these and other vulnerable populations can be found in Chapter 6.) Types of CODs will vary depending on the subpopulation targeted; each program must deal with CODs in a different manner, often by adding other treatment components for CODs to existing program models.

Referral and Placement

Careful assessment will help identify those clients who require more secure inpatient treatment settings (e.g., clients who are actively suicidal or homicidal), as well as those who require 24-hour medical monitoring, those who need detoxification, and those with serious SUDs who may require a period of abstinence or reduced use before they can engage actively in all treatment components. Information about the full screening and assessment process, which includes referral, is in Chapter 3.

Counselors should view clients' placement in outpatient care in the context of continuity of care and the network of available providers and programs. Outpatient treatment programs may serve a variety of functions, including outreach/engagement, primary treatment, and continuing care. Ideally, a full range of outpatient SUD treatment programs would include interventions for unmotivated, disaffiliated clients with CODs, as well as for those seeking abstinence-based primary treatments and those requiring continuity of supports to sustain recovery.

Likewise, ideal outpatient programs will facilitate access to services through rapid response to all agency and self-referral contacts, imposing few exclusionary criteria, and using some client/treatment matching criteria to ensure that all referrals can be engaged in some level of treatment. Additional criteria for admission may be imposed on the treatment agency by individual states, insurance companies, or other funding sources. Per the consensus panel, treatment providers should not place clients in a higher level of care (i.e., more intense) than necessary. A client who may remain engaged in a less intense treatment environment may drop out in response to the demands of a more intense treatment program.

Engagement and Retention

Because clients with CODs often have lower treatment engagement, every effort should be made to use treatment methods with the best prospects for increasing engagement. Clients with CODs, especially those opposed to traditional treatment approaches and those who do not accept that they have CODs, can have difficulty committing to and maintaining treatment. By providing continuous outreach, engagement, direct assistance with immediate life problems (e.g., housing), advocacy, and close monitoring of individual needs,

IMPROVING ENGAGEMENT AND ADHERENCE OF CLIENTS WITH CODS IN OUTPATIENT SETTINGS

- Implement behavioral continuing care contracts for clients transitioning from residential treatment into outpatient care.
- Use reminders (e.g., mailed appointment cards, telephone calls); offer feedback before sessions to promote attendance.
- Follow up by phone with clients who miss appointments.
- Reinforce attendance to appointments with praise and other rewards (e.g., earning a completion certificate after attending a certain number of sessions, earning a medal or other recognition for completing all required sessions).
- Offer peer recovery support services.
- Use incentives to increase clients' buy-in to the need for and importance of treatment. Incentives related to assistance with housing and employment may be particularly meaningful and effective.
- Rather than solely creating treatment goals focused centrally around abstinence, work with clients to develop treatment goals focused on reducing the harmful effects of substance use (e.g., reducing homelessness by gaining independent housing).
- People with CODs who have positive family relationships are more likely to stay engaged in treatment. Encourage clients lacking family support to reach out to relatives and try to gain their support. With permission from the client, include family in treatment and educate them on the importance of being a source of emotional and tangible support for the client.
- Helping clients understand the connection between substance use and negative outcomes (e.g., legal problems, housing and employment instability, exacerbating mental disorder symptoms) can help them understand the need for treatment. This is vital because perceived need for treatment is a common barrier to entering and staying engaged in SUD treatment.

Sources: Brown, Bennett, Li, & Bellack (2011); Demarce, Lash, Stephens, Grambow, & Burden (2008); Mangrum (2009).

the ACT and ICM models provide techniques that enable clients to access services and foster the development of treatment relationships.

Discharge Planning

Discharge planning is important to maintain gains achieved through outpatient care. Clients with CODs leaving an outpatient SUD treatment program have a number of continuing care options. These options include mutual-support programs, relapse prevention groups, continued individual counseling, mental health services (especially important for clients who will continue to require medication), as well as ICM monitoring and supports. A carefully developed discharge plan, produced in collaboration with the client, will identify and match client needs with community resources, providing supports to sustain progress achieved in outpatient treatment. The provider seeks to develop a support network for the client that involves family, community, recovery groups, friends, and significant others.

Clients with CODs often need a range of services besides SUD treatment and mental health services. Generally, prominent needs include housing and case management services to establish access to community health and social services. In fact, these two services should not be considered "ancillary," but key ingredients for clients' successful recovery. Without a place to live and some degree of economic stability, clients with CODs are likely to return to substance use or experience a return of symptoms of mental disorder. **Every SUD treatment provider should keep strong and current linkages with community resources to help address these and other client needs.** Clients with CODs often will require a wide variety of services that cannot be provided by a single program.

Discharge planning for clients with CODs must ensure continuity of services, medication management, and support, without which client stability and recovery are severely compromised. Relapse prevention interventions after outpatient treatment need to be modified so clients can recognize symptoms of SUD or mental disorder relapse on their own, use symptom management techniques (e.g., self-monitoring, reporting to a "buddy," group monitoring), and access

assessment services rapidly, as the return of psychiatric symptoms can often trigger substance use relapse.

Developing positive peer networks is another important facet of discharge planning for continuing care. The provider seeks to develop a support network for the client that involves family, community, recovery groups, friends, and significant others. If a client's family of origin is not healthy and supportive, other networks can be accessed or developed for support. Programs also should encourage client participation in mutual-support programs, particularly those that focus on CODs (e.g., dual recovery mutual-support groups). These groups can provide a continuing supportive network for the clients, who usually can continue to participate in such programs even if they move to a different community. Therefore, these groups are an important method of providing continuity of care.

The consensus panel also recommends that programs working with clients who have CODs try to involve advocacy groups in program activities. These groups can help clients become advocates themselves, furthering the development and responsiveness of the treatment program while enhancing clients' sense of self-esteem and providing a source of affiliation.

Residential SUD Treatment

Residential treatment for SUDs comes in a variety of forms, including long-term residential treatment facilities, criminal justice-based programs, halfway houses, and short-term residential programs. The long-term residential SUD treatment facility is the primary treatment site and the focus of this section of the TIP. Historically, residential SUD treatment facilities have provided treatment to clients with more serious and active SUDs but with less severe mental disorders. Most providers now agree that the prevalence of people with SMI entering residential SUD treatment facilities has risen.

Prevalence

In 2018, 24 percent of SUD treatment facilities in the United States offered any residential treatment (SAMHSA, 2019a). Specifically, 14 percent offered short-term residential care; 19 percent, long-term care; and 8 percent, residential detoxification.

