Chapter 6—Co-Occurring Disorders Among Special Populations

(For Counselors, Other Treatment/Service Providers, Supervisors, and Administrators)

Key Messages

The recovery community is diverse. Assessment, diagnosis, and treatment of substance use disorders (SUDs), mental disorders, or both (co-occurring disorders [CODs]) should be inclusive of all people who need services.

People experiencing homelessness, those involved in the criminal justice system, women, and people who identify with diverse racial/ethnic groups have historically been underserved, often have unique needs and presenting symptoms, and face certain barriers to care (and thus to recovery) that counselors can help address.

Counselors may need to adapt treatment approaches to ensure the most beneficial COD outcomes for these groups. Adaptations are possible across a wide spectrum, involving basic to increasingly complex modifications. Regardless of complexity, all population-specific adaptations should aim to improve the therapeutic alliance, increase clients' engagement in services, and give people with CODs the best chances for long-term recovery.

There are ample resources available to help counselors tailor SUD treatment and mental health services to the needs of special populations with CODs.

Some people with CODs are especially vulnerable to treatment challenges and poor outcomes—namely, women, people from diverse racial/ethnic backgrounds, people experiencing homelessness, and people involved in the criminal justice system. This chapter describes proven and emerging COD treatment strategies that can effectively address substance misuse in these populations. It describes unique aspects of CODs among specific populations and offers recommendations of use to SUD treatment providers, other behavioral health service providers, program supervisors/administrators, and primary care providers who may encounter clients with CODs in their practice.

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

- TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* (Center for Substance Abuse Treatment, 2005b).
- TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009b).
- TIP 55, *Behavioral Health Services for People Who Are Homeless* (SAMHSA, 2013).
- TIP 57, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA, 2014b).
- TIP 59, *Improving Cultural Competence* (SAMHSA, 2014a).

Military Personnel

Active duty military members and veterans are a unique, complex population at risk for CODs, trauma, posttraumatic stress disorder (PTSD), and suicidal ideation. They often lack access to sufficient behavioral health

services. Providers will need to make special considerations regarding military culture (especially surrounding stigma toward mental illness) and circumstances, such as deployments and family stress, to provide behavioral health services that are responsive to this population's needs. See the "Trauma" section in Chapter 4 for more information on military personnel. Chapter 4 also lists resources that address some of the specific behavioral health needs of the military population and how counselors can best meet those needs.

People Experiencing Homelessness

Homelessness continues to be one of the United States' most intractable and complex social problems, although homelessness affects only about 0.2 percent of the U.S. population (Willison, 2017). The Department of Housing and Urban Development (Henry et al., 2018) reported that approximately553,000 people experienced homelessness in the United States on any given night in 2018. Moreover, the prevalence of homelessness is rising. From 2017 to 2018, the number of individuals experiencing homelessness rose by 0.3 percent and the number living in unsheltered locations increased by 3 percent; the number experiencing chronic homelessness increased by 2 percent (Henry et al., 2018).

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

Homelessness, Mental Health, and Substance Misuse

The prevalence of substance misuse and mental illness among people experiencing homelessness is high. Solari, Morris, Shivji, and Souza (2016) found that about 33 percent of adults in permanent supportive housing programs had a mental disorder; 8 percent, substance abuse (per *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* [DSM-IV] criteria); and 25 percent, CODs. Further statistics paint a similar picture:

- Stringfellow et al. (2016) reported that 3-month substance use among individuals experiencing homelessness was 50 percent for alcohol, 19 percent for cannabis, 16 percent for cocaine, 7.5 percent for opioids, and 6.5 percent for sedatives. Furthermore, 59 percent of individuals who took the Alcohol, Smoking, and Substance Involvement Screening Test had moderate or high risk for substance misuse.
- In a study of more than 870,000 veterans with SMI, 7 percent experienced homelessness (Hermes & Rosenheck, 2016).
- Among a sample of women experiencing homelessness who were seeking treatment in primary care settings (Upshur, Jenkins, Weinreb, Gelberg, & Orvek, 2017), self-reported rates of SUDs or mental disorders greatly exceeded those in the general population. Specifically, women reported rates higher than the general population for:
  - SMI (4 times higher).
  - Major depressive disorder (MDD; 5 times higher).
  - Alcohol use disorder (AUD; 4 times higher).
  - Any drug use disorder (12 times higher).
- A study of people ages 50 and older experiencing homelessness (Spinelli et al., 2017) found that:
  - 38 percent had current symptoms of MDD.

- 33 percent had current symptoms of PTSD.
- 19 percent had at least one lifetime hospitalization for psychiatric symptoms.
- 33 percent reported experiencing childhood physical abuse, and 13 percent experienced childhood sexual abuse.
- 63 percent had used an illicit substance in the previous 6 months; the most commonly used illicit substances were cannabis (48 percent), cocaine (38 percent), opioids (7 percent), and amphetamines (7 percent).
- 49 percent drank alcohol in the past 6 months, including 26 percent whose alcohol use was of moderate or greater severity and 15 percent whose use was of high severity.
- 10 percent reported binge drinking.

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

The Importance of Housing

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

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

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

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

Service Models for People With CODs Who Are Experiencing Homelessness

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

- **Supportive housing—**housing combined with access to services and supports to address the needs of individuals without housing so that they may live independently in the community. This model is an option for individuals and families who have lived on the street for longer periods of time or whose needs can best be met by services accessed through their housing.

- **Linear housing—**housing that is contingent on completion of treatment for SUDs or mental disorders. Subsidized housing programs participating in this model typically require abstinence as a condition of housing, often through completion of residential treatment.
- **Integrated treatment—**receipt of housing concurrently with addiction/mental health services.

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

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

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

Supportive Housing Model

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

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

Housing First

The Housing First (HF) model provides housing no matter where a person is in recovery from SUDs or mental disorders. HF is one of the best-known and well-researched approaches to supportive housing. **SAMHSA supports the HF model as a preferred approach for addressing homelessness in individuals with mental illness, SUDs, or both,** as does the U.S. Interagency Council on Homelessness (2014). (See "Resource Alert: Implementing Supportive Housing Programs.")

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

Resource Alert: Implementing Supportive Housing Programs

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

- The National Alliance to End Homelessness's toolkit for adopting an HF approach (https://endhomelessness.org/wp-content/uploads/2009/08/adopting-a-housing-first-approach.pdf)
- Pathways to Housing training and consultation (www.pathwayshousingfirst.org/training)
- Pathways to Housing PA Training Institute's training and technical assistance (https://pathwaystohousingpa.org/Training)
- SAMHSA's Permanent Supportive Housing Evidence-Based Practices toolkit (https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510)
- USICH's *Implementing HF in Permanent Supportive Housing* fact sheet (www.usich.gov/resources/uploads/asset_library/Implementing_Housing_First_in_Permanent_Supportive_Housing.pdf)

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

Pathways to Housing

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

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

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

Linear Housing Model

The linear model provides housing contingent on abstinence from substances. It was once the preferred approach for aiding people with SUDs, mental disorders, or CODs who were experiencing homelessness. Research has since shown this approach to produce less favorable housing retention outcomes than supportive housing (Kertesz et al., 2009; Polcin, 2016). **Linear models often require completion of an SUD treatment program (typically residential treatment) in addition to abstinence before housing is provided, yet SUD treatment completion rates are frequently low.** Often, linear programs also lack

access to and control of stable, permanent housing, which contributes to low rates of housing stability compared with permanent supportive housing programs such as HF (Kertesz et al., 2009; Polcin, 2016).

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

The Role of Recovery Housing for People With CODs

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

Integrated Housing and Treatment Models

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

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

Advice to the Counselor: Working With Clients Who Have CODs and Are Experiencing Homelessness

The consensus panel recommends that providers:

- Address the housing needs of clients.
- Help clients obtain housing.
- Teach clients skills for maintaining housing.
- Collaborate with shelter workers and other providers of services to people experiencing homelessness.

- Address real-life concerns in addition to housing, such as SUD treatment, legal/criminal justice matters, Supplemental Security Insurance/entitlement applications, problems related to children, and healthcare.

People Involved in the Criminal Justice System

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

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

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

Rationale for Treatment

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

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

The rationale for providing SUD treatment in the criminal justice system is based on the well-established link between substance misuse and criminal behavior. The overall goal of SUD treatment for criminal offenders, especially those who have engaged in violence, is to reduce criminality.

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

Treatment Features, Approaches, and Empirical Evidence

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

- Staff are trained and experienced in treating both mental disorders and SUDs.
- Both disorders are treated as “primary.”

- Treatment services are integrated if possible.
- Treatment is comprehensive, flexible, and individualized.
- The focus of the treatment is long term.

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

- IDDT models integrate SUD treatment and mental health services in a single setting; professionals with training in both sets of disorders address all symptoms concurrently. IDDT treatments can be adapted for incarcerated population to address criminal thinking and reduce risk of recidivism.
- RNR models match service intensity to clients' risk of recriminalization after release, which tends to be high in people with CODs. RNR programs are often highly focused on reducing substance misuse, which is strongly linked to reincarceration. Additional recidivism risk factors addressed through this framework include reducing antisocial attitudes and beliefs, addressing family and relationship problems, enhancing education and employment skills, and encouraging prosocial activities.
- CBT can be tailored to offenders with CODs by addressing antisocial thoughts and maladaptive behaviors, increasing coping skills to reduce substance use (e.g., urges, cravings) and criminal behavior, and cognitive restructuring to decrease criminal thinking.

Resource Alert: SAMHSA Publications on Screening, Assessment, and Treatment for Criminal Justice Populations

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

These and other COD treatment approaches can be implemented across a range of criminal justice settings and services, including as part of prebooking diversion programs, drug and mental health courts, reentry programs, and probation supervision. Many prison- and jail-based treatments for offenders with CODs have generated positive results for reincarceration (especially for TCs). Certain interventions, including case management via mental health drug courts, MI combined with cognitive training, and interpersonal psychotherapy, often show no effect on criminal activity and drug use—possibly because of small sample sizes and the low quality of studies (Perry et al., 2015; Peters et al., 2017). However, some research does report positive outcomes, suggesting that COD treatment should not be dismissed outright. For instance, a COD wraparound intervention for drug courts resulted in significant reductions in the average number of nights spent in jail, alcohol use, and drug use, and increases in full-time employment (Smelson et al., 2018).

Evidence in Support of Postrelease Treatment and Follow-Up

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

Forensic adaptations to continuous care for CODs via ACT can be leveraged to improve criminal justice-related, substance-related, and functional outcomes. Integrated, comprehensive approaches to

postrelease treatment and follow-up may help reduce rearrest and reconvictions when adapted for criminal justice populations. Adaptations may include modifications like inclusion of a reentry plan, transportation to and supervision for treatment visits, and acquisition/reinstatement of financial assistance (e.g., Social Security income, Medicaid; Peters et al., 2017).

Smith, Jennings, and Cimino (2010) used a stage progressive recovery model of ACT to help offenders with CODs transition from incarceration on an inpatient forensic unit to community living. Participants were provided stage-specific skills and interventions (e.g., support to improve self-care, medication management, relapse prevention, enhanced socialization). Stages of treatments were tied to behavioral rewards and increased privileges (such as less supervision) and included assessment and orientation, a CBT program, a prerelease stage, and conditional release and community continuing care programming. Ninety percent of individuals who completed the program had "overall success" (e.g., no psychiatric state hospital readmissions and no rearrests following release), 75 percent maintained substance abstinence, and 82 percent maintained steady housing (i.e., keeping a consistent home without being evicted, ejected, or changing residences more than three times in any year). Interestingly, of the 5 individuals who were rearrested following release, all had maintained substance abstinence, stable housing, and employment.

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

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

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

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

Women

Women with CODs can be served in mixed-gender COD programs using the same strategies mentioned elsewhere in this TIP. However, specialized COD programs do exist that address pregnancy and childcare difficulties as well as certain kinds of trauma, violence, and victimization. These issues are sometimes best dealt with in women-only programs.

Substance Misuse and Mental Illness in Women

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

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

Treatment Approaches for Women

SUD treatment

Women disproportionately face barriers to treatment related to children and childcare. Responsibility for care of dependent children is one of the most significant barriers women face in entering treatment, as many programs will not enroll women who lack child care (Taylor, 2010). Women who enter treatment sometimes risk losing public financial assistance and custody of their children, making the decision to begin treatment a difficult one (Taylor, 2010). However, women accompanied by their children into treatment can achieve successful outcomes. The Iowa Pregnant and Postpartum Women's Residential Treatment Program (https://idph.iowa.gov/substance-abuse/programs/ppw), funded through a SAMHSA grant, reported a 76 percent treatment completion rate and 90.5 percent abstinence rate from drugs and alcohol at 5 to 8 months after admission (Jones & Arndt, 2017).

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

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

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

- Women are more likely to be referred to or enter treatment via community-based social services, like welfare and child welfare programs, and are less likely to enter via the criminal justice system.
- Women are more likely to require public assistance to pay for treatment.
- Women may be more likely to initiate treatment after fewer years of substance misuse than men, but their clinical profiles are often more severe (e.g., greater psychosocial distress, greater odds of trauma experience, higher childcare burden, worse functional impairment). They also tend to start substance use at a later age but progress from first use to addiction faster than men do.
- Women with SUDs have a higher reported prevalence of mental disorders, particularly internalizing conditions (e.g., depression, anxiety, eating disorders, PTSD) and lower self-esteem, whereas men with SUDs are more likely to exhibit externalizing conditions (e.g., antisocial personality disorder [PD]).

- Whereas women with SUDs report having more difficulty with emotional problems, their male counterparts report having more trouble with functioning (e.g., work, money, legal problems).

