

Substance Use Disorder Treatment for People With Co-Occurring Disorders

UPDATED 2020

TREATMENT IMPROVEMENT PROTOCOL

TIP 42

SAMHSA

Substance Abuse and Mental Health
Services Administration

This page intentionally left blank.

Please share your thoughts about this publication by completing a brief online survey at:

www.surveymonkey.com/r/KAPPFS

The survey takes about 7 minutes to complete and is anonymous.

Your feedback will help SAMHSA develop future products.

This page intentionally left blank.

Contents

Foreword	vii
Executive Summary	ix
Overall Key Messages	ix
Content Overview	x
Consensus Panel	xvii
TIP Development Participants	xvii
KAP Expert Panel and Federal Government Participants	xviii
Publication Information	xxvii
Chapter 1—Introduction to Substance Use Disorder Treatment for People With Co-Occurring Disorders	1
Scope of This TIP	2
Terminology in This TIP	3
Important Developments That Led to This TIP Update	6
Why Do We Need a TIP on CODs?	7
The Complex, Unstable, and Bidirectional Nature of CODs	11
Conclusion	12
Chapter 2— Guiding Principles for Working With People Who Have Co-Occurring Disorders	13
General Guiding Principles	14
Guidelines for Counselors and Other Providers	16
Guidelines for Administrators and Supervisors	21
Conclusion	29
Chapter 3—Screening and Assessment of Co-Occurring Disorders	31
Screening and Basic Assessment for CODs	32
The Complete Screening and Assessment Process	36
Considerations in Treatment Matching	65
Conclusion	68
Chapter 4—Mental and Substance-Related Disorders: Diagnostic and Cross-Cutting Topics	69
Depressive Disorders	71
Bipolar I Disorder	76
Posttraumatic Stress Disorder	83
Personality Disorders	89
Anxiety Disorders	98
Schizophrenia and Other Psychotic Disorders	104
Attention Deficit Hyperactivity Disorder	110



Feeding and Eating Disorders	114
Substance-Related Disorders	121
Cross-Cutting Topics: Suicide and Trauma.	129
Conclusion.	140
Chapter 5—Strategies for Working With People Who Have Co-Occurring Disorders.	141
Competencies for Working With Clients Who Have CODs	142
Guidelines for a Successful Therapeutic Relationship	142
Protect Confidentiality.	148
Guidance for Working With Clients Who Have Specific Co-Occurring Mental Disorders	160
Conclusion.	163
Chapter 6—Co-Occurring Disorders Among Special Populations	165
People Experiencing Homelessness.	166
People Involved in the Criminal Justice System	170
Women	172
People of Diverse Racial/Ethnic Backgrounds.	179
Conclusion.	182
Chapter 7—Treatment Models and Settings for People With Co-Occurring Disorders	183
Treatment Overview.	184
Treatment Models	188
Empirical Evidence for ACT	192
Treatment Settings.	203
Pharmacotherapy	220
Chapter 8—Workforce and Administrative Concerns in Working With People Who Have Co-Occurring Disorders	229
Recruitment, Hiring, and Retention	230
Avoiding Burnout.	233
Competency and Professional Development	234
Conclusion.	243
Appendix A—Bibliography.	245
Appendix B—Resources	285
Training for Providers and Administrators	285
Other Resources for Counselors, Providers, and Programs	287
Client and Family Resources.	293

Appendix C—Provider Forms, Measures, and Tools	297
Biopsychosocial Intake Forms	297
Suicide and Safety Screening and Assessment Tools	297
Mental Disorder Screening and Assessment Tools	297
Substance Use/Misuse Screening and Assessment Tools	297
Trauma Screening and Assessment Tools	299
Levels of Care Tool	299
Functioning and Disability Tools	310
Stage of Change Tools	310
Additional Screening Tools for Common Mental Disorders	313

Exhibits

Exhibit 1.1. Key Terms	3
EXHIBIT 1.2. Co-Occurring Substance Misuse in Adults Ages 18 and Older With and Without any Mental Illness and SMI (in 2018)	7
Exhibit 2.1. Six Guiding Principles in Treating Clients With CODs	16
Exhibit 2.2. Making “No Wrong Door” a Reality	19
Exhibit 2.3. The Four Quadrants Model	20
Exhibit 2.4. SAMHSA Practice Principles of Integrated Treatment for CODs	21
Exhibit 2.5. Levels of Program Capacity in CODs	31
Exhibit 3.1. Assessment Considerations for Clients With CODs	39
Exhibit 3.2. Biopsychosocial Sources of Information in the Assessment of CODs	40
Exhibit 3.3. Recommended Screening Tools To Help Detect CODs	44
Exhibit 3.4. The Suicide Behaviors Questionnaire-Revised (SBQ-R) - Overview	46
Exhibit 3.5. SBQ-R-Scoring	46
Exhibit 3.6. SBQ-R Suicide Behaviors Questionnaire - Revised	47
Exhibit 3.7. Mental HSF-III	52
Exhibit 3.8. Level of Care Quadrants	57
Exhibit 3.9. Sample Treatment Plan for Case Example George T.	68
Exhibit 3.10. Considerations in Treatment Matching	68
Exhibit 4.1. Diagnostic Criteria for MDD	74
Exhibit 4.2. Diagnostic Criteria for PDD	76
Exhibit 4.3. Diagnostic Criteria for Bipolar I Disorder	80
Exhibit 4.4. Diagnostic Criteria for PTSD	86
Exhibit 4.5 Diagnostic Criteria for General PD	92
Exhibit 4.6 Diagnostic Criteria for BPD	95

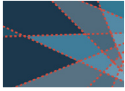


Exhibit 4.7. Diagnostic Criteria for ASPD	99
Exhibit 4.8. Diagnostic Criteria for GAD	101
Exhibit 4.9. Diagnostic Criteria for Panic disorder	102
Exhibit 4.10. Diagnostic Criteria for SAD	103
Exhibit 4.11. Diagnostic Criteria for Schizophrenia	108
Exhibit 4.12. Diagnostic Criteria for ADHD	113
Exhibit 4.13. Diagnostic Criteria for AN	117
Exhibit 4.14. Diagnostic Criteria for BN	118
Exhibit 4.15. Diagnostic Criteria for BED	119
Exhibit 4.16. Substances and Corresponding Substance-Induced Mental Disorders	124
Exhibit 4.17. Substance-Induced Mental Disorder Symptoms (by Substance)	125
Exhibit 4.18. Features of DSM-5 Substance-Induced Mental Disorders	127
Exhibit 4.19. Substances That Precipitate or Mimic Common Mental Disorders	128
Exhibit 4.20. Veterans and CODs	141
Exhibit 6.1. Adapting Treatment Services to Women's Needs	177
Exhibit 7.1. The Four Quadrants of Care	187
Exhibit 7.2. TC Activities and Components	207
Exhibit 7.3. TC Modifications for People With CODs	208
Exhibit 7.4. Traditional Mental Health Settings Versus Integrated Mental Health–Primary Care Settings	220
Exhibit 7.5. Redesigning Addiction Services for Integration With Primary Care: Questions for Addiction Providers and Administrators To Consider	221
Exhibit 7.6. Side Effects of Antidepressants	224
Exhibit 8.1. Building an Effective Recruitment and Retention Plan for Behavioral Health Service Providers	233
Exhibit 8.2. Reducing Staff Turnover in Programs for Clients With CODs	235
Exhibit 8.3. Essential Attitudes and Values for Providers Serving Clients With CODs	237
Exhibit 8.4. Examples of Basic Competencies Needed To Treat People With CODs	239
Exhibit 8.5. Six Intermediate Competencies for Treating People With CODs	240
Exhibit 8.6. Examples of Advanced Competencies for Treatment of People With CODs ..	240
Exhibit 8.7. Certification for Health Professions	244

Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the U.S. Department of Health and Human Services agency that leads public health efforts to reduce the impact of substance abuse and mental illness on America's communities. An important component of SAMHSA's work is focused on dissemination of evidence-based practices, and providing training and technical assistance to healthcare practitioners on implementation of these best practices.

The Treatment Improvement Protocol (TIP) series contributes to SAMHSA's mission by providing science-based, best-practice guidance to the behavioral health field. TIPs reflect careful consideration of all relevant clinical and health service research, demonstrated experience, and implementation requirements. Select nonfederal clinical researchers, service providers, program administrators, and patient advocates comprising each TIP's consensus panel discuss these factors, offering input on the TIP's specific topics in their areas of expertise to reach consensus on best practices. Field reviewers then assess draft content and the TIP is finalized.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of care and treatment of mental and substance use disorders. My sincere thanks to all who have contributed their time and expertise to the development of this TIP. It is my hope that clinicians will find it useful and informative to their work.

Elinore F. McCance-Katz, M.D., Ph.D.

Assistant Secretary for Mental Health and Substance Use
U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

This page intentionally left blank.

Executive Summary

This Treatment Improvement Protocol (TIP) update is intended to provide addiction counselors and other providers, supervisors, and administrators with the latest science in the screening, assessment, diagnosis, and management of co-occurring disorders (CODs). For purposes of this TIP, the term **CODs** refers to co-occurring substance use disorders (SUDs) and mental disorders. Clients with CODs have one or more disorders relating to the use of alcohol or other substances with misuse potential as well as one or more mental disorders. A diagnosis of CODs occurs when at least one disorder of each type can be established independently of the other and is not simply a cluster of symptoms resulting from the one disorder.

Many may think of the typical person with CODs as having a serious mental illness (SMI) combined with a severe SUD, such as schizophrenia combined with alcohol use disorder (AUD). However, counselors working in addiction agencies are more likely to see people with severe addiction combined with mild- to moderate-severity mental disorders. An example would be a person with AUD combined with attention deficit hyperactivity disorder (ADHD) or an anxiety disorder. Efforts to provide treatment that will meet the unique needs of people with CODs have gained momentum over the past two decades in both SUD treatment and mental health services settings.

An expert panel developed the TIP's content based on a review of the most up-to-date literature and on their extensive experience in the field of SUD treatment. Other professionals also generously contributed their time and commitment to this publication.

This TIP is organized to guide counselors and other addiction professionals sequentially through the primary components of proper identification and management of CODs. The TIP is divided into chapters so that readers can easily find the material they need. Following is a summary of the TIP's overall main points and summaries of each of the eight TIP chapters.

The primary focus of this TIP is co-occurring SUDs and mental disorders, not physical disorders. People with mental illness also frequently develop physical conditions that, like SUDs, can exacerbate or induce symptoms (e.g., HIV, hepatitis C virus, hypothyroidism). However, physical conditions are beyond the scope of this publication and are excluded.

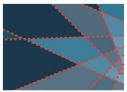
Overall Key Messages

People with SUDs are more likely than those without SUDs to have co-occurring mental disorders.

Addiction counselors encounter clients with CODs as a rule, not an exception. Mental disorders likely to co-occur with addiction include depressive disorders, bipolar I disorder, posttraumatic stress disorder (PTSD), personality disorders (PDs), anxiety disorders, schizophrenia and other psychotic disorders, ADHD, and eating and feeding disorders.

Serious gaps exist between the treatment and service needs of people with CODs and the actual care they receive. Many factors contribute to the gap, such as lack of awareness about and training in CODs by addiction counselors, as well as workforce factors like labor shortages and professional burnout.

Failure to routinely screen clients receiving behavioral health services for mental disorders and SUDs creates a problematic domino effect. A lack of screening means a lack of assessment, which results in a lack of diagnosis, which leads to a lack of treatment, which then reduces a person's chances of achieving long-term recovery for either or both disorders. **Counselors and other providers can prevent this cascade of negative events by understanding how and why to screen, how to perform a full assessment, and how to recognize diagnostic symptoms of mental disorders and SUDs.**



CODs are treatable conditions, and a range of treatment modalities exists that can be implemented across numerous inpatient and outpatient settings. **Counselors may need to adapt interventions based on the treatment setting as well as the unique needs and characteristics of clients**, including their gender, race/ethnicity, life circumstance (e.g., homelessness, involvement in the criminal justice system), symptoms, functioning, stage of change, risk of suicidality, and trauma history.

People with CODs are at an elevated risk for self-harm, especially if they have a history of trauma. **Counselors, other providers, supervisors, and administrators should make client safety a priority and ensure that providers have the necessary training to detect and respond to suicidal thoughts, gestures, and attempts in COD clientele.**

Essential services for people with CODs are person centered, trauma informed, culturally responsive, recovery oriented, comprehensive, and continuously offered across all levels of care and disease course.

There is no “wrong door” by which people with CODs arrive at treatment. Counselors and programs should have a range of interventions and services in their “toolbox” with which they can help all clients.

Administrators and supervisors play a critical role in responding to workforce challenges, such as unmet training needs, low employee retention, staff burnout, and low competency in advanced COD management skills. Such workforce matters are directly tied to treatment availability and quality, so these challenges should be taken seriously and addressed actively by all COD treatment programs.

Content Overview

This TIP is divided into eight chapters designed to thoroughly cover all relevant aspects of screening, assessment, diagnosis, treatment, and programming.

Chapter 1: Introduction to SUD Treatment for People With CODs

This chapter provides a broad introduction to CODs and to SUD treatment for people with CODs. It serves as an outline of the main focus of this TIP. The intended audiences are addiction counselors and other SUD treatment professionals (e.g., psychologists, psychiatrists, licensed clinical social workers, licensed marriage and family therapists, psychiatric and mental health nurses [specialty practice registered nurses]), supervisors, and administrators.

Mental illness is highly comorbid in people with addiction and associated with low rates of treatment engagement, retention, and completion. CODs are linked to numerous negative health outcomes and life circumstances, like elevated risk of homelessness, trauma, and self-harm. To close treatment gaps and ensure that people with SUDs and mental disorders achieve long-lasting recovery, educating counselors, supervisors, and administrators about the prevalence and seriousness of these conditions is essential.

In Chapter 1, readers will learn about:

- The appropriate terminology surrounding CODs and COD treatment approaches.
- The numerous factors that led to the creation of this TIP update.
- The need for this TIP, which addresses CODs and summarizes prevalence and treatment rates, trends in programming, and negative events associated with CODs (e.g., increased hospitalization).
- The complicated and bidirectional relationship between mental disorders and SUDs that can make diagnosing and treating these conditions difficult.

Chapter 2: Guiding Principles for Working With People Who Have CODs

This chapter reviews strategies and recommended guidelines for effective COD services. The intended audiences are counselors and other behavioral health service providers, supervisors, and administrators.

Service provision guidelines help safeguard the well-being of clients with CODs and ensure that they receive high-quality, evidence-based care. Counselors and other providers, supervisors, and administrators can take small but powerful steps to increase the likelihood that clients with CODs get the services they need, such as using person-centered approaches, providing comprehensive care, and integrating research into clinical services. These strategies can have a large impact in terms of generating positive treatment outcomes.

In Chapter 2, readers will learn that:

- Essential services for people with CODs must be recovery oriented, culturally responsive, and inclusive of clients' families or support system (including mutual-help and peer recovery supports).
- Counselors should ensure that they are providing clients full access to treatments; routine screening and complete assessments; services tailored to clients' symptoms and stage of change; and services that are integrated, comprehensive, and continuous across treatment settings and disease course.
- Administrators and supervisors can increase the odds of clients achieving optimal recovery outcomes by ensuring that providers possess the appropriate basic, intermediate, and advanced competencies and have access to training opportunities—both of which are essential if counselors are to confidently and competently manage CODs.
- Integration of evidence-based care into COD programming increases the chances of clients receiving effective therapies that improve their odds of lifelong recovery.
- In addition to establishing essential services (e.g., screening and assessment, onsite prescribing, psychoeducation, mutual support), program developers and administrators should engage in ongoing assessment to ensure that their organization has the capacity to serve clients with CODs and is faithfully following service implementation guidelines.

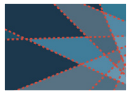
Chapter 3: Screening and Assessment of CODs

This chapter describes the screening and full assessment process for identifying people with and at risk for mental illnesses and SUDs. The intended audiences are addiction counselors and other providers, supervisors, and administrators.

To reduce gaps in treatment access and provision, counselors must appropriately engage in timely, evidence-based screening and assessment. This multistep process is designed to help counselors thoroughly explore all areas of clients' history, symptoms, functioning, readiness for treatment, and other service needs so that treatment decision making is fully informed and tailored to each individual's clinical situation. In short, without timely and effective screening and assessment, the chances of clients receiving appropriate care decrease significantly.

In Chapter 3, readers will learn that:

- All SUD treatment clients should be screened at least annually for SUDs, mental disorders, risk of harm to self and others, functional impairment, and trauma.
- Screening is an informal yet highly effective process of initially identifying people with CODs who may ultimately need formal treatment or other services.
- A full biopsychosocial approach to assessment helps counselors thoroughly explore clients' physical, substance use-related, psychiatric, social, educational/vocational, and family histories for indications of addiction, mental illness, or both.
- Numerous screening and assessment measures are validated for use with people who have mental disorders and SUDs to help counselors make diagnostic determinations and guide decisions about referral for further evaluation (e.g., psychiatric, medical).
- Assessment is more than just administering questionnaires; it includes exploring clients' risk of harm to self and others, trauma history, strengths and supports, cultural needs, and readiness for change.



- When performed correctly, a full assessment should help build rapport between the counselor and the client and foster shared decision making for treatment or other services.

Chapter 4: Mental and Substance-Related Disorders: Diagnostic and Cross-Cutting Topics

This chapter will help readers learn the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013) diagnostic criteria for mental disorders that commonly occur alongside SUDs, as well as symptoms of substance-related disorders. The intended audiences are addiction counselors and other providers, supervisors, and administrators.

Not all addiction counselors are permitted to diagnose mental disorders (regulations vary by state). However, all addiction counselors and other providers should become familiar with the diagnostic criteria for mental illnesses that commonly co-occur with SUDs so that they can refer clients for a full psychiatric evaluation (if needed) and tailor treatment and services accordingly.

Someone with CODs will sometimes need treatment approaches that differ slightly from those for a person who has either an SUD or a mental disorder but not both. Counselors and other providers must understand how to recognize signs of highly comorbid mental illnesses, know how these disorders affect treatment decision making, and recognize the trauma history and risk of self-harm associated with these disorders. Equally important, clinicians should learn how to differentiate independent mental disorders from substance-induced mental disorders, as the latter are often treated differently than the former (if they require treatment at all, given that many substance-induced conditions remit once substance use has ended).

In Chapter 4, readers will learn that:

- Mental disorders that most commonly co-occur with SUDs include major depressive disorder, persistent depressive disorder (dysthymia), bipolar I disorder, PTSD, borderline and antisocial PDs, schizophrenia and other psychotic disorders, generalized anxiety disorder, panic disorder, social anxiety disorder, ADHD, anorexia nervosa, bulimia nervosa, and binge eating disorder.
- Although less common in the general population, all of these mental disorders are likely to be seen by counselors working in SUD treatment settings.
- Counselors may need to treat SUDs in the presence of a mental disorder in slightly different ways than they would treat addiction without comorbid mental illness. The way in which treatment proceeds can vary depending on the mental illness.
- Nearly all CODs carry an increased risk of suicide, and counselors are obligated to thoroughly assess and respond to a current report or history of self-harm.
- Trauma is ubiquitous across CODs and needs to be managed using trauma-informed techniques.
- Many mental disorder symptoms mimic symptoms of SUDs, and vice versa. Being able to differentiate between the two is a core competency.
- Similarly, many mental disorders may appear in the context of substance intoxication or withdrawal. Treatment approaches for these substance-induced disorders can differ from the treatment of independent mental disorders, so counselors must recognize the difference between the two.

Chapter 5: Strategies for Working With People Who Have CODs

This chapter summarizes the importance of establishing a therapeutic alliance with clients who have CODs and discusses how providers can do so. The intended audiences are addiction counselors and other providers, supervisors, and administrators.