Clients admitted to long-term residential care tend to have more severe substance misuse and psychiatric problems. Veterans with SUDs and PTSD admitted to residential treatment reported worse PTSD symptoms, more frequent substance use, more time spent around high-risk people or places, and fewer days spent at work or school than veterans with SUDs and PTSD who entered outpatient care (Haller, Colvonen, et al., 2016). Other studies have found an increased rate of suicide attempt and violence (as a victim and as a perpetrator) among people with CODs entering residential treatment (Havassy & Mericle, 2013; Watkins, Sippel, Pietrzak, Hoff, & Harpaz-Rotem, 2017) as well as lower treatment retention rates, particularly in people with ASPD and SUD (Meier & Barrowclough, 2009).

Empirical Evidence of Effectiveness

Evidence from large-scale, longitudinal, multisite treatment studies supports the effectiveness of residential SUD treatment (Reif, George, et al., 2014; Weinstein, Wakeman, & Nolan, 2018). Residential SUD treatment generally results in significant improvements in substance use, mental health, employment, and physical and social functioning. Residential treatment for CODs is linked to improved SUD outcomes (e.g., illicit drug and alcohol use), mental disorder symptoms, quality of life, and social/community functioning, even if treatment is not integrated (Reif, George, et al., 2014). A multisite study of residential COD treatment programs in Tennessee and California (Schoenthaler et al., 2017) found significant reductions in illicit substance use per month, intoxication per month, alcohol use days per month, and ASI drug and alcohol composite scores from 1 month before treatment admission to 12-month postdischarge.

Designing Residential Programs for Clients With CODs

To design and develop services for clients with CODs, providers and administrators can undertake a series of interrelated program activities. The specific MTC model that appeared previously in this chapter serves as a frame of reference in the following sections, but it is not a prescriptive model.

Intake

Chapter 3 further addresses screening and assessment. This section addresses intake procedures for people with CODs in residential SUD treatment settings. The four interrelated intake steps are:

1. **Written referral.** Referral information from other programs or services can include the client's psychiatric diagnosis, history, current level of mental functioning, medical status (including results of screening for tuberculosis, HIV, sexually transmitted disease, hepatitis), and assessment of functional level. Referrals also may include a psychosocial history and a physical examination.
2. **Intake interview.** An intake interview is conducted at the program site by a counselor or clinical team. At this time, the referral material is reviewed for accuracy and completeness, and each client is interviewed to determine if the referral is appropriate in terms of the history of mental and substance use problems. The client's residential and treatment history is reviewed to assess the adequacy of past treatment attempts. Furthermore, each client's motivation and readiness for change are assessed, and the client's willingness to accept the current placement as part of the recovery process is evaluated. Screening instruments, such as those described in Chapter 3 and located in Appendix C, can be used in conjunction with this intake interview.
3. **Program review.** Each client should receive a complete description of the program and a tour of the facility to ensure that both are acceptable. This review includes a description of the daily operation of the program in terms of groups, activities, and responsibilities; a tour of the physical site (including sleeping arrangements and communal areas); and an introduction to some of the clients who are already enrolled in the program.
4. **Team meeting.** At the end of the intake interview and program review, the team meets with the client to decide whether to proceed with admission to the program. The client's receptivity to the program is considered, and additional information (e.g., involvement with the justice system, suicide attempts) is obtained as needed. It should be noted that the decision-making process is inclusive; that is, a program accepts referrals as long as the clients meet the eligibility criteria, are not currently a danger to self or others, do not refuse medication, express a readiness and motivation for treatment, and accept the placement and the program as part of their recovery process.

Engagement and Retention

Clients with CODs need to be engaged in treatment so they can fully use available services. Successful engagement helps clients view the treatment program as an important resource. To accomplish this, the program must meet essential needs and ensure psychiatric stabilization. Residential treatment programs can accomplish this by offering a wide range of services that include both targeted services for mental disorders and SUDs and other wraparound services, including medical, social, and work-related activities. The extensiveness of residential services has been well documented (Reif, George, et al., 2014).

Clients in residential settings for SUDs are three times more likely to complete treatment than those in outpatient settings (Stahler, Mennis, & DuCette, 2016). Retention in treatment is associated with positive outcomes, and identifying factors that predict length of stay can inform practices to improve engagement and adherence. Shorter stays in residential care are linked to older age, male gender, and low readiness for change (Morse, Watson, MacMaster, & Bride, 2015). Better retention in residential SUD treatment settings is linked to younger age, White race/ethnicity (vs. African Americans and Latinos), type of SUD (i.e., non-OUD), more severe ASI medical-, employment-, and psychiatric-related scale scores, and greater readiness for change (Choi, Adams, MacMaster, & Seiters, 2013).

Discharge Planning

Discharge planning follows many of the same procedures discussed in the section on outpatient treatment. However, several other important points apply to residential programs:

- Discharge planning begins upon entry into the program.

- The latter phases of residential placement should be devoted to developing with the client a specific discharge plan and beginning to follow some of its features.
- Discharge planning often involves continuing in treatment as part of continuity of care.
- Obtaining housing, when needed, is an integral part of discharge planning.

Given the chronic and cyclical nature of SUDs and mental disorders, continuing care following residential services (such as the provision of lower intensity outpatient treatment postdischarge) can help optimize client stability and functioning. Individuals with SUDs who receive continuing care are retained in treatment and maintain abstinence more so than clients who do not participate in continuing care (McKay, 2009).

Acute Care and Other Medical Settings

Although not strictly speaking SUD treatment settings, acute care and other medical settings are included here because important SUD treatment and mental health services occur in medical units. Acute care refers to short-term care provided in intensive care units, brief hospital stays, and EDs. Individuals with substance misuse or mental illness often access care from primary care clinics as opposed to specialty care settings. People going to EDs for treatment for mental disorders and SUDs is also on the rise.

The integration of SUD treatment with primary medical care can be effective in reducing both medical problems and levels of substance use. Clients can be more readily engaged and retained in SUD treatment if that treatment is integrated with medical care than if clients are referred to a separate SUD treatment program—especially individuals with SUDs who have chronic medical needs (Drainoni et al., 2014; Hunter, Schwartz, & Friedmann, 2016). Extensive treatment for SUDs and co-occurring mental disorders may be unavailable in acute care settings given constraints on time and resources; however, brief assessments, referrals, and interventions can help move clients to the next level of treatment.

More information on particular topics relating to SUD screening and treatment in acute and medical care settings can be found in TIP 45, *Detoxification From Alcohol and Other Drugs* (CSAT, 2006b). More information on the use and value of brief interventions can be found in TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* (CSAT, 1999a).

