

Chapter 1—Introduction to Substance Use Disorder Treatment for People With Co-Occurring Disorders

KEY MESSAGES

- People with mental illness are likely to have comorbid substance use disorders (SUDs) and vice versa. Addiction counselors should expect to encounter mental illness in their client population.
- Co-occurring disorders (CODs) are burdensome conditions that have significant physical, emotional, functional, social, and economic consequences for the people who live with these disorders and their loved ones. Society as a whole is also affected by the prevalence of CODs.
- Over the past two decades, the behavioral health field's knowledge of the outcomes, service needs, and treatment approaches for individuals with CODs has expanded considerably. But gaps remain in ready access to services and provision of timely, appropriate, effective, evidence-based care for people with CODs.
- CODs are complex and bidirectional. They can wax and wane over time. Providers, supervisors, and administrators should be mindful of this when helping clients make decisions about treatment and level of care.

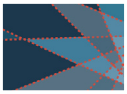
What is health? The World Health Organization (WHO) considers healthy states ones characterized by “complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, n.d.). The Department of Health and Human Services’ (HHS) Healthy People 2020 initiative also supports a broad definition of optimal health, reflected by its overarching goals of (Centers for Disease Control and Prevention [CDC], 2014):

- Helping people achieve high-quality, long lives free of preventable disease, disability, injury, and premature death.
- Establishing health equity, eliminating disparities, and improving the health of all groups.
- Promoting quality of life, healthy development, and healthy behaviors across all life stages.

The concept of “well-being” extends beyond one’s physical condition and includes other important areas of functioning and quality of life, such as mental illness and SUDs. Healthy People 2020 policy and prevention goals include reducing substance use among all Americans (especially children) and decreasing the prevalence of mental disorders (particularly suicidality and depression) while increasing treatment access (Office of Disease Prevention and Health Promotion, 2019).

SUDs and mental disorders are detrimental to the health of individuals and to society as a whole. The tendency of these disorders to co-occur can make the damage they cause more extensive and complex. As knowledge of CODs continues to evolve, new challenges have arisen: What is the best way to manage CODs and reduce lags in treatment? How do we manage especially vulnerable populations with CODs, such as people experiencing homelessness and those in our criminal justice system? What about people with addiction and serious mental illness (SMI), such as bipolar disorder or schizophrenia? What are the best treatment environments and modalities? How can we build an integrated system of care?

The main purpose of this Treatment Improvement Protocol (TIP) is to attempt to answer these and related questions by providing current, evidence-based, practice-informed knowledge about the rapidly advancing field of COD research. This



TIP is primarily for SUD treatment and mental health service providers, clinical supervisors, and program administrators.

This chapter introduces the TIP and is addressed to all potential audiences of the TIP: counselors, other treatment/service providers, supervisors, and administrators. It describes the scope of this TIP (both what is included and what is excluded by design), its intended audience, and the basic approach that has guided the selection of strategies, techniques, and models highlighted in the text. Next, a section on terminology, including a box of key terms, will help provide a common language and facilitate readers' understanding of core concepts in this TIP. The chapter also addresses the developments that led to this TIP revision as well as the underlying rationale for developing a publication on CODs specifically.

Scope of This TIP

The TIP summarizes state-of-the-art diagnosis, treatment, and service delivery for CODs in the addiction and mental health fields. It contains chapters on screening and assessment, diagnosis, and treatment settings and models, as well as recommendations to address workforce and administration needs. It is not intended for trainees or junior professionals lacking a basic background in mental illness and addiction (see the "Audience" section that follows). It therefore excludes generic, introductory information about mental disorders and SUDs. Of note:

- **The primary concern of this TIP is co-occurring SUDs and mental disorders**, even though the vulnerable population with CODs is also subject to many other physical conditions. As such, co-occurring physical disorders common in individuals with SUDs, mental disorders, or both (e.g., HIV, hepatitis C virus) are beyond the scope of this publication and excluded.
- Tobacco use disorder, which was treated in the original TIP as an important cross-cutting issue, is omitted from this update. Since the original development of this TIP, considerable and comprehensive treatment resources have become available specific to nicotine cessation.
- Pathological gambling, which the *Diagnostic and Statistical Manual of Mental Disorders* (5th

ed.; DSM-5; American Psychiatric Association, 2013) classifies along with other SUDs and which was included in the original TIP, is not addressed in this update because behavioral addictions are outside its scope.

- Although the TIP addresses several specific populations (i.e., people experiencing homelessness; people involved in the criminal justice system; people from diverse racial, ethnic, and cultural backgrounds; women; active duty and veteran military personnel), it does so briefly. It also omits content specifically for adolescents. The authors fully recognize, and the TIP states repeatedly, that all COD treatment must be culturally responsive.

Audience

The primary audience for this TIP is SUD treatment providers. It is meant to meet the needs of those with basic education/experience as well as the differing needs of those with intermediate or advanced education. SUD treatment providers include drug and alcohol counselors, licensed clinical social workers and psychologists who specialize in addiction treatment, and specialty practice registered nurses [psychiatric and mental health nurses]). Many such providers have addiction counseling certification or related professional licenses. Some may have credentials in the treatment of mental disorders or in criminal justice services.

Other main audiences for this TIP are mental health service providers, as well as primary care providers (e.g., general practitioners, internal medicine specialists, family physicians, nurse practitioners), who may encounter patients with CODs in their clinics, private practices, or emergency medicine settings.

Secondary audiences include administrators, supervisors, educators, researchers, criminal justice staff, and other healthcare and social service providers who work with people who have CODs.

Approach

The TIP uses three criteria for including a particular strategy, technique, or model:

1. Definitive research (i.e., evidence-based treatments)

2. Well-articulated approaches with empirical support
3. Consensus panel agreement about established clinical practice

The information in this TIP derives from a variety of sources, including the research literature, conceptual writings, descriptions of established program models, accumulated clinical experience and expertise, government reports, and other available empirical evidence. It reflects the current state of clinical wisdom regarding the treatment of clients with CODs.

Guidance for the Reader

This TIP is a resource document and a guide on CODs. It contains up-to-date knowledge and instructive material, reviews selected literature, summarizes many COD treatment approaches, and covers some empirical information. The scope of CODs generated a complex and extensive TIP that is probably best read by chapter or section. It contains text boxes, case histories, illustrations, and summaries to synthesize knowledge that is

grounded in the practical realities of clinical cases and real situations.

A special feature throughout the TIP—“Advice to the Counselor” boxes—provides direct and accessible guidance for the counselor. Readers can study these boxes to obtain concise practical guidance. Advice to the Counselor boxes distill what the counselor needs to know and what steps to take; they are enriched by more detailed reading of the relevant material in each section or chapter.

The chair and co-chair of the TIP consensus panel encourage collaboration among providers and treatment agencies to translate the concepts and methods of this TIP into other useable tools specifically shaped to the needs and resources of each agency and situation. The consensus panel hopes that the reader will gain from this TIP increased knowledge, encouragement, and resources for the important work of treating people with CODs.

Terminology in This TIP

Exhibit 1.1 defines key terms that appear in this TIP.

EXHIBIT 1.1. Key Terms

- **Addiction*:** The most severe form of SUD, associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and recovery.
- **Binge drinking*:** A drinking pattern that leads to blood alcohol concentration levels of 0.08 grams per deciliter or greater. This usually takes place after four or more drinks for women and five or more drinks for men (National Institute on Drug Abuse, n.d.; Center for Behavioral Health Statistics and Quality, 2019). However, older adults are more sensitive to the effects of alcohol and treatment providers may need to lower these numbers when screening for alcohol misuse (Kaiser Permanente, 2019). Additionally, other factors such as weight, decrease in enzyme activity, and body composition, (e.g. amount of muscle tissue present in the body) can also affect alcohol absorption rates.
- **Continuing care:** Care that supports a client's progress, monitors his or her condition, and can respond to a return to substance use or a return of symptoms of a mental disorder. Continuing care is both a process of posttreatment monitoring and a form of treatment itself. It is sometimes referred to as **aftercare**.
- **Co-occurring disorders:** In this TIP, this term refers to co-occurring SUDs and mental disorders. Clients with CODs have one or more mental disorders as well as one or more SUDs.
- **Heavy drinking*:** Consuming five or more drinks for men and four or more drinks for women in one period on each of 5 or more days in the past 30 days (NIAAA, n.d.).
- **Integrated interventions:** Specific treatment strategies or therapeutic techniques in which interventions for the SUD and mental disorder are combined in one session or in a series of interactions or multiple sessions.
- **Mutual support programs:** Mutual support programs consist of groups of people who work together to achieve and maintain recovery. Unlike peer support (e.g., use of recovery coaches), mutual support groups

consist only of people who volunteer their time and typically have no official connection to treatment programs. Most are self-supporting. Although 12-Step groups (e.g., Alcoholics Anonymous and Narcotics Anonymous) are the most widespread and well researched type of mutual support groups, other groups may be available in some areas. They range from groups affiliated with a religion or church (e.g., Celebrate Recovery, Millati Islami) to purely secular groups (e.g., SMART Recovery, Women for Sobriety).

- **Peer recovery support services:** The entire range of SUD treatment and mental health services that help support individuals' recovery and that are provided by peers. The peers who provide these services are called **peer recovery support specialists** ("peer specialists" for brevity), **peer providers**, or **recovery coaches**.
- **Relapse*:** A return to substance use after a significant period of abstinence.
- **Recovery*:** A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Even individuals with severe and chronic SUDs can, with help, overcome their SUD and regain health and social function. This is called remission. When those positive changes and values become part of a voluntarily adopted lifestyle, that is called "being in recovery." Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, pro-social feature.
- **Standard drink*:** Based on the 2015–2020 *Dietary Guidelines for Americans* (HHS, U.S. Department of Agriculture, 2015) one standard drink contains 14 grams (0.6 ounces) of pure alcohol:

12 fl oz. of
regular beer



about 5%
alcohol

8-9 fl oz. of
malt liquor
(shown in a
12 oz glass)



about 7%
alcohol

5 fl oz. of
table wine



about 12%
alcohol

1.5 fl oz. shot
of 80-proof
distilled spirits
(gin, rum, tequila,
vodka, whiskey, etc.)



40% alcohol

The percent of "pure" alcohol, expressed here as alcohol by volume (alc/vol), varies by beverage.