Good provider–client rapport can enhance treatment outcomes and completion and is a cornerstone of providing high-quality care. When working with clients who have CODs, counselors and other providers should be aware of clinical factors and concerns—like confidentiality matters, use of empathy, and cultural responsiveness—that

can make the therapeutic relationship more successful and increase the chances that clients will achieve and maintain recovery.

For co-occurring mental disorders, like depression, anxiety disorders, PTSD, and SMI, specific treatment strategies (e.g., selecting appropriate therapeutic interventions; structuring clinical sessions) can improve client adherence and outcomes. Counselors and other providers should learn these techniques and approaches before treating individuals with CODs so that they are prepared to best respond to clients' needs and help establish good therapeutic alliance from the outset.

In Chapter 5, readers will learn that:

- Rapport building is essential in helping clients achieve and sustain positive behavior change.
- Working with people who have CODs can be challenging given clients' feelings of mistrust or shame. CODs can be complex and lifelong, causing a range of difficulties for people living with them.
- A successful therapeutic alliance is built on empathy and support and by providing services fully responsive to all clients' needs.
- Relapse prevention and skill building are critical components of comprehensive care.
- Culturally sensitive techniques can help build rapport and trust between counselors and clients from various cultural, racial, and ethnic backgrounds.
- For clients with depression, cognitive-behavioral techniques, behavioral activation, and medication evaluation are core services.
- Clients with anxiety may need treatments tailored to their anxiety diagnosis, such as individual therapy for a client with social anxiety and fear of group settings.
- Safety and trust are cornerstones of effective treatment for people with trauma and PTSD.
- People with SMI may have cognitive limitations that undermine treatment participation and adherence and may need help with basic living needs (e.g., housing, employment).

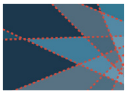
Chapter 6: CODs Among Special Populations

This chapter discusses four populations with CODs who may be especially susceptible to treatment challenges and negative outcomes: people experiencing homelessness, people involved in the criminal justice system, women, and racial/ethnic minorities. The intended audiences are SUD counselors and other providers, supervisors, and administrators.

Although all people with CODs are vulnerable to treatment difficulties and poor outcomes because of the complex and chronic nature of their illnesses, certain COD populations are especially susceptible and may benefit from tailored services. Counselors and other providers need to be sensitive to specific treatment needs of such populations and make adjustments in their assessment, diagnosis, referral, and service provision accordingly.

In Chapter 6, readers will learn that:

- CODs are highly prevalent in people who are experiencing homelessness, but several service models exist to help counselors address clients' behavioral health concerns and their housing needs.
- People involved in the criminal justice system are at risk for CODs both during incarceration and after release into the community.
- Treatment of CODs among justice system-involved people is important because, if left untreated, CODs can increase their risk of recidivism, rearrest, and reincarceration.
- Women are a vulnerable population because of the increased likelihood that they will face trauma, which heightens the occurrence of CODs, and pregnancy/child care-related factors, which can also exacerbate CODs or otherwise affect treatment provision (such as pharmacotherapy).
- Although research suggests that COD treatment outcomes for men and women are generally equivalent, women may benefit from gender-specific services in order to stay engaged in (and thus benefit from) interventions.
- Compared with U.S. Whites, people from racial/ethnic minorities face significantly greater



mental health service and SUD treatment access barriers and are likelier to have negative treatment outcomes.

- Counselors and other providers should learn how to provide culturally responsive assessments and treatments or other services to meet the unique needs facing clients of diverse racial/ethnic backgrounds who have CODs.

Chapter 7: Treatment Models and Settings for People With CODs

This chapter is an overview of treatment models and settings for clients with CODs. It will help counselors and administrators offer empirically supported care for this population. The intended audiences are counselors and other providers, supervisors, and administrators in addiction programs.

CODs are complex conditions, and clients can engage in services across a multitude of inpatient and outpatient settings. Counselors and other providers have at their disposal several empirically validated treatment approaches designed to address the full scope of needs of people with CODs, including services to reduce symptoms, increase abstinence, achieve stable housing, and help clients make meaningful connections with resources and networks of support in the community. Although not appropriate for all clients with CODs, pharmacotherapies are a treatment option that, for certain conditions like AUD and opioid use disorder (OUD), can not only improve functioning but also reduce mortality and morbidity. Counselors and other providers who do not prescribe medication for clients with CODs should nonetheless be aware of their uses, side effects, and interactions/warnings so that they can help monitor clients for safety and offer referrals for medication evaluation as needed.

In Chapter 7, readers will learn that:

- COD treatment can be sequential, simultaneous (but in parallel), or concurrent (and integrated).
- People with CODs face a multitude of individual, logistic, socioeconomic, cultural, organizational, systemic, and policy-related barriers to accessing and using SUD treatment and mental health services. Counselors and administrators play important roles in reducing these barriers

and helping clients overcome such challenges.

- Integrated care is recommended as a best practice for serving people with CODs.
- Assertive community outreach and intensive case management are multidisciplinary approaches that can be easily adapted to integrated settings and thus offer clients comprehensive, continuous care. They can also be adapted to populations vulnerable to CODs and poor outcomes, like people without stable housing and those involved in the criminal justice system.
- Mutual supports, including from peer recovery support specialists, are critical because they offer clients information and support from others with a lived experience with mental illness, SUDs, or both. Many COD-specific mutual-support programs are available, and counselors should keep referral information on hand so they can readily refer clients interested in these services.
- Providers can offer COD services in many different settings, including therapeutic communities, outpatient addiction centers, residential treatment facilities, and acute medical care facilities.
- Pharmacotherapy is often a core part of COD treatment, especially for people with depression, bipolar I disorder, anxiety, schizophrenia/psychotic disorders, AUD, or OUD. Counselors do not prescribe medication, but they should understand what medications their clients are likely to take and the side effects clients are likely to experience so they can offer proper psychoeducation, help monitor for unsafe side effects, and refer clients to prescribers for medication management as needed.

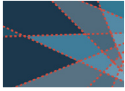
Chapter 8: Workforce and Administrative Concerns in Working With People Who Have CODs

This chapter reviews major issues facing the mental health service and SUD treatment labor force and demonstrates how workforce matters can negatively affect clients with CODs. The intended audiences are supervisors and administrators in SUD treatment.

Projections about the behavioral health workforce suggest that serious gaps will only increase as the number of people entering and staying in the profession is outpaced by the number of people needing those professionals' services. This trend will continue unless there are interventions to support the growing capacity and training needs of the field. These gaps have resulted in people with CODs having fewer opportunities to access high-quality, evidence-based care across a broad continuum of settings and services. Further, unmet training, education, and credentialing in CODs means that there is an insufficient number of counselors and supervisors who understand the treatment needs of this population and how best to manage their conditions. Ensuring better recruitment and retention of well-trained behavioral health professionals is paramount and will help broaden and strengthen the SUD treatment and mental health services systems.

In Chapter 8, readers will learn that:

- This country has a major shortage of mental health and addiction professionals, and the shortage will only continue to grow unless the field uses strategies to increase the size of the workforce and retain current professionals.
- Workforce shortages partly account for why people with CODs face challenges in accessing, engaging in, adhering to, and benefitting from services.
- Recruitment, hiring, and retention techniques can help programs attract and keep the right candidates while reducing turnover.
 - Burnout is a major component of turnover and is prominent in these fields because of the complex and challenging nature of the client population.
 - Many professionals working with clients who have CODs feel uncomfortable or inadequately prepared to offer effective COD services, but better training and active clinical supervision can remedy this.
 - Supervisors and administrators must ensure that counselors are properly trained if good client outcomes are to be achieved. Numerous training resources are available to assist with this process.
 - Professional certification and credentialing give counselors and supervisors the necessary skills to provide effective COD services and convey a sense of staff competency and professionalism within an organization.



TIP ORGANIZATION BY KEY TOPIC AREAS OF INTEREST

The expansive scope of this TIP covers clinically relevant and program-related concepts, guidelines, and topic areas. The section “Content Overview,” broadly outlines the layout of the publication. The following bullets will orient readers to the location of specific subject matter likely to be of high interest. Note that some of the following content may be mentioned or discussed briefly in other chapters; this listing reflects the primary locations in the TIP.

- Ensuring continuity of care: Chapter 2
- Providing essential program services for people with CODs: Chapter 2
- Determining level of service and how to match treatment: Chapter 3
- Screening and assessing for CODs: Chapter 3 (selected tools are located in Appendix C)
- Addressing suicide risk: Chapter 3 (screening and assessment) and Chapter 4 (prevention and management)
- Using motivational enhancement: Chapter 5
- Using relapse prevention techniques: Chapter 5
- Dealing with common clinical challenges in working with clients who have CODs: Chapter 5
- Understanding culture-specific matters, including how to provide culturally competent services: Chapters 5 and 6
- Modifying treatments for clients with CODs based on treatment setting and model: Chapter 7
- Removing treatment barriers and improving service access for people with CODs: Chapter 7
- Offering integrated care: Chapter 7
- Designing residential and outpatient treatment programs: Chapter 7
- Achieving core provider competencies in working with clients who have CODs: Chapter 8

TIP Development Participants

Note: The information given indicates participants' affiliations at the time of their participation in this TIP's original development and may not reflect their current affiliations.

Consensus Panel

Each TIP consensus panel is a group of primarily nonfederal addiction-focused clinical, research, administrative, and recovery support experts with deep knowledge of the TIP's topic. With SAMHSA's Knowledge Application Program team, members of the consensus panel develop each TIP via a consensus-driven, collaborative process that blends evidence-based, best, and promising practices with the panel members' expertise and combined wealth of experience.

Chair

Stanley Sacks, Ph.D.

Director
Center for the Integration of Research and Practice
National Development and Research Institutes, Inc.
New York, New York

Co-Chair

Richard K. Ries, M.D.

Director/Professor
Outpatient Mental Health Services
Dual Disorder Programs
Harborview Medical Center
Seattle, Washington

Workgroup Leaders

Donna Nagy McNelis, Ph.D.

Director, Behavioral Healthcare Education
Associate Professor, Psychiatry
Drexel University
School of Medicine
Philadelphia, Pennsylvania

David Mee-Lee, M.D., FASAM

DML Training and Consulting
Davis, California

James L. Sorenson, Ph.D.

Department of Psychiatry
San Francisco General Hospital
San Francisco, California

Douglas Ziedonis, M.D.

Director, Addiction Services
University Behavioral Healthcare System
Piscataway, New Jersey

Joan E. Zweben, Ph.D.

Executive Director
The 14th Street Clinic and Medical Group
East Bay Community Recovery Project
University of California
Berkeley, California

Panelists

Betty Blackmon, M.S.W., J.D.

Parker-Blackmon and Associates
Kansas City, Missouri

Steve Cantu, LCDC, CADAC, RAS

Clinical Program Coordinator
South Texas Rural Health Services, Inc.
Cotulla, Texas

Catherine S. Chichester, M.S.N., R.N., CS

Executive Director
Co-Occurring Collaborative of Southern Maine
Portland, Maine

Colleen Clark, Ph.D.

Research Associate
Department of Community Mental Health
University of South Florida
Tampa, Florida

**Christie A. Cline, M.D., M.B.A.**

Medical Director
Behavioral Health Sciences Division
New Mexico Department of Health
Santa Fe, New Mexico

Raymond Daw, M.A.

Executive Director
Na'nizhoozhi Center, Inc.
Gallup, New Mexico

Sharon C. Ekleberry, LCSW, LSATP, BCD

Division Director
Adult Outpatient Services
Fairfax County Mental Health Services
Fairfax/Falls Church Community Services Board
Centreville, Virginia

Byron N. Fujita, Ph.D.

Senior Psychologist
Clackamas County Mental Health Center
Oregon City, Oregon

Lewis E. Gallant, Ph.D.

Executive Director
National Association of State Alcohol and Drug
Abuse Directors, Inc.
Washington, DC

Michael Harle, M.H.S.

President/Executive Director
Gaudenzia, Inc.
Norristown, Pennsylvania

Michael W. Kirby, Jr., Ph.D.

Chief Executive Officer
Arapahoe House, Inc.
Thornton, Colorado

Kenneth Minkoff, M.D.

Medical Director
Choate Health Management
Woburn, Massachusetts

Lisa M. Najavits, Ph.D.

Associate Professor of Psychology
Harvard Medical School/McLean Hospital
Belmont, Massachusetts

Tomas A. Soto, Ph.D.

Director
Behavioral Sciences
The CORE Center
Chicago, Illinois

The Chair and Co-Chair would like to thank **Kenneth Minkoff, M.D.**, for his valuable contributions to Chapter 3 of this TIP.

Special thanks go to **Donna Nagy McNelis, Ph.D.**, for providing content on workforce development; **Tim Hamilton**, for providing content about COD mutual-support groups; **Theresa Moyers, Ph.D.**, for her critical review of motivational interviewing content; **George A. Parks, Ph.D.**, for his input about relapse prevention; **Cynthia M. Bulik, Ph.D.**, for writing content about eating disorders; **Lisa M. Najavits, Ph.D.**, for her contributions addressing PTSD; **Barry S. Brown, Ph.D.**, for providing consultation to the Chair; and **Jo Scraba** for her editorial assistance to the Chair.

KAP Expert Panel and Federal Government Participants

Barry S. Brown, Ph.D.

Adjunct Professor
University of North Carolina at Wilmington
Carolina Beach, North Carolina

Jacqueline Butler, M.S.W., LISW, LPCC, CCDC III, CJS

Professor of Clinical Psychiatry College of Medicine
University of Cincinnati
Cincinnati, Ohio

Deion Cash

Executive Director
Community Treatment and Correction Center, Inc.
Canton, Ohio

Debra A. Claymore, M.Ed.Adm.

Owner/Chief Executive Officer WC Consulting, LLC
Loveland, Colorado

Carlo C. DiClemente, Ph.D.

Chair
Department of Psychology
University of Maryland–Baltimore County
Baltimore, Maryland

Catherine E. Dube, Ed.D.

Independent Consultant
Brown University
Providence, Rhode Island

Jerry P. Flanzer, D.S.W., LCSW, CAC

Chief, Services
Division of Clinical and Services Research
National Institute on Drug Abuse
Bethesda, Maryland

Michael Galer, D.B.A.

Chairman of the Graduate School of Business
University of Phoenix—Greater Boston Campus
Braintree, Massachusetts

Renata J. Henry, M.Ed.

Director
Division of Alcoholism, Drug Abuse, and Mental Health
Delaware Department of Health and Social Services
New Castle, Delaware

Joel Hochberg, M.A.

President
Asher & Partners
Los Angeles, California

Jack Hollis, Ph.D.

Associate Director
Center for Health Research Kaiser Permanente
Portland, Oregon

Mary Beth Johnson, M.S.W.

Director
Addiction Technology Transfer Center
University of Missouri—Kansas City
Kansas City, Missouri

Eduardo Lopez, B.S.

Executive Producer
EVS Communications
Washington, DC

Holly A. Massett, Ph.D.

Academy for Educational Development
Washington, DC

Diane Miller

Chief
Scientific Communications Branch
National Institute on Alcohol Abuse and Alcoholism
Bethesda, Maryland

Harry B. Montoya, M.A.

President/Chief Executive Officer
Hands Across Cultures
Española, New Mexico

Richard K. Ries, M.D.

Director/Professor
Outpatient Mental Health Services
Dual Disorder Programs
Seattle, Washington

Gloria M. Rodriguez, D.S.W.

Research Scientist
Division of Addiction Services
New Jersey Department of Health and Senior Services
Trenton, New Jersey

Everett Rogers, Ph.D.

Center for Communications Programs
Johns Hopkins University
Baltimore, Maryland

Jean R. Slutsky, P.A., M.S.P.H.

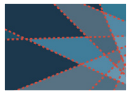
Senior Health Policy Analyst
Agency for Healthcare Research & Quality
Rockville, Maryland

Nedra Klein Weinreich, M.S.

President
Weinreich Communications
Canoga Park, California

Clarissa Wittenberg

Director
Office of Communications and Public Liaison
National Institute of Mental Health
Kensington, Maryland



Consulting Members

Paul Purnell, M.A.
Social Solutions, LLC
Potomac, Maryland

Scott Ratzan, M.D., M.P.A., M.A.
Academy for Educational Development
Washington, DC

Thomas W. Valente, Ph.D.
Director, Master of Public Health Program
Department of Preventive Medicine
School of Medicine
University of Southern California
Alhambra, California

Patricia A. Wright, Ed.D.
Independent Consultant
Baltimore, Maryland

Field Reviewers

Field reviewers represent each TIP's intended target audiences. They work in addiction, mental health, primary care, and adjacent fields. Their direct frontline experience related to the TIP's topic allows them to provide valuable input on a TIP's relevance, utility, accuracy, and accessibility. Additional advisors to this TIP include members of a resource panel and an editorial advisory board.

Calvin Baker
Addicted Homeless Project
Program Coordinator
Division of Addictions and Mental Health
Prince George's County Health Department
Forestville, Maryland

Richard J. Bilangi, M.S.
Executive Director/President
Connecticut Counseling Centers, Inc.
Middlebury, Connecticut

Dennis L. Bouffard, Ph.D.
Program Manager
Connecticut Valley Hospital
Addiction Services Division
Middletown, Connecticut

Kim P. Bowman, M.S.
Executive Director
Chester County Department of Drug and Alcohol Services
West Chester, Pennsylvania

Patricia Hess Bridgman, M.A., CCDC III
Associate Director
Ohio Council of Behavioral Healthcare Providers
Columbus, Ohio

Barry S. Brown, Ph.D.
Adjunct Professor
University of North Carolina at Wilmington
Carolina Beach, North Carolina

Vivian B. Brown, Ph.D.
President/Chief Executive Officer
PROTOTYPES
Culver City, California

Tamara J. Cadet, M.S.W., M.P.H.
Web Content Manager
Free to Grow: Head Start Partnerships to Promote Substance-Free Communities
Columbia University
Andover, Massachusetts

Sharon M. Cadiz, Ed.D.
Senior Director of Special Projects
Project Return Foundation, Inc.
New York, New York

Jerome F. X. Carroll, Ph.D.
Private Practice
Brooklyn, New York

Bruce Carruth, Ph.D., LCSW
Private Practice
Laredo, Texas

Michael Cartwright, Ph.D.
Executive Director
Foundations Associates
Nashville, Tennessee

Catherine S. Chichester, M.S.N., R.N., CS
Executive Director
Co-Occurring Collaborative of Southern Maine
Portland, Maine

CAPT Carol Coley, M.S., USPHS

Senior Program Management Advisor
 Division of State and Community Assistance
 Systems Improvement Branch
 Center for Substance Abuse Treatment
 Substance Abuse and Mental Health Services
 Administration
 Rockville, Maryland

Margaret A. Cramer, Ph.D.

Clinical Psychologist/Instructor
 Melrose, Massachusetts

George De Leon, Ph.D.

Director
 Center for Therapeutic Community Research
 National Development and Research Institutes, Inc.
 New York, New York

Janice M. Dyehouse, Ph.D., R.N., M.S.N.

Professor and Department Head
 College of Nursing
 University of Cincinnati
 Cincinnati, Ohio

Benjam in M. Eiland, M.A., CATS, EAP

Director of Substance Abuse Services
 Haight Ashbury Free Clinic
 San Francisco, California

Dorothy J. Farr

Clinical Director
 Bucks County Drug and Alcohol Commission, Inc.
 Warminster, Pennsylvania

Michael I. Fingerhood, M.D., FACP

Associate Professor
 Department of Medicine
 Center for Chemical Dependence School of Medicine
 Johns Hopkins Bayview Medical Center
 Baltimore, Maryland

Jerry P. Flanzer, D.S.W., LCSW, CAC

Chief, Services
 Division of Clinical and Services Research
 National Institute on Drug Abuse
 Bethesda, Maryland

Byron N. Fujita, Ph.D.