RECOMMENDATIONS FOR CONTINUING CARE FOLLOWING DISCHARGE FROM RESIDENTIAL TREATMENT

- Clients should be engaged in continuing care services for a minimum of 3 to 6 months following discharge.
- Scheduling of continuing care appointments should occur prior to discharge so that appointments are already in place by the time a client leaves inpatient care.
- To facilitate monitoring, programs should implement formal follow-up procedures to ensure staff maintain contact with clients regularly at set time points (e.g., 30 days, 6 months), ideally for at least 12 months.
- Clients should be educated about the importance of continuing care and the availability of treatment options following residential treatment, including the use of pharmacotherapy with outpatient services.
- Residential staff should introduce clients to outpatient providers before discharge so as to provide a "warm handoff" and foster rapport-building between clients and their continuing care providers.
- Programs should be flexible in offering a wide range of continuing care services to meet clients' scheduling and daily living needs (e.g., offer outpatient therapy groups 5 days per week, use telehealth services so clients who live at a distance and are unable to travel to outpatient services regularly can still access treatment).
- Counselors should link clients to mutual-support programs and other community-based supports and resources available.

Sources: Proctor & Herschman (2014); Rubinsky et al. (2017).

HOW COMMON ARE MENTAL DISORDERS AND SUDS IN ACUTE CARE AND OTHER MEDICAL SETTINGS?

- **More than 70 percent of primary care visits are related to psychosocial needs** (National Association of State Mental Health Program Directors, 2012).
  - In a sample of 2,000 adults in primary care clinics in four states, 36 percent met *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013) criteria for an SUD in the last year, including almost 22 percent with a moderate/severe SUD (Wu et al., 2017). About 28 percent endorsed past-year illicit drug or nonmedical medication use.
  - From 2012 to 2014 (Cherry, Albert, & McCaig, 2018), 26 percent of mental health office visits in large metropolitan areas, 44 percent of visits in small-to-medium metropolitan areas, and 54 percent of visits in rural areas were to primary care.
- Of the 1.18 billion ambulatory medical visits that occurred between 2009 and 2011 (Lagisetty, Maust, Heisler, & Bohnert, 2017), **17.6 million involved an SUD diagnosis.**
  - This included 8.6 percent for AUD, 64.2 percent for tobacco use disorder, and 9.6 percent for OUD.
  - Among the people with an SUD, 13.4 percent also had anxiety, 5.7 percent had depression, and 2.3 percent had bipolar disorder.
- Data from the National Hospital Ambulatory Medical Care Survey indicate that **from 2005 to 2011, mental and substance use–related ED visits increased from 27.9 per 1,000 visits to 35.1 per 1,000 visits,** with the greatest increases observed in people ages 25 to 44 (Ayangbayi, Okunade, Karakus, & Nianogo, 2017). Odds of visits were higher in people who were uninsured or on public health insurance, or had been discharged from a hospital in the previous week.
- **Individuals with CODs are more likely than people without CODs to use EDs for mental disorder and SUD-related needs** (Moulin et al., 2018), as are individuals experiencing homelessness (Lam, Arora, & Menchine, 2016).

Prevalence

In 2018, 5 percent of SUD treatment facilities in the United States were hospital-based inpatient services (SAMHSA, 2019a). Specifically, 4 percent of facilities offered hospital-based treatment and 5 percent offered hospital-based detoxification. In 2018, 40 percent of general hospitals offered COD programming (SAMHSA, 2019b).

Empirical Evidence of Effectiveness

Over the past two decades, significant research has emerged in support of team-based, integrated behavioral health services in acute medical care settings (e.g., EDs, primary care clinics). Collaborative behavioral health service models are feasible and can be as effective as (and in some cases even more effective than) usual care in identifying and managing SMI, SUDs, or CODs (Chan, Huang, Bradley, & Unutzer, 2014; Chan, Huang, Sieu, & Unutzer, 2013; Kumar & Klein, 2013; Park, Cheng, Samet, Winter, & Saitz, 2015; Walley et al., 2015). Integrated, collaborative behavioral health services can improve mental disorder symptoms (including remission and recovery), treatment adherence, treatment satisfaction, quality of life (mental and physical), medication adherence, and social functioning and are cost-effective and valued by clients (Epstein, Barry, Fiellin, & Busch, 2015; Goodrich, Kilbourne, Nord, & Bauer, 2013). Most of these studies are focused on mental health services, with comparatively fewer examining integrated SUD treatment, but research suggests addiction models also are feasible and can produce positive outcomes (Goodrich et al., 2013), including long-term abstinence (Savic, Best, Manning, & Lubman, 2017). Primary care–based SUD treatment may also help reduce length of inpatient stay and ED utilization while also increasing recovery coach contacts and use of addiction pharmacotherapy (i.e., buprenorphine and naltrexone) (Wakeman et al., 2019).

Primary care–based SUD treatment can reduce gaps in service use by offering treatment in a setting that clients prefer. More than 42,000 U.S. adults were screened for SUDs to assess

willingness to enter SUD treatment based on service setting (Barry, Epstein, Fiellin, Fraenkel, & Busch, 2016). Those who screened positive but were not currently enrolled in SUD treatment were randomized to one of three hypothetical treatment setting vignettes: treatment in a specialty drug treatment center (i.e., usual care), primary care, or collaborative care in a primary care setting. About a quarter (24.6 percent) of people with an SUD and 18 percent with AUD who were randomized to specialty care were willing to enter treatment, whereas more people randomized to the primary care setting were willing to enter treatment (37 percent with an SUD; 20 percent with AUD). Similarly, more people randomized to the primary/collaborative care setting were willing to enter treatment than people in the specialty care setting (34 percent with an SUD; almost 21 percent with AUD). Nonspecialty settings like primary care clinics may be desirable for individuals needing SUD treatment because of a perceived lack of stigma attached to medical facilities (compared with, for instance, methadone clinics) and the ability of medical settings to address both SUD treatment and physical healthcare needs in one location (Barry et al., 2016).

Designing Acute Medical and Primary Care Programs for Clients With CODs

Programs that rely on identification (i.e., screening and assessment) and referral occupy a service niche in the treatment system. To succeed, they need a clear view of treatment goals and limitations. Effective linkages with various community-based SUD treatment facilities are essential to ensure an appropriate response to client needs and to facilitate access to additional services when clients are ready.

The discussion that follows highlights the essential features of providing treatment to clients with CODs in acute care and other medical settings.