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

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

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

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

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

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

Exhibit 6.1. Adapting Treatment Services to Women's Needs

- Use nonconfrontational, strengths-based, trauma-informed treatment approaches.
- Offer evidence-based interventions that have been researched specifically in female populations.
- Ensure staff training and competencies regarding women-specific problems in substance misuse.
- Provide:
  - Prenatal/postnatal services.
  - Women-only groups.
  - Parenting training/counseling.
  - Trauma/abuse counseling and other services.
  - Education about and referral to women's health services.
- Use gender-specific assessments (including assessment of intimate partner violence and trauma).

- Offer services related to child care and children's needs, including:
  - Onsite child care or, for residential settings, live-in accommodations for children.
  - Screening and assessments for children.
  - Child and family counseling (or referral for those services).
  - Coordinated care with child welfare/children's protective services.
- Ensure the physical treatment environment is safe and secure. Being in close proximity to schools, child care, and public transportation is also desirable.

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

COD Treatment

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

- Experience homelessness.
- Be unmarried.
- Have a past history of physical or sexual abuse.
- Receive public assistance.
- Have a longer substance use history.
- Have more severe alcohol use-related problems.
- Have more severe problems related to employment.
- Have more severe medical conditions.
- Have greater family dysfunctions.
- Be on psychiatric medication.

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

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

Women with CODs—and particularly with SMI and SUDs—often do not receive services for their conditions. Of women who entered SUD treatment with a co-occurring mental illness (Evans et al., 2015), almost 30 percent with a comorbid mental disorder received no mental health services over the course of 8 years, including 7 percent with co-occurring psychosis, 13 percent with bipolar disorder, and 20 percent with depressive disorder.

Pregnancy and CODs

Pregnancy can both aggravate and diminish the symptoms of co-occurring mental illness. Women with schizophrenia may experience a worsening of symptoms, whereas women with bipolar disorder have exhibited lower rates of new onset or recurrence of symptoms (Jones, Chandra, Dazzan, & Howard, 2014). Ample research has examined MDD during the prenatal, perinatal, and postnatal periods. Antidepressant discontinuation or untreated depression during pregnancy can exacerbate symptoms, including those related to risk of suicide, and worsen outcomes for both mother and child (Gentile, 2017; Vigod, Wilson, & Howard, 2016). However, pregnancy has been linked to lower substance use in women, even if abstinence is temporary (Muhuri & Gfroerer, 2009; SAMHSA, 2009c). **Compared with women who have a single disorder or no disorder, pregnant women with CODs are at elevated risk for negative perinatal outcomes**, including birth complications, premature birth, low infant birthweight, nonadherence to prenatal care, child developmental delays, and poorer psychosocial functioning (Benningfield et al., 2010; Lee King, Duan, & Amaro, 2015).

Topics to Address With Co-Occurring Mental Illness

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

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

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

- More flexible treatment schedules.
- Longer sessions.
- Assistance with transportation to and from sessions.
- Group treatments.
- Interpersonal support (from partners, friends, family, and counselors).
- Linkage to community resources (like mutual support programs).
- Treatment environments that convey a sense of safety and comfort.

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

Pharmacological Considerations

Before giving any medications to pregnant women, it is vital that they understand the risks and benefits of taking medications and sign informed consent forms verifying receipt and understanding of

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

Pregnancy and Medication-Assisted Treatment for OUD

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

Considerations for medication-assisted treatment to address OUD in pregnant women include the following:

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

Source: SAMHSA (2018c).

Postpartum Depression and Psychosis

The term “postpartum depression” (PPD) in DSM-5 refers to MDD in which the most recent depressive episode has an onset either during pregnancy or within 4 weeks after delivery (American Psychiatric Association [APA], 2013). DSM-5 designates such cases through the MDD specifier “with peripartum onset.” (See Chapter 4 for DSM-5 diagnostic criteria for MDD.)

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

PPD is considered distinct from postpartum “blues,” which is a mild, transient depression occurring most commonly within 3 to 5 days after delivery in about 30 percent to 80 percent of women after childbirth (Buttner, O’Hara, & Watson, 2012; Jones & Shakespeare, 2014). Prominent in its causes are a woman’s emotional letdown following the excitement and fears of pregnancy and delivery, the discomforts of the

period immediately after giving birth, hormonal changes, fatigue from loss of sleep during labor and while hospitalized, energy expenditure at labor, and anxieties about caring for the newborn at home. Symptoms include weepiness, insomnia, depression, anxiety, poor concentration, moodiness, and irritability. These symptoms tend to be mild and transient, and women usually recover completely with rest and reassurance. Anticipation and preventive reassurance throughout pregnancy can prevent postpartum blues from becoming a problem. Women with sleep deprivation should be assisted in getting proper rest. Follow-up care should ensure that the woman is making sufficient progress and not heading toward a relapse to substance use.

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

Prospects for recovery from PPD are good with supportive mental health counseling (especially for acute cases) accompanied as needed by pharmacotherapy, particularly in severe PPD (Thomson & Sharma, 2017). Various forms of counseling (e.g., CBT, behavioral activation, interpersonal therapy), pharmacotherapy (e.g., SSRIs, selective norepinephrine reuptake inhibitors), and brain stimulation (e.g., electroconvulsive therapy, repetitive transcranial magnetic stimulation) have all been successful in treating PPD (Guille, Newman, Fryml, Lifton, & Epperson, 2013; O'Hara & Engeldinger, 2018; Thomson & Sharma, 2017). **Because some medications pass into breastmilk and can cause infant sedation, it is best to consult an experienced psychiatrist or pharmacist for details on pharmacotherapy.**

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

Postpartum psychosis is associated with an increased risk of suicide and infanticide (Bergink et al., 2016; Brockington, 2017)**. As such, the severity of the symptoms mandates immediate evaluation** (for diagnosis and for safety), which often needs to be performed in an inpatient setting, and treatment with benzodiazepines, lithium, antipsychotics, electroconvulsive therapy, or a combination thereof (Bergink et al., 2016; Doucet, Jones, Letourneau, Dennis, & Blackmore, 2011). The risk of self-harm or harm to the baby needs to be assessed. Monitoring of mother–infant pairs by trained personnel can limit risks.

PPD and substance misuse

Little research has examined the relationship between PPD and substance use. One review of substance use in postpartum women found that problematic alcohol use occurred in 1.5 percent to 8 percent and drug use (cocaine and prescription psychoactive drugs) occurred in 2.5 percent (Chapman & Wu, 2013). Among women who reported using substances postpartum or who had a positive history

of substance misuse, PPD was highly prevalent (20 percent to 46 percent). However, the women participating in these studies were likely to have had higher rates of depression than the general population to begin with because of low income and socially marginalized status (e.g., teenage mothers). The review also found that alcohol or illicit drug use was associated with higher scores of depression in postpartum women. These findings are consistent with an earlier review (Ross & Dennis, 2009) that similarly observed an association between substance use and an increased risk of PPD.

Women, Trauma, and Violence

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

People seeking SUD treatment who have PTSD are 14 times more likely to have an SUD than people without PTSD (McCauley, Killeen, Gros, Brady, & Back, 2012). In the general public, lifetime prevalence rates of PTSD (full or partial) are double in women than in men, with 46 percent of people with full PTSD also meeting criteria for an SUD (Pietrzak et al., 2011). Women who are incarcerated have even higher rates of each disorder—88 percent with full or partial PTSD and 87 percent with an SUD (Wolff et al., 2011). Women with trauma/PTSD may misuse substances to avoid intrusive, distressing symptoms (e.g., flashbacks, nightmares) or to numb themselves to emotional pain (Dass-Brailsford & Safilian, 2017).

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

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

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

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

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

People of Diverse Racial/Ethnic Backgrounds

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

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

Cultural Perceptions of Substance Misuse, Mental Disorders, and Healing

Clients may have culturally determined concepts of what it means to misuse substances or to have a mental disorder, what causes these disorders, and how they may be "cured." **Providers are encouraged to explore these concepts with people who are familiar with the cultures represented in their client population. Counselors should be alert to differences in how their role and the healing process are perceived by people who are of cultures other than their own.** Whenever appropriate, familiar healing practices meaningful to clients should be integrated into treatment. An example would be the use of acupuncture to calm a Chinese client or help control cravings.

Cultural Perceptions and Diagnosis

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

Racial/Ethnic Disparities and SMI

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

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

Source: Maura & Weisman de Mamani (2017).

Treatment Access and Utilization

Compared with Whites, other racial/ethnic populations make up a smaller percentage of the U.S. population with mental disorders, SUDs, or both. Yet concerns remain about treatment access and use, as people of diverse ethnic/racial backgrounds are disproportionately uninsured (Kaiser Family Foundation, 2017; Sohn, 2017). Racial and ethnic populations have historically faced more financial and nonfinancial barriers to healthcare in general than Whites, including low cultural competency in their treatment providers (Mitchell, 2015). These barriers lead to worse health outcomes (e.g., increased morbidity, worse quality of care) as well as higher healthcare costs. Similarly, marginalized groups face systemic, organizational, cultural, and attitudinal obstacles to SUD treatment and mental health services (Holden et al., 2014; Keen et al., 2014; Masson et al., 2013; Maura & Weisman de Mamani, 2017; Pinedo, Zemore, & Rogers, 2018), including:

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

The effects of these barriers are reflected in lagging rates of treatment access, utilization, and completion for mental illnesses, SUDs, or CODs by diverse ethnic/racial populations compared with

Whites (Cook et al., 2017; Holden et al., 2014; Maura & Weisman de Mamani, 2017; Nam et al., 2017; Saloner & Le Cook, 2013; Sanchez et al., 2016). This inequity may result from underassessment, underdiagnosis, and underreferral (Priester et al., 2016) as well as from cultural barriers.

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

Reducing Racial/Ethnic Disparities

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

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

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

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

Cultural Differences and Treatment: Empirical Evidence on Effectiveness

Studies of cultural differences in COD treatment are scarce. However, **culturally adapted mental health services have been linked to small-to-moderate benefits compared with nonadapted treatments,**

placebo, waitlists, and usual care (Cabassa & Baumann, 2013). For example, a review of culturally responsive mental health services for people with SUDs (Gainsbury, 2017) reported that:

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

Cultural competence should be a goal for programs as well as providers. In a study of more than 350 nationally representative outpatient SUD treatment programs (Guerrero & Andrews, 2011), program cultural competence—namely, managers' culturally sensitive beliefs—predicted reduced client wait time and increased retention among Latinos and African Americans. **Program leadership can influence staff uptake of culturally responsive care, translating to potentially better outcomes for clients.**

Advice to the Counselor: Using Culturally Appropriate Methods

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

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

Source: Healey et al. (2017).

Conclusion

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

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

(For Counselors, Other Treatment/Service Providers, Supervisors, and Administrators)

Key Messages

Co-occurring disorders (CODs) are undertreated conditions that exact a serious toll on both the individuals living with them as well as on their families, caregivers, and society as a whole. Early and effective treatments offer people the opportunity to live fulfilling, healthy, productive lives.

Available treatment models work by leveraging education, support, resources, and other services drawn from multiple sources, such as collaborating healthcare professionals across primary care service, mental health services, and substance use disorder (SUD) treatment; mutual support programs; professionals in the recovery community; and peer recovery support specialists.

Treatment providers should not operate in silos nor should they use treatments in isolation. The best way to serve people with CODs is to offer services and programs that are integrated, comprehensive, person-centered, and recovery-oriented in their structure, milieu, and practice.

It is vital that counselors and programs provide effective interventions across multiple settings because people with mental disorders and SUDs often fluctuate across levels of care, and this should not be a barrier to receiving needed evidence-based services.

Although psychosocial services are often a cornerstone of interventions for CODs, counselors working with this population should be familiar with medication treatment, as there are many effective pharmacotherapies available to help people reduce at least some of their symptoms and make appreciable gains in functioning.

Of the 9.1 million adults who had CODs in 2018, approximately half (51 percent) received no treatment at all, and only 8 percent received care for both conditions (Center for Behavioral Health Statistics and Quality, 2019). What happens to people with CODs who enter traditional SUD treatment settings? What can counselors, other providers, supervisors, and administrators do to help people with CODs more successfully access needed services? How can programs provide the best possible services to clients? What treatment options are available, and to what extent are they supported by science? This chapter seeks to answer these and other important questions about the management of co-occurring mental illness and addiction.

This chapter examines treatment models (e.g., integrated care, assertive community treatment [ACT], intensive case management [ICM], mutual support and peer-based programs) and treatment settings (e.g., therapeutic communities [TCs], outpatient and residential care, acute care and other medical settings) for clients with CODs. It opens with an overview of general COD treatment considerations, including types of programs, levels of service (and matching clients to appropriate levels), episodes of treatment, integrated versus nonintegrated treatment, culturally competent services, and barriers to care. The bulk of the material then focuses on three areas: treatment models, treatment settings, and pharmacotherapy. Specific interventions, like cognitive–behavioral therapy (CBT), behavioral therapy, multidimensional family therapy, and dialectical behavior therapy, are beyond the scope of this

Treatment Improvement Protocol (TIP), as readers should already possess a basic understanding of and working familiarity with these commonly used SUD treatments; rather, the material is focused on describing the models and settings in which such interventions are provided.

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

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

Treatment Overview

Treatment Programs

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

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

Program Types

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

- **Co-occurring–capable (COC) programs** are SUD treatment programs that mainly focus on SUDs but can also treat patients with subthreshold or diagnosable but stable mental disorders (Mee-Lee et al., 2013). These programs may offer mental health services onsite or by referral. COC programs in mental health focus mainly on mental disorders but can treat patients with subthreshold or diagnosable but stable SUDs (Mee-Lee et al., 2013). COC programs have addiction counselors onsite or available through referral.
- **Co-occurring–enhanced programs** have a higher level of integration of SUD treatment and mental health services, staff trained to recognize the signs and symptoms of both disorders, and competence in providing integrated treatment for mental disorders and SUDs at the same time.