- **Substance*:** A psychoactive compound with the potential to cause health and social problems, including SUDs (and their most severe manifestation, addiction). The insert at the bottom of this exhibit lists common examples of such substances.
- **Substance misuse*:** The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or to those around them. For some substances or individuals, any use would constitute misuse (e.g., underage drinking, injection drug use).
- **Substance use*:** The use—even one time—of any of the substances listed in the insert.
- **Substance use disorder*:** A medical illness caused by repeated misuse of a substance or substances. According to the DSM-5 (American Psychiatric Association [APA], 2013), SUDs are characterized by clinically significant impairments in health, social function, and impaired control over substance use and are diagnosed through assessing cognitive, behavioral, and psychological symptoms. SUDs range from mild to severe and from temporary to chronic. They typically develop gradually over time with repeated misuse, leading to changes in brain circuits governing incentive salience (the ability of substance-associated cues to trigger substance seeking), reward, stress, and executive functions like decision making and self-control. Multiple factors influence whether and how rapidly a person will develop an SUD. These

factors include the substance itself; the genetic vulnerability of the user; and the amount, frequency, and duration of the misuse. **Note:** A severe SUD is commonly called an addiction.

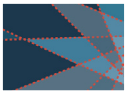
Categories and examples of substances

SUBSTANCE CATEGORY	REPRESENTATIVE EXAMPLES
Alcohol	<ul style="list-style-type: none"> • Beer • Wine • Malt liquor • Distilled spirits
Illicit Drugs	<ul style="list-style-type: none"> • Cocaine, including crack • Heroin • Hallucinogens, including LSD (lysergic acid diethylamide), PCP (phencyclidine), ecstasy, peyote, mescaline, psilocybin • Methamphetamines, including crystal meth • Marijuana, including hashish[†] • Synthetic drugs, including K2, Spice, and “bath salts” • Prescription-type medications that are used for nonmedical purposes <ul style="list-style-type: none"> - Pain relievers—Synthetic, semisynthetic, and nonsynthetic opioid medications, including fentanyl, codeine, oxycodone, hydrocodone, and tramadol products - Tranquilizers, including benzodiazepines, meprobamate products, and muscle relaxants - Stimulants and methamphetamine, including amphetamine, dextroamphetamine, and phentermine products; mazindol products; and methylphenidate or dexamethylphenidate products - Sedatives, including temazepam, flurazepam, or triazolam and any barbiturates
Over-the-Counter Drugs and Other Substances	<ul style="list-style-type: none"> • Cough and cold medicines • Inhalants, including amyl nitrite, cleaning fluids, gasoline and lighter gases, anesthetics, solvents, spray paint, nitrous oxide

[†] As of March 2020, most states and the District of Columbia have legalized medical marijuana use, although some states have stricter limitations than others. Additionally, a significant number of states and the District of Columbia also allow recreational use and home cultivation. It should be noted that none of the permitted uses under state laws alter the status of marijuana and its constituent compounds as illicit drugs under Schedule I of the federal Controlled Substances Act.

Source: HHS Office of the Surgeon General (2016).

*The definitions of all terms marked with an asterisk correspond closely to those given in *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. The standard drink image and the table depicting substance types and categories come from the same source, which is in the public domain. This resource provides a great deal of useful information about substance misuse and its impact on U.S. public health. The report is available online (<https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf>).



The behavioral health field has used many terms to describe the group of individuals who have CODs. Some of these terms do not appear in this TIP, which attempts to reflect a “person-first” approach (see the “Person-Centered Terminology” section). Providers and other professionals working with people who have CODs need to understand that **some terms that have been commonly related to CODs may now be outdated and, in certain cases, pejorative.** Such terms include:

- Dual diagnosis.
- Dually diagnosed.
- Dually disordered.
- Mentally ill chemical abuser.
- Mentally ill chemically dependent.
- Mentally ill substance abuser.
- Mentally ill substance using.
- Chemically abusing mentally ill.
- Chemically addicted and mentally ill.
- Substance abusing mentally ill.

All of these terms have their uses, but many have connotations that are unhelpful or too broad or varied in interpretation to be useful. For example, “dual diagnosis” also can mean having both mental and developmental disorders. Outside of this TIP, readers should not assume that these terms all have the same meaning as CODs and should clarify the client characteristics associated with a particular term. Readers should also realize that the term “co-occurring disorder” is not always precise. As with other terms, it may become distorted over time by common use and come to refer to other conditions; after all, clients and consumers may have a number of health conditions that “co-occur,” including physical illness. **Nevertheless, for the purpose of this TIP, CODs refers only to SUDs and mental disorders.**

Some clients’ mental illness symptoms may not fully meet strict definitions of co-occurring SUDs and mental disorders or criteria for diagnoses in DSM-5 categories. However, many of the relevant principles that apply to the treatment of CODs will also apply to these individuals. Careful assessment and treatment planning to take each disorder into account will still be important.

Person-Centered Terminology

This TIP uses only person-first language—such as “person with CODs.” In recent years, consumer advocacy groups have expressed concerns about how clients are classified. Many object to terminology that seems to put them in a “box” with a label that follows them through life, that does not capture the fullness of their identities. A person with CODs may also be a mother, a plumber, a pianist, a student, or a person with diabetes, to cite just a few examples. Referring to an individual as a person who has a specific disorder—a person with depression rather than “a depressive,” a person with schizophrenia rather than “a schizophrenic,” or a person who uses heroin rather than “a heroin addict”—is more acceptable to many clients because it implies that they have many characteristics beyond a stigmatized illness, and therefore they are not defined by this illness.

Because this TIP’s primary audience is counselors in the addiction and mental health fields, this publication uses the term “client,” rather than “patient” or “consumer.”

Important Developments That Led to This TIP Update

Important developments in a number of areas pointed to the need for a revised TIP on CODs:

- The **revisions to the diagnostic classification of and diagnostic criteria for mental disorders in DSM-5** made an update necessary. See Chapter 4 for an in-depth discussion of DSM-5 diagnoses.
- This update to TIP 42 offers a **greater emphasis on integrated care or concurrent treatment** (e.g., treating a client’s alcohol use disorder [AUD] at the same time that you treat his or her posttraumatic stress disorder [PTSD]), as this is a larger focus of the research and clinical field today than when this TIP was originally published. More information about treatment approaches is in Chapter 7.

- This update reflects a wealth of new data about effective treatment options for people with CODs, including those with SMI (see especially Chapter 7).

Why Do We Need a TIP on CODs?

Empirical evidence confirms that CODs are serious problems in need of better management. Treatment rates are markedly low and outcomes often suboptimal, underscoring the importance of advancing the field's knowledge about and use of appropriate, specialized techniques for screening, assessment, diagnosis, and coordinated care of this population. Findings from four key areas are borne out by prevalence statistics and other nationally representative survey data and reveal the stark reality of underservice in this population.



“Comorbidity is important because it is the rule rather than the exception with mental health disorders.”

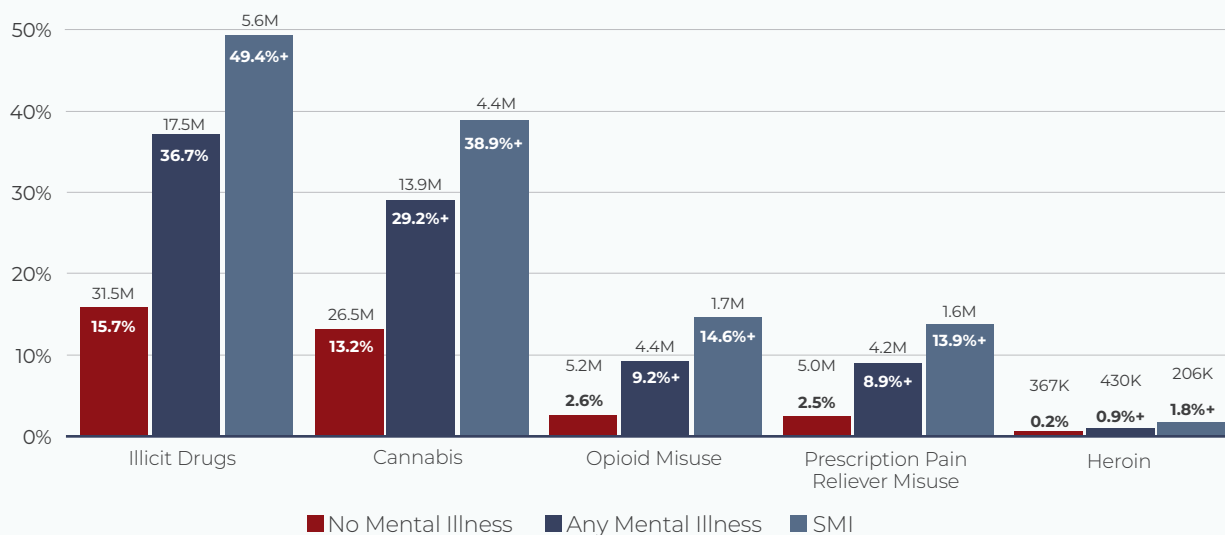
Source: Lai, Cleary, Sitharthan, & Hunt, 2015; p. 8

1. Prevalence and Treatment Need of CODs

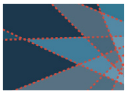
National surveys suggest that mental illness (and SMI in particular) commonly co-occurs with substance misuse in the general adult population, and many individuals with CODs go untreated. The National Survey on Drug Use and Health (NSDUH), based on a sample of more than 67,700 U.S. civilians ages 12 or older in noninstitutionalized settings (Center for Behavioral Health Statistics and Quality [CBHSQ], 2019), offers revealing insights. Notable statistics from the latest survey include the following (CBHSQ, 2019):

- In 2018, 47.6 million (19.1 percent of all adults) ages 18 and older had any mental illness during the previous year, including 11.4 million (4.6 percent of all adults) with SMI.
 - Among these 47.6 million adults with any past-year mental disorder, 9.2 million (19.3 percent) also had an SUD, but only 5 percent of adults without any mental illness in the past year had an SUD.
 - Of the 11.4 million adults with an SMI in the previous year, approximately 28 percent also had an SUD.

EXHIBIT 1.2. Co-Occurring Substance Misuse in Adults Ages 18 and Older With and Without Any Mental Illness and SMI (in 2018)



Source: McCance-Katz (2019). Adapted from material in the public domain.



- SMI is highly correlated with substance misuse (Exhibit 1.2; McCance-Katz, 2019). Adults ages 18 and older with any past-year mental illness were more likely than those without to use illicit drugs or misuse prescription medication. This pattern was even more pronounced among people with SMI. Of the 47.6 million adults with any past-year mental illness, more than half (56.7 percent) received no treatment, and over one-third (35.9 percent) of adults with an SMI in the past year received no treatment. Further, **nearly all (more than 90 percent) of the 9.2 million adults with both a past-year mental illness and SUD did not receive services for both conditions** (McCance-Katz, 2019).
- About 14.2 million adults (about 5.7 percent of all adults) saw themselves as needing mental health services at some point in the previous year but did not receive it (CBHSQ, 2019):
 - Of adults with any mental disorder, 11.2 million (almost 24 percent), or nearly 1 in 4 adults with any mental illness, had a perceived unmet need for mental health services in the past year.
 - Of adults with an SMI, 5.1 million (about 45 percent), or more than 2 out of every 5 adults with SMI, had a perceived unmet need for mental health services in the previous year.
- More than 18 million people ages 12 and older needed but did not receive SUD treatment in the previous year (e.g., they had an SUD or problems related to substance use). Most of those individuals did not see themselves as needing treatment (only 5 percent thought they needed it).
- **Almost half (48.6 percent) of adults ages 18 and older with any mental illness and co-occurring SUD received no treatment at all in 2018.** About 41 percent received mental health services only, 3.3 percent received SUD treatment only, and 7 percent received both.
- **Of adults with SMI and co-occurring SUDs, 30.5 percent received no treatment.** About 56 received mental health services only; almost 3 percent received SUD treatment only; and about 11 percent received both.