Screening and Assessment in Acute and Other Medical Settings

Clients entering acute care or other medical facilities generally are not seeking SUD treatment. Often, providers (primary care and mental health) are not familiar with SUDs. Their lack of expertise can lead

THE INTEGRATION OF CARE FOR MENTAL HEALTH, SUBSTANCE ABUSE AND OTHER BEHAVIORAL HEALTH CONDITIONS INTO PRIMARY CARE: AMERICAN COLLEGE OF PHYSICIANS (ACP) POSITION PAPER

1. The ACP supports the integration of behavioral health care into primary care and encourages its members to address SUDs and mental disorders within the limits of their competencies and resources.
2. The ACP recommends that public and private health insurance payers, policymakers, and primary care and behavioral health care professionals work toward removing payment barriers that impede behavioral health and primary care integration. Stakeholders should also ensure the availability of adequate financial resources to support the practice infrastructure required to effectively provide such care.
3. The ACP recommends that federal and state governments, insurance regulators, payers, and other stakeholders address behavioral health insurance coverage gaps that are barriers to integrated care. This includes strengthening and enforcing relevant nondiscrimination laws.
4. The ACP supports increased research to define the most effective and efficient approaches to integrate behavioral health care in the primary care setting.
5. The ACP encourages efforts by federal/state governments and training and continuing education programs to ensure an adequate workforce to provide for integrated behavioral health care in primary care settings.
6. The ACP recommends that all relevant stakeholders initiate programs to reduce the stigma associated with behavioral health. These programs need to address negative perceptions held by the general population and by many physicians and other providers.

Source: Crowley & Kirschner (2015).

to unrealistic expectations or frustrations, which may be directed inappropriately toward the client.

Even in the absence of indepth training in addiction medicine, primary care and mental health service providers can quickly and easily screen clients for SUDs using brief, validated instruments—leading to better detection of SUDs, more client–provider discussions about substance misuse, and overall improvements in care (Jones, Johnston, Biola, Gomez, & Crowder, 2018; Savic et al., 2017). (Chapter 3 contains a full description of screening and assessment procedures and instruments applicable to CODs, including those that can be used in primary care settings; select instruments are also located in Appendix C.)

Although addiction screening can and should be offered in both nonurgent and urgent medical care settings, approaches may need to be implemented differently for each. O'Grady, Kapoor, and colleagues (2019) describe use of a screening, brief intervention, and referral for treatment (often referred to as SBIRT) program for people with or at risk for addiction that was implemented at EDs and primary care clinics. Compared with people screened as high risk for substance misuse in the primary care clinics, those screened as high risk in the EDs were significantly more likely to also have unstable housing, be unemployed, have self-reported "extreme" stress, have "serious" depression or anxiety, and have poor current health. They also reported higher addiction screening scores and more frequent substance use than people in the primary care clinics. Prescreening in the EDs was less likely to be completed than in primary care because clients were more likely to be in acute states, actively intoxicated, or have altered mental status. Further, more than one-third of people who prescreened positive for substance misuse did not receive full screening and intervention. This finding is consistent with results from two longitudinal surveys of 1,500 ED physicians that found only 15 percent to 20 percent of clients were screened for substance misuse and only 19 percent to 26 percent of ED physicians reported using a formal addiction screening tool (Broderick Kaplan, Martini, & Caruso, 2015).

These data are worrisome, given feedback from the American College of Emergency Physicians (2017) that ED professionals are, "positioned and qualified to mitigate the consequences of alcohol misuse through screening programs, brief intervention, and referral to treatment" and that EDs should maintain "wide availability of resources necessary to address the needs of patients with alcohol-related problems and those at-risk for them." ED staff may therefore require additional training to better recognize and respond to clients with addiction, particularly those with severe disorders. Formal procedures may also be needed to foster successful referral and implementation of brief interventions (e.g., education, harm reduction).

Interventions

Several differences exist in behavioral health service provision (including addiction services) in medical settings versus traditional mental health service settings (Exhibit 7.4). Acute medical settings may be less likely than mental health clinics to have SUD treatment providers on staff, unless the setting offers integrated care. For this reason, acute care and other medical settings should have formal procedures in place so providers know when clients require referral for specialty addition treatment versus in-office brief interventions (e.g., education about substance use, harm reduction tips) (Shapiro, Coffa, & McCance-Katz, 2013). Pharmacologic treatment is likely easier for clients to access in medical settings than in mental health centers because of the widespread availability of onsite prescribers. Pharmacologic treatment should be offered based on the latest evidence-based best practices (e.g., TIP 63, *Medications for Opioid Use Disorder* [SAMHSA, 2018c]; Veterans Administration (VA)/Department of Defense (DoD) *Clinical Practice Guidelines for the Management of Substance Use Disorders* [VA/DoD, 2015]). See the section "Pharmacotherapy" for a full discussion of medication treatment of people with CODs.

In integrated settings, treatment planning will often need to occur in collaboration with the other team providers (Savic et al., 2017). To this end, providers likely will need to engage in greater sharing of confidential client information than in nonintegrated, traditional settings to foster case management and coordination of services (Savic et al., 2017). Clients need to be briefed about these

limits to confidentiality at intake and their consent documented.

Exhibit 7.5 offers a sample (not exhaustive) listing of **questions that addiction providers and administrators should consider if they wish to integrate their services with primary care settings.** (Also see "Resource Alert: How To Integrate Primary Care and Behavioral Health Services for People With SMI.")

Historically, providers in acute care settings have not been concerned with treating SUDs beyond detoxification, stabilization, and referral. However, as the uptake of brief interventions increases and as the healthcare field's awareness grows about the importance of detecting and treating SUDs and mental disorders, treatment options are expanding beyond just stabilization and referral. In EDs, case managers help triage "high users" (who often include people with SUDs, mental disorders, or both [Minassian, Vilke, & Wilson, 2013; Moulin et

EXHIBIT 7.4. Traditional Mental Health Settings Versus Integrated Mental Health–Primary Care Settings

FACTOR	TRADITIONAL MENTAL HEALTH SETTING	INTEGRATED MENTAL HEALTH–PRIMARY CARE SETTING
Service Provision	Individualized/case based	Population based (e.g., services are for all of those attending the primary care clinic, the community served by the clinic)
Service Target(s)	The client/family	The client/family, other colleagues in the integrated system with whom the mental health provider collaborates (e.g., the primary care provider), community at large
Intensity and Length of Care	Comprehensive and long-term (as needed)	Comprehensive but briefer, more episodic, and with larger caseload turnover
Client Motivation	Usually high (unless treatment is compulsory, such as in forensic cases)	Often ambivalent, hesitant; clients may be less amenable to advice or referral for services
Client Confidentiality	High; other providers may or may not be involved in the client's care	Moderate; client information is regularly shared with other integrated care team members
Focus of Treatment	Skill oriented and symptom focused but also exploratory (e.g., interpersonal therapy, psychodynamic therapy)	Tends to be more concrete, skills oriented, and symptom based

Source: Joseph, Kester, O'Brien, & Huang (2017).