- **Complexity capable programs** are designed to meet the needs of individuals (and their families) with multiple complex conditions that extend beyond just CODs. Physical and psychosocial conditions and treatment areas of focus often include chronic medical illnesses (e.g., HIV and other infectious diseases), trauma, legal matters, housing difficulties, criminal justice system involvement, unemployment, education difficulties, childcare or parenting difficulties, and cognitive dysfunctions.

Levels of Service

Because mental disorders and SUDs are complex and vary in their severity and consequences, a wide range of levels of service are needed, from high-intensity inpatient medical service to periodic outpatient treatment. **Not all people with CODs will require the full continuum of services, and not all clients will move through levels of care in a linear fashion.** Clients can transition to and from greater and lower intensity services and should be offered services based on clinical need (e.g., symptom severity, functional ability, person's overall level of stability) and stage of change.

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

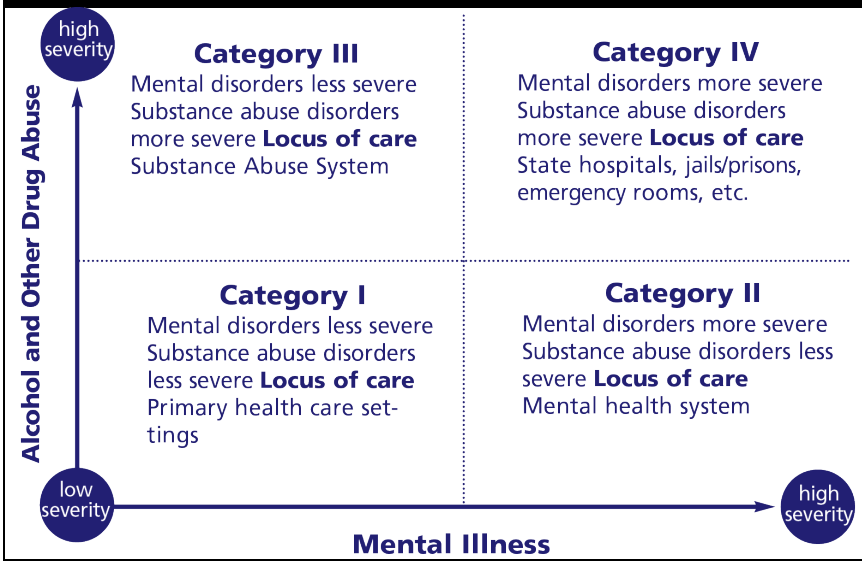
1. Recovery Maintenance / Health Management
2. Low Intensity Community Based Services
3. High Intensity Community Based Services
4. Medically Monitored Non-Residential Services
5. Medically Monitored Residential Services
6. Medically Managed Residential Services

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

Treatment Matching to Levels of Service Using the Quadrants of Care

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

Exhibit 7.1. The Four Quadrants of Care



Under this conceptualization, clients are categorized accordingly:

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

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

Episodes of Treatment

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

Integrated Versus Nonintegrated Treatment

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

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

working closely together. Integrated treatment is a means of actively combining interventions intended to address SUDs and mental disorders in order to treat both disorders, related problems, and the whole person more effectively.

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

Culturally Responsive Treatment

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

Cultural factors that may have an impact on treatment include heritage, history and experience, beliefs, traditions, values, customs, behaviors, institutions, and ways of communicating. The client's culture may include distinctive ways of understanding disease or disorder, including mental disorders and SUDs, which the provider needs to understand. Referencing a model of disease that is familiar to the client can help communication and enhance treatment. The counselor acquires cultural knowledge by becoming aware of the cultural factors that are important to a particular racial/ethnic group or client.

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

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

Barriers to Treatment

People with CODs usually have extensive treatment needs, which unfortunately often go unmet. Among the approximately 8.5 million U.S. adults ages 18 and older with a past-year SUD and any mental illness in 2018, less than 10 percent received treatment for both disorders (Center for Behavioral Health Statistics and Quality, 2019). Similarly, from 2008 to 2014, 52 percent of people with CODs received neither mental health services nor SUD treatment in the prior year (Han et al., 2017). People might avoid pursuing treatment given lack of affordability, not knowing where to access treatment, and low perceived treatment need (e.g., not feeling ready to stop using substances, feeling like they could handle mental illness on their own) (Han et al., 2017). Other common obstacles to accessing and benefiting from COD treatment include (Priester et al., 2016):

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

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

Reducing Barriers to Care: What Can Counselors and Administrators Do?

- **Use person-centered approaches** in assessing and treating clients with CODs. Consider factors such as:
  - The client's gender, age, race/ethnicity, or other demographic characteristic that could affect how the client experiences his or her illnesses and treatment.
  - The client's cultural background, including birth status (i.e., native born vs. immigrant).
  - The client's degree of acculturation and acculturation stress.
  - The client's history of trauma.
  - The client's current functional status (including housing and educational/vocational status).
  - Whether the client is experiencing any cognitive disabilities because of her or her diagnoses (particularly if the person has a psychotic disorder).
  - The interaction style to which the person best responds (e.g., Direct? Nonconfrontational?).
- Consider offering **harm-reduction treatments in addition to abstinence-based services.** Programs that limit themselves to abstinence-only treatments may fail to engage and retain clients who are not ready to stop substance use altogether but are otherwise amenable to treatment.
- Offer informal **pretreatment services** for people who are awaiting intake/appointments.
- **Adapt services to the logistical demands facing clients.** For instance:
  - When possible, offer appointments throughout the week and at various times (including before and after normal business hours to accommodate people who work or attend school full time).
  - Use remote services (e.g., telehealth) to reach and engage clients who are immobile or live at a distance.

- **Make integrated care a priority.** Programs that offer comprehensive services that work to simultaneously address all of a client's needs, using the same set of providers, are more likely to keep clients engaged and participating in treatment than ones that are fragmented. Treating substance use and mental disorders in isolation hinders counselors' ability to help clients address all aspects of functioning and disability, including their housing status, medication needs, family relationships, and more. These factors can become reasons for treatment dropout and require attention.
- **Use a staged-approach to interventions** (i.e., engagement, persuasion, active treatment, relapse prevention) that is tailored to clients' readiness to change and is flexible, as clients often move through stages in a nonlinear fashion. Motivational interviewing can help determine clients' readiness for interventions and aids in the creation of personally meaningful and realistic treatment goals.
- **Use assertive community outreach**, such as ICM and ACT services, as these foster therapeutic alliance and reduce practical/logistical barriers to treatment access and adherence (e.g., providing in-home services).
- **Emphasize COD leadership within programs.** Programs need to have a director on staff whose primary job is to oversee COD programming, services, fidelity, and staff competency/training.

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

Resource Alert: Finding Quality Treatment for Substance Use Disorders

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

Treatment Models

Integrated Care

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

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

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

Integrated Care: Partnerships for Pharmacotherapy

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

- An alternate treatment or service (e.g., another psychotherapy, medication, mutual support) is needed.

- The treatment is a good match the client's level of service need.
- The treatment is a good match for the client's readiness for change.

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

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

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

Empirical Evidence of Integrated Care for CODs

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

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

- **In residential facilities** (McKee, Harris, & Cormier, 2013). Here, integrated care has been associated with significant reductions in mental illness symptoms, improvements in COD-related knowledge and skills, increased self-esteem, and good client satisfaction—even among clients with complex, challenging clinical and psychosocial histories (e.g., presence of PTSD, polysubstance misuse, childhood maltreatment, adolescent substance misuse, unstable housing, reliance on public assistance, being unemployed or out of school).
- **In a variety of criminal justice-related settings,** such as prebooking diversion programs, drug or mental health courts, in jails or prisons, and as a part of community release (Peters et al., 2017; Rojas & Peters, 2015). Integrated COD care has been linked to desirable outcomes such as improved psychiatric symptoms, reduced substance use, and decreased rates of reoffending and recidivism.
- **With people experiencing homelessness** (Polcin, 2016; Smelson et al., 2016). In these populations, integrated COD treatment can help reduce substance use and mental illness symptoms while, depending on the housing service model used, also increasing housing stability and retention.

Resource Alert: Implementing Integrated Care for People With CODs

- SAMHSA's Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices KIT

(https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367)

- Case Western Reserve's Center for Evidence-Based Practices. *Integrated Dual Disorder Treatment Clinical Guide* (www.centerforebp.case.edu/client-files/pdf/iddtclinicalguide.pdf)

ACT

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

Program Model

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

ACT Treatment Activities and Interventions

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

- Outreach/engagement. To involve and sustain clients in treatment, counselors and administrators must develop multiple ways to attract, engage, and re-engage clients. Expectations for clients are often minimal to nonexistent, especially in programs serving very resistant or hard-to-reach clients.
- Practical assistance in life management. This feature incorporates case management activities that facilitate linkages with support services in the community, including employment services. Whereas the role of a counselor in the ACT approach includes standard counseling, in many instances substantial time also is spent on life management and behavioral management matters.
- Tangible support. For some clients, especially with SMI, help with logistical and everyday functional needs is critical to ensuring treatment access, engagement, participation, and retention. Supportive care can include assistance with housing, benefits/insurance, transportation, and childcare.
- Counseling. The nature of the counseling activity is matched to the client's motivation and readiness for treatment. Interventions may also involve family and other support networks as appropriate.
- Crisis assessment and intervention. This is provided during extended service hours (24 hours a day, ideally through a system of on-call rotation).

Nine Essential Features of ACT

1. Services that are provided in the community rather than in clinic offices
2. Assertive engagement with active outreach

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

Source: Bond & Drake (2015).

Key Modifications for Integrating COD Treatment

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

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

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

- Enhancing motivation (for example, through use of motivational interviewing).
- Cognitive–behavioral skills for relapse prevention.

- Mutual support programming, including peer recovery supports to strengthen recovery.
- Psychoeducational instruction about addictive disorders.

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

Populations Served

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

Resource Alert: Implementing ACT for People With CODs

- SAMHSA's ACT for Co-Occurring Disorders Evidence-Based Practices KIT
  https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4366
- Georgia Department of Behavioral Health & Developmental Disabilities Program Tool Kit for ACT
  https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/document/Georgia%20Toolkit%20for%20ACT%20Teams%20docxfinal%202015.pdf

Empirical Evidence for ACT

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

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

as usual in terms of substance use, hospitalizations, stable housing, and negative and disorganized symptoms of psychosis but was no better than integrated case management at reducing substance use and improving psychiatric symptom severity.

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

Examples of ACT Programs

The University of Washington Program for ACT

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

Resource Alert: University of Washington PACT Implementation and Engagement Tools

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

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

- Recovery assessment.
- Strengths assessment.
- Nicotine use.
- Psychiatric rehabilitation.

Mercy Maricopa ACT Program

Mercy Maricopa, an integrated physical and behavioral health Medicaid managed care plan, offers an ACT program of 23 ACT teams (including 3 forensic ACT programs) specifically focused on people with SMI. ACT Teams provides comprehensive, multidisciplinary wraparound care including psychiatric and SUD treatment, medication management, case management, social services, vocational rehabilitation, housing and vocational assistance, and peer support.

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

ICM

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

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

Program Model

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

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

Advice to Administrators: Treatment Principles From ICM

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

Treatment Activities and Interventions

Examples of ICM activities and interventions include:

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

Key Modifications of ICM for CODs

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

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

Empirical Evidence

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

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

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

Regarding CODs, ICM appears effective in specific populations (e.g., veterans, people with housing needs, individuals in the criminal justice system), although it is unclear the magnitude of effect of these programs and whether they are superior to ACT or other approaches. In military veterans, a rural-based ICM for people with and without CODs (Mohamed, 2013) helped more people with CODs engage in rehabilitation, housing, vocational, and addiction services than it did veterans without CODs. The ICM program was associated with improvements in mental disorder symptoms, distress, quality of life, treatment satisfaction, income, and days employed; however, there were no differences in any of these variables between veterans with and without CODs. Malte, Cox, and Saxon (2017) also examined veterans receiving ICM but with a focus on promoting housing stability and addiction recovery. Almost 60 percent of program participants had a comorbid depressive disorder, 43 percent PTSD, 31 percent an anxiety disorder, 21 percent a psychotic disorder, and 19 percent a bipolar disorder. Over time, participants increased their percent of days spent in their own home or in transitional housing; decreased days spent homeless or living with others; increased rates of 30-day abstinence; and improved their Addiction Severity Index (ASI) scores (legal, drug, and psychiatric composite scales). However, none of these improvements were significantly different from those observed in the control condition (a housing support group). Nevertheless, the addiction/housing ICM program was associated with more days spent in SUD treatment (almost 53 days longer than controls), greater treatment participation, and higher treatment satisfaction. Furthermore, the Northern Kentucky Female Offender Reentry Project (McDonald & Arlinghaus, 2014) examined ICM among incarcerated women with SMI, SUDs, or both (78 percent had a CODs). Compared to women who only participated in the program

while incarcerated, women who participated during imprisonment **and** after release demonstrated better outcomes in educational attainment (e.g., obtaining a General Equivalency Degree, enrolling in college after release), obtaining part-or full-time work, SUD treatment and mental health service engagement, and recidivism.

Examples of ICM Programs

SAMHSA's Cooperative Agreement to Benefit Homeless Individuals

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

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

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

Pathways to Housing, Inc.'s HF Programs

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

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

- Housing retention rate (i.e., continuously housed for 12 months or longer): 94 percent
- 72 percent of clients reduced their substance use at 6 months
- 70 percent scored at minimal or no risk for substance misuse at 6 months

- 69 percent reported at least 3 months of abstinence
- 79 percent had a reduction in self-reported trauma symptoms at 6 months
- 81 percent achieved trauma-related treatment gains in 6 months
- 100 percent of clients were successfully linked to healthcare services through peer support and nurse-led assessment and triage

Comparison of ACT and ICM

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

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

Differences Between ACT and ICM

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

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

ICM most frequently involves the coordination of services across different systems over extended periods of time, whereas ACT integrates and provides treatment for CODs within the team. As a consequence, advocacy with other providers is a major component of ICM, but advocacy in ACT focuses on ancillary services. The ACT multidisciplinary team approach to treatment emphasizes providing

integrated treatment for clients with CODs directly, assuming that the team members include both mental health and SUD treatment counselors and are fully trained in both approaches.