Senior Psychologist
 Clackamas County Mental Health Center
 Oregon City, Oregon

Gerard Gallucci, M.D., M.H.S.

Medical Director
 Community Psychiatry Program
 Bayview Medical Center
 Johns Hopkins University
 Baltimore, Maryland

Mary Gillespie, Psy.D., CASAC

Psychologist
 Saratoga Springs, New York

Karen Scott Griffin, M.S.

Director of Administration
 Gaudenzia, Inc.
 Norristown, Pennsylvania

Valerie A. Gruber, Ph.D., M.P.H.

Assistant Clinical Professor
 University of California, San Francisco
 San Francisco, California

Nancy Handmaker, Ph.D.

Professor
 Department of Psychology
 University of New Mexico
 Albuquerque, New Mexico

Edward Hendrickson, LMFT, MAC

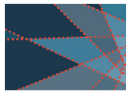
Clinical Supervisor
 Arlington County MHSASD
 Arlington, Virginia

David Hodgins, Ph.D.

Professor
 Department of Psychology
 University of Calgary
 Calgary, Canada

Kimberly A. Johnson

Director
 Maine Office of Substance Abuse
 Augusta Mental Health Complex
 Augusta, Maine

**Edith Jungblut**

Public Health Advisor
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services
Administration
Rockville, Maryland

George A. Kanuck

Public Health Analyst
Co-Occurring and Homeless Branch
Division of State and Community Assistance
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services
Administration
Rockville, Maryland

Michael W. Kirby, Jr., Ph.D.

Chief Executive Officer
Arapahoe House, Inc.
Thornton, Colorado

Daniel R. Kivlahan, Ph.D.

Director
VA Center of Excellence in Substance Abuse
Treatment and Education
VA Puget Sound Health Care System
Seattle, Washington

TingFun May Lai, M.S.W., CSW, CASAC

Director
Chinatown Alcoholism Services
New York, New York

Linda Lantrip, D.O., R.N.

Medical Director
Central Oklahoma Community Mental Health Center
Norman, Oklahoma

Robert M. Long, M.S., LCDC, LADC

Director
Substance Abuse and Dual Diagnosis Services
Kennebec Valley Mental Health Center
Augusta, Maine

Russell P. MacPherson, Ph.D., CAP, CAPP, CCP, CDVC, DAC

President
RPM Addiction Prevention Training
Sanford, Florida

Philip R. Magaletta, Ph.D.

Clinical Training Coordinator
Federal Bureau of Prisons
Washington, DC

G. Alan Marlatt, Ph.D.

Professor of Psychology
Director
The Addictive Behaviors Research Center
University of Washington
Seattle, Washington

Julia W. Maxwell, LICSW, CAS

Branch Manager
Department of Mental Health/Community Services
Mental Health and Addiction Services
St. Elizabeth's Campus
Washington, DC

Frank A. McCorry, Ph.D.

Director
Clinical Services Unit
N.Y.S. Office of Alcoholism and Substance Abuse
Services
New York, New York

Gregory J. McHugo, Ph.D.

Research Associate Professor
Dartmouth Medical School
New Hampshire-Dartmouth Psychiatric Research
Center
Lebanon, New Hampshire

David Mee-Lee, M.D., FASAM

DML Training and Consulting
Davis, California

Kenneth Minkoff, M.D.

Medical Director
Choate Health Management
Woburn, Massachusetts

Theresa Moyers, Ph.D.

Assistant Research Professor
Department of Psychology
University of New Mexico
Albuquerque, New Mexico

Ethan Nebelkopf, Ph.D., MFCC

Clinic Director
Family and Child Guidance Center
Native American Health Center
Oakland, California

Gwen M. Olitsky, M.S.

Chief Executive Officer
The Self-Help Institute for Training and Therapy
Lansdale, Pennsylvania

Thomas A. Peltz, M.Ed., LMHC, CAS

Private Practice Therapist
Beverly Farms, Massachusetts

Stephanie W. Perry, M.D.

Assistant Commissioner of Health
Bureau of Alcohol and Drug Abuse Services
Tennessee Department of Health
Nashville, Tennessee

Lawrence D. Rickards, Ph.D.

CoOccurring Disorders Program Manager
Homeless Programs Branch
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services
Administration
Rockville, Maryland

Jeffery L. Rohacek, M.S., CASAC

Psychologist II
McPike Addiction Treatment Center
Utica, New York

Edwin M. Rubin, Psy.D.

Psychologist
Aurora Behavioral Health Services
Aurora Health Care
Milwaukee, Wisconsin

Theresa Rubin-Ortiz, LCSW

Clinical Director
Bonita House, Inc.
Oakland, California

Margaret M. Salinger, M.S.N., R.N., CARN

Unit/Program Manager
Coatesville VA Medical Center
Coatesville, Pennsylvania

Steven V. Sawicki

Assistant Program Director
Center for Human Development
Connecticut Outreach-West
Waterbury, Connecticut

Anna M. Scheyett, M.S.W., LCSW, CASWCM

Clinical Assistant Professor
School of Social Work
University of North Carolina
Chapel Hill, North Carolina

Marilyn S. Schmal, M.A., CSAC

Mental Health Therapist II
Arlington County Mental Health
Substance Abuse Services
Arlington, Virginia

Darren C. Skinner, Ph.D., LSW, CAC

Director
Gaudenzia, Inc.
Gaudenzia House West Chester
West Chester, Pennsylvania

David E. Smith, M.D.

Founder and President
Haight Ashbury Free Clinics, Inc.
San Francisco, California

Antony P. Stephen, Ph.D.

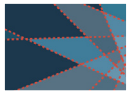
Executive Director
Mental Health and Behavioral Sciences
New Jersey Asian American Association for Human
Services, Inc.
Elizabeth, New Jersey

Norm Suchar

Program and Policy Analyst
National Alliance to End Homelessness
Washington, DC

Richard T. Suchinsky, M.D.

Associate Chief for Addictive Disorders and
Psychiatric Rehabilitation
Mental Health and Behavioral Science Services
Department of Veterans Affairs
Washington, DC

**Kimberly N. Sutton, Ph.D.**

Director/Associate Professor of Psychiatry
Cork Institute on Alcohol and Other Drug Abuse
Morehouse School of Medicine
Atlanta, Georgia

Mary Lynn Ulrey, M.S., ARNP

Chief Operating Officer
Operation PAR, Inc.
Pinellas Park, Florida

Robert Walker, M.S.W., LCSW

Assistant Professor
Center on Drug and Alcohol Research
University of Kentucky
Lexington, Kentucky

Verner Stuart Westerberg, Ph.D.

President
Addiction Services Research
Albuquerque, New Mexico

Aline G. Wommack, R.N., M.S.

Deputy Director
Division of Substance Abuse and Addiction
Medicine
UCSF Deputy Department of Psychiatry
San Francisco, California

Ann S. Yabusaki, Ph.D.

Director
Coalition for a DrugFree Hawaii
Honolulu, Hawaii

Mariko Yamada, LCSW

Clinical Supervisor
Asian American Drug Abuse Program Inc.
Gardena, California

Debby Young

Windsor, California

Joan E. Zweben, Ph.D.

Executive Director
The 14th Street Clinic and Medical Group
East Bay Community Recovery Project
University of California
Berkley, California

Resource Panel**Robert E. Anderson**

Director
Research and Program Applications
National Association of State Alcohol and Drug
Abuse Directors
Washington, DC

Nancy Bateman, LCSWC, CAC

Senior Staff Associate
Division of Professional Development and Advocacy
National Association of Social Workers
Washington, DC

James F. Callahan, D.P.A.

Executive Vice President
American Society of Addiction Medicine
Chevy Chase, Maryland

Frank Canizales, M.S.W.

Management Analyst, Alcohol Program
Division of Clinical and Preventive Services
Indian Health Service
Rockville, Maryland

Cathi Coridan, M.A.

Senior Director
Substance Abuse Programs and Policy
National Mental Health Association
Alexandria, Virginia

Jennifer Fiedelholz

Public Health Analyst
Office of Policy and Program Coordination
Substance Abuse and Mental Health Services
Administration
Rockville, Maryland

Ingrid D. Goldstrom, M.Sc.

Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services
Administration
Rockville, Maryland

Lynne M. Haverkos, M.D., M.P.H.

Program Director
Behavioral Pediatrics and Health Promotion
Research Program
National Institute of Child Health and Human
Development
Bethesda, Maryland

Edward Hendrickson, LMFT, MAC

Clinical Supervisor
Arlington County Mental Health and Substance
Abuse Services Division
Arlington, Virginia

Kevin D. Hennessy, Ph.D.

Senior Health Policy Analyst
Office of the Assistant Secretary for Planning and
Evaluation
Department of Health and Human Services
Washington, DC

James (Gil) Hill, Ph.D.

Director
Office of Rural Health and Substance Abuse
American Psychological Association
Washington, DC

Hendree E. Jones, Ph.D.

Assistant Professor
Department of Psychiatry and Behavioral Sciences
Johns Hopkins University Center
Baltimore, Maryland

Diane M. Langhorst

Clinical Supervisor Substance Abuse Services
Henrico Area Mental Health and Retardation Services
Richmond, Virginia

Tom Leibfried, M.P.A.

Vice President of Government Relations
National Council for Community Behavioral
Healthcare
Rockville, Maryland

James J. Manlandro, D.O.

Director
Family Addiction Treatment Services, Inc.
Dennisville, New Jersey

Julia W. Maxwell, LICSW, CAS

Branch Director
Mental Health Addiction and Services Branch
Commission on Mental Health Services District of
Columbia
Washington, DC

William F. Northey, Jr., Ph.D.

Research Specialist
American Association for Marriage and Family
Therapy
Alexandria, Virginia

Fred C. Osher, M.D.

Director
Center for Behavioral Health, Justice and Public
Policy
University of Maryland
Jessup, Maryland

Terry C. Pellmar, Ph.D.

Director
Board on Neuroscience and Behavioral Health
Institute of Medicine
Washington, DC

Ernst Quimby, Ph.D.

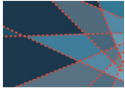
Associate Professor
Department of Sociology and Anthropology
Howard University
Washington, DC

Susan E. Salasin

Director
Mental Health and Criminal Justice Program
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services
Administration
Rockville, Maryland

Laurel L. Stine, J.D., M.A.

Director of Federal Relations
Bazelon Center for Mental Health Law
Washington, DC

**Richard T. Suchinsky, M.D.**

Associate Director for Addictive Disorders and
Psychiatric Rehabilitation
Mental Health and Behavioral Sciences Services
Department of Veterans Affairs
Washington, DC

Jan Towers, Ph.D., CRNP

Director
Health Policy
American Academy of Nurse Practitioners
Washington, DC

Steve Wing

Senior Advisor for Drug Policy
Office of Policy and Program Coordination
Substance Abuse and Mental Health Services
Administration
Rockville, Maryland

**Cultural Competency and Diversity
Network Participants****Raymond Daw, M.A.**

Executive Director
Na'nizhoozhi Center, Inc.
Gallup, New Mexico
Disabilities Work Group

Michael I. Fingerhood, M.D., FACP

Associate Professor
Department of Medicine
Center for Chemical Dependence School of
Medicine
Johns Hopkins Bayview Medical Center
Baltimore, Maryland
Aging Work Group

Ting-Fun May Lai, M.S.W., CSW, CASAC

Director
Chinatown Alcoholism Center
Hamilton-Madison House
New York, New York
Asian and Pacific Islanders Work Group

Antony P. Stephen, Ph.D.

Executive Director
Mental Health & Behavioral Sciences
New Jersey Asian American Association for Human
Services, Inc.
Elizabeth, New Jersey
Asian and Pacific Islanders Workgroup

Richard T. Suchinsky, M.D.

Associate Chief for Addictive Disorders and
Psychiatric Rehabilitation
Mental Health and Behavioral Sciences Services
Department of Veterans Affairs
Washington, DC
Disabilities Work Group

Ann S. Yabusaki, Ph.D.

Director
Coalition for a DrugFree Hawaii
Honolulu, Hawaii
Asian and Pacific Islanders Work Group

Publication Information

Acknowledgments

This publication was prepared under the Knowledge Application Program (KAP) for the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration (SAMHSA). Karl D. White, Ed.D., and Andrea Kopstein, Ph.D., M.P.H., served as the Contracting Officer's Representatives (CORs) for initial TIP development. Content was reviewed and updated in 2020. Suzanne Wise served as the COR, Candi Byrne served as the Alternate COR, and Valerie Tarantino, LCSW-C, as the Product Champion.

Disclaimer

The views, opinions, and content expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of SAMHSA. No official support of or endorsement by SAMHSA for these opinions or for the instruments or resources described is intended or should be inferred. The guidelines presented should not be considered substitutes for individualized client care and treatment decisions.

Public Domain Notice

All materials appearing in this volume except those taken directly from copyrighted sources are in the public domain and may be reproduced or copied without permission from SAMHSA or the authors. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, Department of Health and Human Services.

Electronic Access and Copies of Publication

This publication may be ordered or downloaded from SAMHSA's Publications and Digital Products webpage at store.samhsa.gov. Or, please call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

Recommended Citation

Substance Abuse and Mental Health Services Administration. *Substance Use Disorder Treatment for People With Co-Occurring Disorders*. Treatment Improvement Protocol (TIP) Series, No. 42. SAMHSA Publication No. PEP20-02-01-004. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

Originating Office

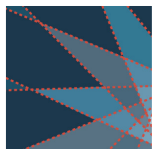
Quality Improvement and Workforce Development Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857.

Nondiscrimination Notice

SAMHSA complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SAMHSA cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad, o sexo.

SAMHSA Publication No. PEP20-02-01-004
First printed 2005
Updated 2020

This page intentionally left blank.



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

KEY MESSAGES

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

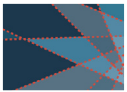
What is health? The World Health Organization (WHO) considers healthy states ones characterized by “complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, n.d.). The Department of Health and Human Services’ (HHS) Healthy People 2020 initiative also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

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

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

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

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



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

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

Scope of This TIP

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

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

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

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

Audience

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

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

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

Approach

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

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

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

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

Guidance for the Reader

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

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

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

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

Terminology in This TIP

Exhibit 1.1 defines key terms that appear in this TIP.

EXHIBIT 1.1. Key Terms

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

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

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

12 fl oz. of
regular beer



about 5%
alcohol

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



about 7%
alcohol

5 fl oz. of
table wine



about 12%
alcohol

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



40% alcohol

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

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

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

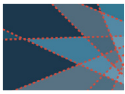
Categories and examples of substances

SUBSTANCE CATEGORY	REPRESENTATIVE EXAMPLES
Alcohol	• Beer • Wine • Malt liquor • Distilled spirits
Illicit Drugs	• Cocaine, including crack • Heroin • Hallucinogens, including LSD (lysergic acid diethylamide), PCP (phencyclidine), ecstasy, peyote, mescaline, psilocybin • Methamphetamines, including crystal meth • Marijuana, including hashish[†] • Synthetic drugs, including K2, Spice, and “bath salts” • Prescription-type medications that are used for nonmedical purposes – Pain relievers—Synthetic, semisynthetic, and nonsynthetic opioid medications, including fentanyl, codeine, oxycodone, hydrocodone, and tramadol products – Tranquilizers, including benzodiazepines, meprobamate products, and muscle relaxants – Stimulants and methamphetamine, including amphetamine, dextroamphetamine, and phentermine products; mazindol products; and methylphenidate or dexamethylphenidate products – Sedatives, including temazepam, flurazepam, or triazolam and any barbiturates
Over-the-Counter Drugs and Other Substances	• Cough and cold medicines • Inhalants, including amyl nitrite, cleaning fluids, gasoline and lighter gases, anesthetics, solvents, spray paint, nitrous oxide

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

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

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



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

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

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

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

Person-Centered Terminology

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

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

Important Developments That Led to This TIP Update

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

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

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

Why Do We Need a TIP on CODs?

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



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

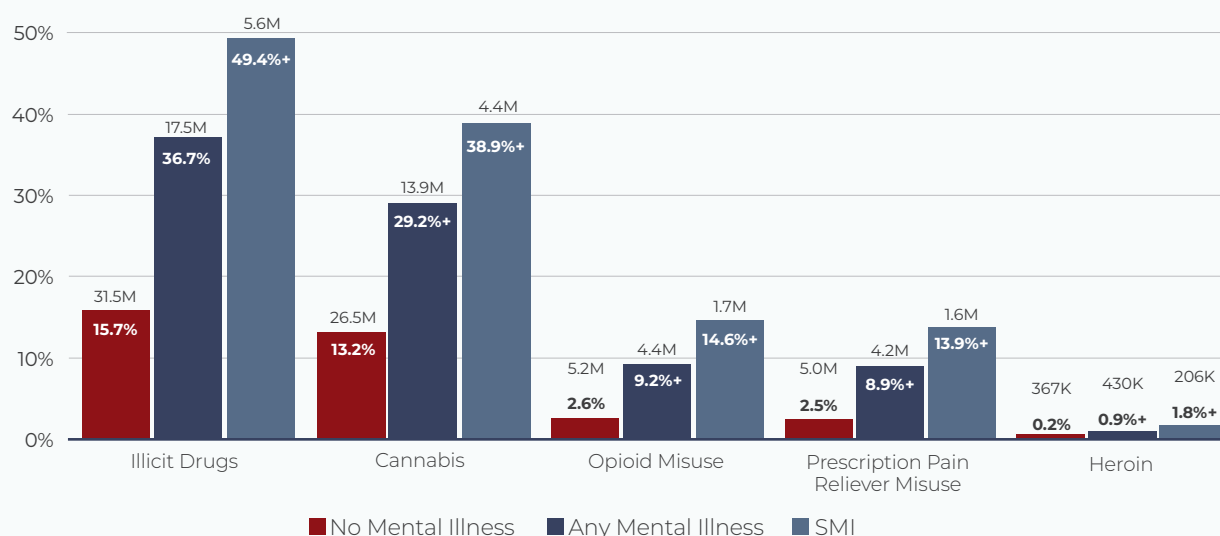
Source: Lai, Cleary, Sitharthan, & Hunt, 2015; p. 8

1. Prevalence and Treatment Need of CODs

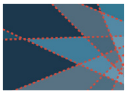
National surveys suggest that mental illness (and SMI in particular) commonly co-occurs with substance misuse in the general adult population, and many individuals with CODs go untreated. The National Survey on Drug Use and Health (NSDUH), based on a sample of more than 67,700 U.S. civilians ages 12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

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

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



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



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

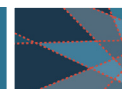
Other nationally representative survey datasets confirm the high rate of comorbidity and treatment need for mental disorders and SUDs in the general adult population. An analysis of Wave 3 of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC-III; Grant et al., 2015) revealed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

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

2. CODs and Hospitalizations

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

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



OPIOID USE DISORDER AND THE PROBLEM OF CODs

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

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

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

an upsurge in mental disorder/SUD-related hospitalizations:

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

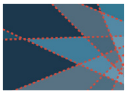
hospitalizations in the United States involved a COD, 21 percent a mental disorder diagnosis only, and about 6 percent an SUD only. Of inpatient stays involving a primary diagnosis of mental illness or SUD, 46 percent were because of a COD, whereas 40 percent of inpatient stays involved a mental disorder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

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

3. Trends in COD Programming

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

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



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

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

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

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

4. Complications of CODs

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

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

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

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

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

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

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

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

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

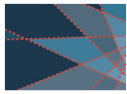
Wallace, 2017), about 48 percent have a history of mental illness (of whom 29 percent had an SMI), 26 percent, a history of an SUD. Of those with mental illness, 49 percent also have a co-occurring SUD.