EXHIBIT 7.5. Redesigning Addiction Services for Integration With Primary Care: Questions for Addiction Providers and Administrators To Consider

Administrative Questions

- Is integration a part of your organization's vision and mission?
- What type of integration do you want to implement? Different options include:
  - Addressing substance use problems only.
  - Addressing substance use in primary care.
  - Addressing all substance use and mental disorder needs without primary care.
  - Addressing all substance use and mental disorder needs with primary care.
- Have you developed a strategic plan related to integration?
- Do you/your staff understand the primary care and SUD needs of the population you are serving?
- Do you have administrative policies in place to support integration (e.g., confidentiality, billing and reimbursement, ethics)?
- What clinical and business practices in your organization need to change to facilitate integration?

Capacity/Resource Questions

- Do you have existing relationships (formal or informal) with other service providers in mental health and primary care? If not, what needs to be done to establish those relationships?
- What existing community resources can you draw on (e.g., community coalitions, prevention programs)?
- Do you have relationships with medical providers at various levels of care (e.g., inpatient, outpatient) so you can refer clients seamlessly across the entire continuum of care?
- Do you have staff and other resources to treat primary care- and substance-related disorders? Is your organization licensed to provide these services? If not, what licensing regulations need to be met?
- Does your program have staff with a range of expertise and competencies in providing integrated care (e.g., case management, care coordination, wellness programming)?
- Does your program currently offer any integrated components, even if on an informal basis and not part of a defined program structure (e.g., as-needed use of case management to coordinate services)?

Financing Questions

- Do you have professional staff capable of providing billable primary care or mental health services?
- What expenditures—such as hiring staff or investing in training or other resources—might be required?
- What profit does your organization need to make to support your integrated care vision (key elements: number of consumers seen; how often they are seen per year; payer mix; reimbursement per visit)?
- Can you organization accept all types of payment (i.e., Medicaid, Medicare, private insurance)?
- What do you need to learn about joining provider networks of major payers?

Clinical Supports Questions

- Does your organization use a certified electronic medical records system?
- Can your records system create patient data registries (or link to existing registries) to support integration?
- Does your records system have a formal way of documenting coordination of care?
- Does your records system have a formal way of documenting physical health-related services?

Source: SAMHSA-Health Resources and Services Administration Center for Integrated Health Solutions (2013).

RESOURCE ALERT: HOW TO INTEGRATE PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES FOR PEOPLE WITH SMI

Milbank Memorial Fund's *Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness* (www.milbank.org/wp-content/uploads/2016/04/Integrating-Primary-Care-Report.pdf)

al., 2018; Smith, Stocks, & Santora, 2015]) to appropriate levels of care (e.g., admission, outpatient referral) (Turner & Stanton, 2015). Aspects of case management interventions—which are typically delivered not solely by case managers but collaboratively with other ED team members like nurses, physicians, and social workers—that can reduce ED visits, and in some cases reduce ED costs (Kumar & Klein, 2013) include:

- Educating clients about and linking them to community resources to address symptoms/problems.
- Offering referral to mental health services and SUD treatment.
- Assisting clients with transportation needs.
- Assisting clients with financial benefits/public assistance.
- Performing crisis intervention.
- Helping clients acquire stable housing.
- Working with clients to create an ED treatment plan or other individualized care plan.
- Following up with clients after discharge, including when providing referrals to specialty care.

Interview-based interventions, like motivational interviewing and brief negotiated interviews, decrease alcohol and illicit drug use in some studies, but other studies have reported inconsistent results (Hawk & D'Onofrio, 2018). Some research suggests that brief ED interventions affect substance use no more than minimal screening alone (Bogenschutz et al., 2014a), possibly because people presenting to the ED with substance-related problems tend to have higher levels of severity. Overdose education and distribution of naloxone kits are also being used increasingly in EDs, given the surge of evidence demonstrating the effectiveness of MAT for OUD; however, evidence for their effectiveness in preventing overdose and substance use over time has yet to be borne out (Hawk & D'Onofrio, 2018).

Research on the placement of peer recovery support specialists in EDs also appears to be promising but is still in its early stages (Ashford, Meeks, Curtis, & Brown, 2018; Samuels et al., 2018). The AnchorED Program in Rhode Island found that, during its first year, use of certified recovery coaches in the ED for people experiencing opioid overdose resulted in high engagement of recovery support services after discharge (83 percent), including enrollment at a local recovery community organization (Joyce & Bailey, 2015). Only 5 percent of people who engaged with the recovery coach experienced repeat ED visits. From 2016 to 2017, 87 percent of people engaged with AnchorED recovery coaches after ED discharge, and 51 percent accepted service referrals (e.g., inpatient treatment program, outpatient treatment program, MAT program) (Waye et al., 2019). However, more evidence is needed to elucidate the efficacy and effectiveness of peer-based approaches for ED populations.

Pharmacotherapy

This TIP does not comprehensively discuss pharmacotherapies for SUDs and mental illness. This section is an overview of medications for certain SUDs (i.e., OUD, AUD) and for mental disorders likely to co-occur with SUDs. The aim of this section is to foster appropriate monitoring and treatment planning by educating counselors about common medications that clients with CODs may be taking and side effects they may experience. For indepth discussion of medication for opioid addiction, see TIP 63, *Medications for Opioid Use Disorder* (SAMHSA, 2018c). "Resource Alert: Learning More About Pharmacotherapy and CODs" offers more information about medication treatment for CODs.

Medication for Mental Illness

Mental disorders are diseases of the brain or central nervous system. They affect a person's thinking, emotions, and mood. Medications can relieve distressing symptoms and improve functioning for people with mental illness, and they work in a variety of ways. Medications may be effective for more than one disorder but be referred to by the condition they are most often used to treat. For example, a medication may be referred to as an "antidepressant" but also help with anxiety or an eating disorder. Antipsychotic medications are typically associated with diseases like schizophrenia but may also be used for bipolar disorder or severe depression. **Because the same medication can be used to treat various disorders, always ask clients for which condition they take a medication.**

A person may have a history of taking different medications in the past or may report a change in his or her medications while working with a counselor. People need different medications depending on how their illness is expressing itself (e.g., which symptoms are most severe or most disabling). Medications used to treat the first episode of a mental illness may be different from those used later in disease course. Age may affect medication selection and dosage; aging affects metabolism and the bioavailability of some drugs. Sometimes a medication becomes less effective over time and will have to be changed or another medication added. There may also be periods when no medication is used at all.