Recommendations for Extending ACT and ICM in SUD Treatment Settings

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

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

Vocational Services and Treatment Models

Vocational rehabilitation has long been one of the services offered to clients recovering from mental disorders and, to some degree, to those recovering from SUDs. The fact is that many individuals with CODs are not working, including 9 percent who are unemployed and 23 percent not in the labor force for other reasons (e.g., disabled, retired, in school) (Center for Behavioral Health Statistics and Quality, 2019). However, it is

unreasonable to expect employers to tolerate employees who are actively using alcohol on the job or who violate their drug-free workplace policies.

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

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

Dual Recovery Mutual Support Programs

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

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

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

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

- **Stigma and prejudice:** Stigma related to both SUDs and mental illness continues to be problematic, despite the efforts of many advocacy organizations. Unfortunately, these negative attitudes may surface within a meeting. When this occurs, people in dual recovery may find it difficult to maintain a level of trust and safety in the group setting.
- **Inappropriate or controversial advice (confused bias):** Many members of addiction recovery groups recognize the real problem of cross-addiction and are aware that people do use certain prescription medications as intoxicating drugs. Confusion about the appropriate role of psychiatric medication exists, and as a result, some members may offer well-intended, but inappropriate, advice by cautioning newcomers against using medications. Clearly, confused bias against medications may create either of two problems. First, newcomers may follow inappropriate advice and stop taking their medications, causing a recurrence of symptoms. Second, newcomers quickly may recognize confused bias against medications within a meeting, feel uncomfortable, and keep a significant aspect of their recovery a secret.

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

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

Dual Recovery Mutual Support Approaches

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

Mutual-Support Groups

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

1. **Double Trouble in Recovery (DTR).** This organization provides 12 Steps that are based on a traditional adaptation of the original 12 Steps. For example, the identified problem in step one is changed to CODs, and the population to be assisted is changed in Step 12 accordingly. The organization provides a format for meetings that are chaired by members of the fellowship.
2. **Dual Disorders Anonymous.** This organization follows a similar format to DTR. It provides a meeting format that is used by group members who chair the meetings.
3. **Dual Recovery Anonymous.** This organization provides 12 Steps adapted and expanded from the traditional 12 Steps, similar to DTR and Dual Disorders Anonymous. The terms "assets" and

"liabilities" are used instead of the traditional term "character defects." In addition, it incorporates affirmations into three of the 12 Steps. Similar to other dual recovery fellowships, this organization provides a suggested meeting format that is used by group members who chair the meetings.

4. **Dual Diagnosis Anonymous.** This organization provides a hybrid approach that uses 5 additional steps in conjunction with the traditional 12 Steps. The five steps differ from those of other dual recovery groups in underscoring the potential need for medical management, clinical interventions, and therapies. Similar to other dual recovery fellowships, this organization provides a meeting format that is used by group members who chair the meetings.

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

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

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

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

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

Resource Alert: Locating Mutual Support Groups for People With CODs

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

Access and Linkage

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

Referral to dual recovery fellowships is informal:

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

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

Common Features of Dual Recovery Mutual-Support Fellowships

Dual recovery fellowships tend to have the following in common:

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

Empirical Evidence

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

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

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

- Fellowship building (e.g., meeting others with similar problems).

- Addressing spiritual needs/topics (this may be considered a negative aspect by some clients).
- Building comradery, affiliation, and a sense of community.
- Having a "safe space" to share experiences without fear of judgment or rejection.
- Increased knowledge/insight about mental illness and SUDs (especially how they interrelate).
- Learning skills and tools that facilitate recovery.
- Feeling empowered.
- Developing a sense of hope for recovery.
- Access to therapy/therapeutic services that would otherwise be inaccessible, given lack of insurance.

Peer Recovery Support Services

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

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

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

Little research has examined the use of peer supports for CODs. Given the success of peer services in promoting recovery and wellness in people with either mental illness or addiction, it is reasonable to hypothesize that peer support could also be effective for individuals with both. O'Connell, Flanagan,

Delphin-Rittmon, & Davidson (2017) found inclusion of peer supports for people with co-occurring psychosis and substance misuse significantly improved positive (but not negative) symptoms of psychosis, number of days of alcohol use, number of days experiencing alcohol-related problems, self-rated importance of getting treatment for alcohol misuse, feelings of relatedness, social functioning, and inpatient readmissions relative to a treatment as usual condition. Evidence-based interventions for CODs, such as ACT and integrated therapies, were not originally designed to include peer support, but **more and more, peer providers are becoming a formal part of COD treatment teams** (Harrison, Cousins, Spybrook, & Curtis, 2017). Including peers in COD services might improve staff treatment fidelity, which is critical for ensuring evidence-based services produce intended outcomes (Harrison et al., 2017).

Treatment Settings

TCs

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

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

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

What Makes TCs Work?

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

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

Modified TCs for Clients With CODs

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

Treatment Activities/Interventions

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

Exhibit 7.2. TC Activities and Components

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

Source: NIDA (2015).

Key Modifications

The MTC alters the traditional TC approach in response to the client's psychiatric and addiction-related symptoms, cognitive impairments, reduced level of functioning, short attention span, and poor urge

control. A noteworthy alteration is the change from encounter group to conflict resolution group. Conflict resolution groups have the following features:

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

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

1. **Increased flexibility**
2. **Decreased intensity**
3. **Greater individualization**

More recent adaptations also can include:

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

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

Exhibit 7.3. TC Modifications for People With CODs

Structural modifications	Process modifications	Intervention modifications
There is increased flexibility in program activities.	Sanctions are fewer with greater opportunity for corrective learning experiences.	Orientation and instruction are emphasized in programming/planning.
Meetings and activities are shorter.		Individual counseling is provided more frequently to enable clients to absorb the TC experience.
There is greatly reduced intensity of interpersonal interaction.	Engagement and stabilization receive more time and effort.	Task assignments are individualized.
More explicit affirmation is given for achievements.		Breaks are offered frequently during work tasks.
Greater sensitivity is shown to individual differences.	Progression through the program is paced individually, according to the client's rate of learning.	Individual counseling and instruction are more immediately provided in work-related activities.
Greater responsiveness to the special developmental needs of the individual.		Engagement is emphasized throughout treatment.
More staff guidance is given in the implementation of activities; many	Criteria for moving to the next phase are	Activities are designed to overlap.

activities remain staff assisted for a considerable period of time.	flexible to allow lower-functioning clients to move through the program phase system.	
There is greater staff responsibility to act as role models and guides.		Activities proceed at a slower pace.
Smaller units of information are presented gradually and are fully discussed.	Live-out re-entry (continuing care) is an essential component of the treatment process.	Individual counseling is used to assist in the effective use of the community.
Greater emphasis is placed on assisting individuals.		The conflict resolution group replaces the encounter group.
Increased emphasis is placed on providing instruction, practice, and assistance.	Clients can return to earlier phases to solidify gains as necessary.	
Source: Sacks & Sacks (2011).		

Advice to Administrators: Recommended Treatment and Services From the MTC Model

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

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

Role of the Family

Many MTC clients come from highly impaired, disrupted family situations. MTC programs offer them a new reference and support group. Some clients do have available intact families or family members who are supportive. For these clients, MTC programs offer various family-centered activities like special family weekend visiting, family education and counseling sessions, and, if children are involved, classes focused on prevention. All such activities occur later in treatment to facilitate client reintegration into the family and into mainstream living.

Empirical Evidence

A series of studies has established that:

- MTCs affect a wide range of clinical and functional variables, including substance use, mental disorder symptoms, criminal behavior, employment, and housing (Sacks, McKendrick, Sacks, & Cleland, 2010). For instance, a review of TCs and MTCs (Magor-Blatch, Bhullar, Thomson, & Thorsteinsson, 2014) reported reduced substance use (including increased abstinence and reduced risk of relapse), decreased criminal behavior (including rearrests and reincarcerations), and improved psychological functioning among diverse populations, including people with CODs. However, benefits were more consistent from pre–post treatment than when comparing TCs/MTCs with control groups (e.g., no treatment, other treatment).

- Among people involved in the criminal justice system who have CODs, MTCs can effectively reduce SUD and mental illness symptoms, delay relapse, improve social functioning, reduce criminal activity, and decrease recidivism compared with traditional TCs (Magor-Blatch et al., 2014; Peters et al., 2017). MTCs also appear to reduce reincarceration better than parole supervision (Sacks, Chaple, Sacks, McKendrick, & Cleland, 2012).
- People with CODs and HIV receiving MTC continuing care had a greater decrease in SUD and mental illness symptoms at 6 months than people receiving standard continuing care (Sacks, McKendrick, Vazan, Sacks, & Cleland, 2011). Larger improvements were observed in MTC clients who had higher levels of psychosocial functioning and health at the start of treatment.
- MTCs can meet the various needs of pregnant and parenting women with SUDs—many of whom have co-occurring mental disorders, experiences with homelessness, criminal justice involvement, or a combination thereof. One such program (Bromberg, Backman, Krow, & Frankel, 2010) reduced recidivism, promoted long-term abstinence (about 90 percent of clients remained abstinent for 2 years after program completion), and facilitated drug-free births and healthy infant development.

Resource Alert: How to Implement TC/MTC Programming

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

- NIDA's *Therapeutic Communities* Research Report (https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/therapueticcomm_rrs_0723.pdf)
- The Arkansas Department of Human Services' *Therapeutic Communities Certification Manual* (https://humanservices.arkansas.gov/images/uploads/dbhs/DBHS_Therapuetic_Communities_Certification_-_FINAL_1.docx)
- Missouri Department of Corrections and Maryville Treatment Center's *Therapeutic Community Program Handbook* (www.law.umich.edu/special/policyclearinghouse/Documents/MO%20-%20Maryville%20Treatment%20Center%20Therapeutic%20Community%20Program%20Handbook.pdf)
- National Institute of Justice's *Program Profile: Modified Therapeutic Community for Offenders With Mental Illness and Chemical Abuse Disorders* (www.crimesolutions.gov/ProgramDetails.aspx?ID=90)
- University of Delaware Center for Drug and Alcohol Studies. *Therapeutic Community Treatment Methodology: Treating Chemically Dependent Criminal Offenders in Corrections* (www.cdhs.udel.edu/content-sub-site/Documents/CDHS/CTC/Treating%20Chemically%20Dependent%20Criminal%20Offenders%20in%20Corrections.pdf)

Outpatient SUD Treatment

Treatment for SUDs occurs most frequently in outpatient settings—a term that encompasses a variety of disparate programs (Cohen, Freeborn, & McManus, 2013; NIDA, 2018b; SAMHSA, 2019b). Some offer high-intensity services, like several hours of treatment each week, which can include mental health and other support services as well as individual and group counseling for substance misuse; others provide minimal services, such as only one or two brief sessions to give clients information and refer them elsewhere (NIDA, 2018b). Some agencies offer outpatient programs that provide services several hours per day and several days per week, thus meeting the LOCUS criteria for High Intensity Community Based Services.

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

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

Prevalence

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

CODs are commonly found in clients who enter SUD treatment. In 2018, 50.2 percent of individuals in SUD treatment had a COD, and 99.8 percent of SUD treatment facilities reported having clients with CODs (SAMHSA, 2019b). Despite the complexity of CODs, outpatient programs have good capacity (e.g., organization structures and policies) to meet the treatment needs of these populations, perhaps even more so than intensive outpatient programs and residential programs (Lambert-Harris, Saunders, McGovern, & Xie, 2013).

Empirical Evidence of Effectiveness

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

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

Outpatient treatment can also be leveraged as a form of continuing care, such as following discharge from hospitalization or release from jail/prison, to help clients maintain long-term recovery and wellness (Grella & Shi, 2011). Six-month outpatient ACT treatment for men with SMI and SUD (Noel, Woods, Routhier, & Drake, 2016) was effective in sustaining improvements clients experienced during the previous 6 months in residential treatment, including improvements in mental health, substance use,

housing, education, employment, family functioning, spirituality, and sleep hygiene. Outpatient mental health services focused on supporting community reintegration following release from jail were associated with 12-month declines in number of arrests and number of days in jail among people with CODs and people with mental disorders only (Alarid & Rubin, 2018).

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

Designing Outpatient Programs for Clients With CODs

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

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

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

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

Resource Alert: Outpatient SUD Treatment

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

Referral and Placement

Careful assessment will help identify those clients who require more secure inpatient treatment settings (e.g., clients who are actively suicidal or homicidal), as well as those who require 24-hour medical

monitoring, those who need detoxification, and those with serious SUDs who may require a period of abstinence or reduced use before they can engage actively in all treatment components. Information about the full screening and assessment process, which includes referral, is in Chapter 3.

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

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

Engagement and Retention

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

Improving Engagement and Adherence of Clients With CODs in Outpatient Settings

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

need for treatment. This is vital as perceived need for treatment is a common barrier to entering and staying engaged in SUD treatment.

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

Discharge Planning

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

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

It is imperative that discharge planning for clients with CODs ensures continuity of services, medication management, and support, without which client stability and recovery are severely compromised. Relapse prevention interventions after outpatient treatment need to be modified so clients can recognize symptoms of SUD or mental disorder relapse on their own, use symptom management techniques (e.g., self-monitoring, reporting to a "buddy," group monitoring), and access assessment services rapidly, as the return of psychiatric symptoms can often trigger substance use relapse.