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

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

The Complex, Unstable, and Bidirectional Nature of CODs

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



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

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

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

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

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

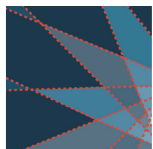
For a more detailed description of this model, see Chapter 2. To learn how to integrate the quadrants of care framework into assessment and treatment decision-making processes, see Chapter 3.

SUDs, Mental Illness, and “Self-Medicating”

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

Conclusion

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



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

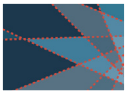
KEY MESSAGES

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

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

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

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



General Guiding Principles

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

Exhibit 2.1. Six Guiding Principles in Treating Clients With CODs

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

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

Use a Recovery Perspective

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

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

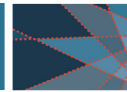
- Develop a treatment plan that provides for continuity of care over time. In preparing this plan, the provider should recognize that treatment may occur in different settings over time (e.g., residential, outpatient) and that much of the recovery process typically occurs outside of or following treatment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

Adopt a Multiproblem Viewpoint

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

Develop a Phased Approach to Treatment

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



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

Address Specific Real-Life Problems Early in Treatment

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

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

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

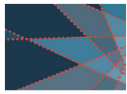
continuing treatment. Engagement is a critical part of SUD treatment generally and of treatment for CODs specifically, because remaining in treatment for an adequate length of time is essential to achieving behavioral change.

Plan for Clients’ Cognitive and Functional Impairments

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

Use Support Systems To Maintain and Extend Treatment Effectiveness

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



Mutual Support

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

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

Building Community

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

Reintegration With Family and Community

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

Peer-Based Services

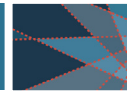
Peer recovery support services typically refers to services provided by people with a lived experience with substance misuse, mental disorders, or both (or, in the case of family peer services, people who have a lived experience of having a loved one with substance misuse, mental disorders, or both).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

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

Guidelines for Counselors and Other Providers

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

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



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

Providing Access

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

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

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

Exhibit 2.2. Making “No Wrong Door” a Reality

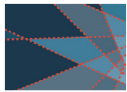
The consensus panel strongly endorses a “no wrong door” policy: effective systems must ensure that an individual needing treatment will be identified and assessed and will receive treatment, either directly or through appropriate referral, no matter where he or she enters the realm of services (Center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

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

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

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

Source: CSAT (2000a).



Completing a Full Assessment

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

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

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

Providing an Appropriate Level of Care

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

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

Severity and Levels of Care

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

EXHIBIT 2.3. The Four Quadrants Model

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

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

Achieving Integrated Treatment

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

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

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

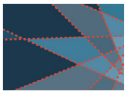
Exhibit 2.4. SAMHSA Practice Principles of Integrated Treatment for CODs

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

Source: SAMHSA (2009a).

Providing Comprehensive Services

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



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

Ensuring Continuity of Care

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

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

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

Continuity of Care and Outpatient Treatment Settings

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

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

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

Continuity of Care and Residential Treatment Settings

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

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

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

Empirical Evidence Related to Continuity of Care

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

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

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

Guidelines for Administrators and Supervisors

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

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

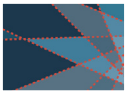
Critical challenges face SUD treatment systems and programs that aim to improve care for clients with CODs. This section addresses these challenges by discussing how supervisors and administrators can foster more effective COD programming, such as:

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

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

Providers' Competencies

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



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

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

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

Intermediate competencies encompass skills such as:

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

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

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

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

Continuing Professional Development

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

Education and Training

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

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

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

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

Program Orientation and Ongoing Supervision

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

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

Avoiding Burnout and Reducing Staff Turnover

Burnout

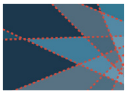
Assisting clients who have CODs is difficult and emotionally taxing; the danger of burnout is considerable. Among mental health and SUD clinicians, the effects of working with clients with trauma can lead to compassion fatigue, vicarious traumatization, or secondary traumatic stress (Huggard, Law, &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

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

Turnover

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

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



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

Integrating Research and Practice

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

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

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

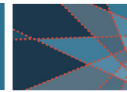
Establishing Essential Services for People With CODs

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

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

Develop a COD program with these components:

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



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

Screening, Assessment, and Referral for People With CODs

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

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

Physical and Mental Health Consultation

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

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

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

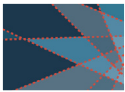
A psychiatrist provides services crucial to sustaining recovery and stable functioning for people with CODs: assessment, diagnosis, periodic reassessment, medication, and rapid response to crises. If lack of funding prevents the SUD treatment agency from hiring a consultant psychiatrist, the agency could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

Prescribing Onsite Psychiatrist

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

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

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



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

Medication and Medication Monitoring

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

Psychoeducational Classes

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

Relapse Prevention

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

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

Case Management

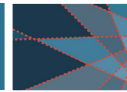
CODs are complex conditions that affect many areas of a person’s life, including his or her physical and emotional functioning, vocation/education, social and family relationships, and daily functioning. Case management is needed to ensure that clients receive a continuum of support services at the intensity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

COD-Specific Treatment Components

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

Continuing Care Services

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



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

Double Trouble Groups (Onsite)

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

Dual Recovery Mutual-Support Groups (Offsite)

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

Assessing the Agency's Capacity To Serve Clients With CODs

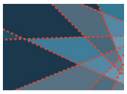
Every agency that already is treating or planning to treat clients with CODs should assess the current profile of its clients, as well as the estimated number and type of potential new clients in the community. It must also consider its current capabilities, its resources and limitations, and the services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

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

12-STEP FACILITATION AND CODs

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

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



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

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

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

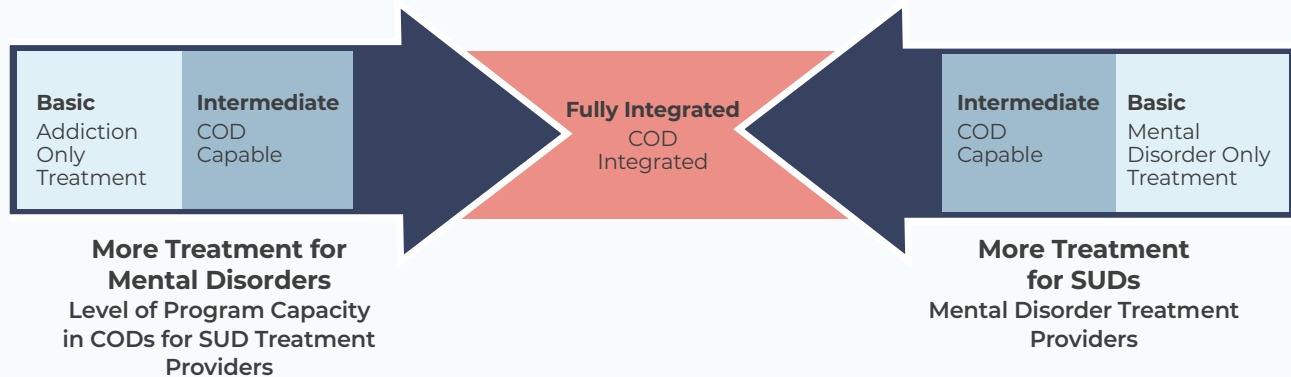
and implementing supervision or other professional consultation processes (like case reviews or other formal approaches to staff monitoring and support) to ensure ethical, evidence-based care

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

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

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

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

EXHIBIT 2.5. Levels of Program Capacity in CODs

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

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

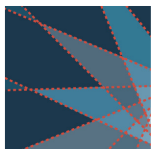
The suggested classification has several advantages. For one, it avoids use of the term “dual diagnosis” and allows a more general, flexible approach to describing capacity without

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

Conclusion

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

This page intentionally left blank.



Chapter 3—Screening and Assessment of Co-Occurring Disorders

KEY MESSAGES

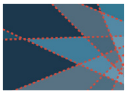
- Screening and assessment are central to identifying and treating clients with co-occurring disorders (CODs) in a manner that is timely, effective, and tailored to all of their needs. The assessment process helps fulfill a critical need, as most people with CODs receive either treatment for only one disorder or no treatment at all.
- Most counseling professionals can initiate the screening process. Understanding why, whom, and when to screen and which validated tools to use are the keys to success.
- The assessment process is a multifactor, biopsychosocial approach to determining which symptoms and diagnoses might be present and how to tailor decisions about treatment and follow-up care based on assessment results.
- The 12 steps of assessment are designed to foster a thorough investigation of pertinent biopsychosocial factors contributing to, exacerbating, and mitigating the client's current symptomatology and functional status. At its core is the client's chronological history of past symptoms of substance use disorders (SUDs) or mental illness, as well as diagnosis, treatment, and impairment related to these issues. Counselors should get a detailed description of current strengths, supports, limitations, skill deficits, and cultural barriers. Identification of a client's stage of change and readiness to engage in services will inform treatment planning and optimize adherence and outcomes.

A serious treatment gap exists between the mental disorder and SUD needs of people with CODs and the number of people who actually receive services. According to the 2018 National Survey on Drug Use and Health, of the 9.2 million U.S. adults ages 18 and older who had CODs in the past year, more than 90 percent did not receive treatment for both disorders, and approximately 50 percent received no treatment at all (Center for Behavioral Health Statistics and Quality, 2019). Underlying these statistics is the failure of addiction and mental health professionals to adequately recognize CODs.

Screening and assessment are critical components of establishing diagnosis and getting people on the right path to treatment or other needed services. This chapter, whose audiences are counselors, other treatment/service providers, supervisors, and administrators, offers guidance to help addiction counselors understand the purpose and process for effective screening and assessment of clients for possible CODs. It has three parts:

1. An overview of the basic screening and assessment approach that should be a part of any program for clients with CODs
2. An outline of the 12 steps to an ideal complete screening and assessment, including some instruments that can be used in assessing CODs (see Appendix C for select screening tools)
3. A discussion of key considerations in treatment matching

Ideally, information needs to be collected continually and assessments revised and monitored as clients move through recovery. A comprehensive assessment, as described in the main section of this chapter, leads to improved treatment planning and this chapter aims to provide a model of the optimal process of evaluation for clients with CODs and to encourage the field to move toward



this ideal. Nonetheless, the panel recognizes that not all agencies and providers have the resources to conduct immediate and thorough screenings. Therefore, the chapter provides a description of the initial screening and the basic or minimal assessment of CODs necessary for the initial treatment planning.

Note that medical problems (including physical disability and sexually transmitted diseases), cultural topics, gender-specific and sexual orientation matters, and legal concerns always must be addressed, whether basic or more comprehensive assessment is performed. The consensus panel assumes that appropriate procedures are in place to address these and other important areas that must be included in treatment planning. However, the focus of this chapter, in keeping with the purpose of this Treatment Improvement Protocol (TIP), is on screening and assessment for CODs.

Screening and Basic Assessment for CODs

This section provides an overview of the screening and basic assessment process for CODs. A basic assessment covers the key information required for treatment matching and treatment planning. Specifically, the basic assessment offers a structure for obtaining:

- Demographic and historical information, established or probable diagnoses, and associated impairments.
- General strengths and problem areas.
- Stage of change or level of service needed for both substance misuse and mental illness.
- Preliminary determination of the severity of CODs as a guide to final level of care determination.

In carrying out these processes, counselors should understand the limitations of their licensure or certification authority to diagnose or assess mental disorders. Generally, however, collecting screening and assessment information is a legitimate and legal activity even for unlicensed providers, as long as they do not use diagnostic

labels as conclusions or opinions about the client. Information gathered in this way is needed to ensure that the client is placed in the most appropriate treatment setting (see the section “Step 5: Determine Level of Care”) and to assist in providing mental disorder and addiction care that addresses each disorder.

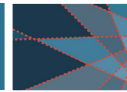
In addition, a number of circumstances that can affect validity and test responses may not be obvious to the beginning counselor, such as the manner in which instructions are given to the client, the setting where the screening or assessment takes place, privacy (or the lack thereof), and trust and rapport between the client and counselor. Throughout the process be sensitive to cultural context and to the different presentations of both SUDs and mental disorders that may occur in various cultures (see Chapter 5 of this TIP for more information about culturally sensitive care for clients with CODs). Detailed discussions of these important screening/assessment and cultural matters are beyond the scope of this TIP.

For more information on screening and assessment for CODs, see *Screening and Assessment of Co-Occurring Disorders in the Justice System* (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015b). For information on cultural topics, see TIP 59, *Improving Cultural Competence* (SAMHSA, 2014a).

Screening

For the purposes of this TIP, **screening** is a formal process of testing to determine whether a client warrants further because of a co-occurring SUD or mental disorder. The screening process for CODs seeks to answer a “yes” or “no” question: Does the substance misuse (or mental disorder) client being screened show signs of a possible mental (or substance misuse) problem?

Although both screening and assessment are ways of gathering information about the client in order to better treat him or her, assessment differs from screening in that screening is a process for evaluating the possible presence of a particular problem and typically precedes assessment, whereas assessment is a process for defining the nature of that problem and developing specific



ADVICE TO THE COUNSELOR: DOS AND DON'TS OF ASSESSMENT FOR CODs

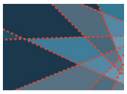
- **Do** keep in mind that assessment is about getting to know a person with complex and individual needs. Tools alone cannot produce a comprehensive assessment.
- **Do** always make every effort to contact all involved parties, including family members, people who have treated the client previously, and probation officers, as quickly as possible in the assessment process. (These other sources of information will henceforth be referred to as collaterals.)
- **Don't** allow preconceptions about addiction to interfere with learning about what the client really needs. CODs are as likely to be underrecognized as overrecognized. Assume initially that an established diagnosis and treatment regimen for mental illness is correct, and advise clients to continue with those recommendations until careful reevaluation has taken place.
- **Do** become familiar with the diagnostic criteria for common mental disorders, including serious mental illness (SMI) (e.g., bipolar disorder, schizophrenia, other psychotic disorders). Also become familiar with the names and indications of common psychiatric medications and with the criteria in your own state for determining who is a mental disorder priority client. Know the process for referring clients for mental illness case management services or for collaborating with mental health services providers.
- **Don't** assume there is one correct treatment approach or program for any type of COD. The purpose of assessment is to collect information on multiple variables, enabling individualized treatment matching. Assess stage of change for each problem and clients' level of ability to follow treatment recommendations.
- **Do** get familiar with the specific role your program plays in delivering services related to CODs in the wider context of the system of care. This allows you to have a clearer idea of what clients your program will best serve and helps you to facilitate access to other settings for clients who might be better served elsewhere.
- **Don't** be afraid to admit when you don't know, either to the client or yourself. If you do not understand what is going on with a client, acknowledge that to the client, indicate that you will work with the client to find the answers, and then ask for help. Identify at least one supervisor who is knowledgeable about CODs as a resource for asking questions.
- Most important, **do** remember that empathy and hope are the most valuable components of your work with a client. When in doubt about how to manage a client with COD, stay connected, be empathic and hopeful, and work with the client and the treatment team to try to figure out the best approach over time.

treatment recommendations for addressing the problem. Thus, assessment is a more thorough and comprehensive process than screening.

The consensus panel recommends that all clients presenting for SUD treatment, mental health services, or both be screened at least annually by SUD treatment and mental health services providers for past and present substance misuse

and mental disorders. SUD treatment and mental health counselors should also screen clients who report experiencing or otherwise show signs or symptoms of an SUD or a mental disorder.

Counselors can conduct screening processes, if properly designed (see next paragraph), using their basic counseling skills. All counselors can be trained to screen for COD. There are seldom



ADVICE TO THE COUNSELOR: KNOW THE BASICS OF SCREENING

- **What is screening?** Screening is a simple process of determining whether more indepth assessment is needed, often consisting of asking the client basic “yes” or “no” questions.
- **Who should conduct screening?** Nearly any counselor can screen. Generally, no special training is required.
- **When does screening take place?** The consensus panel recommends that all SUD treatment clients and mental disorder treatment clients be screened for CODs at least annually. Screening is also needed when clients report or exhibit symptoms suggesting another disorder may be present.
- **Where does screening occur?** Screening can happen anywhere that services are offered.
- **Why screen?** Screening is a necessary first step to ensure that clients receive the right diagnosis and treatment.
- **How should screening be performed?** A variety of easy-to-administer screening tools are available and are located or linked to throughout this chapter as well as in Appendix C.

any legal or professional restraints on who can be trained to conduct a screening. Counselors should work with their program administrators to determine how often to screen, which tools to use, and who will perform the screening.

The purpose of screening is not necessarily to identify what kind of disorder the person might have or how serious it might be. Rather, screening determines whether further assessment is warranted. Screening processes always should define a protocol for determining which clients screen positive and for ensuring that those clients receive a thorough assessment. That is, a professionally designed screening process establishes precisely how any screening tools or questions are to be scored and indicates what constitutes scoring positive for a particular possible problem (often called “establishing cutoff scores”). The screening protocol details exactly what takes place after a client scores in the positive range and provides the necessary standard forms to be used to record the results of all later assessments and to document that each staff member has carried out his or her responsibilities in the process.

So, what can an SUD treatment or mental health counselor do to screen clients? Screening often entails having a client respond to a specific set of questions, scoring those questions according to the counselor’s training, and then taking the next step

in the process depending on the results and the design of the screening process. In SUD treatment or mental health service settings, every counselor or clinician who conducts intake or assessment should be able to screen for the most common CODs and know the protocol for obtaining COD assessment information and recommendations. For SUD treatment agencies instituting mental disorder screening or mental health service programs instituting substance misuse screening, see the section, “Assessment Step 3: Screen for and Detect COD.” Selected instruments from that section appear in this chapter and in Appendix C.

Basic Assessment

A basic **assessment** assessment consists of gathering key information and engaging clients in a process that enables counselors to understand clients’ readiness for change, problem areas, COD diagnoses, disabilities, and strengths. An assessment typically involves a clinical examination of the functioning and well-being of the client and includes a number of tests and written and oral exercises. The COD diagnosis is established by referral to a psychiatrist, clinical psychologist, or other qualified healthcare professional. Assessment of the client with CODs is an ongoing process that should be repeated over time to capture the changing nature of the client’s status. Intake information includes:

- Background—family, trauma history, history of domestic violence (as either a perpetrator or a victim), marital status, legal involvement and financial situation, health, education, housing status, strengths and resources, and employment.
- Substance use—age of first use, primary substance(s) used (including alcohol), patterns of substance use, treatment episodes, and family history of substance use problems.
- Mental illness—family history of mental illness; client history of mental illness, including diagnosis, hospitalization and other treatment; current symptoms and mental status; and medications and medication adherence.

In addition, the basic information can be augmented by some objective measurement (see “Step 3: Screen for and Detect COD” and Appendix C). It is essential for treatment planning that the counselor organize the collected information in a way that helps identify established mental disorder diagnoses and current treatment. The following text box highlights the role of instruments in assessment.

Careful attention to the characteristics of past episodes of substance misuse and abstinence with regard to mental disorder symptoms, impairments, diagnoses, and treatments can illuminate the role of substance misuse in maintaining, worsening, and interfering with the treatment of any mental disorder. Understanding a client’s mental disorder symptoms and impairments that persist during periods of abstinence of 30 days or more can be useful, particularly in understanding what the client copes with even when the acute effects of substance misuse are not present. For any period of abstinence that lasts a month or longer, ask the client about mental health services, SUD treatment, or both.

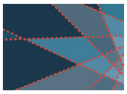
If mental disorder symptoms (even suicidality or hallucinations) occur within 30 days of intoxication or withdrawal from the substance, symptoms may be substance induced. The best way to manage them is by maintaining abstinence from substances. Even if symptoms are substance induced, formal treatment strategies should be applied to help the client newly in recovery best manage the symptoms.

THE ROLE OF ASSESSMENT TOOLS

Providers frequently ask, what is the best assessment tool for COD? The answer is that there is no single gold standard assessment tool for COD.