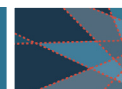
Other nationally representative survey datasets confirm the high rate of comorbidity and treatment need for mental disorders and SUDs in the general adult population. An analysis of Wave 3 of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC-III; Grant et al., 2015) revealed an increased risk of comorbid mental illness among people with 12-month and lifetime AUD. Specifically, the odds of having major depression, bipolar disorder, antisocial personality disorder (PD), borderline PD (BPD), panic disorder, specific phobia, or generalized anxiety disorder (GAD) ranged from 1.2 to 6.4. Only 20 percent of people with lifetime AUD and 8 percent of people with 12-month AUD received treatment.

From the same survey, any 12-month drug use disorder (i.e., SUD not involving alcohol) was associated with significantly increased odds of also having a co-occurring mental disorder, including 1.3 times the odds of having major depressive disorder (MDD), 1.5 odds of dysthymia, 1.5 odds of bipolar I disorder, 1.6 odds of PTSD, 1.4 odds of antisocial PD, and 1.8 odds of BPD (Grant et al., 2016). Lifetime drug use disorder had similar comorbidities but also was associated with a 1.3 increase in odds of also having GAD, panic disorder, or social phobia. Only 13.5 percent of people with a 12-month drug use disorder and about a quarter of people with any lifetime drug use disorder received treatment in the past year.

2. CODs and Hospitalizations

Compared with people with mental disorders or SUDs alone, people with CODs are more likely to be hospitalized. Some evidence suggests that the hospitalization rate for people with CODs is increasing.

Since the 1960s, treatment for mental disorders and SUDs in the United States has shifted away from state-owned facilities to psychiatric units in general hospitals and private psychiatric hospitals (Parks & Radke, 2014). **Psychiatric bed capacity has continued to shrink over the past few decades in the United States and elsewhere** (Allison, & Bastiampillai, 2017; Lutterman, Shaw, Fisher, & Manderscheid, 2017; Tyrer, Sharfstein, O'Reilly, Allison, & Bastiampillai, 2017), **despite**



OPIOID USE DISORDER AND THE PROBLEM OF CODs

Opioid addiction and overdose are a public health crisis and the target of numerous federal prevention and treatment campaigns. Among the causes for concern is the high rate of CODs among people with opioid use disorder (OUD). Of 2 million U.S. adults with OUD in the 2015 to 2017 NSDUH (Jones & McCance-Katz, 2019):

- 77 percent also had another SUD or nicotine dependence in the past year.
- 64 percent also had any co-occurring mental illness in the past year.
- 27 percent had a past-year comorbid SMI.

In terms of service provision, 38 percent of people with OUD and any past-year mental illness or SMI received SUD treatment in the previous year. Mental health services were more common, with 55 percent of people with OUD and any mental illness and 65 percent of those with OUD and SMI receiving care in the previous year. However, comprehensive treatment for both disorders was low and reported by only one-quarter of people with OUD and any mental illness and 30 percent of people with OUD and SMI.

an upsurge in mental disorder/SUD-related hospitalizations:

- The Agency for Healthcare Research and Quality found that from 2005 to 2014, the number of hospital inpatient stays for people with mental disorders or SUDs increased by 12 percent, and the proportion of total inpatient stays accounted for by mental disorders or SUDs also increased, by 20 percent (McDermott, Elixhauser, & Sun, 2017).
- CODs are also linked to rehospitalizations for non-behavioral-health reasons (i.e., for physical health conditions). Among a large sample of Florida Medicaid recipients (Becker, Boaz, Andel, & Hafner, 2017), 28 percent of people with SMI and an SUD were rehospitalized within 30 days of discharge, whereas rehospitalization occurred in only 17 percent of people with neither disorder, 22 percent of people with SMI only, 27 percent of people with a drug use disorder, and 24 percent of people with AUD.
- In the 2000 to 2012 Treatment Episode Data Set (TEDS), SUD treatment-related admissions of adults ages 55 and older that also involved co-occurring psychiatric problems nearly doubled, from 17 percent to 32 percent (Chhatre, Cook, Mallik, & Jayadevappa, 2017).
- As reported in the 2012 Healthcare Cost and Utilization Project (Heslin, Elixhauser, & Steiner, 2015), almost 6 percent of all inpatient

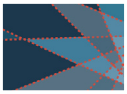
hospitalizations in the United States involved a COD, 21 percent a mental disorder diagnosis only, and about 6 percent an SUD only. Of inpatient stays involving a primary diagnosis of mental illness or SUD, 46 percent were because of a COD, whereas 40 percent of inpatient stays involved a mental disorder only and 15 percent an SUD only (Heslin et al., 2015).

Hospitalizations and early readmissions are costly, potentially preventable occurrences. Identifying individuals at risk for either or both (such as individuals with CODs) could inform more effective discharge planning and wraparound services.

3. Trends in COD Programming

Some evidence supports an increased prevalence of people with CODs in treatment settings and of more programs for people with CODs. However, treatment gaps remain.

Data from the Nationwide Inpatient Sample of the Healthcare Cost and Utilization Project (Zhu & Wu, 2018) found that the number of people ages 12 and older hospitalized for inpatient detoxification who had a co-occurring mental disorder diagnosis increased significantly from 43 percent in 2003 to almost 59 percent in 2011. This included a significant rise in co-occurring anxiety disorders (8 percent vs. 17 percent) and nonsignificant but notable increases in mood disorders (35



percent vs. 46 percent) and schizophrenia or other psychotic disorders (3 percent vs. 5 percent). Recent survey data (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018e) revealed a significant increase in the proportion of clients with CODs in SUD treatment facilities from 2007 (37 percent) to 2017 (50 percent).

COD programming has not kept pace with the increase in clients needing such services. In 2018, almost every SUD treatment facility surveyed through the National Survey of Substance Abuse Treatment Services (99.8 percent) reported having clients in treatment with a diagnosed COD (SAMHSA, 2019a). However, **only 50 percent of the facilities indicated that they provided specifically tailored programs or group treatments for clients with CODs.**

The 2018 National Mental Health Services Survey (SAMHSA, 2019b) reported similar findings: Only 46 percent of mental health service facilities offered COD-specific programming. Facilities most likely to offer COD programming were private psychiatric hospitals (65 percent), Veterans Administration medical centers (56 percent), and multisetting mental health facilities (59 percent), and community mental health centers (54 percent). Among those least likely to offer COD programs were partial hospitalization/day treatment facilities (37 percent) and general hospitals (40 percent). A national survey of 256 SUD treatment and mental health service programs (McGovern, Lambert-Harris, Gotham, Claus, & Xie, 2014) found **only 18 percent of addiction programs and 9 percent of mental health services programs were rated as COD “capable”** (in terms of their capacity to adequately deliver COD services).

The types of assessment and pretreatment services at SUD treatment facilities varied in 2018 (SAMHSA, 2019a), with 96 percent providing screening for substance misuse, 93 percent providing comprehensive substance misuse assessment or SUD diagnosis, 75 percent screening for mental disorders, and 53 percent providing comprehensive psychiatric assessment or diagnosis.

4. Complications of CODs

CODs can complicate treatment and, if poorly managed, can hinder recovery. Further, rates of mental disorders appear to increase as the number of SUDs increases, meaning people with polysubstance use are especially vulnerable to CODs.

Epidemiologists have observed increasing rates of SUD treatment admissions among people with multiple SUDs. Analyses of TEDS data (SAMHSA, CBHSQ, 2019) reveal that in 2017, more than 25 percent of people ages 12 and older admitted for SUD treatment reported both alcohol and other substance misuse. This could partially account for the increase in clients with CODs in SUD treatment settings, as it appears that having multiple mental disorders increases the odds of having multiple SUDs or vice versa. In the NESARC-III (McCabe, West, Jutkiewicz, & Boyd, 2017), people with one lifetime mental disorder had more than three times the odds of having multiple past-year SUDs compared with people with no lifetime mental disorders. **But people with multiple mental disorders (particularly mood disorders, PDs, and PTSD) are nearly nine times more likely to have multiple past-year SUDs.** Individuals with multiple previous SUDs were also less likely to experience remission from substance misuse than were people with a single SUD.

SUD treatment facilities are increasingly seeing nonalcohol substances as the primary substance of misuse among people entering treatment. For instance, from 2005 to 2015, the proportion of alcohol admissions decreased from about 40 percent to 34 percent and opiate admissions increased from 18 percent to 34 percent (with opiates other than heroin increasing from 4 percent to 8 percent) (SAMHSA, 2017). This and the trend of increased polysubstance misuse are worrisome, as NESARC-III data clearly demonstrate both drug use disorders and AUD each independently confer an exaggerated risk of co-occurring mental disorders (Grant et al., 2015; Grant et al., 2016).

CODs can be an obstacle to addiction recovery, especially when untreated. Data from the 2009 to 2011 TEDS-Discharges show that, of people admitted to SUD treatment, 28 percent had a co-occurring psychiatric condition (Krawczyk et

al., 2017). Prevalence rates of CODs varied across individual states and ranged from 8 percent to 62 percent. People with a psychiatric comorbidity were significantly more likely than those without a psychiatric comorbidity to report using three or more substances (27 percent vs. 17 percent).

Of people who did not complete treatment, 42 percent had a COD, versus 36 percent without.

This translated to about a 1.3 increase in odds of not completing treatment and a 1.1 increase in odds of earlier time to attrition for people with CODs compared with those with an SUD only.

CODs are strongly associated with socioeconomic and health factors that can challenge recovery, such as unemployment, homelessness, incarceration/criminal justice system involvement, and suicide.