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

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

Residential SUD Treatment

Residential treatment for SUDs comes in a variety of forms, including long-term residential treatment facilities, criminal justice-based programs, halfway houses, and short-term residential programs. The long-term residential SUD treatment facility is the primary treatment site and the focus of this section of

the TIP. Historically, residential SUD treatment facilities have provided treatment to clients with more serious and active SUDs but with less SMI. Most providers now agree that the prevalence of people with SMI entering residential SUD treatment facilities has risen.

Prevalence

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

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

Empirical Evidence of Effectiveness

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

Designing Residential Programs for Clients With CODs

To design and develop services for clients with CODs, providers and administrators can undertake a series of interrelated program activities. The specific MTC model that appeared previously in this chapter serves as a frame of reference in the following sections, but it is not a prescriptive model. Related observations are applicable to MTCs that follow this model and to the development of other residential programs specific to COD treatment.

Intake

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

1. **Written referral.** Referral information from other programs or services can include the client's psychiatric diagnosis, history, current level of mental functioning, medical status (including results of screening for tuberculosis, HIV, sexually transmitted disease, and hepatitis), and assessment of functional level. Referrals also may include a psychosocial history and a physical examination.
2. **Intake interview.** An intake interview is conducted at the program site by a counselor or clinical team. At this time, the referral material is reviewed for accuracy and completeness, and each client is interviewed to determine if the referral is appropriate in terms of the history of mental and

substance use problems. The client's residential and treatment history is reviewed to assess the adequacy of past treatment attempts. Furthermore, each client's motivation and readiness for change are assessed, and the client's willingness to accept the current placement as part of the recovery process is evaluated. Screening instruments, such as those described in Chapter 3 and located in Appendix C, can be used in conjunction with this intake interview.

3. **Program review.** Each client should receive a complete description of the program and a tour of the facility to ensure that both are acceptable. This review includes a description of the daily operation of the program in terms of groups, activities, and responsibilities; a tour of the physical site (including sleeping arrangements and communal areas); and an introduction to some of the clients who are already enrolled in the program.
4. **Team meeting.** At the end of the intake interview and program review, the team meets with the client to decide whether to proceed with admission to the program. The client's receptivity to the program is considered, and additional information (e.g., involvement with the justice system, suicide attempts) is obtained as needed. It should be noted that the decision-making process is inclusive; that is, a program accepts referrals as long as they meet the eligibility criteria, are not currently a danger to self or others, do not refuse medication, express a readiness and motivation for treatment, and accept the placement and the program as part of their recovery process.

Engagement and Retention

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

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

Discharge Planning

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

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

Given the chronic and cyclical nature of SUDs and mental disorders, continuing care following residential services (such as the provision of lower-intensity outpatient treatment postdischarge) can help optimize

client stability and functioning. Individuals with SUDs who receive continuing care often and maintain abstinence more so than clients who do not participate in continuing care (McKay, 2009).

Recommendations for Continuing Care Following Discharge from Residential Treatment

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

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

Acute Care and Other Medical Settings

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

How Common are Mental disorders and SUDs in Acute Care and Other Medical Settings?

- **More than 70 percent of primary care visits are related to psychosocial needs** (National Association of State Mental Health Program Directors, 2012).
  - In a sample of 2,000 adults in primary care clinics in four states, 36 percent met *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* criteria for an SUD in the last year, including almost 22 percent with a moderate/severe SUD (Wu et al., 2017). About 28 percent endorsed past-year illicit drug or nonmedical medication use.
  - From 2012 to 2014 (Cherry, Albert, & McCaig, 2018), 26 percent of mental health office visits in large metropolitan areas, 44 percent of visits in small-to-medium metropolitan areas, and 54 percent of visits in rural areas were to primary care.
- Of the 1.18 billion ambulatory medical visits that occurred between 2009 and 2011 (Lagisetty, Maust, Heisler, & Bohnert, 2017), **17.6 million involved an SUD diagnosis.**
  - This included 8.6 percent for AUD, 64.2 percent for tobacco use disorder, and 9.6 percent for OUD.
  - Among the people with an SUD, 13.4 percent also had anxiety, 5.7 percent had depression, and 2.3 percent had bipolar disorder.
- Data from the National Hospital Ambulatory Medical Care Survey indicate that **from 2005 to 2011, mental and substance use-related ED visits increased from 27.9 per 1,000 visits to 35.1 per 1,000 visits**, with the greatest increases observed in people ages 25 to 44 (Ayangbayi, Okunade, Karakus, & Nianogo, 2017). Odds

of visits were higher in people who were uninsured, on public health insurance, or discharged from a hospital in the previous week.

- **Individuals with CODs are more likely than people without CODs to use EDs for mental disorder and SUD-related needs** (Moulin et al., 2018), as are individuals experiencing homelessness (Lam, Arora, & Menchine, 2016).

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

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

Prevalence

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

Empirical Evidence of Effectiveness

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

Primary-care–based SUD treatment can reduce gaps in service use by offering treatment in a setting that clients prefer. More than 42,000 U.S. adults were screened for SUDs to assess willingness to enter SUD treatment based on service setting (Barry, Epstein, Fiellin, Fraenkel, & Busch, 2016). Those who screened positive but were not currently enrolled in SUD treatment were randomized to one of three hypothetical treatment setting vignettes: treatment in a specialty drug treatment center (i.e., usual care), primary care, or collaborative care in a primary care setting. About a quarter (24.6 percent) of

people with an SUD and 18 percent with AUD who were randomized to specialty care were willing to enter treatment, whereas more people randomized to the primary care setting were willing to enter treatment (37 percent with an SUD; 20 percent with AUD). Similarly, more people randomized to the primary/collaborative care setting were willing to enter treatment than people in the specialty care setting (34 percent with an SUD; almost 21 percent with AUD). Nonspecialty settings like primary care clinics may be desirable for individuals needing SUD treatment because of a perceived lack of stigma attached to medical facilities (vs., for instance, methadone clinics) and the ability of medical settings to address both SUD treatment and physical healthcare needs in one location (Barry et al., 2016).

Designing Acute Medical and Primary Care Programs for Clients With CODs

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

The Integration of Care for Mental Health, Substance Abuse and Other Behavioral Health Conditions Into Primary Care: American College of Physicians (ACP) Position Paper

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

Source: Crowley & Kirschner (2015).

This section highlights the essential features of providing treatment to clients with CODs in acute care and other medical settings.

Screening and Assessment in Acute and Other Medical Settings

Clients entering acute care or other medical facilities generally are not seeking SUD treatment. Often, providers (primary care and mental health) are not familiar with SUDs. Their lack of expertise can lead to unrealistic expectations or frustrations, which may be directed inappropriately toward the client.

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

including those that can be used in primary care settings; select instruments are also located in Appendix C.)

Although addiction screening can and should be offered in both nonurgent as well as urgent medical care settings, approaches may need to be implemented differently for each. O'Grady et al. (2019) describe use of a screening, brief intervention and referral for treatment program for people with or at risk for addiction that was implemented at EDs and primary care clinics. Compared to people screened at high risk for substance misuse in the primary care clinics, those screened as high risk in the EDs were significantly more likely to also have unstable housing, be unemployed, have self-reported "extreme" stress, have "serious" depression or anxiety, and poor current health. They also reported higher addiction screening scores and more frequent substance use than people in the primary care clinics. Prescreening in the EDs was less likely to be completed than in primary care because clients were more likely to be in acute states, actively intoxicated, or have altered mental status. Further, more than one-third of people who prescreened positive for substance misuse did not receive full screening and intervention. This finding is consistent with results from 2 longitudinal surveys of 1,500 ED physicians that found only 15 percent to 20 percent of clients were screened for substance misuse and only 19 percent to 26 percent of ED physicians reported using a formal addiction screening tool (Broderick Kaplan, Martini, & Caruso, 2015). These data are worrisome, given feedback from the American College of Emergency Physicians (2017) that ED professionals are, "positioned and qualified to mitigate the consequences of alcohol misuse through screening programs, brief intervention, and referral to treatment" and that EDs should maintain "wide availability of resources necessary to address the needs of patients with alcohol-related problems and those at-risk for them." ED staff may therefore require additional training to better recognize and respond to clients with addiction, particularly those with severe disorders. Formal procedures may also be needed to foster successful referral and implementation of brief interventions (e.g., education, harm reduction).

Interventions

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

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

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

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

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

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

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

Administrative Questions

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

Capacity/Resource Questions

- Do you have existing relationships (formal or informal) with other service providers in mental health and primary care? If not, what needs to be done to establish those relationships?

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

Financing Questions

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

Clinical Supports Questions

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

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

Resource Alert: How to Integrate Primary Care and Behavioral Health Services for People With SMI

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

Historically, providers in acute care settings have not been concerned with treating SUDs beyond detoxification, stabilization, and referral. However, as the uptake of brief interventions increases and as the healthcare field's awareness grows about the importance of detecting and treating SUDs and mental disorders, treatment options are expanding beyond just stabilization and referral. In EDs, case managers help triage "high users" (which often include people with SUDs, mental disorders, or both [Minassian, Vilke, & Wilson, 2013; Moulin et al., 2018; Smith, Stocks, & Santora, 2015]) to appropriate levels of care (e.g., admission, outpatient referral) (Turner & Stanton, 2015). Aspects of case management interventions—which are typically delivered not solely by case managers but collaboratively with other ED team members like nurses, physicians, and social workers—that can reduce ED visits, and in some cases reduce ED costs (Kumar & Klein, 2013) include:

- Educating clients about and linking them to community resources to address symptoms/problems.
- Offering referral to mental health services and SUD treatment.
- Assisting clients with transportation needs.
- Assisting clients with financial benefits/public assistance.

- Performing crisis intervention.
- Helping clients acquire stable housing.
- Working with clients to create an ED treatment plan or other individualized care plan.
- Following up with clients after discharge, including when providing referrals to specialty care.

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

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

Pharmacotherapy

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

Medication for Mental Illness

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

A person may have a history of taking different medications in the past or may report a change in his or her medications while working with a counselor. People need different medications depending on how their illness is expressing itself (e.g., which symptoms are most severe or most disabling). Medications

used to treat the first episode of a mental illness may be different from those used later in disease course. Age may affect medication selection and dosage; aging affects metabolism and the bioavailability of some drugs. Sometimes a medication becomes less effective over time and will have to be changed or another medication added. There may also be periods when no medication is used at all.

Medication Management

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

Knowing When To Refer for Medication Management

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

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

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

- Physician.
- Psychiatrist.
- Advanced practice registered nurse (especially a psychiatric/mental health specialty nurse).

Considerations for the SUD Treatment Provider

A patient who appears sedated, agitated, or intoxicated may be experiencing a medication side effect or other medical illness. Medications that work in the brain are considered "psychotropic", meaning they affect a person's mental state. Drugs of misuse are psychotropic, too. **The benefits, side effects, and drug interactions of medications for mental illness can affect clients similarly to, or look like some of the effects of, illicit substances.** This may be triggering for the client or those around him or her or lead to misuse of prescribed medication. Illicit substances and prescribed medications may interact with one another, potentially reducing the beneficial effects of the prescribed medication (Lindsey, Stewart, & Childress, 2012).

Medication for Depression

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

There are several classes of medications approved for the treatment of depression (Food and Drug Administration [FDA], 2017), including selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRI), tricyclic antidepressants (TCA), and monoamine oxidase inhibitor (MAOI). Each work in different ways but ultimately treat depression by changing the balance of chemicals (neurotransmitters) in the brain that regulate mood, such as serotonin, norepinephrine, and dopamine. Sometimes medication not specifically approved for depression, such as mood stabilizers or antipsychotics, will be added to the antidepressant to address specific symptoms (FDA, 2017).

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

Side Effects

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

Exhibit 7.6. Side Effects of Antidepressants

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

A Note About Serotonin Syndrome

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

Mild serotonin syndrome can look like opioid withdrawal. More serious serotonin syndrome can look like intoxication with a stimulant or hallucinogen or withdrawal from a benzodiazepine. Fever, dangerously high blood pressure, and seizure can lead to organ failure and death if the syndrome is not recognized and treated.

Counselors should remain vigilant for and seek medical evaluation for possible serotonin syndrome when clients with CODs present with unexpected withdrawal or intoxication symptoms.

Medication for Anxiety Disorders

Anxiety disorders are best treated with combined psychotherapy and medication (Benich, Bragg, & Freedy, 2016). Medication can help relieve distressing symptoms. Antidepressants and benzodiazepines are the most common classes of FDA-approved medication for anxiety. Antidepressants in the SSRI and SNRI classes are considered first-line therapy. Benzodiazepines should generally be used only for short periods, taken per a schedule rather than as needed (Benich et al., 2016). **Taking benzodiazepines with opioids markedly increases the risk of overdose** (NIDA, Revised March 2018).

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

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

Medication for PTSD

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

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

Medication for Bipolar Disorder

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

Mood Stabilizers

Medication to prevent severe mood fluctuations can be effective at treating mania, particularly the first-line medication lithium (Fountoulakis et al., 2017). Mood stabilizers treat and prevent mania by decreasing abnormal activity in the brain. People taking lithium need to see a physician regularly for monitoring of blood levels and kidney and thyroid functioning. Side effects that may improve with time are nausea, diarrhea, dizziness, muscle weakness, fatigue, and feeling “dazed.” Other symptoms are likely to continue, such as fine tremor, frequent urination, and thirst. Lithium can cause skin disorders

like acne, psoriasis, and rashes. Serious side effects include irregular heart rhythm and serotonin syndrome. Anesthesia and antidepressants are associated with serotonin syndrome when taken with lithium. Elevated blood levels of lithium can cause uncontrollable shaking, clumsiness, ringing in the ears, slurred speech, and blurred vision. **Salt, caffeine, alcohol, other medications, and dosing mistakes can cause lithium toxicity, which can be a medical emergency.**

Antiseizure Medication

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

Antipsychotic Medication

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

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

Medication for Schizophrenia and Other Psychotic Disorders

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

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

Side Effects

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

The typical or first-generation antipsychotics may cause rigidity and muscle spasms, tremors, and restlessness. They may also cause a condition of abnormal muscle movements called **tardive dyskinesia**, which can persist even when the medication is discontinued. Some antipsychotics cause electrocardiogram abnormalities, such as QT prolongation. **It is possible to overdose on antipsychotics, especially if they are combined with alcohol or other sedating drugs.**

Medication for Attention Deficit Hyperactivity Disorder

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

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

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

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

Medication for PDs

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

Medication for Feeding and Eating Disorders

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

Certain stimulants known to suppress appetite have shown some success with reducing symptoms of BED (Davis & Attia, 2017).