- Many traditional clinical tools focus narrowly on a specific problem. An example of such a tool is the Beck Depression Inventory (Beck & Steer, 1987), a list of 21 questions about mood and other symptoms of feeling depressed.
- Other tools have a broader focus and organize a range of information so that the collection of such information is done in a standard, regular way by all counselors. The Addiction Severity Index (ASI), which is not a comprehensive assessment tool but a measure of addiction severity in multiple problem domains, is an example of this type of tool (McLellan et al., 1992). Not only does a tool such as the ASI help a counselor, through repetition, become adept at collecting the information, it also helps the counselor refine his or her sense of similarities and differences among clients.
- Knowing the appropriateness of a tool is also critical. Has the assessment been well studied? Is it considered valid and reliable? Is it validated for use in a population the client represents? If the answer to any of these questions is “no,” that might mean that the results from the assessment are not reliable, valid, interpretable, applicable to the client, or some combination thereof. This is especially true with clients from diverse populations. Race/ethnicity, educational background, age, gender—all of these factors affect life experiences and can affect the answers a person gives to a questionnaire. Wherever possible, be sure to use tools that are appropriately matched to the client.
- A standard mental status examination can also collect information on current mental health. Some very good tools exist, but no one tool stands in for comprehensive clinical assessment.

Provider and client together should try to understand the specific effects that substances



have had on mental disorder symptoms, including possible triggering of psychiatric symptoms through substance use. The consensus panel notes that many individuals with CODs have well-established diagnoses when they enter SUD treatment and encourages counselors to find out about any known diagnoses.

As part of basic assessment, assess clients' mental health and SUD history by asking questions like:

- “Tell me about your mental ‘ups and downs’. What is it like for you when things are worse? What is it like when things are better or stable?”
- “How do you notice using alcohol (or whatever substance the client is misusing) affects your depression (or whichever mental disorder symptom the client is experiencing)?”
- “What mental disorders have you been diagnosed with in the past? When was that, and what happened after you received the diagnosis?”
- “What (mental disorder or substance misuse) treatment seemed to work best for you?”
- “What treatment did you like or dislike? Why?”

The Complete Screening and Assessment Process

This chapter is organized around 12 specific steps in the assessment process. Through these steps, the counselor seeks to:

- Get a more **detailed chronological history** of mental symptoms, diagnosis, treatment, and impairment, particularly preceding substance misuse and during periods of extended abstinence.
- Get a more **detailed description of current strengths, supports, limitations, skill deficits, and cultural barriers** related to following a recommended treatment regimen for a disorder or problem.

ADVICE TO THE COUNSELOR: HOW TO MAKE THE ASSESSMENT PROCESS A SUCCESS

Counselors can increase the chances of a successful assessment process by taking some basic steps to help clients feel relaxed and open.

- First, create a welcoming environment by taking an open, nonjudgmental attitude.
 - SUD and mental illness each carry their own stigma, and people who have both disorders may feel even more marginalized, leading to underreporting or denial of symptoms and treatment needs.
 - Research suggests that some mental health professionals possess especially negative attitudes and beliefs about individuals with SMI, like psychotic disorders, and SUDs (Avery, Zerbo, & Ross, 2016).
 - By being aware of personal biases and taking steps to create a warm and open environment, counselors can increase the likelihood that clients will feel comfortable discussing distressing symptoms and dysfunctions, which can better inform treatment needs.
- Use open-ended rather than just “yes” or “no” questions. Open-ended questions will allow counselors to elicit a greater depth of information and will feel more conversational in tone to the client. “Yes” or “no” questions can feel more judgmental and detached. Open-ended questions are also more thought provoking and can lead the client to greater self-exploration and self-awareness.
- Furthermore, be sure to address motivation by talking with clients about their ambivalence toward engaging in services. More information about motivational interviewing techniques can be found in the update of TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* (SAMHSA, 2019c).

- Determine **stage of change for each problem** and identify external contingencies that might help promote treatment adherence.

Assessment steps appear sequential, but some can occur simultaneously or in a different order, depending on the situation. Providers should identify and attend to acute safety needs, which often must be addressed before a more comprehensive assessment process can occur. Sometimes, however, components of the assessment process are essential to address clients' specific safety needs. Furthermore, counselors should recognize that although the assessment seeks to identify individual needs and vulnerabilities as quickly as possible to initiate appropriate treatment, **assessment is an ongoing process.** As treatment proceeds and as other changes occur in clients' lives and mental status, counselors must actively seek current information rather than proceed on assumptions that might be no longer valid. Exhibit 3.1 lists general considerations for the assessment of clients with CODs.

The following section discusses the availability and utility of validated assessment tools to assist counselors in this process. A number of tools

are required by various states for use in their SUD treatment systems (e.g., ASI, [McLellan et al., 1992]; American Association of Community Psychiatry – Level of Care Utilization System [LOCUS]). Particular attention will be given to the role of these tools in the COD assessment process, with suggested strategies for reducing duplication of effort when possible.

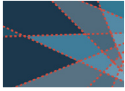
It is beyond the scope of this TIP to provide detailed instructions for administering the tools mentioned, but select information about cutoff scores is included in this chapter (and select measures are included in Appendix C). Basic information about each instrument is also given in this chapter, and readers can obtain more detailed information about administration and interpretation from the sources given for obtaining these instruments.

This discussion is directed toward providers working in SUD treatment settings, although many of the steps apply equally well to mental health clinicians in mental health service settings. At certain key points in the discussion, particular information relevant to mental health clinicians is identified and described.

EXHIBIT 3.1. Assessment Considerations for Clients With CODs

- Providers should maintain a nonjudgmental attitude while taking a matter-of-fact approach to asking about past and current substance misuse and mental illness.
- First asking about past substance misuse and mental illness could help clients feel more open and amenable to discussing current problems, which people sometimes minimize.
- Counselors should explain to clients why they are asking about substance misuse and mental illness and discuss the role of such information in treatment planning.
- Self-report assessments can be informative, but counselors should gather laboratory data and collateral information from family and friends as needed.
- Counselors should be able to recognize the common demographic correlates of COD, such as gender, younger age, lower educational attainment, and single marital status. These give counselors an idea of which clients may be more vulnerable to these disorders and potentially in need of screening and assessment. However, these factors should not be used to justify not screening or assessing certain people. **Screen all clients for substance misuse and mental illness at least once per year.** All clients who screen positive for symptoms, functional impairment, or other service needs should be fully assessed.

Source: Mueser & Gingerich (2013).



Using a Biopsychosocial Approach

Because addictions and mental disorders are complex conditions with multiple contributing factors, clinicians should conduct assessments using a biopsychosocial approach that thoroughly investigates clients' history and current status in a holistic manner. "Biopsychosocial" in this context refers to a clinical philosophy and approach to care that seeks to understand clients and their experience through a medical, psychological, emotional, sociocultural, and socioeconomic lens. This is particularly important when assessing and treating CODs given that numerous determinants and exacerbating and mitigating factors may potentially be relevant to diagnosis, treatment planning, and outcomes. **Biopsychosocial assessment is evidence based and the standard**

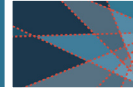
of care. It is comprehensive and widely addresses all aspects of clients' lives that may be relevant to his or her symptoms and service needs.

By definition, a biopsychosocial assessment will rely on input from multidisciplinary team members including physicians and nurses (including psychiatric and mental health nurses [specialty practice registered nurses]); psychologists, psychiatrists, and other mental health professionals; social workers; and addiction counselors and other SUD treatment professionals. Addiction counselors will not be able to assess all biopsychosocial assessment areas (Exhibit 3.2) and will focus primarily on the psychological and social sources of information. Appendix C contains links to sample biopsychosocial assessment forms.

EXHIBIT 3.2. Biopsychosocial Sources of Information in the Assessment of CODs

TOPIC AREA	SUD AREAS OF ASSESSMENT	MENTAL DISORDER AREAS OF ASSESSMENT
Biological	• Alcohol on the breath • Positive urine tests • Abnormal laboratory tests • Withdrawal symptoms • Injuries and trauma • Medical signs and symptoms of toxicity and withdrawal • Impaired cognition	• Abnormal laboratory tests (e.g., magnetic resonance imaging) • Neurological exams • Use of psychiatric and other medications
Psychological	• Intoxicated behavior • Functional impairment • Responses to SUD assessments • Documented substance misuse history • History of trauma	• Mental status exam results • Responses to mental disorder/symptom screens (e.g., depressed mood, psychosis, anxiety) • History of or current diagnosis of and treatment for mental illness • Stress and situational factors • Self-image and personality • History of trauma

Continued on next page



Continued

TOPIC AREA	SUD AREAS OF ASSESSMENT	MENTAL DISORDER AREAS OF ASSESSMENT
Social	• Collateral information from others (e.g., family, caregivers) • Social interactions, recreation/interests, lifestyle • Family history of SUDs • Availability of support systems (e.g., family, friends, close others) • Housing, education, and job histories • Military history • Ethnic and cultural background • Legal history (e.g., involvement in the criminal justice system)	• Collateral information from others (e.g., family, caregivers) • Social interactions, recreation/interests, lifestyle • Family history of mental disorders • Availability of support systems (e.g., family, friends, close others) • Housing, education, and employment histories • Military history • Ethnic and cultural background • Legal history (e.g., involvement in the criminal justice system)

TWELVE STEPS IN THE ASSESSMENT PROCESS

Step 1: Engage the client.

Step 2: Identify and contact collaterals (family, friends, other providers) to gather additional information.

Step 3: Screen for and detect CODs.

Step 4: Determine quadrant and locus of responsibility.

Step 5: Determine level of care.

Step 6: Determine diagnosis.

Step 7: Determine disability and functional impairment.

Step 8: Identify strengths and supports.

Step 9: Identify cultural and linguistic needs and supports.

Step 10: Identify problem domains.

Step 11: Determine stage of change.

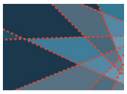
Step 12: Plan treatment.

Assessment Step 1: Engage the Client

The first step in the assessment process is to engage the client in an empathic, welcoming manner and build rapport to facilitate open disclosure of information regarding mental illness, SUDs, and related concerns. The aim is to create a safe and nonjudgmental environment in which sensitive personal information may be discussed. Counselors should recognize that cultural matters, including the use of the client's preferred language, play a role in creating a sense of safety and promote accurate understanding of the client's situation and options. Such topics therefore must be addressed sensitively at the outset and throughout the assessment process.

The consensus panel identified five key concepts that underlie effective engagement during initial clinical contact:

- Universal access ("no wrong door")
- Empathic detachment
- Person-centered assessment
- Cultural sensitivity
- Trauma-informed services



All staff, including SUD treatment providers and mental health clinicians, in any service setting need to develop competency in engaging and welcoming individuals with CODs. (See Chapter 5 for a discussion of working successfully with people who have CODs and establishing a therapeutic alliance.) Whereas engagement is presented here as the first necessary step for assessment to take place, in a larger sense engagement represents an ongoing concern of the counselor—to understand the client's experience and to keep him or her positive and engaged relative to the prospect of better health and recovery.

No Wrong Door

"No wrong door" refers to formal recognition by a service system that individuals with CODs may enter through a range of community service sites, that they are a high priority for engagement in treatment, and that proactive efforts are necessary to welcome them into treatment and prevent them from falling through the cracks. Addiction and mental health counselors are encouraged to identify individuals with CODs, welcome them into the service system, and initiate proactive efforts to help them access appropriate treatment in the system, regardless of their initial site of presentation. The recommended attitude counselors should embody is, **"The purpose of this assessment is not just to determine whether the client fits in my program but to help the client figure out where he or she fits in the system of care and to help him or her get there."**

Empathic Detachment

Empathic detachment requires the assessing clinician to:

- Acknowledge that the provider and client are working together to make decisions to support the client's best interest.
- Recognize that the provider cannot transform the client into a different person but can only support change that he or she is already making.
- Maintain an empathic connection even if the client does not seem to fit into the provider's expectations, treatment categories, or preferred methods of working.

Providers should be prepared to demonstrate responsiveness to the requirements of treating clients with CODs. Counselors should be careful not to label mental disorder symptoms immediately as caused by addiction but instead should be comfortable with the strong possibility that a mental disorder may be present independently and encourage disclosure of information that will help clarify the meaning of any CODs for that client. (See Chapter 4 for guidance on distinguishing independent mental disorders from substance-induced mental disorders.)

Person-Centered Assessments

Person-centered assessments emphasize that the focus of initial contact is not on getting forms filled out or answering a battery of questions, or on establishing program fit. Instead the focus is on finding out what the client wants, seen from his or her perspective on the problem, what he or she wants to change, and how he or she thinks that change will occur.

Ewing, Austin, Diffin, and Grande (2015) developed an evidence-based practice tool for conducting person-centered assessment and planning with caregivers of palliative care patients. The framework and key approaches they propose could be generalized to other health issues—including mental illness and substance misuse—and offer useful guidance for ensuring assessment processes are focused on the client and his or her problems, goals, and needs. However, research is needed on the use of their framework in people with CODs.

Sensitivity to Culture, Gender, and Sexual Orientation

An important component of a person-centered assessment is always recognizing the significant role of culture on a client's view of problems and treatments. Cultures differ significantly in their views of SUDs and mental disorders, which may affect how a client presents. Clients may participate in treatment cultures (mutual-support programs, Dual Recovery Self-Help, psychiatric rehabilitation) that also affect their view of treatment. Cultural sensitivity requires recognizing one's own cultural perspective and having a genuine spirit of inquiry into how cultural factors influence the clients' requests for help.

During the assessment process, counselors should learn about clients' sexual orientation and any gender identity matters, as part of understanding the clients' personal identity, living situation, and relationships. Counselors should also be aware that clients often have family-related and other concerns that must be addressed to engage them in treatment, such as the need for child care.

For more information about culturally competent treatment, see Chapters 5 and 6 of this TIP as well as TIP 59, *Improving Cultural Competence* (SAMHSA, 2014a) and TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (SAMHSA, 2009c).

Trauma-Informed Care

The high prevalence of trauma in individuals with CODs requires a clinician to consider the possibility of a trauma history even before beginning to assess the client. Trauma may include early childhood physical, sexual, or emotional abuse; experiences of rape or interpersonal violence as an adult; and traumatic experiences associated with political oppression, as might be the case in refugee or other immigrant populations. The approach to the client must be sensitive to the possibility that the client has suffered previous traumatic experiences that may interfere with his or her ability to trust the counselor. A clinician who observes guardedness on the part of the client should consider the possibility of trauma and try to promote safety in the interview by providing support and gentleness, rather than trying to "break through" evasiveness that might look like resistance or denial. All questioning should avoid "retraumatizing" the client.

See Chapter 4 for information about trauma-informed care, Chapter 6 for information on women's concerns in CODs, and TIP 57, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA, 2014b).

Assessment Step 2: Identify and Contact Collaterals (Family, Friends, Other Providers) To Gather Additional Information

Clients presenting for SUD treatment, particularly those who have current or past mental disorder symptoms, may be unable or unwilling to report past or present circumstances accurately. For this reason, all assessments should include routine procedures for identifying and contacting family and other collaterals (with clients' permission) who may have useful information.

Information from collaterals is valuable as a supplement to the client's own report in all of the assessment steps listed in the remainder of this chapter. It is valuable particularly in evaluating the nature and severity of mental disorder symptoms when the client may be so impaired that he or she is unable to provide that information accurately. Note, however, that the process of seeking such information must be carried out strictly in accordance with applicable guidelines and laws regarding confidentiality¹ and with the client's permission.

Assessment Step 3: Screen for and Detect CODs

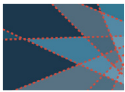
Because of the high prevalence of co-occurring mental disorders in SUD treatment settings, and because treatment outcomes for individuals with multiple problems improve if each problem is addressed specifically, the consensus panel recommends that:

- **SUD treatment providers screen all new clients for co-occurring mental disorders.**
- **Mental disorder treatment providers screen all new clients for any substance misuse.**

The type of screening will vary by setting. Substance misuse screening in mental disorder service settings should:

- Screen for acute safety risk related to serious intoxication or withdrawal.

¹ 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).



- Screen for past and present substance use, substance-related problems, and substance-related disorders (i.e., SUDs and substance-induced mental disorders).

Mental disorder screening has four major components in SUD treatment settings:

- Screen for acute safety risk, including for:
 - Suicide.
 - Violence to others.
 - Inability to care for oneself.

- Risky behaviors.
- Danger of physical or sexual victimization.
- Screen for past and present mental illness symptoms and disorders.
- Screen for cognitive and learning deficits.
- Regardless of setting, screen all clients for past and present victimization and trauma.

Exhibit 3.3 lists recommended, validated screening tools across behavioral health service settings.

EXHIBIT 3.3. Recommended Screening Tools To Help Detect CODs

Client safety

- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Suicide Behaviors Questionnaire-Revised (SBQ-R)
- Risk of harm section of the LOCUS
- Humiliation, Afraid, Rape, and Kick

Past or present mental disorders

- ASI
- Mental Health Screening Form-III (MHSF-III)
- Modified Mini Screen
- *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. [DSM-5]; American Psychiatric Association, 2013) Cross-Cutting Symptom Measure

Past or present substance misuse

- 10-item Drug Abuse Screening Test (DAST-10)
- Alcohol Use Disorders Identification Test (AUDIT) and Alcohol Use Disorders Identification Test—Concise (AUDIT-C)
- CAGE Questionnaire Adapted To Include Drugs
- Michigan Alcoholism Screening Test (MAST)
- National Institute on Drug Abuse (NIDA)-Modified Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Simple Screening Instrument for Substance Abuse (SSI-SA)

Trauma

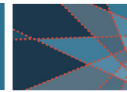
- The Primary Care PTSD Screen for DSM-5
- The PTSD Checklist for DSM-5

Level of care

- LOCUS

Functioning and impairment

- World Health Organization (WHO) Disability Assessment Schedule 2.0



Safety Screening

Safety screening requires that, early in the interview, the provider specifically ask the client whether he or she has any immediate impulse to engage in violent or self-injurious behavior, or whether he or she is in any immediate danger from others. These questions should be asked directly of the client and of anyone else who is providing information. If the answer is yes, the provider should obtain more detailed information about the nature and severity of the danger, the client's ability to avoid the danger, the immediacy of the danger, what the client needs to do to be safe and feel safe, and any other information relevant to safety. Additional information can be gathered depending on counselor/staff training for crisis/emergency situations and the interventions appropriate to the treatment provider's particular setting and circumstances. Once this information is gathered, **if it appears that the client is at immediate risk, the provider should arrange for a more indepth risk assessment by a mental health-trained clinician, and the client should not be left alone or unsupervised.**

Screening for Risk of Suicide or Self-Harm

A variety of validated tools are available for screening for risk of suicide or other self-harm:

- C-SSRS is a commonly used, well-supported tool to quickly assess suicidal ideation, behavior, and lethality in adult and adolescent populations (Posner et al., 2011). It is available in over 100 languages and has been used in many settings that serve people with CODs, including primary care, military hospitals, and the criminal justice system. Screeners can be selected based on the setting in which they are being used, the population being screened, and the language needed. Columbia University maintains versions of the C-SSRS at <http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english>.
- SBQ-R (Osman et al., 2001) has demonstrated good reliability and validity in measuring past suicide attempts, frequency of suicidal ideation, previous suicidal communication, and likelihood of future suicide attempt in adults in inpatient and community settings (Batterham et al., 2015). For the full instrument with an overview and scoring instructions, see Exhibits 3.4 through 3.6, beginning on page 44.
- Some systems use the LOCUS (Sowers, 2016) to determine level of care for both mental disorders and addiction. One dimension of LOCUS specifically provides guidance for scoring severity of risk of harm.