- According to SAMHSA's *Mental Health Annual Report*, in 2017, **29 percent of people with CODs were unemployed and 50 percent were not in the labor force** (e.g., disabled, retired, student) (SAMHSA, 2019d). The current national unemployment rate at the time of this publication is 3.8 percent (Bureau of Labor Statistics, March 3, 2020).
- **Of people 12 and older with CODs, 7.5 percent experience homelessness**, including 8.3 percent of people with an SUD and schizophrenia or other psychotic disorder, 6.9 percent with an SUD and bipolar disorders, and 7.8 percent with an SUD and depressive disorders (SAMHSA, 2019d). Rates of lifetime and past-year homelessness in the general community per NESARC-III (Tsai, 2018) are about 4 percent and 1.5 percent, respectively. The 2017 *Annual Homeless Assessment Report to Congress* (Henry, Watt, Rosenthal, & Shivji, 2017) found that almost 23 percent of adults in permanent supportive housing programs had transferred from an SUD treatment center; 15 percent, from a mental health services facility. Furthermore, of the 552,830 total individuals experiencing homelessness, about 20 percent (111,122) had an SMI and about 16 percent (86,647) had a chronic SUD (U.S. Department of Housing and Urban Development, 2018).
- Of people incarcerated in U.S. state prisons (Al-Rousan, Rubenstein, Sieleni, Deol, &

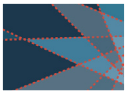
Wallace, 2017), about 48 percent have a history of mental illness (of whom 29 percent had an SMI), 26 percent, a history of an SUD. Of those with mental illness, 49 percent also have a co-occurring SUD.

- **Mental disorders that commonly co-occur with SUDs—including depression, anxiety disorders, bipolar disorders, schizophrenia, and PTSD—are highly prevalent in people who have completed suicide**, (Stone, Chen, Daumit, Linden, & McGinty, 2019). Suicide is also a well-known risk factor in SUDs and a leading cause of death for people with addiction (Center for Substance Abuse Treatment, 2009; Yuodelis-Flores & Ries, 2015). In CDC's National Vital Statistics System dataset (Stone et al., 2019), 46 percent of all individuals in the United States who died by suicide between 2014 and 2016 had a known mental condition, and 28 percent misused substances, and of this 28 percent almost one-third (32 percent) also had a known mental health condition.

These figures reflect the need for specifically tailored COD assessments, interventions, treatment approaches, and clinical considerations (e.g., COD programming specific to people without stable housing; COD interventions designed for implementation in criminal justice settings). More information about how these variables factor into service provision and outcomes can be found in Chapters 4 and 6.

The Complex, Unstable, and Bidirectional Nature of CODs

Counselors working with clients who have CODs often want to know which disorder developed first. The answer is not always clear because the temporal nature of CODs can be inconsistent and nuanced. In some cases, a mental disorder may obviously have led to the development of an SUD. An example would be someone with long-standing major depressive disorder who starts using alcohol excessively to cope and develops AUD. In other instances, substance use clearly precipitated the mental disorder—such as when someone develops a cocaine-induced psychotic disorder. In many cases, it will be uncertain which disorder occurred first.



Furthermore, CODs can be bidirectional. For some clients, there may be a third condition that is influencing both or either of the two comorbid disorders (e.g., HIV, chronic pain). Environmental factors, like homelessness or extreme stress, can also affect one or both disorders. Thus, even when it is clear which disorder developed first, the causal relationship may be unknown. Regardless of the temporal-causal relationship between a client's SUD and mental illness, the two are likely to affect, and possibly exacerbate, one another. This means that both need to be treated with equal seriousness.

In addition to inducing a mental disorder, substance misuse can sometimes mimic a mental disorder. Thus, it is important to use thorough screening and assessment approaches to help disentangle all symptoms and make an accurate diagnosis. Learn more about screening and assessment for CODs in Chapter 3.

CODs are not necessarily equal in severity. Often, one disorder is more severe, distressing, or impairing than the other. Recognizing this is important for treatment planning and requires a person-centered rather than cookie-cutter approach to determining diagnosis, comorbidities, functioning, treatment and referral needs, and stage of change. Models are available to help counselors make such decisions based on the severity and impact of each disorder. For instance, the Four Quadrants Model (National Association of State Mental Health Program Directors & National Association of State Alcohol and Drug Abuse Directors, 1999) classifies clients in four basic groups based on relative symptom severity, not diagnosis:

- Category I: Less severe mental disorder/less severe substance disorder
- Category II: More severe mental disorder/less severe substance disorder

- Category III: Less severe mental disorder/more severe substance disorder
- Category IV: More severe mental disorder/more severe substance disorder

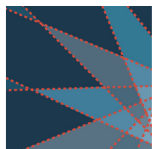
For a more detailed description of this model, see Chapter 2. To learn how to integrate the quadrants of care framework into assessment and treatment decision-making processes, see Chapter 3.

SUDs, Mental Illness, and “Self-Medicating”

The notion that SUDs are caused, in whole or in part, by one's attempts to “self-medicate” symptoms with alcohol or illicit drugs has been a source of debate. The consensus panel cautions that the term “self-medication” should not be used, as it equates drugs of misuse (which usually worsen health) with true medications (which are designed to improve health). Although some people with mental conditions may misuse substances to alleviate their symptoms or otherwise cope (Sarvet et al., 2018; Simpson, Stappenbeck, Luterek, Lehavot, & Kaysen, 2014), this is not always the case. Counselors should not assume self-medication is the causal link between a client's mental disorder and SUD.

Conclusion

The COD recovery trajectory often has pitfalls, but our understanding of CODs and COD-specific service delivery has improved over the past 20 years. Despite these advances, significant gaps remain in the accurate and timely assessment, diagnosis, and treatment of people with CODs. To achieve lower cost mental health services and SUD treatment, better client outcomes, and a more positive treatment experience, providers and administrators must collectively place more focus on CODs in their work. By better understanding the risks and responding to the service needs of people with CODs, behavioral health service providers can help make long-term recovery an attainable goal for all clients with CODs.



Chapter 2— Guiding Principles for Working With People Who Have Co-Occurring Disorders

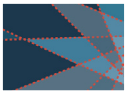
KEY MESSAGES

- General guiding principles of good care for people with co-occurring disorders (CODs) ensure that counselors and other providers, administrators, and supervisors fully meet clients' comprehensive needs—effectively and ethically.
- Counselors should offer clients full access to a range of integrated services through the continuum of recovery.
- Administrators and supervisors are responsible for the training, professional development, recruitment, and retention of qualified counselors and other professional staff working with people who have CODs. Failure to attend to these workforce matters will only further inhibit client access to care.
- Several core essential services exist for clients with comorbid conditions, and supervisors and administrators should regularly evaluate their program's capacity and performance to monitor its effectiveness in providing these services and correct course when needed.

Many treatment providers and agencies recognize the need to provide quality care to people with CODs but see it as a daunting challenge beyond their resources. Programs that already have incorporated some elements of integrated services and want to do more may lack a clear framework for determining priorities. Addiction counselors might recognize the need to be able to effectively treat clients with CODs but not fully

understand the best approaches to doing so. As counselors and programs look to improve their effectiveness in treating this population, what should they consider? How could the experience of other agencies or counselors inform their planning process? Are resources available that could help turn such a vision into reality? This chapter is designed to help both providers and agencies that want to improve services for their clients with CODs, whether that means establishing services where there currently are none or learning to improve existing ones.

The chapter is designed for counselors, other treatment/service providers, supervisors, and administrators and begins with a review of general guiding principles derived from proven models, clinical experience, and the growing base of empirical evidence. Building on these guiding principles, the chapter turns to the specific core components for effective service delivery for addiction counselors and other providers and for administrators and supervisors, respectively. For providers, this includes addressing in concrete terms the challenges of providing access, screening and assessment, appropriate level of care, integrated treatment, comprehensive services, and continuity of care. For supervisors and administrators, effective service delivery requires staff to develop essential core competencies and take advantage of opportunities for professional development. Achieving optimal COD programming means integrating research into clinical services to ensure that practices are evidence based, establishing essential services to meet the varied needs of people with CODs, and conducting program assessments to gauge whether services adequately fulfill clients' access and treatment needs.



General Guiding Principles

The consensus panel developed a list of guiding principles to serve as fundamental building blocks for working with clients who have CODs (Exhibit 2.1). These principles are derived from a variety of sources: conceptual writings, well-articulated program models, a growing understanding of the essential features of CODs, elements common to separate treatment models, clinical experience, and available empirical evidence. These principles may be applied at both a program level (e.g., providing literature for people with cognitive impairments) or at the individual level (e.g., addressing the client's basic needs).

Exhibit 2.1. Six Guiding Principles in Treating Clients With CODs

1. Use a recovery perspective.
2. Adopt a multiproblem viewpoint.
3. Develop a phased approach to treatment.
4. Address specific real-life problems early in treatment.
5. Plan for the client's cognitive and functional impairments.
6. Use support systems to maintain and extend treatment effectiveness.

The following section discusses the six principles and the related field experience underlying each one.

Use a Recovery Perspective

The recovery perspective has two main features: It acknowledges that recovery is a long-term process of internal change, and it recognizes that these internal changes proceed through various stages. (See De Leon [1996] and Prochaska, DiClemente, & Norcross [1992] for a detailed description. Also see Chapter 5 of this Treatment Improvement Protocol (TIP) for a discussion of the recovery perspective as a guideline for establishing therapeutic alliance.)

The recovery perspective applies to clients with CODs and generates two main practice principles:

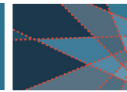
- Develop a treatment plan that provides for continuity of care over time. In preparing this plan, the provider should recognize that treatment may occur in different settings over time (e.g., residential, outpatient) and that much of the recovery process typically occurs outside of or following treatment (e.g., through participation in mutual-support programs, through family, peer, and community support, including the faith community). The provider needs to reinforce long-term participation in these continuous care settings.
- Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the COD recovery process. Whether within the substance use disorder (SUD) treatment or mental health services system, the provider is advised to use sensible stepwise approaches in developing and using treatment protocols. In addition, markers that are unique to individuals—such as those related to their cultural, social, or spiritual context—should be considered. The provider needs to engage the client in defining markers of progress that are meaningful to him or her and to each stage of recovery.

Adopt a Multiproblem Viewpoint

People with CODs generally have an array of mental, medical, substance use, family, and social problems. Most need substantial rehabilitation and habilitation (i.e., initial learning and acquisition of skills). Treatment should address immediate and long-term needs for housing, work, health care, and a supportive network. Therefore, services should be comprehensive to meet the multidimensional problems typically presented by clients with CODs.

Develop a Phased Approach to Treatment

Using a staged or phased approach to COD treatment helps counselors optimize comprehensive, appropriate, and effective care for all client needs. Generally, three to five phases are identified, including engagement, stabilization/persuasion, active treatment, and continuing care



or continuing care/relapse prevention (Mueser & Gingerich, 2013; Substance Abuse and Mental Health Services Administration [SAMHSA], 2009a). These phases are consistent with, and parallel to, stages identified in the recovery perspective. The use of these phases enables the provider (whether within the SUD treatment or mental health services system) to develop and use effective, stage-appropriate treatment protocols. (See the revised TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* [SAMHSA, 2019c]).