Medication for SUDs

Because SUDs are brain-based diseases, pharmacologic research has explored the development of agents that can effectively target disruptions in neurotransmitters and neuromodulators that occur as a part of addiction. These medications often help reduce withdrawal symptoms or craving, which in turn can make abstinence easier to achieve and sustain. In general, pharmacotherapy for SUDs is considered supportive rather than curative and is typically combined with psychotherapy, behavioral counseling, psychoeducation, mutual support, other recovery services, or a combination of these.

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

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

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

Medication for AUD

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

Medication for OUD

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

Resource Alert: Learning More About Pharmacotherapy and CODs

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

- SAMHSA's TIP 63, *Medications for Opioid Use Disorder* (https://store.samhsa.gov/system/files/sma18-5063fulldoc_0.pdf)
- SAMHSA's *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide* (https://store.samhsa.gov/system/files/sma15-4907.pdf)
- APA's *Practice Guideline for the Pharmacological Treatment of Patients With Alcohol Use Disorder* (https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9781615371969)
- National Library of Medicine's Drug Information Portal (https://druginfo.nlm.nih.gov/drugportal/)
- FDA's Medication Guides (www.fda.gov/drugs/drugsafety/ucm085729.htm)
- NIMH's Mental Health Medications (www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml)
- University of Washington's Commonly Prescribed Psychotropic Medications (https://aims.uw.edu/resource-library/commonly-prescribed-psychotropic-medications)

Conclusion

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

Chapter 8—Workforce and Administrative Concerns in Working With People Who Have Co-Occurring Disorders

(For Supervisors and Administrators)

Key Messages

Mental health and addiction labor force problems directly affect treatment access, quality, and cost. Without addressing gaps in personnel and training, the behavioral health field will struggle to meet the needs of the growing numbers of people living with co-occurring disorders (CODs).

Although current workforce challenges may seem daunting, substance use disorder (SUD) treatment supervisors and administrators can help confront and overcome these difficulties by creating, implementing, and sustaining professional development and training opportunities within their organizations. This in turn will help support the uptake and utilization of best practices.

Recruitment and retention priorities are urgently needed because of the challenging nature of the addiction and mental health service professions, which lead to high rates of staff burnout and turnover.

Professional education and accreditation strategies, combined with mentoring and supervision, can help increase adoption of core and advanced clinical competencies, increase providers' comfort with working with people who have CODs, reduce stigma surrounding the profession/field, and provide structured career development.

Availability, quality, and cost of SUD treatment and mental health services are intricately tied to the current state of the behavioral health workforce. Without a robust, sizeable labor force, how will people with mental disorders and addiction problems have their needs met? Without enough trainees entering the field or staff willing to stay in their jobs long term, how will addiction and mental health service organizations keep their doors open? What sort of ripple effects might an understaffed or ill-prepared workforce have on our healthcare system, economy, and society as a whole?

Rather than serve as a primer on labor difficulties in the mental health and addiction fields, this chapter provides an informative update on the current state of mental health and addictions professions. The goal is to help supervisors, administrators, and other organizational leadership understand aspects of the workforce relevant to their organization's ability to provide quality, cost effective, evidence-based services for CODs and help them feel better prepared to address workforce gaps in their own agency.

This chapter is divided into two main sections:

- The first half addresses recruitment, hiring, and retention in the behavioral health workforce. Finding, getting, and keeping the right employees is critical to ensuring the long-term sustainability, viability, and effectiveness of the field. In support of this endeavor, the chapter contains links to practical web-based resources for programs and administrators, including toolkits and manuals.
- As important to a program as acquiring and retaining employees is ensuring the competency and professional development of its staff. This is the focus of the second half of this chapter. This section includes detailed discussions about the role of training, supervision, and credentialing, all of which

are necessary components of preparing the field to deliver evidence-based care and fostering increased service provision.

Note that general guidelines aimed at supervisors and administrators serving people with CODs are in Chapter 2 and information about implementing various treatment models and settings is in Chapter 7.

This chapter discusses training needs for addiction counselors working with clients who have CODs. However, **any behavioral health service provider in any setting** (e.g., primary care, a social worker's office, SUD treatment, a psychologist's/psychiatrist's office) should have the skills and competencies to recognize CODs and provide at least a basic screening that encompasses CODs, with enough knowledge of community resources to refer for integrated COD treatment if the provider can't provide such treatment himself/herself.

Recruitment, Hiring, and Retention

As of January 2019, the Health Resources and Services Administration (HRSA) has identified approximately 5,125 mental health professional shortage areas in the United States, requiring 6,894 mental health practitioners to fill the shortage (HRSA, 2019). **The behavioral health workforce is fraught with profession gaps and similar challenges that serve as barriers to treatment access for people with mental disorders and SUDs.** For instance (Olfson, 2016; Weil, 2015):

- Formal education in psychology and psychiatry is time consuming and costly, making it harder to recruit and retain trainees.
- The number of medical trainees specializing in psychiatry is shrinking.
- Within psychiatry, types of services provided are variable (e.g., medication management only vs. psychotherapy and pharmacotherapy).
- Psychiatrists are less likely to accept Medicaid than other medical specialties, which is particularly damaging to individuals with serious mental illness (SMI), like schizophrenia, who often require public assistance. Psychologists also are unlikely to accept Medicaid given low reimbursement rates.
- Psychologists and psychiatrists tend to be disproportionately clustered in certain geographic regions, leaving shortages in rural areas (vs. more affluent urban and suburban areas) and particular regions of the United States (e.g., Midwest, Deep South).
- People with SMI are grossly underserved due in part to factors like lack of formal training opportunities in SMI and low provider comfort with working with these populations.
- Social workers and primary care providers can help fill critical workforce and service gaps left by psychiatry and psychology (particularly in treating clients with SMI), but this will require additional training in behavioral health assessment, diagnosis, and treatment and better compensation.

A focus group of mental health and SUD treatment providers identified organizational and system-related factors they believed hindered their ability to adequately care for clients with CODs (Padwa, Guerrero, Braslow, & Fenwick, 2015):

- Lack of support for COD services, such as low allocation of resources, discontinuing consultations with outside COD experts, discontinuing onsite drug testing of clients, and not implementing integrated care procedures even when already developed by staff
- Lack of COD training opportunities
- An inability to bill for CODs (e.g., certain organizations would only permit billing for mental health services and not SUD treatment)

- Lack of local addiction services, which make coordinating care, referring clients to specialty services, and linking clients to needed resources more difficult. Even when these services are present, available slots are limited and wait-times are often long.
- Large caseloads and limited time to work with clients
- Difficulty initiating and maintaining contact with outside SUD treatment providers, especially with providers in residential treatment settings
- Fragmented, nonintegrated care that results in different providers using different (and sometimes opposing) treatment approaches with the same client. This is particularly problematic when clients on pharmacotherapy attend mutual support groups or treatment programs that strongly discourage psychotropic medication.

Recruitment and Retention

The documented workforce shortage in SUD treatment and mental health services underscores the need for aggressive, effective, and even creative recruitment and hiring strategies and policies. Extended vacancies in behavioral health service positions leave programs—and the clients they serve—vulnerable to negative outcomes like further turnover, high stress, low morale, and fragmented, ineffective care.

The ability to recruit and hire quality, long-term employees first requires attracting the right candidates. Job postings and advertisements in multiple outlets, such as websites, on social media, at job fairs, in newspapers, and within the community, can increase exposure and widen the potential pool of applications. Less traditional but nonetheless effective places to advertise include churches, synagogues, and other faith-based organizations; community welfare agencies and housing offices; shopping centers; and health clinics and senior centers. Staff referral incentives encourage current employees to act as recruiters and also helps increase retention.

Exhibit 8.1. outlines steps from the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Recruitment and Retention Toolkit, designed to aid behavioral health organizations in building more effective recruitment, hiring, and retention practices. The toolkit offers a six-step approach and includes numerous resources (e.g., templates, samples, worksheets) to guide programs at each step (see "Resource Alert: Recruitment and Retention Toolkits").

Exhibit 8.1. Building an Effective Recruitment and Retention Plan for Behavioral Health Service Providers

- **Step 1. Gather organizational baseline information.** Before programs can effectively recruit and hire the right personnel, they first need to assess the landscape: What are the current retention rates for healthcare providers? What previously used recruitment and hiring strategies have proved effective and ineffective for the field? What can be learned about job satisfaction from exit interviews?
- **Step 2. Decide on a priority recruitment and retention focus (job position).** Programs should gather and analyze data to identify their most pressing hiring needs and challenges. This should result in programs selecting the most urgent priority position to fill.
- **Step 3. Analyze the selected job position.** Once a priority position is selected from Step 2, programs need to identify the benefits and challenges of the position so as to develop a clear and accurate position description.
- **Step 4. Write an accurate job description.** The position description needs to be articulate, direct, and thorough to attract the best fitting, most-qualified candidates possible.

- **Step 5. Identify the strategy and intervention.** Programs can choose from among several options the best recruitment or retention strategy that fits their needs and that they feel will be most effective at helping them overcome their specific challenges.
- **Step 6. Develop an action plan.** At this step, the strategy and intervention are implemented. In preparation, programs should develop and assign specific tasks, appoint managers to oversee the process, define outcomes for their intervention, determine steps for monitoring, communicating about, and assessing the intervention's effectiveness, and finalizing the implementation plan.

Source: SAMHSA (n.d.).

Resource Alert: Recruitment and Retention Resources for the Behavioral Health Workforce

- Addiction Technology Transfer Center (ATTC) Network's *National Workforce Report 2017: Strategies for Recruitment, Retention, and Development of the Substance Use Disorder Treatment and Recovery Services Workforce* (https://attcnetwork.org/centers/global-attc/national-workforce-study)
- Behavioral Health Education Center of Nebraska's Retention Toolkit (www.naadac.org/assets/2416/samhsa-naadac_workforce_bhecn_retention_toolkit2.pdf)
- NAADAC and SAMHSA webinar, Focus on the Addiction and Mental Health Workforce: Increasing Retention For Today and Tomorrow (www.naadac.org/assets/2416/2016-09-12_wf_retention_webinarslides.pdf)
- SAMHSA Recruitment and Retention Toolkit (http://toolkit.ahpnet.com/Home.aspx)

Reducing Staff Turnover

Behavioral health service provider turnover and burnout can strain organizational infrastructure, prevent clients from receiving much-needed services, and weaken the field as a whole. The Department of Labor's Bureau of Labor Statistics estimates a national turnover rate across all professions of around 3.7 percent (Bureau of Labor Statistics, October 9, 2019). By comparison, **turnover in the behavioral health field is quite high.** Among addiction counselors and supervisors, average annual turnover has been estimated to range between 23 percent and 33 percent (Eby, Burk, & Maher, 2010; Knight, Broome, Edwards, & Flynn, 2011; Laschober & Eby, 2013) and between approximately 17 percent and 26 percent among mental health therapists and supervisors (Beidas et al., 2016; Bukach, Ejaz, Dawson, & Gitter, 2017). In both sectors, turnover is usually voluntary—an additional cause for concern. Reasons for behavioral health service providers to leave their jobs voluntarily include burnout (driven by factors like high workload and not having a clear understanding of job roles and duties), receiving low levels of support from supervisors and coworkers, and job dissatisfaction (related to high workload and poor supervisory relationships) (Garner & Hunter, 2014; Yanchus, Periard, & Osatuke, 2017; Young, 2015). (Also see the section "Burnout.")

Turnover is destabilizing to an agency for numerous reasons (Young, 2015). Turnover often negatively affects an organization's capacity to serve clients, efficiency, profit-earning potential, operational spending, and staff morale and stress levels. The issue of staff turnover is especially important for professionals 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. It matters, too, because of the crucial importance of the treatment relationship to successful outcomes. Rapid turnover disrupts the context in which recovery occurs. Clients in such agencies may become discouraged about the possibility of being helped by others.

Turnover sometimes results from the unique professional and emotional demands of working with clients who have CODs. On the other hand, most providers in this area are very dedicated and find the

work to be rewarding. Evidence suggests that turnover may be connected to providers' feelings of preparedness to serve clients with CODs. SUD treatment providers who leave an organization but stay in the field (program turnover) are more likely to have formal education, training, and experience in SUDs than addiction counselors who leave an organization **and** withdraw from the field entirely (profession turnover) (Eby, Laschober, & Curtis, 2014). This suggests that **programmatic training and professional development could help strengthen not only the individual agency but the workforce as a whole.**

Turnover in the addiction field is linked to attitudinal and organizational predictors, including lower job satisfaction, lower job involvement, lower support from supervisors or coworkers, and poor role manageability (Garner & Hunter, 2014). These factors are largely modifiable and are important targets for monitoring and implementing programmatic changes to help providers feel satisfied, supported, and competent on the job (Yanchus et al., 2017). Exhibit 8.2 offers methods for reducing staff turnover.