Medication Management

A person with a mental illness should be cared for by a team of providers, which may include a primary care provider, a psychiatrist, and a behavioral health professional, such as a psychologist, social worker, or counselor. Different members of the care team may serve as primary contact over time. Medications will typically be prescribed by the primary care provider or psychiatrist. The team should work together to monitor the effects and side effects of the medication. Monitoring may include blood tests and checking blood pressure and weight.

KNOWING WHEN TO REFER FOR MEDICATION MANAGEMENT

Sometimes a nonprescribing professional in behavioral health (e.g., licensed clinical social workers, addiction counselors, most psychologists) will need to refer a client for an evaluation to explore pharmacotherapy options and appropriateness. Such situations include when a client:

- Has not had success improving symptoms or functioning after trying multiple psychotherapies.
- Has had limited success improving symptoms or functioning with psychotherapy but is still experiencing symptoms that are distressing or interfere with the person's functioning.
- Wants to be abstinent but has had difficulty stopping substance use (especially use of opioids or alcohol).
- Reports having previous success with a medication and expresses an interest in trying the medication again.
- Has (or is suspected to have):
  - Psychotic symptoms (e.g., hallucinations, delusions).
  - Schizophrenia.
  - Severe depression (especially with suicidal thoughts, behaviors, or attempts).
  - Bipolar disorder or mania.

Equally important is knowing to whom you should refer clients for medication evaluation. You should refer to primary care or behavioral health professionals with prescribing privileges, such as:

- A physician.
- A psychiatrist.
- An advanced practice registered nurse (especially a psychiatric/mental health specialty nurse).

Considerations for the SUD Treatment Provider

A patient who appears sedated, agitated, or intoxicated may be experiencing a medication side effect or other medical illness. Medications that work in the brain are considered "psychotropic," meaning they affect a person's mental state. Drugs of misuse are psychotropic, too. **The benefits, side**

effects, and drug interactions of medications for mental illness can affect clients similarly to, or look like some of the effects of, illicit substances. This may be triggering for the client or those around him or her or lead to misuse of prescribed medication. Illicit substances and prescribed medications may interact with one another, potentially reducing the beneficial effects of the prescribed medication (Lindsey, Stewart, & Childress, 2012).

Medication for Depression

Medication can be used to treat major depression at all levels of severity; it should be started early and combined with psychotherapy (American Psychiatric Association [APA], 2010; Schulz & Arora, 2015). The goal of medication is to relieve distressing symptoms and help restore function.

Several classes of medications have been approved for treating depression (FDA, 2017), including selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), and monoamine oxidase inhibitors (MAOIs). Each works in different ways but ultimately treats depression by changing the balance of chemicals (neurotransmitters) in the brain that regulate mood, such as serotonin, norepinephrine, and dopamine. Sometimes medication not specifically approved for depression, such as mood stabilizers or anti-psychotics, will be added to the antidepressant to address specific symptoms (FDA, 2017).

In 2019, FDA approved the first ever nasal spray antidepressant (FDA, 2019), derived from a pain reliever called ketamine. The spray (esketamine) is specifically for treatment-resistant major depression and is designed to begin relieving symptoms, in a matter of hours. Its release represents the first time FDA has approved a new antidepressant since the medication Prozac entered the market in 1988.

Side Effects

Common side effects when antidepressants are started or when the dose is increased are nausea, vomiting, and diarrhea (Exhibit 7.6). These usually improve in a few weeks. Side effects such as weight gain, sleep disturbances, and sexual dysfunction can be longer lasting. Some medication side effects may mimic signs of intoxication or withdrawal or may be triggering for clients. Medication for depression might increase suicidal thoughts in young adults (i.e., people ages 18 through 24). Some antidepressants are associated with birth defects or cause the newborn to experience a withdrawal syndrome.

Medication for Anxiety Disorders

Anxiety disorders are best treated with combined psychotherapy and medication (Benich, Bragg, & Freedy, 2016). Medication can help relieve distressing symptoms. Antidepressants and benzodiazepines are the most common classes

EXHIBIT 7.6. Side Effects of Antidepressants

MEDICATION CLASS	SIDE EFFECTS
SSRI	High blood pressure, headache, sexual dysfunction, hyperalertness, restlessness, teeth grinding, sweating, internal bleeding, insomnia, nausea/vomiting, osteopenia
SNRI	Dry mouth, sexual dysfunction, hyperalertness, restlessness, sweating, insomnia, nausea/vomiting, weight gain
TCA	Irregular heart rhythm, low blood pressure with risk of falls, constipation, dry mouth, sweating, sedation, weight gain
MAOI	High blood pressure, low blood pressure with risk of falls, weight gain
Other	Seizure, insomnia, nausea/vomiting, sedation, weight gain

A NOTE ABOUT SEROTONIN SYNDROME

Serotonin syndrome is a potentially fatal condition caused by too much serotonin (Bartlett, 2017). It can occur if a person takes too much of a prescribed SSRI or SNRI or when multiple prescribed medications interact. Over-the-counter cold and allergy medications and certain illicit substances (e.g., cocaine, other stimulants, opioids) can also cause serotonin syndrome.

Mild serotonin syndrome can look like opioid withdrawal. More serious serotonin syndrome can look like intoxication with a stimulant or hallucinogen or withdrawal from a benzodiazepine. Fever, dangerously high blood pressure, and seizure can lead to organ failure and death if the syndrome is not recognized and treated. Counselors should remain vigilant for and seek medical evaluation for possible serotonin syndrome when clients with CODs present with unexpected withdrawal or intoxication symptoms.

of FDA-approved medication for anxiety. Antidepressants in the SSRI and SNRI classes are considered first-line therapy. Benzodiazepines should generally be used only for short periods, taken per a schedule rather than as needed (Benich et al., 2016). **Taking benzodiazepines with opioids markedly increases the risk of overdose** (NIDA, Revised March 2018).

Benzodiazepines can cause dependence after relatively brief periods of regular use. People dependent on benzodiazepines will experience withdrawal if they stop taking them abruptly.

Side effects of antidepressants prescribed for anxiety are the same as those for depression (Exhibit 7.6). Benzodiazepines carry an increased risk of central nervous system depression, which can lead to sedation, fatigue, dizziness, and impaired driving ability (Bandelow, Michaelis, & Wedekind, 2017). Older adults taking benzodiazepines can have negative changes in cognition, such as memory, learning, and attention. Older adults taking benzodiazepines are thus at an increased risk of falls and fracture (Markota, Rummans, Bostwick, & Lapid, 2016).

Medication for PTSD

Medication combined with psychotherapy can be effective in relieving symptoms of PTSD (VA/DoD, 2017). The FDA has approved two SSRIs for the treatment of PTSD. Studies are also underway to explore the benefit of using certain antipsychotics in PTSD.