Address Specific Real-Life Problems Early in Treatment

Growing recognition that CODs arise in a context of personal and social problems, with disruption of personal and social life, has prompted approaches that address specific life problems early in treatment. These approaches may incorporate case management and intensive case management to help clients surmount bureaucratic hurdles or handle legal and family matters. Specialized interventions that target important areas of client need, such as housing-related support services (Clark, Guenther, & Mitchell, 2016), can also help. Vocational services help clients with CODs make concrete improvements in career goal setting, job seeking, work attainment, and earned wages (Luciano & Carpenter-Song, 2014; Mueser, Campbell, & Drake, 2011).

For people in recovery from mental disorders or SUDs, workforce participation is not only valuable because of its economic contributions; it can also enhance individual self-efficacy, improve self-identity (e.g., help people feel “normal” as opposed to “like a patient”), offer a sense of belonging with society at large, provide a way for people to build relationships with others, and improve quality of life (Charzynska, Kucharska, & Mortimer, 2015; Walsh & Tickle, 2013). A review of the effects of employment interventions for people with SUDs found that employment was associated with reduced substance use and more stable housing (Walton & Hall, 2016).

Solving financial, housing, occupational, and other problems of everyday living is often an important first step toward achieving client engagement in

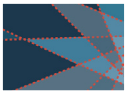
continuing treatment. Engagement is a critical part of SUD treatment generally and of treatment for CODs specifically, because remaining in treatment for an adequate length of time is essential to achieving behavioral change.

Plan for Clients’ Cognitive and Functional Impairments

Services for clients with CODs, especially those with more serious mental disorders, must be tailored to individual needs and functioning. Clients with CODs often display cognitive and other functional impairments that affect their ability to comprehend information or complete tasks (Duijkers, Vissers, & Egger, 2016). The manner in which interventions are presented must be compatible with client needs and functioning. Such impairments frequently call for relatively short, highly structured treatment sessions that are focused on practical life problems. Gradual pacing, visual aids, and repetition are often helpful. Even impairments that are comparatively subtle (e.g., certain learning disabilities) may still have significant impact on treatment success. Careful assessment of such impairments and a treatment plan consistent with the assessment are therefore essential.

Use Support Systems To Maintain and Extend Treatment Effectiveness

The mutual-support movement, the family, peer providers, the faith community, and other resources that exist within the client’s community can play an invaluable role in recovery. This can be particularly true for clients with CODs, many of whom have not enjoyed a consistently supportive environment for decades. In some cultures, the stigma surrounding SUDs or mental disorders is so great that the client and even the entire family may be ostracized by the immediate community. For instance, some mutual-support programs are not very accepting of members with CODs who take psychiatric medication. Furthermore, the behaviors associated with active substance use may have alienated the client’s family and community. The provider plays a role in ensuring that the client is aware of available support systems and motivated to use them effectively.



Mutual Support

Based on the Alcoholics Anonymous (AA) model, the mutual-support movement has grown to encompass a wide variety of addictions. AA and Narcotics Anonymous are two of the largest mutual-support organizations for SUDs; Dual Recovery Anonymous is most known for CODs. Personal responsibility, self-management, and helping one another are the basic tenets of mutual-support approaches. Such programs apply a broad spectrum of personal responsibility and peer support principles. However, in the past, clients with CODs felt that either their mental or their substance use problems could not be addressed in a single-themed mutual-support program. That has changed.

Mutual-support principles, highly valued in the SUD treatment field, are now widely recognized as important components in the treatment of CODs. Mutual support can be used as an adjunct to primary treatment, as a continuing feature of treatment in the community, or both. These programs not only provide a vital means of support during outpatient treatment but also are commonly used in residential programs such as therapeutic communities (TCs). As clients gain employment, travel, or relocate, mutual support can become the most easily accessible means of providing continuity of care. For a more extensive discussion of dual recovery mutual-support programs applicable to people with CODs, including those structured around peer-recovery support services, see Chapter 7.

Building Community

The need to build an enduring community arises from three interrelated factors: the persistent nature of CODs, the recognized effectiveness of mutual-support principles, and the importance of client empowerment. The TC, modified mutual programs for CODs (e.g., Double Trouble in Recovery), and the client consumer movement all reflect an understanding of the critical role clients play in their own recovery, as well as the recognition that support from other clients with similar problems promotes and sustains change.

Reintegration With Family and Community

The client with CODs who successfully completes treatment must face the fragility of recovery, the potential toxicity of the past or current environment, and the negative impact of previous associates who might encourage substance use and illicit or maladaptive behaviors. Groups and activities that support change are needed. In this context, clients should receive support from family and significant others where that support is available or can be developed. Clients also need help reintegrating into the community through such resources as spiritual, recreational, and social organizations.

Peer-Based Services

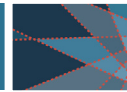
Peer recovery support services typically refers to services provided by people with a lived experience with substance misuse, mental disorders, or both (or, in the case of family peer services, people who have a lived experience of having a loved one with substance misuse, mental disorders, or both). Peer recovery support specialists are nonclinical professionals who help individuals both initiate and maintain long-term recovery by offering support, education, and linkage to resources. Peers also serve as role models for successful recovery and healthy living.

For more information on peer recovery support services for CODs and the potential role of peer recovery support specialists in promoting and maintaining recovery, see Chapter 7.

Guidelines for Counselors and Other Providers

The general guiding principles described previously serve as the fundamental building blocks for effective treatment, but ensuring effective treatment requires counselors and other providers to attend to other variables. This section discusses six core components that form the ideal delivery of addiction counseling services for clients with CODs. These are:

1. Providing access.
2. Completing a full assessment.



3. Providing an appropriate level of care.
4. Achieving integrated treatment.
5. Providing comprehensive services.
6. Ensuring continuity of care.

Providing Access

“Access” refers to the process by which a person with CODs makes initial contact with the service system, receives an initial evaluation, and is welcomed into services that are appropriate for his or her needs. There are four main types of access:

1. Routine access for individuals seeking services who are not in crisis
2. Crisis access for individuals requiring immediate services because of an emergency
3. Outreach, in which agencies target individuals in great need (e.g., people experiencing homelessness) who are not seeking services or cannot access ordinary or crisis services
4. Access that is involuntary, coerced, or mandated by the criminal justice system, employers, or the child welfare system

Treatment access may be complicated by clients’ criminal justice involvement, homelessness, or health status. A “no wrong door” policy should be applied to the full range of clients with CODs, and counselors (as well as programs) should address obstacles that bar entry to treatment for those with either a mental disorder or an SUD. (See Chapter 7 for recommendations on removing systemic barriers to care and Exhibit 2.2 for more on the “no wrong door” approach to behavioral health services.)

Exhibit 2.2. Making “No Wrong Door” a Reality

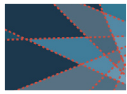
The consensus panel strongly endorses a “no wrong door” policy: effective systems must ensure that an individual needing treatment will be identified and assessed and will receive treatment, either directly or through appropriate referral, no matter where he or she enters the realm of services (Center for Substance Abuse Treatment [CSAT], 2000a).

The focus of the “no wrong door” imperative is on constructing the healthcare delivery system so that treatment access is available at any point of entry. A client with CODs needing treatment might enter the service system by means of a primary care facility, homeless shelter, social service agency, emergency room, or criminal justice setting. Some clients require creation of a “right door” to enter treatment. For example, mobile outreach teams can access clients with CODs who are otherwise unlikely to seek treatment on their own.

The “no wrong door” approach has five major implications for service planning:

1. Assessment, referral, and treatment planning across settings is consistent with a “no wrong door” policy.
2. Creative outreach strategies are available to encourage people to engage in treatment.
3. Programs and staff can change expectations and program requirements to engage reluctant and “unmotivated” clients.
4. Treatment plans are based on clients’ needs and respond to changes as they progress through stages of treatment.
5. The overall system of care is seamless, providing continuity of care across service systems. This is only possible via established patterns of interagency cooperation or clear willingness to attain that cooperation.

Source: CSAT (2000a).



Completing a Full Assessment

Whereas Chapter 3 provides a complete description of the assessment process, this section highlights several important features of assessment that support effective service delivery. Assessment of individuals with CODs involves a combination of:

- Screening to detect the presence of CODs in the setting where the client is first seen for treatment.
- Evaluating background factors (e.g., family history, trauma history, marital status, health, education, work history), mental disorders, SUDs, and related medical and psychosocial problems (e.g., living circumstances, employment) that are critical to address in treatment planning.
- Diagnosing the type and severity of SUDs and mental disorders.
- Initial matching of individual client to services. (Often, this must be done before a full assessment is completed and diagnoses clarified. Also, the client's motivation to change with regard to one or more of the CODs may not be well established.)
- Appraising existing social and community support systems.
- Conducting continuous evaluation (that is, reevaluating over time as needs and symptoms change and as more information becomes available).

The challenge of assessment for individuals with CODs in any system involves maximizing the likelihood of the identification of CODs, immediately facilitating accurate treatment planning, and revising treatment over time as the client's needs change.

Providing an Appropriate Level of Care

Clients enter the treatment system at various levels of need and encounter agencies with varying capacity to meet those needs. Ideally, clients should be placed in the level of care appropriate to the severity of both their SUD and their mental illness.

The American Association of Community Psychiatry's Level of Care Utilization System (LOCUS) is one standard way of identifying appropriate levels of care and service intensity. The LOCUS describes six levels of care sequentially increasing in intensity, based on the client's individually assessed needs across six dimensions. Further, a treatment program's ability to address CODs as "addiction-only services," "dual diagnosis capable," and "dual diagnosis enhanced" is another useful perspective in care determination and decision making (Chapter 3 discusses frameworks to help with treatment placement).

Severity and Levels of Care

Models are available to help counselors make treatment and referral decisions based on the severity and impact of each disorder. For instance, the quadrants of care (also called the Four Quadrants Model) is a conceptual framework that classifies clients in four basic groups based on relative symptom severity, not diagnosis (Exhibit 2.3). The quadrants of care were derived from a conference, the National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders, which was supported by SAMHSA and two of its centers—CSAT and the Center for Mental Health Services—and co-sponsored by the National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors. The quadrants of care is a model originally developed by Ries (1993).

EXHIBIT 2.3. The Four Quadrants Model

III—Less severe mental disorder/more severe SUD	IV—More severe mental disorder/more severe SUD
I—Less severe mental disorder/less severe SUD	II—More severe mental disorder/less severe SUD

Chapter 3 offers more detail about the four quadrants and their use in comprehensive assessment.

Achieving Integrated Treatment

The seminal concept of integrated treatment for people with severe mental disorders and SUDs, as articulated by Minkoff (1989), emphasized the need for correlation between the treatment models for mental health services and SUD treatment in a residential setting. Minkoff's model stressed the importance of well-coordinated, stage-specific treatment (i.e., engagement, primary treatment, continuing care) of SUDs and mental disorders, with emphasis on dual recovery goals as well as the use of effective treatment strategies from the mental health and SUD treatment fields.