Exhibit 8.2. Reducing Staff Turnover in Programs for Clients With CODs

To decrease staff turnover, whenever possible, programs should:

- Hire staff members who have familiarity with both SUDs and mental disorders and have a positive regard for clients with either disorder.
- Hire staff members who are critically minded and can think independently, but who are also willing to ask questions and listen, remain open to new ideas, maintain flexibility, work cooperatively, and engage in creative problem-solving.
- Provide staff with a framework of realistic expectations for the progress of clients with CODs.
- Establish reasonable client caseloads and scheduled time during work hours to follow-up with case management matters and paperwork.
- Provide opportunities for consultation among staff members who share the same client (including medication providers).
- Ensure that supervisory staff are supportive and knowledgeable about areas specific to clients with CODs.
- Provide and support opportunities for further education and training.
- Provide structured opportunities for staff feedback in the areas of program design and implementation.
- Solicit feedback from staff about their perceptions of the work environment, including levels of support, civility, resource needs, and relationships with supervisors.
- Conduct exit interviews with departing employees to gather perspectives on areas for improvement.
- Promote knowledge of, and advocacy for, CODs among administrative staff, including those in decision making positions (e.g., directors) and others (e.g., financial officers, billing personnel, State reporting monitors).
- Provide 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, and efforts to adjust workloads.

Avoiding Burnout

A logical approach to reducing turnover is to prevent the occurrence of burnout. Burnout has been reported in as much as 67 percent of professionals in the mental health field (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Reasons mirror those for turnover, including, but not limited to, demanding workloads and not feeling rewarded by one's work (Young 2015). Often, mental health service and SUD treatment providers are expected to manage growing and more complex caseloads. "Compassion fatigue" may occur when the pressures of work erode a counselor's spirit and outlook and begin to interfere with the counselor's personal life; see also Treatment Improvement Protocol (TIP) 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (Center for Substance

Abuse Treatment [CSAT], 2000c, p. 64). Assisting clients who have CODs is difficult and emotionally taxing; the danger of burnout is considerable. It is especially important that program administrators maintain awareness of the problem of burnout and the benefits of reducing turnover. It is vital that staff feel that program administrators are interested in their well-being in order to sustain morale and esprit de corps.

To lessen counselor burnout when working with a demanding caseload that includes clients with CODs, behavioral health organizations should (Atkinson, Rodman, Thuras, Shiroma, & Lime, 2017; Oser, Biebel, Pullen, & Harp, 2013; Morse et al., 2012):

- Create a collegial environment for staff, particularly by encouraging support between coworkers.
- Increase the amount of supervision given to staff, not only for skill building but because supervision can serve as another outlet for emotional support and encouragement much needed by providers.
- Advocate for and help staff cultivate self-care and self-compassion. For instance, provide staff with cognitive–behavioral interventions to improve their coping skills, foster positive attitudes, and increase relaxation, and promote mindfulness.
- Decrease workloads, increase provider autonomy, and clarify roles and expectations.

Resource Alert: Dealing With Stress in Behavioral Health Service Settings

SAMHSA's Recruitment and Retention Toolkit chapter, Dealing With Stress in the Workplace: Frustration, Stress, and Compassion Fatigue/Burnout http://toolkit.ahpnet.com/Dealing-with-Stress-in-the-Workplace.aspx

Competency and Professional Development

This section focuses on some key areas programs face in developing a workforce able to meet the needs of clients with CODs. These include:

- The attitudes and values providers must have to work successfully with these clients.
- Essential competencies for providers (basic, intermediate, and advanced).
- Opportunities for continuing professional development as well as professional licensure.

Areas of weakness exist in many COD programs' services, staff training/supervision, and staff competencies (Petrakis, Robinson, Myers, Kroes, & O'Connor, 2018). Of 256 U.S. addiction treatment and mental health service programs surveyed (McGovern et al., 2014), only 18 percent of SUD programs and 9 percent of mental disorder programs were COD "capable." In a survey of 30 publicly funded COD programs (Padwa et al., 2013):

- About 43 percent met or exceeded criteria for COD "capable" programming.
- About half had mission statements, organizational certification and licensure, service coordination, and financial incentives focused on treating either mental illness or SUDs but not both.
- 24 of 30 programs could only bill for mental health services or SUD treatment but not both.
- 18 programs routinely used clinical interview assessment techniques adapted to CODs, but only 6 of those programs had formal standardized screening tools for CODs. Only 5 programs had formal procedures in place to conduct comprehensive assessments of clients who screen positive for CODs.
- Most programs lacked stagewise treatments specifically for CODs, including a lack of psychoeducation about and recovery support for both mental disorders and SUDs.
- 18 programs had onsite prescribers.

- 23 programs used supervision and consultation to address mental conditions and substance use. However, most programs did not have licensed or otherwise competently trained staff to provide COD services other than pharmacotherapy management.
- Over 80 percent of the sites offered direct staff training in basic competencies (e.g., prevalence, signs and symptoms, assessment procedures), but only about 57 percent of programs had staff with at least some advanced competency training in treating CODs.

The consensus panel underscores the importance of an investment in creating a supportive environment for staff that encourages professional development to include skill acquisition, values clarification, training, and competency attainment equal to an investment in new COD program development. An organizational commitment to both is necessary for successful implementation of programs. Examples of staff support may include standards of practice related to consistent high-quality supervision, favorable tuition reimbursement and release time policies, helpful personnel policies related to bolstering staff wellness practices, and incentives or rewards for work-related achievement, etc. Together these elements help in the creation of needed infrastructure for quality of service.

In support of all behavioral health service providers embodying "no wrong door" policy for service readiness, **the consensus panel strongly suggests all administrators consider providing COD training as part of their workforce development for staff, even if their program is not a specialty COD program.**

Attitudes and Values

Attitudes and values guide the way providers meet client needs and affect the overall treatment climate. They not only determine how the client is viewed by the provider (thereby generating assumptions that could either facilitate or deter achievement of the highest standard of care), but also profoundly influence how the client feels as he or she experiences a program. Attitudes and values are particularly important in working with clients who have CODs because the counselor is confronted with two disorders that require complex interventions.

Attitudes and values are important targets of professional development and traineeship. Some research indicates that behavioral health service providers and trainees have more negative attitudes toward people with SMI and with SUDs–either separately or in combination–than they do toward people with medical or other mental disorders, and that attitudes toward individuals with comorbid SUDs and psychotic disorders in particular are among the most negative and worsen over time (Avery et al., 2016; Avery et al., 2017; Avery & Zerbo, 2015; Mundon, Anderson, & Najavits, 2015). Education-focused training and increased exposure to SMI, SUD, and COD populations could potentially help increase provider comfort, competency, and confidence while diluting personal biases that directly affect clinical care.

The essential attitudes and values for working with clients who have CODs shown in Exhibit 8.3 are adapted from Technical Assistance Publication 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (CSAT, 2006a). The consensus panel believes these attitudes and values also are consistent with the attitudes and values of the vast majority of those who commit themselves to the challenging fields of SUD treatment and mental health services.

Exhibit 8.3. Essential Attitudes and Values for Providers Serving Clients With CODs

- Desire and willingness to work with people who have CODs Desire and willingness to work with people who have CODs
- Appreciation of the complexity of CODs
- Openness to new information
- Awareness of personal reactions and feelings
- Recognition of the limitations of one's own personal knowledge and expertise
- Recognition of the value of client input into treatment goals and receptivity to client feedback
- Patience, perseverance, and therapeutic optimism
- Ability to use diverse theories, concepts, models, and methods
- Flexibility of approach
- Cultural competence
- Belief that all people have strengths and are capable of growth and development (added by consensus panel)
- Recognition of the rights of clients with CODs, including the right and need to understand assessment results and the treatment plan

How to Improve Providers' Attitudes Toward Clients With CODs

Several strategies can help reduce stigma and negative attitudes and opinions among behavioral health service providers about people with CODs. These include (Avery et al., 2016):

- Increasing didactic and clinical exposure to clients with these disorders to improve provider knowledge and experience.
- Providing education about commonly held negative attitudes and misperceptions about CODs, and encouraging trainees to reflect on and discuss their own experiences and beliefs (e.g., via journaling, writing reflection papers).
- Offering supervision and mentorship by senior providers trained in addiction medicine.

Provider Competencies

Provider competencies are the specific and measurable skills provider must possess. Several States, university programs, and expert committees have defined the key competencies for working with clients who have CODs. Typically, these competencies are developed by training mental health and SUD treatment counselors together, often using a case-based approach that allows trainees to experience the insights each field affords the other.

One challenge of training is to include culturally sensitive methods and materials that reflect consideration for the varying levels of expertise and background of participants. The consensus panel recommends viewing competencies as basic, intermediate, and advanced to foster continuing professional development of all counselors and clinicians in the field of CODs. Clearly, the sample competencies listed within each category cannot be completely separated from each other (e.g., competencies in the "basic" category may require some competency in the "intermediate" category). Some of the categorizations may be debatable, but the grouping within each category reflects, on the whole, different levels of provider competency.

Providers in the field face unusual challenges and often provide effective treatment while working within their established frameworks. In fact, research studies previously cited have established the effectiveness of SUD treatment approaches in working with people who have low-to moderate-severity mental disorders. Still, the classification of competencies supports continued professional development and promotes training opportunities.

Basic, intermediate, and advanced competencies are discussed further in the following sections. See also "Resource Alert: Oregon Health Authority's Competency Checklists for COD Providers" and Technical Assistance Publication (TAP) 21, *Addiction Counseling Competencies* (CSAT, 2006a) for more examples of provider skills within these competency categories.

Resource Alert: Oregon Health Authority's Competency Checklists for COD Providers

The Oregon Health Authority maintains a resource webpage (www.oregon.gov/oha/HSD/AMH/Pages/Co-occurring.aspx) that includes checklists for ensuring behavioral health service providers working with clients who have CODs meet basic, intermediate, and advanced competencies:

- Basic Competencies (www.oregon.gov/oha/HSD/AMH/CoOccurring%20Resources/Basic%20Compentencies%20Checklist.pdf)
- Intermediate Competencies (www.oregon.gov/oha/HSD/AMH/CoOccurring%20Resources/Intermediate%20Compentencies%20CheckList.pdf)
- Advanced Competencies (www.oregon.gov/oha/HSD/AMH/CoOccurring%20Resources/Advanced%20Competencies%20Checklist.pdf)

Basic Competencies

Every SUD treatment and mental health service program should require counselors to have certain basic skills. Basic COD competencies include having a perfunctory understanding and working knowledge of the prevalence of CODs, screening and assessment procedures, common signs and symptoms, how to triage clients appropriately (e.g., referring for specialty care, engaging in treatment), how to provide brief interventions, and how to engage clients in treatment decision making (SAMHSA, 2011b). In keeping with the principle that there is "no wrong door," the consensus panel recommends that clinicians working in SUD treatment settings should be able to carry out the mental-health–related activities shown in Exhibit 8.4.

Exhibit 8.4. Examples of Basic Competencies Needed To Treat People With CODs

- Perform a basic screening to determine whether CODs might exist and be able to refer the client for a formal diagnostic assessment by someone trained to do this.
- Form a preliminary impression of the nature of the disorder a client may have, which can be verified by someone formally trained and licensed in mental disorder diagnosis.
- Conduct a preliminary screening of whether a client poses an immediate danger to self or others and coordinate any subsequent assessment with appropriate staff and consultants.
- Be able to engage the client in such a way as to enhance and facilitate future interaction.
- De-escalate the emotional state of a client who is agitated, anxious, angry, or in another vulnerable emotional state.
- Manage a crisis involving a client with CODs, including a threat of suicide or harm to others. This may involve seeking out assistance by others trained to handle certain aspects of such crises; for example, processing commitment papers and related matters.
- Refer a client to the appropriate mental health service or SUD treatment facility and follow up to ensure the client receives needed care.
- Coordinate 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

Intermediate competencies encompass skills in engaging SUD treatment clients with CODs, screening, obtaining and using mental health assessment data, treatment planning, discharge planning, mental health system linkage, supporting medication, running basic mental disorder education groups, and implementing routine and emergent mental disorder referral procedures. In a mental health unit, mental health providers would exhibit similar competencies related to SUDs. The consensus panel recommends the intermediate level competencies shown in Exhibit 8.5, developed jointly by the New York State Office of Mental Health and the New York State Office of Alcohol and Substance Abuse Services.

Exhibit 8.5. Six Intermediate Competencies for Treating People With CODs

- Competency I: Integrated Diagnosis of Substance Abuse and Mental Disorders. Differential diagnosis, terminology (definitions), pharmacology, laboratory tests and physical examination, withdrawal symptoms, cultural factors, effects of trauma on symptoms, staff self-awareness
- Competency II: Integrated Assessment of Treatment Needs. Severity assessment, lethality/risk, assessment of motivation/readiness for treatment, appropriateness/treatment selection
- Competency III: Integrated Treatment Planning. Goal-setting/problem solving, treatment planning, documentation, confidentiality, legal/reporting standards, documenting clinical concerns for managed care providers
- Competency IV: Engagement and Education. Staff self-awareness, engagement, motivating, educating
- Competency V: Early Integrated Treatment Methods. Emergency/crisis intervention, knowledge and access to treatment services, when and how to refer or communicate
- Competency VI: Longer Term Integrated Treatment Methods. Group treatment, relapse prevention, case management, pharmacotherapy, alternatives/risk education, ethics, confidentiality,[3] mental health, reporting requirements, family interventions

Advanced Competencies

At the advanced level, the practitioner goes beyond an awareness of the addiction and mental health fields as individual disciplines to a more sophisticated appreciation for how CODs interact. This enhanced awareness leads to an improved ability to provide appropriate integrated treatment. At a minimum, advanced competencies in CODs should include possessing an indepth knowledge of specific therapies and treatment interventions, assessment and diagnosis procedures, and basic knowledge of pharmacotherapies (SAMHSA, 2011b). Exhibit 8.6 gives examples of advanced skills.