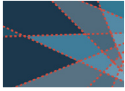


EXHIBIT 3.4. The Suicide Behaviors Questionnaire-Revised (SBQ-R) - Overview

The SBQ-R has 4 items, each tapping a different dimension of suicidality:*

- Item 1 taps into lifetime suicide ideation and/or suicide attempt.
- Item 2 assesses the frequency of suicidal ideation over the past twelve months.
- Item 3 assesses the threat of suicide attempt.
- Item 4 evaluates self-reported likelihood of suicidal behavior in the future.

Clinical Utility

Due to the wording of the four SBQ-R items, a broad range of information is obtained in a very brief administration. Responses can be used to identify at-risk individuals and specific risk behaviors.

Scoring

See scoring guideline on the following page.

Psychometric Properties*

	Cutoff Score	Sensitivity	Specificity
Adult General Population	≥7	93%	95%
Adult Psychiatric Inpatients	≥8	80%	91%

*Osman A, Bagge CL, Gutierrez PM, Konick LC, Kooper BA, Barrios FX. The Suicidal Behaviors Questionnaire-Revised (SBQ-R): Validation with clinical and nonclinical samples. *Assessment*, 2001, (5), 443-454.

Source: Center for Quality Assessment and Improvement in Mental Health (2007).

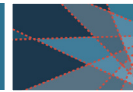
EXHIBIT 3.5. SBQ-R-Scoring

ITEM 1: TAPS INTO LIFETIME SUICIDE IDEATION AND/OR SUICIDE ATTEMPTS

Selected response 1	Non-Suicidal subgroup	1 point	Total Points
Selected response 2	Suicide Risk Ideation group	2 points	
Selected response 3a or 3b	Suicide Plan subgroup	3 points	
Selected response 4a or 4b	Suicide Attempt subgroup	4 points	

ITEM 2: ASSESSES THE FREQUENCY OF SUICIDAL IDEATION OVER THE PAST 12 MONTHS

Selected Response:	Never	1 point	Total Points
	Rarely (1 time)	2 points	
	Sometimes (2 times)	3 points	
	Often (3-4 times)	4 points	
	Very often (5 or more times)	5 points	

**ITEM 3: TAPS INTO THE THREAT OF SUICIDE ATTEMPT**

Selected response 1		1 point	
Selected response 2a or 2b		2 points	
Selected response 3a or 3b		3 points	Total Points

ITEM 4: EVALUATES SELF-REPORTED LIKELIHOOD OF SUICIDAL BEHAVIOR IN THE FUTURE

Selected Response:	Never	0 point	
	No chance at all	1 points	
	Rather unlikely	2 points	
	Unlikely	3 points	
	Likely	4 points	
	Rather Likely	5 points	
	Very Likely	6 points	Total Points

Sum all the scores circled/checked by the respondents.

The total score should range from 3-18.

Total Score

AUC = AREA UNDER THE RECEIVER OPERATING CHARACTERISTIC CURVE; THE AREA MEASURES DISCRIMINATION, THAT IS, THE ABILITY OF THE TEST TO CORRECTLY CLASSIFY THOSE WITH AND WITHOUT THE RISK. [.90-1.0 = EXCELLENT; .80-.90 = GOOD; .70-.80 = FAIR; .60-.70 = POOR]

	Sensitivity	Specificity	PPV	AUC
Item 1: a cutoff score of ≥ 2				
Validation Reference: Adult Inpatient	0.80	0.97	.95	0.92
Validation Reference: Undergraduate College	1.00	1.00	1.00	1.00
Total SBQ-R: a cutoff score of ≥ 7				
Validation Reference: Undergraduate College	0.93	0.95	0.70	0.96
Total SBQ-R: a cutoff score of ≥ 8				
Validation Reference: Adult Inpatient	0.80	0.91	0.70	0.96

EXHIBIT 3.6. SBQ-R Suicide Behaviors Questionnaire—Revised

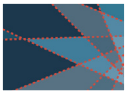
Patient Name _____ Date of Visit _____

Instructions: Please check the number beside the statement or phrase that best applies to you.

Have you ever thought about or attempted to kill yourself? (check one only)

- ☐ 1. Never
- ☐ 2. It was just a brief passing thought
- ☐ 3a. I have had a plan at least once to kill myself but did not try to do it

Continued on next page

*Continued*

- ☐ 3b. I have had a plan at least once to kill myself and really wanted to die
- ☐ 4a. I have attempted to kill myself, but did not want to die
- ☐ 4b. I have attempted to kill myself, and really hoped to die

How often have you thought about killing yourself in the past year? (check one only)

- ☐ 1. Never
- ☐ 2. Rarely (1 time)
- ☐ 3. Sometimes (2 times)
- ☐ 4. Often (3-4 times)
- ☐ 5. Very Often (5 or more times)

Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)

- ☐ 1. No
- ☐ 2a. Yes, at one time, but did not really want to die
- ☐ 2b. Yes, at one time, and really wanted to die
- ☐ 3a. Yes, more than once, but did not want to do it
- ☐ 3b. Yes, more than once, and really wanted to do it

How likely is it that you will attempt suicide someday? (check one only)

- ☐ 0. Never
- ☐ 1. No chance at all
- ☐ 2. Rather unlikely
- ☐ 3. Unlikely
- ☐ 4. Likely
- ☐ 5. Rather likely
- ☐ 6. Very likely

Copyright © Osman et al. (2001). All Rights Reserved.

For more indepth discussion of how to manage suicidal ideation and behaviors in clients seeking treatment for substance misuse, see Chapter 4 of this TIP as well as TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT], 2009).

No tool is definitive for safety screening. Providers and programs should use one of these tools only as a starting point, and then use more detailed questions to get all relevant information.

Providers should not underestimate risk because the client is actively using substances. For example, although people who are intoxicated might only seem to be making threats of self-harm (e.g., “I’m just going to go home and blow my head off if nobody around here can help me”), all statements about harming oneself or others must be taken seriously. Individuals who have suicidal or aggressive impulses when intoxicated may act on those impulses. Remember, alcohol and drug misuse are among the highest predictors of danger to self or others—even without any co-occurring mental disorder.

Determining whether and to what extent an intoxicated client may be suicidal requires a skilled mental health assessment, plus information from collaterals who know the client best. (See Chapter 4 for a more detailed discussion of suicidality in people with CODs.) In addition, remember that the vast majority of people who are misusing substances will experience at least transient symptoms of depression, anxiety, and other mental disorders. Moreover, even a skilled clinician may not be able to determine whether an intoxicated suicidal patient is making a serious threat of self-harm; however, safety is a critical and paramount concern.

Positive Suicide Screens

If a client screens positive for suicide risk, counselors should conduct a suicide risk assessment to more thoroughly determine the client's potential for self-harm. No generally accepted and standardized suicide assessment has been shown to be reliable and valid, but most established suicide assessments contain similar elements. The assessment questions below are drawn from the National Institute of Mental Health's Ask Suicide-Screening Questions (ASQ) Toolkit (n.d.; <https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml>).

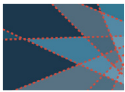
Ask questions about the client's feelings about living, such as:

- Ask questions about the client's feelings about living, such as:
 - "Do you ever wish you weren't alive?"
 - "Have you ever felt that your life wasn't worth living any longer?"
- For people who endorse thoughts of suicide or self-harm questions, ask questions like:
 - "Do you have any thoughts of killing yourself now?"
 - "Do you have a plan for how you would kill yourself?"
 - "If you decided to kill yourself, how would you do it?"
- For people who have tried to commit suicide in the past, ask:
 - "Why did you try to commit suicide? When was this? What were the circumstances? What did you do?"
 - "What happened after you tried to kill yourself?"
 - "Did you want to die?"
 - "Did you get medical or psychiatric treatment after? Was treatment offered to you? (If yes) How did that go for you?"
- Also be sure to ask about other symptoms and factors that might increase or decrease risk of dying by suicide, such as:
 - "What are some reasons you would not kill yourself?"
 - "Do you know anyone who has killed themselves or tried to?"
 - "In the past few weeks, have you felt so sad or down that it was hard to do things you normally enjoy?"
 - "In the past few weeks, have you felt hopeless or as though things will never get better?"
 - "Do you often act without thinking?"
 - "Is there a trusted adult or other person you can talk to?"
 - "Are there any problems in your household that are hard to handle?"

The provider needs to determine, based on the client's assessment responses, whether the risk of imminent suicide is mild, moderate, or high. The provider must also determine to what degree the client is willing and able to follow through with a set of interventions to keep safe. Screening personnel should also assess whether suicidal feelings are transitory or reflect a chronic condition.

Factors that may predispose a client toward suicide should also be considered in client evaluation. Vulnerable populations include (U.S. Department of Health and Human Services, 2012):

- American Indians/Alaska Natives.
- Individuals who have lost a loved one to suicide.
- Individuals involved in the criminal justice system or child welfare system.
- Individuals who engage in nonsuicidal self-injury (see Section III of DSM-5).
- Individuals with a history of suicide attempts.
- Individuals with debilitating physical conditions.
- Individuals with mental disorders, SUDs, or both.
- Individuals in the lesbian/gay/bisexual/transgender/questioning community.



- Members of the armed forces and veterans.
- Middle-aged and older men.

Asking people about thoughts of suicide does not make them more likely to try to kill themselves. On the contrary, asking about suicide displays a level of care and concern that can help people with suicidal thoughts and intentions open up and feel more receptive to help. Counselors should not avoid asking such questions out of fear that asking them will “put the idea” of suicide into their clients’ minds; this is simply not true.

Counselors should also be prepared to probe the client’s likelihood of inflicting harm on another person. Specifically, **counselors should ask questions that establish whether homicidal ideation, plans, means, access, and protective factors are present. Also ask about past experiences and future expectations.** Questions can include the following:

- “Have you had any thoughts of harming others?”
- “Have you had any thoughts of harming anyone specific? Who?”
- “If you decided to harm (*name of person*), how would you do it?”
- “On a scale of 0 to 10, with 0 meaning ‘not likely at all,’ how likely are you to harm this person in the next week?”
- “What reasons do you have to not harm this person? What might stop you from harming him/her?”
- “What else could you do to deal with your anger (*or name whatever other feelings the client reports feeling*) instead of harming this person?”
- “In the past, have you acted on thoughts of harming someone? What happened?”
- “How might your life change if you harm this person? What might happen to you or to your family? What might happen to this person’s family?”
- “Would you be willing to agree to tell someone before you do this?”
- “How confident are you in remaining sober over the next week? What can you do to increase the chances you will remain sober? (for example, use of 12-Step meetings, supports, or treatment).”

Screening for Risk of Violence

The U.S. Preventive Services Task Force (USPSTF) recommends that providers routinely screen all women of childbearing age for risk of intimate partner violence (USPSTF, 2016). Similarly, addiction counselors and mental health counselors should be vigilant for risk of victimization among female clients, although men too can and do experience intimate partner violence and should be screened if counselors suspect victimization. The screener recommended for high sensitivity and specificity (Arkins, Begley, & Higgins, 2016; USPSTF, 2016) is called **Humiliation, Afraid, Rape, and Kick**. This four-question tool (which has been validated only for women) screens for emotional, physical, and sexual violence (Sohal, Eldridge, & Feder, 2007). See Appendix C for the tool.

Screening for Past and Present Mental Disorders

Screening for past and present mental disorders accomplishes three goals:

1. **To understand a client’s history and, if the history is positive for a mental disorder, to alert the counselor and treatment team to the types of symptoms that may reappear** so that the counselor, client, and staff can watch out for the emergence of any such symptoms.
2. **To identify clients who may have a current mental disorder** and need assessment to determine the nature of the disorder and an evaluation to plan for its treatment.
3. **To determine the nature of the symptoms that may increase and decrease to help clients with current CODs monitor their symptoms—**especially how the symptoms improve or worsen in response to medications, “slips” (i.e., substance use), and treatment interventions. For example, clients often need help seeing that the treatment goal of avoiding isolation improves their mood. So, when they call their sponsor and go to a meeting, they break the cycle of depressed mood, seclusion, dwelling on oneself

and one's mood, increased depression, and other symptoms or consequences of depression.

Several screening, assessment, and treatment planning tools are available to assist the SUD treatment team (see Appendix C). Hundreds of assessment and treatment planning tools exist for assessment of specific disorders and for differential diagnosis and treatment planning. The National Institute on Alcohol Abuse and Alcoholism offers professional education materials that address screening and assessment for alcohol misuse, including links to several screening instruments (www.niaaa.nih.gov/publications/clinical-guides-and-manuals). A NIDA research report (NIDA, 2018a) provides broad background information on assessment processes pertinent to CODs and specific information on many mental disorders, treatment planning, and substance misuse tools. The mental health field contains a vast array of screening and assessment devices, and subfields are devoted primarily to the study and development of evaluative methods.

Almost all SAMHSA TIPs, available online (<https://store.samhsa.gov/series/tip-series-treatment-improvement-protocols-tips>), have a section on assessment; many have appendixes with wholly reproduced assessment tools or information about locating such tools.

Advanced assessment techniques include assessment instruments for general and specific purposes and advanced guides to differential diagnosis. Most highpower assessment techniques center on a specific type of problem or set of symptoms, are typically lengthy, often require specific doctoral training to use, and can be difficult to adapt properly for some SUD treatment settings. For these reasons, such assessments are not included in this publication.

When using any of the wide array of tools that detect symptoms of mental disorders, counselors should bear in mind that symptoms of a mental disorder can be mimicked by substances. For example, hallucinogens may produce symptoms that resemble psychosis, and depression commonly

occurs during withdrawal from many substances. Even with well-tested tools, distinguishing between a mental disorder and a substance-related disorder can be difficult without additional information such as the history and chronology of symptoms. In addition to interpreting the results of such instruments in the broader context of what is known about the client's history, counselors are also reminded that retesting often is important, particularly to confirm diagnostic conclusions for clients who have used substances.

The next section briefly highlights some instruments available for mental disorder screening.

Mental Health Screening Tools

MHSF-III

MHSF-III (Exhibit 3.7) has only 17 simple questions and is designed to screen for present or past symptoms of most major mental disorders (Carroll & McGinley, 2001). The MHSF-III was developed in an SUD treatment setting, and it has face validity—that is, if a knowledgeable diagnostician reads each item, it is clear that a “yes” would warrant further evaluation of the client for the mental disorder for which the item represents typical symptomatology. It has been used as a part of integrated behavioral health and physical health services (Chaple, Sacks, Randell, & Kang, 2016) and in behavioral health courts (Miller & Khey, 2016). The MHSF-III is reprinted in Appendix C.

The MHSF-III is only a screening device, because it asks only one question for each disorder for which it attempts to screen. If a client answers “no” because of a misunderstanding of the question or a momentary lapse in memory focus, the screen will produce a “false negative.” This means the client might have the mental disorder, but the screen falsely indicates that he or she probably does not have the disorder.

The MHSF-III is scored by totaling the “yes” responses (1 point each), for a maximum score of 17. A “yes” response to any of the items on questions 3 through 17 suggests that a qualified mental health specialist should be consulted to determine whether follow-up, including a diagnostic interview, is warranted.

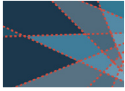


EXHIBIT 3.7. Mental Health Screening Form-III

Please circle “yes” or “no” for each question.

1. Have you <i>ever</i> talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?	Yes	No
2. Have you <i>ever</i> felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?	Yes	No
3. Have you <i>ever</i> been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?	Yes	No
4. Have you <i>ever</i> been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?	Yes	No
5. Have you <i>ever</i> heard voices no one else could hear or seen objects or things which others could not see?	Yes	No
6. (a) Have you <i>ever</i> been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself?	Yes	No
(b) Did you <i>ever</i> attempt to kill yourself?	Yes	No
7. Have you <i>ever</i> had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed?	Yes	No
8. Have you <i>ever</i> experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?	Yes	No
9. Have you <i>ever</i> given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property?	Yes	No
10. Have you <i>ever</i> felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior?	Yes	No
11. Have you <i>ever</i> experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?	Yes	No
12. Was there <i>ever</i> a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate binge eating, taking enemas, or forcing yourself to throw up?	Yes	No
13. Have you <i>ever</i> had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly nonstop, when you moved quickly from one activity to another, when you needed little sleep, and when you believed you could do almost anything?	Yes	No
14. Have you <i>ever</i> had spells or attacks when you suddenly felt anxious, frightened, or uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, or you felt dizzy or unsteady, as if you would faint?	Yes	No

Continued on next page

Continued

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate.	Yes No
16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, or with your family and friends as a result of your gambling?	Yes No
17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?	Yes No

Source: Carroll & McGinley (2000). The MHSF-III may be reproduced or copied, in entirety, without permission.

Counselors should bear in mind that symptoms of substance misuse can mimic symptoms of mental disorders.

Modified Mini Screen

The Mini-International Neuropsychiatric Interview (M.I.N.I.) is a simple tool that takes 15 to 30 minutes to administer and that covers 20 mental disorders and SUDs. Considerable validation research exists on the M.I.N.I. (Sheehan et al., 1998). However, a modified version of the M.I.N.I.—the Modified Mini Screen (MMS)—that contains only 22 items can be used to screen even more quickly for mental disorders in three diagnostic areas: mood disorders, anxiety disorders, and psychotic disorders. The MMS has been validated for use with adults in SUD treatment, social service, and criminal justice settings (Alexander, Layman, & Haugland, 2013; SAMHSA, 2015b).

ASI

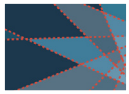
The ASI (McLellan et al., 1992) does not screen for mental disorders and provides only a lowpower screen for generic mental health concerns. Use of the ASI ranges widely. Some SUD treatment programs use a scaledown approach to gather basic information about a client's alcohol use;

drug use; legal status; and employment, family/ social, medical, and psychiatric status. Other programs use the ASI as an indepth assessment and treatment planning instrument, with a trained interviewer administering it and making complex judgments about the client's presentation and attitudes about and willingness to take the ASI. Counselors can be trained to make clinical judgments about how the client comes across, how genuine and legitimate the client's way of responding seems, whether there are any safety or selfharm concerns requiring further investigation, and where the client falls on a nine-point scale for each dimension.

With about 200 items, the ASI is a lowpower instrument with a broad range, covering the seven areas mentioned previously and requiring about 1 hour to complete. The continuing development of and research into the ASI includes training programs, computerization, and critical analyses. It is a public domain document that has been used widely for two decades. It has been found to be effective in predicting inpatient psychiatric admissions among people seeking SUD treatment (Drymalski & Nunley, 2016).

DSM-5 Cross-Cutting Symptom Measure

Among the major revisions to DSM-5 was the inclusion of a newly developed patient assessment tool to help providers screen for common mental



disorders and symptoms needing treatment, including major depression, generalized anxiety, mania, somatic conditions, sleep disturbance, cognitive dysfunction, and substance misuse. The DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult contains 23 items that correspond to diagnostic categories in DSM-5 (e.g., depressive disorders, psychotic disorders) or to specific symptom domains (e.g., mania, anger, suicidal ideation).

Because the screener is included in DSM-5's Section III for "emerging measures," meaning it requires further research before being implemented in routine clinical practice, little is known about its validation. No published studies to date have examined its use with COD populations. Nonetheless, the measure is worthy of consideration, especially in research settings. It is available online with scoring information (<https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures#Disorder>).

Screening for Past and Present SUDs

This section is intended primarily for counselors working in mental health service settings and suggests ways to screen clients for substance misuse.

Screening begins with inquiry about past and present substance use and related problems and disorders. **If the client answers "yes" to having problems or a disorder, further assessment is warranted. If the client acknowledges a past substance problem but states that it is now resolved, assessment is still required.** Careful exploration of what current strategies the individual is using to prevent relapse is warranted. Such information can help ensure that the individual continues to use those strategies while focusing on mental health services.