The pharmacist from whom a client gets his or her prescriptions may be a helpful source of information if counselors have concerns or questions about side effects or drug interactions.

Medication for Bipolar Disorder

Bipolar disorder is typically managed with both medication and psychotherapy, given its lifelong course and need for continuous treatment (SAMHSA, 2016). The goal of medication in bipolar disorder is to prevent or suppress mania while relieving depression (Fountoulakis et al., 2017). Sometimes people will have already begun treatment for depression when mania presents for the first time. When this happens, the antidepressant may be stopped and restarted later. Medications used to treat bipolar disorder are often referred to as "mood stabilizers." This is not a single class of medication but a group of different types of medications that reduce the abnormal brain activity that causes mania and rapidly changing mood states. Mood stabilizers, antiseizure medications, and antipsychotic medications may be used to treat bipolar disorder; sometimes these medications are used in combination.

Mood Stabilizers

Medication to prevent severe mood fluctuations can be effective at treating mania, particularly the first-line medication lithium (Fountoulakis et al., 2017). Mood stabilizers treat and prevent mania by decreasing abnormal activity in the brain. People taking lithium need to see a physician regularly for monitoring of blood levels and kidney and thyroid functioning. Side effects that may improve with time are nausea, diarrhea, dizziness, muscle weakness, fatigue, and feeling "dazed."

Other symptoms are likely to continue, such as fine tremor, frequent urination, and thirst. Lithium can cause skin disorders like acne, psoriasis, and rashes. Serious side effects include irregular heart rhythm and serotonin syndrome. Anesthesia and antidepressants are associated with serotonin syndrome when taken with lithium. Elevated blood levels of lithium can cause uncontrollable shaking, clumsiness, ringing in the ears, slurred speech, and blurred vision. **Salt, caffeine, alcohol, other medications, and dosing mistakes can cause lithium toxicity, which can be a medical emergency.**

Antiseizure Medication

Antiepileptic medications can be used to treat bipolar disorder (Fountoulakis et al., 2017; National Institute of Mental Health [NIMH], 2016). These medications may have both benign and life-threatening side effects, including rash, damage to internal organs, and a decrease in blood cells (e.g., platelets, white blood cells). These medications can interact negatively with medications used to treat common medical concerns, such as diabetes and high blood pressure. They also can make hormonal contraceptives less effective. Other serious side effects include peeling or blistering of the skin, bruising, bleeding, weakness, headache, stiff neck, chest pain, nausea/vomiting, vision changes, swelling of the face/eyes/lips, dark urine, yellowing of the skin or eyes, abnormal heartbeat, loss of appetite, and abdominal pain. Common but less-serious side effects include blurred or double vision; dizziness; uncontrollable movements; sleepiness; weight change; ringing in the ears; hair loss; back, stomach, or joint pain; painful menstrual periods; confusion; difficulty speaking; and dry mouth.

Antipsychotic Medication

Antipsychotic medication may be used to treat mania with psychosis. See the section "Medication for Schizophrenia and Other Psychotic Disorders" for detailed information about the medications.

Tobacco smoke affects how medications are absorbed, spread through the body, are metabolized, and eliminated by the body; how medications work can also be affected (Lucas & Martin, 2013). Changing the amount of tobacco smoked, including stopping or starting, can interfere with medication effectiveness or risk of side effects.

Medication for Schizophrenia and Other Psychotic Disorders

Antipsychotics are the most common medications for schizophrenia and other psychotic disorders (Lally & MacCabe, 2015; Patel, Cherian, Gohil, & Atkinson, 2014). They have many side effects and require careful monitoring. Most are taken daily, but a few long-lasting forms can be administered once or twice a month.

Antipsychotics are divided into two categories: "first-generation" or "typical" antipsychotics and "second-generation" or "atypical" antipsychotics. Both types can be used to help treat schizophrenia and mania related to bipolar disorder. Some antipsychotics have a wider range of uses, including severe depression, generalized anxiety disorder, obsessive-compulsive disorder, PTSD, dementia, and delirium. Symptoms such as agitation and hallucinations may remit within a few days of starting the medication, whereas delusions may take a few weeks to resolve. The full effect of an antipsychotic may not be seen for up to 6 weeks. A person may need to stay on the antipsychotic for months or years to stay well.

Side Effects

All antipsychotics have the potential to cause side effects such as drowsiness, dizziness, restlessness, dry mouth, constipation, nausea, vomiting, blurred vision, low blood pressure, and uncontrollable muscle movements (NIMH, 2016). People who take antipsychotics need to have their blood cell counts, blood glucose, and cholesterol monitored by a healthcare provider. Care should be taken when starting or stopping other medications, given the many potential drug interactions, not all of which are known. The typical or first-generation antipsychotics may cause rigidity and

muscle spasms, tremors, and restlessness. They may also cause a condition of abnormal muscle movements called **tardive dyskinesia,** which can persist even when the medication is discontinued. Some antipsychotics cause electrocardiogram abnormalities, such as QT prolongation, a condition in which the heart takes longer to recharge between beats. **An individual can overdose on antipsychotics, especially if they are combined with alcohol or other sedating drugs.**

Medication for Attention Deficit Hyperactivity Disorder

Attention deficit hyperactivity disorder (ADHD) in adults may be treated with short- or long-acting stimulants, nonstimulant medications, and behavioral therapy (NIMH, 2016). Typically, a nonstimulant medication is prescribed first; a stimulant is prescribed only if nonstimulant response is insufficient. Stimulant medications help people with ADHD focus and feel calmer but can cause euphoria (SAMHSA, 2015a).

Stimulants may be misused by people who have no prescription. Typically, people who misuse stimulants are motivated to improve academic/work performance and hope to experience enhanced concentration and alertness rather than euphoria. Many people who consistently misuse prescription stimulants exhibit symptoms of ADHD. Adults who are prescribed stimulants for ADHD may misuse them by taking larger doses than prescribed. Some evidence exists that adults who misuse stimulants prescribed to them are more likely to report misuse of other substances as well (Wilens et al., 2016).

No specific guidelines exist on whether stimulants should be prescribed for co-occurring ADHD in people with SUDs. Available research is unclear as to whether stimulants are effective for ADHD in the presence of an SUD. Although efficacious in reducing ADHD symptoms, stimulant medications generally do not alleviate SUD symptoms (Cunill et al., 2015; De Crescenzo et al., 2017; Luo & Levin, 2017). Thus, ADHD medication alone, if used at all, is an insufficient treatment approach for ADHD-SUD (Crunelle et al., 2018; Zulauf et al., 2014). Stimulants do have misuse potential, but current evidence suggests that most people with ADHD and SUD generally do not divert or misuse stimulant medication for ADHD (e.g., to experience euphoria) (Luo & Levin, 2017). However, diversion can and does occur in some people. Use of long-acting or extended-release medication or of antidepressants instead of stimulants can help reduce the chances of diversion and misuse.