During the last decade, integrated treatment continued to evolve. Several models have shown success in community addiction treatment and mental health service programs (Chow, Wieman, Cichocki, Qvicklund, & Hiersteiner, 2013; Kelly & Daley, 2013; McGovern et al., 2014), including programs in which COD services were combined with supportive housing services (Pringle, Grasso, & Lederer, 2017); programs serving people in the criminal justice system (Peters, Young, Rojas, & Gorey, 2017); programs in outpatient and residential settings (Hunt, Siegfried, Morley, Sitharthan, & Cleary, 2014; Morse & Bride, 2017); TCs (Dye, Roman, Knudsen, & Johnson, 2012); and opioid treatment programs (Brooner et al., 2013; Kidorf et al., 2013).

The literature from the addiction and mental health fields has evolved to describe integrated treatment as a unified treatment approach to meet clients' addiction, mental disorder, and related needs (Exhibit 2.4). It is the preferred model of treatment. Chapter 7 further discusses integrated treatment models.

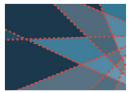
Exhibit 2.4. SAMHSA Practice Principles of Integrated Treatment for CODs

- Mental illness and SUDs are both treated concurrently to meet the full range of clients' symptoms equally.
- Providers of integrated care receive training in the treatment of both SUDs and mental disorders.
- CODs are treated with a stage-wise approach that is tailored to the client's stage of readiness for treatment (e.g., engagement, persuasion, active treatment, relapse prevention).
- Motivational techniques (e.g., motivational interviewing [MI], motivational counseling) are integrated into care to help clients reach their goals—and particularly at the engagement stage of treatment.
- Addiction counseling is used to help clients develop healthier, more adaptive thoughts and behaviors in support of long-term recovery.
- Clients are offered multiple treatment formats, including individual, group, family, and peer support, as they move through the various stages of treatment.
- Pharmacotherapy is discussed in multidisciplinary teams, offered to clients as appropriate, and monitored for safety (e.g., interactions), adherence, and response.

Source: SAMHSA (2009a).

Providing Comprehensive Services

People with CODs have a range of medical and social problems—multidimensional problems that require comprehensive services. In addition to treatment for SUDs and mental disorders, these clients often require various other services to address social problems and stabilize living conditions. Treatment providers should prepare to help clients access an array of services, including life skills development, English as a second language, parenting, nutrition, and employment assistance. Two areas of particular value are housing and work. (See Chapter 6 for a



discussion about people with CODs experiencing homelessness and Chapter 7 for further information about vocational services as a part of treatment.)

Ensuring Continuity of Care

Continuity of care implies coordination of care as clients move across different service systems (Puntis, Rugkåsa, Forrest, Mitchell, & Burns, 2015; Weaver, Coffey, & Hewitt, 2017). Both SUDs and mental disorders frequently are long-term conditions, so treatment for people with CODs should take into consideration rehabilitation and recovery over a significant period of time. Therefore, to be effective, treatment must address the three features that characterize continuity of care:

- **Consistency** between primary treatment and ancillary services
- **Seamlessness** as clients move across levels of care (e.g., from residential to outpatient treatment)
- **Coordination** of present and past treatment episodes (i.e., making sure you are aware of previous treatments given, how the client responded, and the client's treatment preferences)

It is important to set up systems that prevent gaps between service system levels and between clinic-based services and those outside the clinic. The ideal is to include outreach, employment, housing, health care and medication, financial supports, recreational activities, and social networks in a comprehensive and integrated service delivery system.

Continuity of Care and Outpatient Treatment Settings

Continuing care and relapse prevention are especially important with this population given that mental disorders are often cyclical, recurring illnesses and substance misuse is likewise a chronic condition subject to periods of relapse and remission. Clients with CODs often require long-term continuity of care that supports their progress, monitors their condition, and can respond to a return to substance use or a return of symptoms of mental disorder. Continuing care is both a process of posttreatment monitoring and a form of treatment itself. (In the present context, the term "continuing care" is used to describe the treatment options available to a client after leaving one program for another, less intense, program.)

The relative seriousness of a client's mental disorders and SUDs may be very different at the time he or she leaves a primary treatment provider; thus, different levels of intervention will be appropriate. After leaving an outpatient program, some clients with CODs may need to continue intensive mental health services but can manage their SUD through mutual-support group participation. Others may need minimal mental health services but require continued formal SUD treatment. For people with serious mental illness (SMI), continued treatment often is warranted. A treatment program can provide these clients with structure and varied services not usually available from mutual support-groups.

Encourage clients with CODs who leave a program to return if they need assistance with either disorder. The status of these individuals can be fragile; they need quick access to help in times of crisis. Regular informal check-ins with clients also can help alleviate potential problems before they become serious enough to threaten recovery. A good continuing care plan will include steps for when and how to reconnect with services. The plan and provision of these services also makes readmission easier for clients with CODs who need to come back. Clients with CODs should maintain contact postdischarge (even if only by telephone or informal gatherings). Increasingly, addiction programs are using follow-up contacts and periodic group meetings to monitor client progress and assess the need for further service.

Continuity of Care and Residential Treatment Settings

Returning to life in the community after residential placement is a major undertaking for clients with CODs, with relapse an ever-present risk. The goals of continuing care programming are:

- Sustaining abstinence.
- Continuing recovery.
- Mastering community living.
- Developing vocational skills.
- Obtaining gainful employment.
- Deepening psychological understanding.
- Assuming increasing responsibility.
- Resolving family difficulties.
- Consolidating changes in values and identity.

The key services are life skills education, relapse prevention, mutual-support programs, case management (especially for housing), and vocational training and employment.

Empirical Evidence Related to Continuity of Care

A systematic review (McCallum, Mikocka-Walus, Turnbull, & Andrews, 2015) investigating the effects of continuity of care on treatment outcomes for people with CODs showed mixed results. Putting in place continuity of care has generally involved linking clients from one level of care to another and providing multidimensional services. Positive associations reported by some studies included better treatment commitment, reduced violent behavior, improved service satisfaction, better generic and disease-specific quality of life, and enhanced community functioning. However, there was no consistent evidence that continuity of care was associated with abstinence.

The belief that continuous care benefits people with CODs is also informed by positive research findings on continuity of care for addiction populations and SMI populations separately. A meta-analysis of studies exploring continuing care among people with substance misuse found a small but positive effect on substance-related outcomes (Blodgett, Maisel, Fuh, Wilbourne, & Finney, 2014). Continuity of care following residential detoxification is associated with decreased rates of readmission for detoxification (Lee et al., 2014). More recently, a continuing care intervention for people in the first year of SUD recovery (McKay, Knepper, Deneke, O'Reilly, & DuPont, 2016) found a 70-percent adherence rate over 1 year for providing urine samples and a mere 4-percent positive urine sample rate (for drugs or alcohol).

A review of international studies examining continuity of care and patient outcomes in mental health found wide variability in the research methodology and outcomes (Puntis et al., 2015). In studies conducted in the United States, continuity of care (in some but not all of the U.S. studies) was associated with reduced psychiatric symptom severity, lower risk of rehospitalization, improved functioning, reduced Medicaid expenditures, and fewer violent behaviors.

Guidelines for Administrators and Supervisors

This section focuses on some key matters administrators and supervisors face in developing a workforce able to meet the needs of clients with CODs. Guidelines to address these core topics include:

1. Identifying and providing to counselors the essential competencies (basic, intermediate, and advanced), values, and attitudes to be successful in COD service delivery.
2. Offering opportunities for professional development, including staff training and education.
3. Using effective burnout and turnover reduction techniques, as these are common problems for any SUD treatment provider, but particularly so for those who work with clients who have CODs.

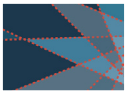
Critical challenges face SUD treatment systems and programs that aim to improve care for clients with CODs. This section addresses these challenges by discussing how supervisors and administrators can foster more effective COD programming, such as:

1. Integrating research and practice into programming.
2. Establishing essential services for people with CODs.
3. Assessing agency potential to serve clients with CODs via adequate and responsive programming.

This section only briefly addresses guidelines for administrators and supervisors. More detailed discussions about workforce improvement and administrative matters, including descriptions of provider competencies, supervision, staff training, hiring, turnover, and retention, are in Chapter 8.

Providers' Competencies

Provider competencies are measurable skills and specific attitudes and values counselors should learn and develop. Attitudes and values guide how providers meet client needs and affect overall treatment climate. They are particularly important in working with clients who have CODs because



the counselor is confronted with two disorders that require complex interventions. Essential values and attitudes that inform effective care for clients with CODs include a desire and willingness to work with populations with CODs, an appreciation for the complexity of CODs, and an awareness of one's own personal feelings about and reactions to working with people who have CODs. These are discussed primarily in Chapter 8.

Basic competencies are rudimentary, introductory skills all counselors should possess, such as:

- Performing a basic screening and assessment to determine whether CODs might exist and, if needed, referring for more thorough and formal diagnostic testing.
- Conducting a preliminary screening to determine whether a client poses an immediate danger to self or others and coordinating any subsequent assessment with appropriate staff or consultants.
- Referring a client to the appropriate mental health services or SUD treatment and following up to ensure that the client receives needed care.
- Coordinating care with a mental health counselor serving the same client to ensure that the interaction of the client's disorders is well understood and that treatment plans are coordinated.

Intermediate competencies encompass skills such as:

- Performing more indepth screening.
- Treatment planning.
- Discharge planning.
- Linking clients to other mental health system services.

Advanced competencies go beyond an awareness of the addiction and mental health fields as individual disciplines to a more sophisticated appreciation for how CODs interact in an individual. This can include:

- Understanding the effects of level of functioning and degree of disability related to both substance-related and mental disorders, separately and combined.

- Using integrated models of assessment, intervention, and recovery for people with both substance-related and mental disorders, as opposed to parallel treatment efforts that resist integration.
- Collaboratively developing and implementing an integrated treatment plan based on thorough assessment that addresses both/all disorders and establishes sequenced goals based on urgent needs, considering the stage of recovery and level of engagement.
- Involving the person, family members, and other supports and service providers (including peer supports and those in the natural support system) in establishing, monitoring, and refining the treatment plan.

Continuing Professional Development

Given the complexity of CODs and lagging treatment rates, there is a pressing need for professionals to develop the necessary skills to accurately identify and manage these conditions. This TIP makes an effort to integrate available information on continuing professional development. Counselors reading this TIP can review their own knowledge and determine what they need to continue their professional development. More information can also be found in Chapter 8.