Screening for the presence of substance misuse involves four components, which are:

- Substance misuse symptom checklists.
- Substance misuse severity assessment.
- Formal screening tools that work around denial.
- Screening of urine, saliva, or hair samples.

Symptom Checklists

Checklists address common categories of substances, problems associated with use for a given substance, and a history of meeting SUD criteria. Overly detailed checklists are unhelpful; they lose value as simple screening tools. Including misuse of over-the-counter medication (e.g., cold medications) and of prescribed medication is helpful.

Severity Assessment

Monitor the severity of an SUD (if present). This process can begin with simple questions about past or present diagnosis of an SUD and the client's experience of associated difficulties. DSM-5 offers guidance on assessing SUD severity based on symptom count. Specifically, two to three symptoms would be considered a mild SUD, four or five a moderate SUD, and six or more a severe SUD (American Psychiatric Association [APA], 2013). Some programs may use formal SUD diagnostic tools; others use the ASI (McLellan et al., 1992) or similar instruments, even in the mental disorder service setting.

SCREENING AND INTOXICATION/WITHDRAWAL

Counselors cannot formally screen or assess clients who are actively intoxicated. If clients are obviously intoxicated, treat them with empathy and firmness, and ensure their physical safety.

If clients report that they are experiencing withdrawal, or appear to be exhibiting signs of withdrawal, formal withdrawal scales can help even inexperienced providers gather information from which medically trained personnel can determine if medical intervention is required. Such tools include the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (Sullivan, Sykora, Schneiderman, Naranjo, & Sellers, 1989) for alcohol withdrawal and the Clinical Institute Narcotic Assessment (Zilm & Sellers, 1978) for opioid withdrawal. These are included in Appendix C.

Substance Misuse Screening Tools

AUDIT and AUDIT-C

The AUDIT (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001) and its abbreviated version, the AUDIT-C (Bush, Kivlahan, McDonell, Fihn, & Bradley, 1998), have been validated for use in screening adults at risk for alcohol misuse (Dawson, Smith, Saha, Rubinsky, & Grant, 2012; Johnson, Lee, Vinson, & Seale, 2013). These instruments measure current alcohol use, drinking behaviors, and consequences of drinking. Cutoff scores suggesting hazardous alcohol use are 8 or higher on the AUDIT (Babor et al., 2001) and 3 or higher on the AUDIT-C for SUD or heavy drinking (Bush et al., 1998). Both measures are in Appendix C.

CAGE-AID

The CAGE-AID (Cut Down, Annoyed, Guilty, Eye-opener—Adapted to Include Drugs) is a variation of the four-question CAGE screener, which focuses solely on detecting alcohol misuse. The CAGE-AID instead screens for drug use and alcohol misuse. It is brief, valid, and reliable (Mdege & Lang, 2011), and recommended by the USPSTF and others for substance misuse screening, particularly in primary care populations (Halloran, 2013; Lanier & Ko, 2008). Respondents who endorse one or more items on the CAGE-AID should be considered for full assessment of substance misuse. The CAGE-AID is online at <https://www.hiv.uw.edu/page/substance-use/cage-aid>.

NIDA-Modified ASSIST

WHO's ASSIST tool (WHO ASSIST Working Group, 2002) is an effective measure for lifetime and current substance misuse, but its length and complex computer scoring system have hindered its widespread adoption. NIDA developed an abbreviated version called the NIDA-Modified ASSIST, which is recommended by APA for use with DSM-5 (NIDA, 2015) and is recommended for primary care as well as general medical populations (NIDA, 2012; Zgierska, Amaza, Brown, Mundt, & Fleming, 2014).

The NIDA-Modified ASSIST can be completed online (www.drugabuse.gov/nmassist/) or on paper. It opens with a Quick Screen to determine whether further assessment is warranted. If the client

answers as at risk on the Quick Screen, the full NIDA-Modified ASSIST should be administered.

DAST-10

The DAST-10 (Skinner, 1982) is a moderately-to-highly reliable and valid measure that has been widely used in practice and research (Mdege & Lang, 2011; Yudko, Lozhkina, & Fouts, 2007). It assesses past-year use of substances other than alcohol and can be administered quickly. Scores of 3 or higher warrant consideration of further assessment for a possible SUD (Skinner, 1982). The DAST-10 can be accessed online (<https://www.hiv.uw.edu/page/substance-use/dast-10>).

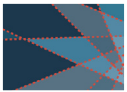
MAST

The MAST (Selzer, 1971) is a widely used self-report screening tool for problematic substance use. A systematic review of its psychometric properties suggests the MAST is moderate to robust in reliability and validity (Minnich, Erford, Bardhoshi, & Atalay, 2018).

This 25-item measure asks about lifetime alcohol use and consequences. It takes 8 to 10 minutes to complete. A score of 0 to 3 suggests no drinking problems. A score of 4 suggests early or moderate problems. A score of 5 or higher indicates problem drinking and warrants further assessment. See Appendix C for the measure.

SSI-SA

Developed by CSAT, the SSI-SA (CSAT, 1994) screens for alcohol consumption and other substance use, preoccupation and loss of control, negative consequences of substance use, problem recognition, and tolerance and withdrawal. The SSI-SA has strong psychometric properties (Boothroyd, Peters, Armstrong, Ryneerson-Moody, & Caudy, 2015) and includes items drawn from existing validated substance screeners, including the AUDIT, CAGE, DAST, and MAST. It is often used in criminal justice settings (SAMHSA, 2015b) but also has been found effective in hospital settings (Mdege & Lang, 2011). A score of 4 or higher is considered indicative of moderate to high risk of substance misuse and warrants further assessment (Boothroyd et al., 2015). See Appendix C for this instrument.



Trauma Screening

Trauma refers to an event or circumstance experienced, witnessed, or learned of by an individual that has a protracted, negative influence on his or her physical, emotional, psychological, social, spiritual, or functional well-being. Common traumatic events include childhood maltreatment (e.g., physical, sexual, or emotional abuse; neglect); being a victim of physical or sexual assault; experiencing a terrorist event, natural or man-made disaster, accident, fire, or mass casualty event; repeatedly being exposed to details of horrific or violent events (e.g., first responders seeing injured or dead victims, police officials repeatedly hearing details about child abuse); or learning that something extremely disturbing happened to a loved one or close friend (e.g., learning that your child has died).

Trauma is common in individuals with SUDs, mental disorders, or both, particularly women and military populations (Berenz & Coffey, 2012; Carter, Capone, & Short, 2011; Gilmore et al., 2016; Kline et al., 2014; Konkoly Thege et al., 2017; Mandavia, Robinson, Bradley, Ressler, & Powers, 2016; Mason & Du Mont, 2015; Palmer et al., 2016; Vest, Hoopsick, Homish, Daws, & Homish, 2018; Walsh, McLaughlin, Hamilton, & Keyes, 2017; see also Chapter 4 for more discussion).

To determine whether trauma screening is warranted, counselors can ask clients about past traumatizing events directly or use a structured tool, like the Adverse Childhood Experiences Study Score Calculator (available online at <https://acestoohigh.com/got-your-ace-score/>). In screening for a history of trauma or obtaining a preliminary diagnosis of PTSD, asking clients to describe traumatic events in detail can be traumatizing. **Limit questioning to very brief and general questions**, such as “Have you ever experienced childhood physical abuse? Sexual abuse? A serious accident? Violence or the threat of it? Have there been experiences in your life that were so traumatic they left you unable to cope with day-to-day life?”

To screen for PTSD, assuming the client has a positive trauma history, consider using these scales:

- The Primary Care PTSD Screen for DSM-5 (Prins et al., 2015) and administration and scoring

information are available online (www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf).

- The PTSD Checklist for DSM-5 (Weathers et al., 2013) and administration and scoring information are available online (<https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>).

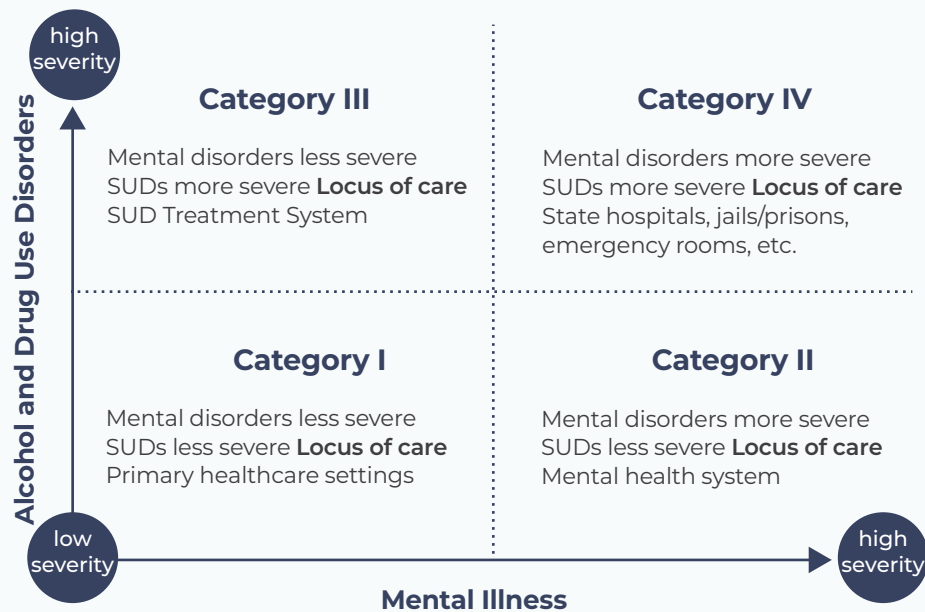
See TIP 57, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA, 2014b), for more indepth discussion of screening, assessment, and management of trauma in behavioral health populations. Valuable guidance about counseling people with CODs and trauma is in Chapter 7 of this TIP.

Assessment Step 4: Determine Quadrant and Locus of Responsibility

Quadrants of care (i.e., Four Quadrants Model) is a conceptual framework that classifies clients in four basic groups based on relative symptom severity, not diagnosis (Exhibit 3.8).

Quadrant assignment is based on the severity of the mental disorders and SUDs as follows:

- **Category/Quadrant I: This quadrant includes individuals with low-severity substance misuse and low-severity mental disorders.** These low-severity individuals can be accommodated in intermediate outpatient settings of either mental disorder or chemical dependency programs, with consultation or collaboration between settings if needed. Alternatively, some people will be identified and managed in primary care settings with consultation from mental health service or SUD treatment providers.
- **Quadrant II: This quadrant includes individuals with high-severity mental disorders who are usually identified as priority clients within the mental health system and who also have low-severity SUDs** (e.g., SUD in remission or partial remission). These individuals ordinarily receive continuing care in the mental health system and are likely to be well served in a variety of intermediate-level mental health programs using integrated case management.

EXHIBIT 3.8. Level of Care Quadrants

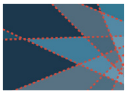
- **Quadrant III:** This quadrant includes individuals who have severe SUDs and low- or moderate-severity mental disorders. They are generally well accommodated in intermediate-level SUD treatment programs. In some cases, coordination and collaboration with affiliated mental health programs are needed to provide ongoing treatment of the mental disorders.
- **Quadrant IV:** Quadrant IV has two subgroups. One includes people with serious, persistent mental illness (SPMI) who also have severe and unstable SUDs. The other includes people with severe and unstable SUDs and severe and unstable behavioral problems (e.g., violence, suicidality) who do not (yet) meet criteria for SPMI. These individuals require intensive, comprehensive, and integrated services for both their SUDs and mental disorders. The locus of treatment can be specialized residential SUD treatment programs such as modified therapeutic communities in state hospitals, jails, or even in settings that provide acute care such as emergency departments (EDs).

The quadrants of care were derived from a conference, the National Dialogue on Co-Occurring

Mental Health and Substance Abuse Disorders, supported by SAMHSA and two of its centers—CSAT and the Center for Mental Health Services—and co-sponsored by the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD). The quadrants of care model was originally developed by Ries (1993) and used by the State of New York (NASMHPD & NASADAD, 1999; see also Rosenthal, 1992). It has two distinct uses:

- To help conceptualize an individual client's treatment and to guide improvements in system integration (for example, if the client has acute psychosis and is known to the treatment staff to have a history of alcohol use disorder (AUD), the client will clearly fall into Category IV—that is, severe mental disorder and severe SUD). However, the severity of the client's needs, diagnosis, symptoms, and impairments all determine level of care placement.
- To guide improvements in systems integration, including efficient allocation of resources.

The model is considered valid, reliable, and feasible (McDonnell et al., 2012), which is



particularly beneficial for clients with CODs given that conditions tend to fluctuate over time, underscoring the need for a stable framework that can accurately classify individuals and capture their potential treatment needs throughout the course of their illnesses.

Step 2 will collect most information necessary to make this determination, but there will sometimes be additional nuances to consider. Certain states formally specify procedures for quadrant determination. In the absence of formal procedures, SUD treatment providers in any setting can follow Exhibit 3.8.

Determination of SMI Status

Every state mental health system has developed a set of specific criteria for determining who can be considered seriously mentally ill and therefore eligible to be considered a mental health priority client. These criteria are based on combinations of specific diagnoses, severity of disability, and duration of disability (usually 6 months to 1 year). Some require that the condition be independent of an SUD. These criteria are different for every state. It would be helpful for SUD treatment providers to obtain copies of the criteria for their own states, as well as copies of the specific procedures by which eligibility is established by their states' mental health systems. By determining that a client might be eligible for consideration as a mental health priority client, the SUD treatment counselor can assist the client in accessing various services and benefits the client may not know are open to her or him.

To gauge SMI status, start by asking whether the client already gets mental health priority services (e.g., "Do you have a mental health case manager?" "Are you a Department of Mental Health client?").

- If the client already is a mental health client, then he or she will be assigned to quadrant II or IV. Contact the mental health case manager and establish collaboration to promote case management.
- If the client is not already a mental health client but appears to be eligible, and the client and family are willing, arrange a referral for eligibility determination.

- Clients who present in SUD treatment settings who look as if they might have SMI, but have not been so determined, should be considered to belong to quadrant IV.

For assistance in determining the severity of symptoms and disability, the SUD treatment provider can use the severity criteria listed in DSM-5. For disorders in which DSM-5 does not offer any guidance on determining severity, counselors can use Dimension 3 (Co-Morbidity) subscales in the LOCUS (see the section "Assessment Step 5: Determine Level of Care"), particularly the levels of severity of comorbidity and impairment/functionality.

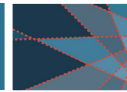
Determination of Severity of SUDs

Presence of active or unstable substance misuse or serious substance misuse as indicated by a DSM-5 severity rating of "severe" would identify the individual as being in quadrant III or IV. Less serious SUD (a DSM-5 severity rating of "mild" or "moderate") identifies the individual as being in quadrant I or II.

If the client is determined to have SMI with a serious SUD, he or she falls in quadrant IV; those with SMI and a mild SUD fall in quadrant II. A client with a serious SUD who has mental disorder symptoms that do not constitute SMI falls into quadrant III. A client with mild to moderate mental disorder symptoms and a less serious SUD falls into quadrant I.

Clients in quadrant III who present in SUD treatment settings are often best managed by receiving care in the SUD treatment setting, with collaborative or consultative support from mental health providers. Individuals in quadrant IV usually require intensive intervention to stabilize and determine eligibility for mental health services and appropriate locus of continuing care. If they do not meet SMI criteria, once their more serious mental symptoms have stabilized and substance use is controlled initially, they begin to look like individuals in quadrant III, and can respond to similar services.

Note, however, that this discussion of quadrant determination is not validated by clinical research. It is merely a practical approach to adapting an



ASSESSMENT STEP 5—APPLICATION TO CASE EXAMPLES (JANE B.)

Jane B. is a 28-year-old single White woman diagnosed with paranoid schizophrenia, AUD, and cocaine use disorder. She has a history of multiple episodes of sexual victimization. She is experiencing homelessness (living in a shelter), is actively psychotic, and will not admit to substance misuse. She often visits the local ED for mental and medical complaints but refuses follow-up treatment. Her main requests are for money and food, not treatment. Jane has been offered involvement in a housing program that requires no treatment engagement or sobriety but has refused because of paranoia about working with staff in this setting. Jane B. declines medication, given her paranoia, but does not seem acutely dangerous to herself or others.

The severity of Jane B.'s condition and her psychosis, homelessness, and lack of stability may lead the provider initially to consider psychiatric hospitalization or referral for residential SUD treatment. In fact, application of assessment criteria in the LOCUS might have led easily to that conclusion. In the LOCUS, more flexible matching is possible. The first consideration is whether the client meets criteria for involuntary psychiatric commitment (usually, suicidal or homicidal impulses, or inability to feed oneself or obtain shelter). In this instance, she is psychotic and experiencing homelessness but has been able to find food and shelter; she is unwilling to accept voluntary mental health services. Further, residential SUD treatment is inappropriate, both because she is completely unmotivated to get help and because she is likely to be too psychotic to participate in treatment effectively. The LOCUS would therefore recommend Level 3 – “High Intensity Community Based Services.”

If after extended participation in the engagement strategies described earlier, she began to take antipsychotic medication, after some time her psychosis might clear up, and she might begin to express interest in getting sober. In that case, if she had determined that she is unable to get sober on the street, residential SUD treatment would be indicated. Because of the longstanding severity of her mental illness, she likely would continue to have some level of symptoms of her mental disorder and disability even when medicated. In this case, Jane B. probably would require a residential program able to supply an enhanced level of services.

existing framework for clinical use, in advance of more formal processes being developed, tested, and disseminated.

In many systems, the process of assessment stops largely after assessment Step 4 with the determination of placement. Some information from subsequent steps (especially Step 7) may be included in this initial process, but usually more indepth or detailed consideration of treatment needs may not occur until after “placement” in an actual treatment setting.

Assessment Step 5: Determine Level of Care

Client placement in the appropriate care setting for his or her needs is necessary to optimize treatment completion and desirable outcomes. Placing a client in a level of care is also often required by private and public payers (i.e., Medicaid) for authorization of mental health services or SUD treatment decisions. Thus, the availability of valid

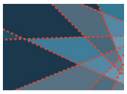
and reliable commonly used tools can not only help increase the odds of effective treatment matching but can help providers meet documentation requirements for reimbursement.

Tools for Determining Level of Care

LOCUS

The LOCUS Adult Version 20 (Sowers, 2016) can be used as a systemwide level of care assessment instrument for either mental disorder service settings only or for both mental disorder service and SUD treatment settings. The LOCUS uses multiple dimensions of assessment, including:

- Risk of harm.
- Functional status.
- Comorbidity (medical, addictive, psychiatric).
- Recovery environment.
- Treatment and recovery history.
- Engagement and recovery status.



The LOCUS (Plakun, 2018) helps:

- Determine a client's level of service needs.
- Describe all levels of care, from short-term outpatient services to inpatient residential care.
- Provide a quantified approach to defining level of care based on scores on its six dimensions.

LOCUS has a point system for each dimension that permits aggregate scoring to suggest level of service intensity. It permits level of care assessment for clients with mental disorders or SUDs only, as well as for those with CODs. It is highly correlated with the DSM-IV-TR Global Assessment of Functioning scale and has demonstrated good sensitivity in assessing severity of symptoms, particularly those that are psychiatric in nature (Thurber, Wilson, Realmuto, & Specker, 2018).