Exhibit 8.6. Examples of Advanced Competencies for Treatment of People With CODs

- Understand the transtheoretical model and how client motivation and readiness to change affect behavior.
- Learn to enhance motivation via motivational interviewing and motivational enhancement therapy skills.
- Be aware of the relapse prevention model and integrating relapse prevention skills into treatments.
- Use criteria from *Diagnostic and Statistical Manual of Mental Disorders*, *Fifth Edition* (American Psychiatric Association [APA], 2013) to assess substance-related and other mental disorders.
- Understand the effects of level of functioning and degree of disability related to both substance-related and mental disorders, separately and combined.

[3] Confidentiality is governed by the federal "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations (42 C.F.R. Part 2) and the federal "Standards for Privacy of Individually Identifiable Health Information" (45 C.F.R. Parts 160 and 164).

- Apply knowledge of psychotropic medications, their actions, medical risks, side effects, and possible interactions with other substances.
- Use integrated models of assessment, intervention, and recovery for people having both substance-related and mental disorders, as opposed to sequential treatment efforts that resist integration.
- Collaboratively develop and implement 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, stage of change, and level of engagement.
- Involve 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 current treatment plan.
- Help clients expand their social networks and systems of support.

Supervision

Relational skills are requisite for staff working in COD programs (Petrakis et al., 2018), skills that are best learned through clinical supervision. A lack of high-quality supervision can hinder the ability of individual providers and programs as a whole to provide effective, evidence-based treatments for clients with COD (Petrakis et al., 2018; Sacks et al., 2013). To feel capable and confident in delivering appropriate treatments, providers need regular, ongoing, structured supervision that not only addresses specific aspects of individual caseloads but broad didactics about COD populations as a whole. Active listening, interviewing techniques, the ability to summarize, and the capacity to provide feedback are all skills that can be best modeled by a supervisor. Strong, active supervision of ongoing cases is a key element in assisting staff to develop, maintain, and enhance relational skills. (See also "Resource Alert: Competencies and Training for SUD treatment Supervisors.") **Leadership efforts among supervisors, administrators, management, and senior staff help improve the uptake and provision of evidence-based COD services by providers and COD processes by organizations, leading to better outcomes for clients.** Such efforts include actively championing and encouraging COD-specific clinical training and supervision practices and securing resources to support integrated care (Guerrero, Padwa, Lengnick-Hall, Kong, & Perrigo, 2015).

To achieve COD capability, SAMHSA (2011b) recommends that programs ideally offer supervision that:

- Is provided by professionals with licensure/certification in the addiction field, such as licensed/certified addiction counselors, clinical psychologists, psychiatrists, clinical social workers, psychological counselors, marriage and family therapists, and specialty practice nurse practitioners (psychiatric and mental health nurses).
- Is provided formally and routinely, preferably onsite. Otherwise, supervision should at least be available as needed and offered on a semistructured basis.
- Includes a focus on assessment and treatment skill development and, at the very least, should cover topics of case disposition and crisis management.
- Is performed individually, in groups, or both.
- Uses multiple methods of oversight, such as reviewing provider–supervisor rating forms, reviewing audio/video recordings of client sessions, direct observation, or a combination thereof.

Resource Alert: Competencies and Training for SUD Treatment Supervisors

- Family Health International 360's *Training Curriculum on Drug Addiction Counseling Trainer Manual.* Chapter 9: Clinical Supervision and Support

(www.fhi360.org/sites/default/files/media/documents/Training%20Curriculum%20on%20Drug%20Addiction%20Counseling%20-%20Chapter%209.pdf)

- SAMHSA's TAP 21-A: *Competencies for Substance Abuse Treatment Clinical Supervisors* (https://store.samhsa.gov/system/files/sma12-4243.pdf)
- SAMHSA's Recruitment and Retention Toolkit chapter on Supervision Intervention Strategies (http://toolkit.ahpnet.com/Supervision-Intervention-Strategies.aspx)

Continuing Professional Development

The consensus panel is aware that many providers in the SUD treatment and mental health services fields have performed effectively the difficult task of providing services for clients with CODs, until recently without much guidance from an existing body of knowledge or available systematic approaches. The landscape has changed, and a solid knowledge base is now available to the counselor. However, that knowledge typically is scattered through many journals and reports. This TIP makes an effort to integrate the available information. Counselors reading this TIP can review their own knowledge and determine what they need to continue their professional development.

Counselors should check with their states' certification bodies to determine whether training leading to formal credentials in counseling people with CODs is available (also see the Section "COD/Addiction Certification in Health Disciplines" for links to websites that offer such information). Appendix B also lists some resources counselors can use to enhance their professional knowledge and development.

Education and Training

Although many COD programming staff do possess basic skills, advanced provider skills and specialized training in CODs are frequently lacking (Padwa et al., 2013; Petrakis et al., 2018; Sacks et al., 2013). Training (along with supervision) in mental health service and SUD treatment can be effective in improving providers' competence and treatment fidelity, which in turn have been associated with reductions in the severity of clients' mental illness symptom and substance use (Meier et al., 2015). Inadequate staff training is a barrier to people with CODs receiving needed treatment (Padwa et al., 2015). Rather than focusing on staff performance, like managing large caseloads and increasing billable hours, providers may benefit more from COD-specific training to enhance their didactic knowledge of and comfort treating clients who have co-occurring SUDs (Padwa et al., 2015).

Staff in integrated primary care and behavioral health service settings report desiring more education, training, and support related to SUD treatment services (Zubkoff, Shiner, & Watts, 2016), including:

- Hiring more staff, especially professionals with previous knowledge and experience in SUDs.
- Additional tangible resources (e.g., more therapy rooms).
- More guidance in providing brief addiction interventions, such as motivational interviewing.
- Training on how to address clients with complex substance-related needs.
- Education about the availability of different SUD treatment options.
- Quick and easy access to as-needed consultations (e.g., phone-based consultations with peers with experience in treating SUDs).

The scope of practice that addiction counselors must follow legally and under which they can be reimbursed vary from state to state (University of Michigan Behavioral Health Workforce Research Center, 2018). In some states, practice privileges are broad, and in others they are quite restrictive. For instance, certain states mandate that addiction counselors can only conduct assessments and provide treatments for SUDs, limiting their ability to serve clients with CODs. Certification requirements and authorized services also are inconsistent.

The lack of standardized training, credentialing, and practices makes it difficult for the behavioral health field as a whole to effectively respond to gaps in COD treatment access and provision.

Discipline-Specific Education

Staff education and training are fundamental to all SUD treatment programs. Although there have been improvements in the past decade, there are still very few university-based programs that offer a formal curriculum on CODs. Many professional organizations are promoting the development of competencies and practice standards for intervening with substance use problems, including the APA, American Psychological Association; the American Society of Addiction Medicine (ASAM); the National Association of Social Workers (NASW); and the American Counseling Association. They are also specifically encouraging faculty members to enhance their knowledge in this area so they can better prepare their students to meet the needs of clients with CODs. The consensus panel encourages all such organizations to identify standards and competencies for their membership related to CODs and to encourage the development of training for specific disciplines.

Because the consequences of both addiction and mental disorders can present with physical or psychiatric manifestations, it is equally important for medical students, internal medicine and general practice residents, and general psychiatry residents to be educated in the problems of CODs. Too few hours of medical education are devoted to the problems of addiction and mental disorders. Medication can play a critical role in the treatment of CODs, so it is important to have adequately trained physicians who can manage medication therapies for clients with CODs.

Meeting the Growing Demand for Addiction Counselors in the Future: Faring Well or Falling Short?

HRSA (2018) projects the number of addiction counselors will increase by 6 percent from 2016 to 2030. However, during that same time period, they calculate a 21 percent increase in the demand for addiction counselors, leaving a deficit of 13,600 full-time addiction counselor positions in the labor force. When calculating the supply and demand while also accounting for the millions of Americans who will have unmet behavioral health service needs, demand will exceed supply by 38 percent. Under this scenario, there would be a deficit of nearly 35,000 addiction counselors.

Continuing Education and Training

Many SUD treatment counselors learn through continuing education and facility-sponsored training. Continuing education and training involves participation in a variety of courses and workshops from basic to advanced level offered by a number of training entities. The strength of continuing education and training courses and workshops is that they provide the counselor with the opportunity to review and process written material with a qualified instructor and other practitioners.

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, designed for adult students, and must include examples and role models. It is optimal if the instructors have extensive experience as practitioners in the field.

Continuing education is 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.

Recent survey data (SAMHSA, 2018e) involving approximately 13,600 SUD treatment facilities nationwide about their quality assurance practices and found almost 98 percent included continuing education among their standard operating procedures. Nearly all facilities (almost 94 percent) regularly conducted case reviews between providers and supervisors. About 92 percent conducted client satisfaction surveys.

Cross-Training

Cross-training is the simultaneous provision of material and training to more than one discipline at a time (e.g., addiction and social work counselors; addiction counselors and corrections officers). Counselors who have primary expertise in either addiction or mental health will be able to work far more effectively with clients who have CODs if they have some degree of cross-training in the other field. The consensus panel recommends 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. Cross-trained individuals who know their primary field of training well, and also have an appreciation for the other field, provide a richness of capacity that cannot be attained using any combination of personnel familiar with one system alone.

When training is offered in this manner, interaction and communication between the counselors from each discipline is facilitated. This helps to remove barriers, increase understanding, and promote integrated work. Cross-training is particularly valuable for staff members who will work together in the same program. Consensus panel members have found cross-training very valuable in mental health services, SUD treatment, and criminal justice work.

National Training Resources

Curricula and other educational materials are available through ATTCs, universities, state entities, and private consultants. These materials can help enhance the ability of SUD treatment counselors to work with clients who have mental disorders, as well as to enable mental health personnel to improve their efforts with people who have SUDs. ATTCs offer workshops, courses, and online remote location courses. (See Appendix B for training sources.)

COD/Addiction Certification in Health Disciplines

The disciplines of medicine and psychology have recognized subspecialties in CODs with a defined process for achieving a certificate in this area. Exhibit 8.7 summarizes current information on certification by discipline. Drug and alcohol certification requirements vary by state (review at https://addictionstraininginstitute.com/certifications-in-florida/) as do addiction counselor requirements (www.addiction-counselors.com/).

Exhibit 8.7. Certification for Health Professions

Profession	Certification in SUDs or CODs
Physicians	Physicians from any specialty, including primary care, psychiatry, and internal medicine can become certified by the ASAM. Psychiatrists can receive added qualifications in Addiction Psychiatry through the formal American College of Graduate Medical Education Board

	Certification process or through the American Academy of Addiction Psychiatry (AAAP). Osteopathic physicians from any specialty can receive addiction qualifications through the American Osteopathic Association: • ASAM Addiction Medicine Certification (www.asam.org/education/certification-MOC) • AAAP (www.aaap.org/clinicians/) • American Osteopathic Academy of Addiction Medicine (https://aoaam.org/PCSS-waiver-eligibility-training) • American Board of Preventive Medicine Addiction Medicine Certification (www.theabpm.org/become-certified/subspecialties/addiction-medicine/)
Nurses	Registered nurses can gain licensure in addiction medicine through a partnership between the Addictions Nursing Certification Board and the Center for Nursing Education and Testing, Inc. • Certified Addictions Registered Nurse (www.cnetnurse.com/certified-addictions-registered-nurse/) • Certified Addictions Registered Nurse-Advanced Practice (www.cnetnurse.com/certified-addictions-registered-nurse-%20%20advanced-practice/)
Psychologists	• The Society of Addiction Psychology (Division 50 of the American Psychological Association) offers credentialing in addiction psychology (https://addictionpsychology.org/education-training/certification). • Psychologists can also obtain Master Addiction Counselor With Co-Occurring Disorders Component credentials from NAADAC (www.naadac.org/mac).
Social Workers	NASW offers a Certified Clinical Alcohol, Tobacco & Other Drugs Social Worker credential (www.socialworkers.org/Careers/Credentials-Certifications/Apply-for-NASW-Social-Work-Credentials/Certified-Clinical-Alcohol-Tobacco-Other-Drugs-Social-Worker).
Counselors	NAADAC offers several certifications in addiction and COD specialties: • National Certified Addiction Counselor, Level I (www.naadac.org/ncac-i) • National Certified Addiction Counselor, Level II (www.naadac.org/ncac-ii) • Master Addiction Counselor With Co-Occurring Disorders Component (www.naadac.org/mac) The International Certification & Reciprocity Consortium also offers counselor certifications in CODs: Advanced Alcohol and Drug Counselor (certification for CODs) (https://internationalcredentialing.org/creds/aadc)
Other	• Adler Graduate School offers in-person and online training leading to a Certificate in Co-Occurring Disorders and Addiction Counseling; providers may need to meet additional state-specific licensure requirements (http://alfredadler.edu/programs/certificate/certificate-in-COD). • Breining Institute offers credentialing as a Certified Co-Occurring Disorders Specialist (www.breining.edu/index.php/professional-certification/certified-co-occurring-disorders-specialist-ccds/).

Conclusion

The consensus panel strongly encourages counselors to acquire competencies specific to working effectively with clients who have CODs. Juggling a high, demanding workload with continuing professional development is difficult. The panel urges agency and program administrators, including line-level and clinical supervisors, to develop COD competencies themselves and to support and encourage continuing workforce education and training. To the extent possible, they should customize education and training efforts—in content, schedule, and location—to meet the needs of counselors in the field. That is, bring the training to the counselor. Rewards can include salary and advancement tied to counselors' efforts to increase effectiveness in serving clients with CODs, shown via job performance. Clinicians in primary care settings, community mental health centers, or private mental health offices also should enhance their knowledge of alcohol and drug use in clients with mental difficulties.

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