Education and Training

Education and training are critical to ensuring professional development and competency of providers and should take place throughout the continuum of one's formal education and career. Various forms of education and training are central to evidence-based, high-quality care for people with CODs:

- **Staff education and training** are fundamental to all SUD treatment programs. Few university-based programs offer a formal curriculum on CODs, although the past decade has seen some improvement.
- Many SUD treatment counselors learn through **continuing education and facility-sponsored training**. Continuing education is useful because it can respond rapidly to the needs of a workforce that has diverse educational

backgrounds and experience. To have practical utility, competency training must address the day-to-day concerns that counselors face in working with clients who have CODs. The educational context must be rich with information, culturally sensitive, and designed for adult students, and must include examples and role models. Ideally, the instructors will have extensive experience as practitioners in the field. Continuing education is also essential for effective provision of services to people with CODs, but it is not sufficient in and of itself. Counselors must have ongoing support, supervision, and opportunity to practice new skills if they are to truly integrate COD content into their practice.

- **Cross-training** is simultaneous provision of material and training in more than one discipline (e.g., addiction and social work counselors, addiction counselors and corrections officers). Counselors with primary expertise in either addiction or mental health can work far more effectively with clients who have CODs if they have some cross-training in the other field. The consensus panel suggests that counselors of either field receive at least basic level cross-training in the other field to better assess, refer, understand, and work effectively with the large number of clients with CODs.

Program Orientation and Ongoing Supervision

Staff education and training have two additional components: (1) program orientation that clearly presents the mission, values, and aims of service delivery; and (2) strong, ongoing supervision. The orientation can use evidence-based initiatives as well as promising practices. Successful program orientation for working with clients who have CODs will equip staff members with skills and decision-making tools that will enable them to provide optimal services in real-world environments.

Skills best learned through direct supervision and modeling include active listening, interviewing techniques, the ability to summarize, and the capacity to provide feedback. Strong, active supervision of ongoing cases is a key element in assisting staff to develop, maintain, and enhance relational skills.

Avoiding Burnout and Reducing Staff Turnover

Burnout

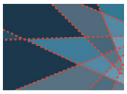
Assisting clients who have CODs is difficult and emotionally taxing; the danger of burnout is considerable. Among mental health and SUD clinicians, the effects of working with clients with trauma can lead to compassion fatigue, vicarious traumatization, or secondary traumatic stress (Huggard, Law, & Newcombe, 2017; Newell, Nelson-Gardell, & MacNeil, 2016). If untreated, these can have profound negative effects on a clinician's ability to function at work effectively, care for clients, and care for oneself (Baum, 2016).

Program administrators must stay aware of burnout and the benefits of reducing turnover. In order for staff to sustain their morale and esprit de corps, they need to feel that program administrators are interested in their well-being. Most important, supervision should be supportive, providing guidance and technical knowledge. Programs can proactively address burnout by placing high value on staff well-being; routinely discussing well-being; providing activities such as retreats, weekend activities, yoga, and other healing activities at the worksite; and creating a network of ongoing support.

Turnover

The issue of staff turnover is especially important for staff working with clients who have CODs because of the limited workforce pool and the high investment of time and effort involved in developing a trained workforce. Rapid turnover disrupts the context in which recovery occurs. Clients in such agencies may become discouraged about the possibility of being helped by others. Ways to reduce staff turnover in programs for clients with CODs can include:

- Hiring staff members familiar with both SUD and mental disorders who have a positive regard for clients with either or both disorders.
- Ensuring that staff have realistic expectations for the progress of clients with CODs.
- Ensuring that supervisory staff members are supportive and knowledgeable about problems and concerns specific to clients with CODs.



- Providing and supporting opportunities for further education and training.
- Offering a desirable work environment through:
 - Adequate compensation.
 - Salary incentives for COD expertise.
 - Opportunities for training and for career advancement.
 - Involvement in quality improvement or clinical research activities.
 - Efforts to adjust workloads.

Integrating Research and Practice

To be effective, resources must be used to implement the evidence-based practices most appropriate to the client population and the program needs. The importance of the transfer of knowledge and technology has come to be well understood. Conferences to explore “bridging the gap” between research and field practice are now common. Although not specific to CODs, these efforts have clear implications for our attempts to share knowledge of what is working for clients with CODs. For instance, since 2007, the National Institutes of Health has cosponsored the Annual Conference on the Science of Dissemination and Implementation in Health, designed to foster better integration of healthcare research into practice and policy. CODs have been an underrepresented topic at these gatherings, but presentations on implementation studies in addiction and in mental health, separately, likely will still be informative for enhancing the use and measurement of research-based practices for CODs.

In the SUD treatment field, implementation research has accelerated in response to evidence

suggesting that the uptake of empirical findings into actual practice is lagging (McGovern, Saunders, & Kim, 2013). This lag has persisted despite the availability of research supporting the efficacy and effectiveness of SUD treatment, including pharmacotherapies and psychosocial interventions. In mental health, significant efforts over the previous two decades have led to increased utilization of evidence-based practices and program evaluation strategies to monitor fidelity and outcomes (Stirman, Gutner, Langdon, & Graham, 2016). But more research–practice partnerships in mental health are needed, because many clients still cannot access or do not receive evidence-based care. Similarly, within COD treatment settings, more work is needed to provide research-based services that are feasible, acceptable, effective, and sustainable. SAMHSA (2009a) developed an evidence-based practice toolkit to help SUD and mental disorder treatment programs incorporate empirically supported policies and practices into their organizations, with the aim of giving clients the best chances at achieving long-term abstinence by translating COD knowledge into practice.

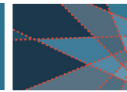
Establishing Essential Services for People With CODs

Individuals with CODs are found in all SUD treatment settings, at every level of care. Although some of these individuals have SMI or disabilities, many have disorders of mild to moderate severity. As SUD treatment programs serve the increasing number of clients with CODs, the essential program elements required to meet their needs must be defined clearly and set in place.

ADVICE TO ADMINISTRATORS: RECOMMENDATIONS FOR PROVIDING ESSENTIAL SERVICES FOR PEOPLE WITH CODs

Develop a COD program with these components:

1. Screening, assessment, and referral for people with CODs
2. Physical and mental health consultation
3. Prescribing onsite psychiatrist
4. Psychoeducational classes
5. Relapse prevention
6. Case management
7. COD-specific treatment components
8. Continuing care services
9. Double Trouble groups (onsite)
10. Dual recovery mutual-help groups (offsite)



Program components described in this section should inform any SUD treatment program seeking to provide integrated addiction and mental health services to clients with CODs. These elements reflect a variety of strategies, approaches, and models that the consensus panel discussed and that often appear in current clinical programming. The consensus panel believes these elements constitute the best practices for designing COD programs in SUD treatment agencies. What follows are program considerations for implementing these essential components. Information about designing residential and outpatient treatment services can be found in Chapter 7.

Screening, Assessment, and Referral for People With CODs

All SUD treatment programs should have appropriate procedures for screening, assessing, and referring clients with CODs. Each provider must be able to identify clients with both mental disorders and SUDs and ensure their access to the care needed for each disorder. For a detailed discussion, see Chapter 3.

If the screening and assessment process establishes an SUD or mental disorder beyond the capacity and resources of the agency, referral should be made to a suitable residential or mental health facility, or other community resource. Mechanisms for ongoing consultation and collaboration are needed to ensure that the referral is suitable to the treatment needs of people with CODs.

Physical and Mental Health Consultation

Any SUD treatment program that serves a significant number of clients with CODs would do well to expand standard staffing to include mental health specialists and to incorporate consultation (for assessment, diagnosis, and medication) into treatment services.

Adding a master's level clinical specialist with strong diagnostic skills and expertise in working with clients who have CODs can strengthen an agency's ability to provide services for these clients. These staff members could function as consultants to the rest of the team on matters related to mental disorders, in addition to being

the liaison for a mental health consultant and provision of direct services.

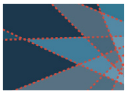
A psychiatrist provides services crucial to sustaining recovery and stable functioning for people with CODs: assessment, diagnosis, periodic reassessment, medication, and rapid response to crises. If lack of funding prevents the SUD treatment agency from hiring a consultant psychiatrist, the agency could establish a collaborative relationship with a mental health agency to provide those services. A memorandum of agreement formalizes this arrangement and ensures the availability of a comprehensive service package for clients with CODs.

Prescribing Onsite Psychiatrist

An onsite psychiatrist brings diagnostic, prescribing, and mental health counseling services directly to the location at which clients receive most of their treatment. An onsite psychiatrist can reduce barriers presented by offsite referral, including distance and travel limitations, the inconvenience of enrolling in another agency, separation of clinical services (more "red tape"), fears of being seen as "mentally ill" (if referred to a mental health agency), cost, and difficulty getting comfortable with different staff.

The consensus panel is aware that the cost of an onsite psychiatrist is a concern for many programs. Many agencies that use the onsite psychiatrist model find that they can afford to hire a psychiatrist part time, even 4 to 16 hours per week, and that a significant number of clients can be seen that way. A certain amount of that cost can be billed to Medicaid, Medicare, insurance agencies, or other funders. For larger agencies, the psychiatrist may be full time or share a full-time position with a nurse practitioner. The psychiatrist can also be employed concurrently by the local mental health program, an arrangement that helps to facilitate access to other mental health services such as intensive outpatient treatment, psychosocial programs, and even inpatient psychiatric care if needed.

Ideally, SUD treatment agencies should hire a psychiatrist with SUD treatment expertise to work onsite. Finding psychiatrists with this background



may present a challenge. Psychiatrists certified by the American Society of Addiction Medicine or the American Osteopathic Association (for osteopathic physicians) can provide leadership, advocacy, development, and consultation for SUD treatment staff.

Medication and Medication Monitoring

Many clients with CODs require medication to control their psychiatric symptoms and to stabilize their mental status. The importance of stabilizing clients with CODs on psychiatric medication when indicated is now well established in the SUD treatment field. (Chapter 7 covers in more depth the role of medication in treating CODs.) One important role of psychiatrists in SUD treatment settings is to provide medication based on the assessment and diagnosis of the client, with subsequent regular contact and review of medication. These activities include careful monitoring and review of medication adherence.

Psychoeducational Classes

Psychoeducational classes on mental disorders and SUDs are important elements in basic COD programs. These classes typically focus on the signs and symptoms of mental disorders, medication, and the effects of mental disorders on substance misuse. Psychoeducational classes of this kind increase client awareness of their specific problems and do so in a safe and positive context. Most important, however, is that education about mental disorders be open and generally available within SUD treatment programs. Information should be presented in a factual manner. Some mental health clinics have prepared synopses of mental illnesses for clients in terms that are factual but unlikely to cause distress. A range of literature written for the layperson is also available through government agencies and advocacy groups (see Appendix B). This material provides useful background information for the SUD treatment counselor as well as for the client.