Medications for ADHD can have potentially life-threatening cardiovascular side effects (Sinha, Lewis, Kumar, Yeruva, & Curry, 2016). Changes in heart rhythm and blood pressure can occur that raise risk of stroke and heart attack, especially in adults with preexisting heart conditions (Zukkoor, 2015). These medications should be prescribed cautiously and with consideration of the client's personal and family history of cardiovascular problems. Combined medication and psychotherapy may provide the best long-term relief of ADHD symptoms (Arnold, Hodgkins, Caci, Kahle, & Young, 2015).

Medication for PDs

No medications are FDA approved to treat any PD. Antidepressants, mood stabilizers, antipsychotics, and antianxiety medications can be prescribed to target symptoms/improve function.

Medication for Feeding and Eating Disorders

Medication is generally not a first-line or standalone treatment approach for eating disorders, and only one medication—the SSRI fluoxetine (Prozac)—is approved by the FDA to treat these conditions (specifically, bulimia nervosa [BN]) (Davis & Attia, 2017). Other antidepressants may be effective for the management of BN and binge eating disorder (BED) but have been relatively less successful with anorexia nervosa (AN; Davis & Attia, 2017). Second-generation antipsychotics (notably olanzapine) may offer a promising pharmacotherapy option for AN, but more research is needed (Davis & Attia, 2017). Certain stimulants known to suppress appetite have shown some success with reducing symptoms of BED (Davis & Attia, 2017).

Medication for SUDs

Because SUDs are brain-based diseases, pharmacologic research has explored the development of agents that can effectively target disruptions in neurotransmitters and

neuromodulators that occur as a part of addiction. These medications often help reduce withdrawal symptoms or craving, which in turn can make abstinence easier to achieve and sustain. In general, pharmacotherapy for SUDs is considered supportive rather than curative and is typically combined with psychotherapy, behavioral counseling, psychoeducation, mutual support, other recovery services, or a combination of these.

The sections that follow briefly discuss medications for AUD and OUD. Currently no FDA-approved pharmacotherapies exist for cocaine, methamphetamine, or cannabis use disorders. Clinicians often use FDA-approved nicotine replacement therapy and nonnicotine medications to manage tobacco use disorder. Tobacco use is outside the scope of this TIP, so these pharmacotherapies are not discussed. Readers interested in learning more can review FDA's guidance about medication to support tobacco cessation (www.fda.gov/ForConsumers/ConsumerUpdates/ucm198176.htm).

Medication use by people battling addiction has been controversial given attitudes by some providers and mutual-support programs, like AA and Narcotics Anonymous, that view medication use as incompatible with abstinence and therefore not a valid part of recovery. Counselors should be sensitive to this and educate clients about the potential value of medication as well as possible negative reactions they might face from some mutual-support programs and addiction professionals.

Medication is not a cure for addiction and is not right for everyone. But the science is clear: in certain instances (e.g., for OUD), pharmacotherapy can not only help improve lives, it can help save them as well.

Medication for AUD

Three medications are FDA approved for AUD (disulfiram, naltrexone, and acamprosate), and each has a different mechanism of action. These include disincentivizing use by causing unpleasant side effects (e.g., nausea, headache, vomiting) when alcohol is consumed (disulfiram); blocking the euphoric effects of intoxication (naltrexone); and normalizing neurotransmitter activity that is dysregulated in addiction and during withdrawal (acamprosate). Other medications, including anticonvulsants, antipsychotics, and antidepressants, can help reduce consumption and craving and potentially help support abstinence (Akbar, Egli, Cho, Song, & Noronha, 2018).

Medication for OUD

Unlike AUD and other SUDs, **pharmacotherapy (with or without adjunctive psychosocial treatment) is the recommended approach to managing OUD.** Ample research strongly supports the effectiveness of MAT for OUD in increasing abstinence, preventing or reversing overdose, reducing risk of relapse, and mitigating negative outcomes associated with opioid addiction, like infectious diseases and incarceration (SAMHSA, 2018c). FDA-approved medications for OUD include methadone, buprenorphine, and naltrexone. In addition, the FDA-approved rescue medication naloxone can rapidly reverse opioid overdose and prevent fatality. Readers should consult TIP 63, *Medications for Opioid Use Disorder* (SAMHSA, 2018c), for extensive information about opioid pharmacotherapy and its role in helping clients manage symptoms and achieve long-term recovery.

RESOURCE ALERT: LEARNING MORE ABOUT PHARMACOTHERAPY AND CODs

Pharmacology interventions can be safe and effective for many individuals with CODs. Although prescribing is outside the practice of addiction counselors, licensed clinical social workers, and most psychologists, all providers should become familiar with common psychotropic medications, their side effects, and their potential risks. Following are several resources to help nonprescribing behavioral health service providers learn more about pharmacotherapy for mental disorders and SUDs:

- SAMHSA's TIP 63, Medications for Opioid Use Disorder (https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder)
- SAMHSA's Medication for the Treatment of Alcohol Use Disorder: A Brief Guide (https://store.samhsa.gov/system/files/sma15-4907.pdf)
- APA's Practice Guideline for the Pharmacological Treatment of Patients With Alcohol Use Disorder (https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9781615371969)
- National Library of Medicine's Drug Information Portal (https://druginfo.nlm.nih.gov/drugportal/)
- FDA's Medication Guides (www.fda.gov/drugs/drugsafety/ucm085729.htm)
- NIMH's Mental Health Medications (www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml)
- University of Washington's Commonly Prescribed Psychotropic Medications (https://aims.uw.edu/resource-library/commonly-prescribed-psychotropic-medications)

Conclusion

CODs are exceedingly common in both the SUD population and the mental illness population, and addiction counselors should expect to see both conditions in their work. A wide range of treatment approaches are available and can be adapted to the specific needs of people with CODs, including their symptoms as well as their stages of change and readiness to engage in services. Because the disease course of SUDs and mental disorders is often unstable and unpredictable, counselors must be ready to offer COD-appropriate interventions across all settings, including nontraditional settings like jails and prisons. Continuous, integrated treatment modalities that link clients with resources and supports in the community give people with addiction the best chances at achieving lasting recovery.

Substance Use Disorder Treatment for People With Co-Occurring Disorders

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TREATMENT IMPROVEMENT PROTOCOL

TIP 42

SAMHSA
Substance Abuse and Mental Health Services Administration