Relapse Prevention

Programs can adopt strategies to help clients become aware of cues or “triggers” that make them more likely to misuse substances and help them develop alternative coping responses to

those cues. Some providers use “mood logs” to increase clients’ awareness of situational factors that underlie urges to use substances. These logs help answer the question, “When I have an urge to drink or use, what is happening?” Basic treatment programs can train clients to recognize cues for the return of psychiatric symptoms, to manage emotions, and to identify, contain, and express feelings appropriately. (For more information about relapse prevention and COD services, turn to Chapter 5.)

Case Management

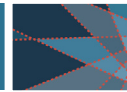
CODs are complex conditions that affect many areas of a person’s life, including his or her physical and emotional functioning, vocation/education, social and family relationships, and daily functioning. Case management is needed to ensure that clients receive a continuum of support services at the intensity and level needed to meet their service needs and readiness for change. Administrators should ensure that staff case managers are service providers and advocates for the specific needs of clients with CODs. Additionally, programs should offer case management that facilitates client transitions from one level of care to the next and that is responsive to all recovery-related needs.

COD-Specific Treatment Components

People with CODs face unique challenges compared with individuals who have only a mental illness or an SUD. For instance, their risk of homelessness, incarceration, and recovery relapse are particularly high. Further, symptoms of one condition can exacerbate the other (especially if untreated), and treatment components should comprehensively address all diagnoses and symptoms. Administrators should ensure that program elements speak directly to CODs by hiring staff with COD training and experience and implementing programs adapted to the particular needs of COD populations. (See Chapter 7 for guidance on adapting various treatment models for CODs.)

Continuing Care Services

Long-term follow-up is critical to recovery. SUDs and mental illness are chronic diseases, and clients will likely face struggles (including relapse) long



after they leave treatment. Programs have many options for providing continuing care, including mutual support and peer recovery support programs, relapse prevention groups, ongoing individual or group counseling, and mental health services (e.g., medication checks). For inpatient settings, long-term follow-up should be discussed collaboratively as part of clients' discharge plan so clients are fully aware of the supports and services in place to help them succeed. (Also see the section "Ensuring Continuity of Care.")

Double Trouble Groups (Onsite)

Onsite groups such as Double Trouble in Recovery provide a forum for discussing the interrelated problems of mental disorders and SUDs, helping participants to identify triggers for relapse. Clients describe their psychiatric symptoms (e.g., hearing voices) and their urges to use drugs. They are encouraged to discuss, rather than to act on, these impulses. Double Trouble groups can also be used to monitor medication adherence, psychiatric symptoms, substance use, and adherence to scheduled activities. Double Trouble provides a constant framework for assessment, analysis, and planning. Through participation, the individual with CODs develops perspective on the interrelated nature of mental disorders and SUDs and becomes better able to view his or her behavior within this framework.

Dual Recovery Mutual-Support Groups (Offsite)

Various dual recovery mutual-support groups exist in many communities. SUD treatment programs can refer clients to dual recovery mutual-support groups tailored to the special needs of people with CODs. These groups provide a safe forum for discussion about medication, mental health, and substance misuse problems in an understanding, supportive environment where coping skills can be shared. Chapter 7 contains a more comprehensive description of this approach.

Assessing the Agency's Capacity To Serve Clients With CODs

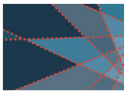
Every agency that already is treating or planning to treat clients with CODs should assess the current profile of its clients, as well as the estimated number and type of potential new clients in the community. It must also consider its current capabilities, its resources and limitations, and the services it wants to provide in the future. Organizational tasks to determine service capacity include:

- Conducting a needs assessment to determine the prevalence of CODs in the client population, the demographics of those clients, and the nature of the disorders and accompanying problems they present. Data gathered can be used to support grant proposals for increasing service capacity.

12-STEP FACILITATION AND CODs

12-Step facilitation (TSF) is a treatment engagement strategy designed to move clients toward participation in mutual support as a part of their plan for achieving and sustaining long-term recovery. Less research has been conducted on TSF for COD populations than for SUD-only populations, but early findings suggest that it may be helpful in teaching clients with CODs about their illnesses and about the benefits of mutual-support program participation (Hagler et al., 2015).

In one randomized, controlled trial (Bogenschutz et al., 2014b), people with alcohol use disorder and SMI were exposed to 12 weeks of TSF adapted for CODs. Compared with treatment as usual, those in the TSF condition were more than twice as likely to participate in 12-Step groups (65.8 percent vs. 29.4 percent) and, on average, attended more meetings. Although there were no differences in substance use between the two conditions, 12-Step participation was a significant predictor of future proportion of days abstinent and drinking intensity (i.e., number of drinks per drinking day).



- Determining what changes need to be made in staff, training, accreditation, and other factors to provide effective services for clients with CODs.
- Assessing community capacity to understand what resources and services are already available within their local and state systems of care before deciding what services to provide.
- Identifying missing levels of care/gaps in services to help programs better respond to client needs.

SAMHSA's Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit (SAMHSA, 2011b) helps SUD treatment systems and programs assess and enhance their capacity to effectively serve clients with CODs. The toolkit features an assessment measure (the DDCAT Index) that provides feedback on numerous program elements critical to implementation and maintenance of competent service delivery for CODs. To clarify the guiding principles and approaches that optimize COD programming success, these elements are further classified into seven dimensions:

1. A structure that offers unrestricted, **integrated, collaborative services** to clients with CODs
2. A **culture that is welcoming to clients with CODs** and readily offers education about CODs
3. Use of **routine screening, assessment, and diagnosis** (or referral to diagnosis, if needed) for clients with CODs that takes into account each client's severity and persistence of symptoms
4. A clinical process that includes **stage-wise treatment planning; ongoing assessment and monitoring of symptoms of both disorders throughout the course of care; and numerous approaches to interventions**, such as pharmacotherapy management, psychoeducation and support (for the client and for family), specialized interventions in behavioral health, and peer-based services
5. **Provision of continuous care** through collaborative approaches, recovery maintenance strategies, and follow-up services (including community-based and peer-based services)
6. **Attention to staffing needs**, such as including prescribers; ensuring that clinicians possess required licensure, competency, and experience;

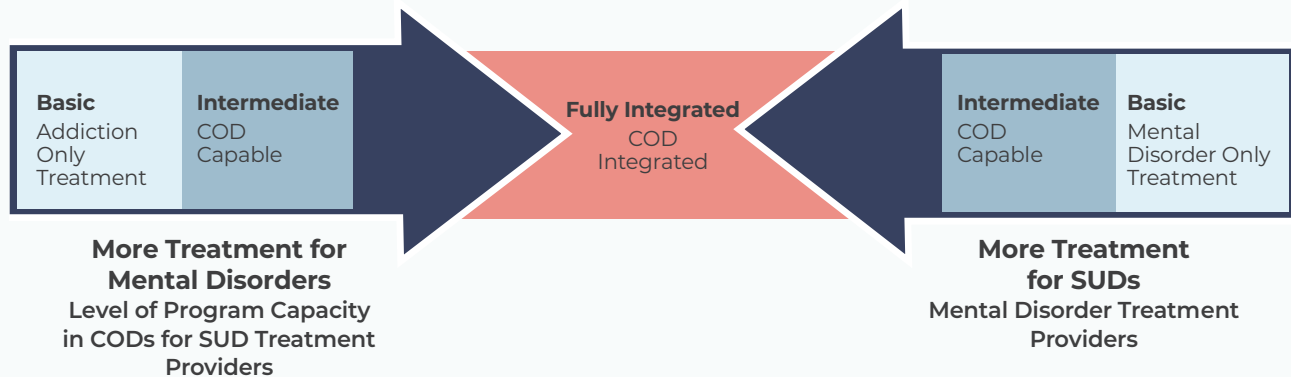
and implementing supervision or other professional consultation processes (like case reviews or other formal approaches to staff monitoring and support) to ensure ethical, evidence-based care

7. **Staff training on CODs**, including training that imparts basic skills and knowledge (e.g., screening and assessment, symptoms, prevalence rates) as well as advanced training (e.g., specific interventions, including basic understanding of pharmacotherapies)

Trauma-informed care should be the standard among all programs providing COD services. Trauma is exceedingly common among people with co-occurring mental disorders and SUDs and, if untreated, can make recovery very challenging. For more information about integrating trauma-informed services, like assessments and treatments, into COD programming, see TIP 57, *Trauma-Informed Care in Behavioral Health Services*, as well as Chapters 3 and 6 of this TIP.

The consensus panel suggests the following classification system: basic, intermediate, advanced or fully integrated. As conceived by the consensus panel:

- A **basic** program has the capacity to provide treatment for one disorder but also screens for the other disorder and can access necessary consultations.
- A program with an **intermediate** level of capacity tends to focus primarily on one disorder without substantial modification to its usual treatment, but also explicitly addresses some specific needs related to the other disorder. For example, an SUD treatment program may recognize the importance of continued use of psychiatric medications in recovery, or a psychiatrist could provide MI regarding substance use while prescribing medication for mental disorders.
- A program with **advanced** capacity provides integrated SUD treatment and mental health services for clients with CODs. Chapter 7

EXHIBIT 2.5. Levels of Program Capacity in CODs

describes several such program models. These programs address CODs from an integrated perspective and provide services for both disorders. For some programs, this means strengthening SUD treatment in the mental health services setting by adding interventions that target specific COD symptoms or disorders and relapse prevention strategies that intertwine identification of cues, warning signs, and coping skills for both disorders. For other programs, it means adding mental health services, such as psychoeducational classes on mental disorder symptoms and groups for medication monitoring, in SUD treatment settings. Collaboration with other agencies can aid comprehensiveness of services.

- A **fully integrated** program actively combines SUD and mental illness interventions to treat disorders, related problems, and the whole person more effectively.

The suggested classification has several advantages. For one, it avoids use of the term “dual diagnosis” and allows a more general, flexible approach to describing capacity without

specific criteria. In addition, the classification system reflects a bidirectionality of movement wherein either addiction or mental health agencies can advance toward more integrated care for clients with CODs, as shown in Exhibit 2.5.

Conclusion

Co-occurring mental disorders and SUDs are complex. They present significant clinical, functional, social, and economic challenges for people living with them as well as for the counselors, administrators, supervisors, and programs who treat them. To help address the full range of symptoms clients experience and optimize outcomes, providers and programs must understand the components of comprehensive, high-quality care for CODs and have plans in place to implement core strategies, skills, and services. By using treatment frameworks, philosophies, and approaches empirically shown to net the best outcomes for people living with CODs, the SUD treatment and mental health service fields can close gaps in access and treatment so that people with CODs can live healthier, more functional lives.

Substance Use Disorder Treatment for People With Co-Occurring Disorders

UPDATED 2020

TREATMENT IMPROVEMENT PROTOCOL

TIP 42

SAMHSA

Substance Abuse and Mental Health
Services Administration

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