Assessment Step 6: Determine Diagnosis

Determining the diagnosis can be a formidable clinical challenge in the assessment of CODs. Clinicians in both mental disorder services and SUD treatment settings recognize that it can be impossible to establish a firm diagnosis when confronted with the mixed presentation of mental symptoms and ongoing substance misuse. Of course, substance misuse contributes to the emergence or severity of mental symptoms and therefore confounds the diagnostic picture. Therefore, this step often includes dealing with confusing diagnostic presentations. Three guiding principles can help counselors thoroughly assess the client's current and past history of mental and substance-related symptoms and problems:

1. Conduct a thorough interview to establish past mental and SUD diagnoses and treatments.
2. Document all past diagnoses, including their relationship to certain time periods (e.g., just before the diagnosis, just after the diagnosis, during symptomatic phases) and events, symptoms, and levels of functioning during those time periods.
3. Determine the timing of mental disorder symptoms, particularly in relationship to periods of substance use and SUDs (e.g., during periods of abstinence, within 30 days of onset of an SUD).

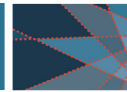
Addiction counselors who want to improve their competencies to address CODs are urged to become conversant with the basic resource used to diagnose mental disorders, DSM5 (APA, 2013). In-depth discussion of what counselors need to know concerning DSM-5 diagnostic criteria, differential diagnosis, and management of mental disorders in the context of co-occurring addiction is in Chapter 4.

Principles of Determining Diagnosis

1. The Importance of Client History

Diagnosis is established more by history than by current symptom presentation. This applies to both mental disorders and SUDs. The first step in determining the diagnosis is to determine whether the client has an established diagnosis or is receiving ongoing treatment for an established disorder. This information can be obtained by the counselor as part of the routine intake process. If there is evidence of a disorder but the diagnosis or treatment recommendations are unclear, the counselor should immediately begin the process of obtaining this information from collaterals. If there is a valid history of a mental disorder diagnosis at admission to SUD treatment, that diagnosis should be considered presumptively valid for initial treatment planning, and any existing stabilizing treatment should be maintained. In addition to confirming an established diagnosis, the client's history can provide insight into patterns that may emerge and add depth to knowledge of the client.

For example, if a client comes into the clinician's office and says she hears voices (whether or not she is sober currently), no diagnosis should be made on that basis alone. People hear voices for many reasons. They may be related to substance-related syndromes (e.g., substance-induced psychosis or hallucinosis, which is the experience of hearing voices that the client knows are not real, and that may say things that are distressing or attacking—particularly when the client has a history of trauma—but are not bizarre). With CODs, most causes will be independent of substance use (e.g., schizophrenia, schizoaffective disorder, affective disorder with psychosis or dissociative hallucinosis related to PTSD). Psychosis usually involves loss of ability to tell that the voices are



not real and increased likelihood that they are bizarre in content. Methamphetamine psychosis is particularly confounding because it can mimic schizophrenia. Many clients with psychotic disorders will still hear voices when on medication, but the medication makes the voices less bizarre and helps clients know they are not real.

If clients state, for example, that they have heard voices, although not as much as they used to; have been abstinent for 4 years; have remembered to take medication most days, but may forget; and have had multiple hospitalizations for psychosis 10 years ago but none since, then they clearly have a diagnosis of psychotic illness (probably schizophrenia or schizoaffective disorder). Given their continuing symptoms while abstinent and on medication, it is quite possible that the diagnosis will persist.

Chapter 4 offers additional information about differential diagnosis.

2. Documenting Prior Diagnoses

Even though SUD treatment counselors may not be licensed to make a mental disorder diagnosis, they should document prior diagnoses and gather information related to current diagnoses.

Diagnoses established by history should not be changed at the point of initial assessment. If the clinician has a suspicion that a long-established diagnosis may be invalid, he or she needs to take time to gather additional information, consult with collaterals, get more careful and detailed history, and develop a better relationship with the client before recommending diagnostic reevaluation. The counselor should raise concerns related to diagnosis with the clinical supervisor or at a team meeting.

In many instances, no well-established mental disorder diagnosis exists, or multiple diagnoses confuse the picture. Even with an established diagnosis, gathering information to confirm that diagnosis is helpful. During initial assessment, SUD treatment counselors can gather data that can assist diagnosis, either by supporting the findings of the existing mental health assessment or by providing useful background information in the event a new mental health assessment is

conducted. **The key is not merely to gather lists of past and present symptoms but to connect those symptoms to periods in the client's life that are helpful in the diagnostic process—namely, before the onset of an SUD and during periods of abstinence (or very limited use) or after SUD onset and persisting for more than 30 days.**

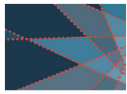
The clinician should determine whether mental disorder symptoms occur only when the client is using substances actively. Therefore, it is important to determine the nature and severity of the symptoms of the mental disorder when the SUD is stabilized. Note whether the client recently had a complete physical, including appropriate labs. Physical diseases can also present with or mimic mental disorders (e.g., hypothyroidism presenting with or like depression) and need to be identified and treated accordingly.

3. Linking Mental Symptoms to Specific Periods

For diagnostic purposes, it is almost always necessary to tie mental disorder symptoms to specific periods of time in the client's history, in particular those times when an active SUD was not present.

Most SUD assessment tools do not require connection of mental disorder symptoms to substance use or abstinence. Mental disorder symptom information obtained from such tools can confuse counselors and make them feel that the whole process is not worth the effort. In fact, when clinicians seek information about mental disorder symptoms during periods of abstinence, such information is almost never part of traditional assessment forms. The mental disorder history and substance use history have in the past been collected separately and independently. As a result, the opportunity to evaluate interaction, which is the most important diagnostic information beyond the history, has routinely been lost. Newer and more detailed assessment tools overcome these historical and potentially misleading divisions.

The M.I.N.I. Plus (a more detailed version of the Mini-International Neuropsychiatric Interview [Sheehan et al., 1998]) is structured to connect any identified symptoms to periods of abstinence. Clinicians can use this information to distinguish substance-induced mental disorders from



independent mental disorders. The Timeline Follow-Back Method also is a valid and practical tool that can be used with individuals with substance misuse or CODs (Hjorthoj, Hjorthoj, & Nordentoft, 2012) to gather a detailed and comprehensive assessment of patterns of substance misuse beyond just quantity and frequency.

Consequently, the SUD treatment counselor can proceed in two ways:

- Ask whether mental disorder symptoms or treatments identified in screening were present during periods of 30 days of abstinence or longer, or were present before onset of substance use. ("Did this symptom or episode occur during a period when you were abstinent for at least 30 days?")
- Define with the client specific time periods when the SUD was in remission, and then get detailed information about mental disorder symptoms, diagnoses, impairments, and treatments during those periods of time. ("Can you recall a time when you were not using? Did these symptoms [or whatever the client has reported] occur during that period?") This approach may yield more reliable information.

During this latter process, the counselor can use one of the medium-power symptom screening tools as a guide. Alternatively, the counselor can use the handy outlines of the DSM-5 criteria for common disorders (provided in Chapter 4) and inquire whether those criteria symptoms were met, whether they were diagnosed and treated, and if so, with what methods and how successfully. This information can suggest or support the accuracy of diagnoses. Documentation also can facilitate later diagnostic assessment by a mental health-trained clinician.

Assessment Step 7: Determine Disability and Functional Impairment

Determination of both current and baseline functional impairment contributes to identification of the need for case management or higher levels of support. This step also relates to the determination of level of care requirements. Assessment of current cognitive capacity, social skills, and other functional abilities also is necessary

to determine whether there are deficits that may require modification in the treatment protocols of relapse prevention efforts or recovery programs. For example, the counselor might inquire about past participation in special education or related testing.

Assessing Functional Capability

Current level of impairment is determined by assessing functional capabilities and deficits in each of the areas indicated in the following list. Similarly, baseline level of impairment is determined by identifying periods of extended abstinence and mental health stability (greater than 30 days) according to the methods described in the previous assessment step. The clinician determines:

- Is the client capable of **living independently** (in terms of independent living skills, not in terms of maintaining abstinence)? If not, what types of support are needed?
- Is the client capable of **supporting himself or herself financially**? If so, through what means? If not, is the client disabled, or dependent on others for financial support?
- Can the client engage in reasonable **social relationships**? Are there good social supports? If not, what interferes with this ability, and what supports would the client need?
- What is the client's level of **cognitive functioning**? Is there a developmental or learning disability? Are there cognitive or memory impairments that impede learning? Is the client limited in ability to read, write, or understand? Is there difficulty focusing, concentrating, and completing tasks?

Functional Assessment Tools

Several freely available, reliable, well-validated tools measure functioning and impairment in clients with mental illness, substance misuse, or both (Gold, 2014; National Academies of Sciences, Engineering, and Medicine, 2016; Sanchez-Moreno, Martinez-Aran, & Vieta, 2017), including:

- **WHO Disability Assessment Schedule 2.0** ([WHODAS 2.0] Üstün & WHO, 2010; www.who.int/classifications/icf/whodasii/en/). When DSM-5 removed the Global Assessment of Functioning (Axis V in DSM-IV), APA proposed

in its place the WHODAS 2.0 as a tool to rate global impairment and functional capabilities (APA, 2013). The WHODAS 2.0 assesses six major domains, which are:

- Understanding and communicating.
- Getting around (mobility).
- Self-care.
- Getting along with people (social and interpersonal functioning).
- Life activities (home, academic, and occupational functioning).
- Participation in society (participation in family, social, and community activities).
- **ASI** (McLellan et al., 1992), a mental health screening tool that provides information about level of functioning for clients with SUDs. This is valuable when supplemented by interview information. (Note that the ASI also exists in an expanded version specifically for women, ASI-F [SAMHSA, 2009c].)

In a clinical interview, the counselor also should inquire about any current or past difficulties the client has had in learning or using relapse prevention skills, participating in mutual-support recovery programs, or obtaining medication or following medication regimens. In the same vein, the clinician may inquire about use of transportation, budgeting, self-care, and other related skills, and their effect on life functioning and treatment participation.

For individuals with CODs, impairment may be related to intellectual/cognitive ability or the mental disorder, which may exist in addition to the SUD. The clinician should establish level of intellectual/cognitive functioning in childhood, whether impairment persists, and if so, at what level, during the periods when substance use is in full or partial remission, just as in the previous discussion of diagnosis.

Determining the Need for Capable or Enhanced-Level Services

A specific tool to assess the need for capable- or enhanced-level services for people with CODs currently is not available. The consensus panel recommends a process of “practical assessment” that seeks to match the client’s assessment (mental

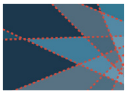
health, substance misuse, level of impairment) to the type of services needed. The individual may even be given trial tasks or assignments to determine in concert with the counselor if his or her performance meets the requirements of the program being considered.

ASAM criteria for COD-capable and -eligible programs are as follows (Mee-Lee, Shulman, Fishman, Gastfriend, & Miller 2013):

- **Co-occurring-capable (COC) programs** in addiction treatment focus primarily on SUDs but can treat patients with subthreshold or diagnosable but stable mental disorders (Mee-Lee et al., 2013). Mental health services may be onsite or available by referral. COC programs in mental health are those that mainly focus on mental disorders but can treat patients with subthreshold or diagnosable but stable SUDs (Mee-Lee et al., 2013). Addiction counselors are onsite or available through referral.
- **Co-occurring-enhanced (COE) programs** have more integrated addiction and mental health services and have staff who are trained to recognize the signs and symptoms of both disorders and are competent in providing integrated treatment for both 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 like HIV, trauma, legal matters, housing difficulties, criminal justice system involvement, unemployment, education concerns, childcare or parenting difficulties, and cognitive dysfunctions.

Assessment Step 8: Identify Strengths and Supports

All assessment must include some specific attention to the individual’s current strengths, skills, and supports, both in relation to general life functioning, and in relation to his or her ability to manage either mental disorders or SUDs.



This often provides a more positive approach to treatment engagement than does focusing exclusively on deficits that need to be corrected. This is no less true for individuals with serious mental disorders than it is for people with SUDs only. Questions might focus on:

- Talents and interests.
- Areas of educational interest and literacy; vocational skill, interest, and ability, such as social skills or capacity for creative self-expression.
- Areas connected with high levels of motivation to change, for either disorder or both.
- Existing supportive relationships—treatment, peer, or family—particularly ongoing mental disorder treatment relationships.
- Previous mental health services and SUD treatment successes and exploration of what worked.
- Identification of current successes: What has the client done right recently for either disorder?
- Building treatment plans and interventions based on utilizing and reinforcing strengths and extending or supporting what has worked previously.

ASSESSMENT STEP 8— APPLICATION TO CASE EXAMPLES (JANE B.)

Jane B. expressed significant interest in work once her paranoia subsided. She was attempting to address her SUD on an outpatient basis, as a residential treatment program was unavailable. Her case management team noted her interest and experience in caring for animals. Via individualized placement and support, they helped her obtain a part-time job at a local pet shop two afternoons per week. She was proud of her job and reported that it helped maintain her motivation to stay away from substances and to keep taking medication.

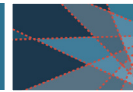
For individuals with SMI or substance misuse, the Individualized Placement and Support model of psychiatric rehabilitation has demonstrated that it is a cost-effective way to generate positive vocational and mental health outcomes compared with other models of vocational rehabilitation for this population, including improved rates of obtaining competitive employment, greater number of hours worked, increased wages, improvements in self-esteem and quality of life, and reductions in mental health service use (Drake, Bond, Goldman, Hogan, & Karakus, 2016; LePage et al., 2016). In this model, clients with disabilities who want to work may be placed in sheltered work activities based on strengths and preferences, even when actively using substances and inconsistently complying with medication regimens. In nonsheltered work activities, it is critical to remember that many employers have substance-free workplace policies.

Participating in ongoing jobs is valuable to self-esteem in itself and can generate the motivation to address mental disorders and substance misuse problems, as they appear to interfere specifically with work success. Taking advantage of educational and volunteer opportunities also may enhance self-esteem and is often a first step in securing employment.

Assessment Step 9: Identify Cultural and Linguistic Needs and Supports

Detailed cultural assessment is beyond the scope of this publication. Cultural assessment of individuals with CODs is not substantially different from cultural assessment for those with SUDs or mental disorders only, but some specific areas are worth addressing, such as:

- Problems with literacy.
- Not fitting into the treatment culture (SUD or mental health culture); conflict in treatment.
- Cultural and linguistic service barriers.



ASSESSMENT STEP 9—APPLICATION TO CASE EXAMPLE (GEORGE T.)

The client is a 34-year-old married, employed African American man with cocaine use disorder, alcohol misuse, and bipolar disorder (stabilized on lithium) mandated to cocaine treatment by his employer after a failed drug test. George T. and his family realize he needs help not to use cocaine. He complains that his mood swings intensify when he is using cocaine.

George T.'s counselor originally referred him to Cocaine Anonymous (CA). When George T. went, however, he reported back to the counselor that he did not feel comfortable there. He felt that as a family man with a responsible job, he had pulled himself out of the “street culture” that this specific meeting reflected. He also noted that most participants were White. Unlike many people with CODs who feel more ashamed of mental disorders than addiction, he felt more ashamed at the CA meeting than at his support group for people with mental disorders. Therefore, for George T., it was culturally appropriate to address the shame surrounding his substance use, encourage him to try other mutual-support program meetings, and continue to provide positive feedback about his attendance at the support group for his mental disorder.

Not Fitting Into the Treatment Culture

To a certain degree, individuals with addiction and SMI may have difficulty fitting into existing treatment cultures. Many clients are aware of a variety of different attitudes toward their disorders that can affect relationships with others. Traditional culture carriers (parents, grandparents) may have different views of clients' problems and the most appropriate treatment compared with peers. Individual clients may have positive or negative allegiance to a variety of peer or treatment cultures (e.g., mental health consumer movement, having mild or moderate severity mental disorders vs. SMI, 12-Step or dual recovery mutual support) based on past experience or on fears and concerns related to the mental disorder. Specific questions to explore with the client include:

- “How are your substance use and mental health concerns defined by your parents? Peers? Other clients?”
- “What do they think you should be doing to remedy these problems?”
- “How do you decide which suggestions to follow?”
- “In what kinds of treatment settings do you feel most comfortable?”
- “What do you think I (the counselor) should be doing to help you improve your situation?”

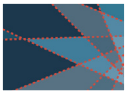
Cultural and Linguistic Service Barriers

Cultural and linguistic barriers can compound access to COD treatment. The assessment process must address whether these barriers prevent access to care (e.g., the client reads or speaks only Spanish; the client is illiterate) and if so, determine options for providing more individualized intervention or for integrating intervention into naturalistic culturally and linguistically appropriate human service settings.

Chapter 5 describes components of culturally responsive services. Chapter 6 offers information about the needs of people of diverse racial/ethnic backgrounds with CODs and how counselors can help reduce treatment access and outcome disparities experienced by marginalized racial/ethnic groups.

Assessment Step 10: Identify Problem Domains

Individuals with CODs may have difficulties in multiple life domains (e.g., medical, legal, vocational, family, social). The ASI can identify and quantify substance use–related problems across domains, to see which require attention. It is used most effectively as a component of a comprehensive assessment.



A comprehensive, biopsychosocial evaluation for individuals with CODs requires clarifying how each disorder interacts with the problems in each domain, as well as identifying contingencies that might promote treatment adherence for mental health, SUD treatment, or both. Information about others who might assist in the implementation of such contingencies (e.g., probation officers, family, friends) needs to be gathered, including appropriate releases to obtain information.

Assessment Step 11: Determine Stage of Change

A key evidence-based best practice for treatment matching clients with CODs is **to match interventions not only to specific diagnoses but also to stage of change and stage of treatment for each disorder.**

In SUD treatment settings, stage of change assessment usually involves determination of Prochaska and DiClemente Stages of Change: precontemplation, contemplation, preparation (or determination), action, maintenance, and relapse (Prochaska & DiClemente, 1992). This can involve using questionnaires such as the University of Rhode Island Change Assessment Scale (McConaughy, Prochaska, & Velicer, 1983; available at <https://habitslab.umbc.edu/urica/>) or the Stages of Change Readiness and Treatment Eagerness Scale (Miller & Tonigan, 1996; available at <https://casaa.unm.edu/inst/SOCRATESv8.pdf>). Stage of change can be determined clinically by interviewing clients and evaluating their responses in the context of change. For example, one approach to stage of change identification is to ask

clients, for each problem, to select the statement that most closely fits their view of that problem:

- No problem, no interest in change, or both (Precontemplation).
- Might be a problem; might consider change (Contemplation).
- Definitely a problem; getting ready to change (Preparation).
- Actively working on changing, even if slowly (Action).
- Has achieved stability, and is trying to maintain (Maintenance).

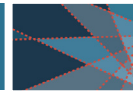
Stage of change assessment ideally will be applied separately to each mental disorder and to each SUD. For example, a client may be willing to take medication for a depressive disorder but unwilling to discuss trauma, or motivated to stop using cocaine but unwilling to consider alcohol as a problem.

For more indepth discussion of the stages of change and motivational enhancement, see TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* (SAMHSA, 2019c).

Assessment Step 12: Plan Treatment

A comprehensive assessment is the basis for an individualized treatment plan. Appropriate treatment plans and treatment interventions can be quite complex, depending on what might be discovered in each domain. **No single, correct intervention or program exists for individuals with CODs. Rather, match appropriate treatment to individual needs per these multiple considerations.**

The following case (Maria M.) illustrates how the noted factors help generate an integrated treatment plan that is appropriate to the needs and situation of a particular client.



ASSESSMENT STEP 12—APPLICATION TO CASE EXAMPLE (MARIA M.)

The client is a 38-year-old Latina woman who is the mother of two teenagers. Maria M. presents with an 11-year history of cocaine dependence, a 2-year history of opioid dependence, and a history of trauma related to a longstanding abusive relationship (now over for 6 years). She is not in an intimate relationship at present and there is no current indication that she is at risk for either violence or self-harm. She also has persistent major depression and panic treated with antidepressants. She is very motivated to receive treatment.

Ideal Integrated Treatment Plan: The plan for Maria M. might include medication-assisted treatment (e.g., methadone or buprenorphine), continued antidepressant medication, a mutual-support program, and other recovery group support for cocaine dependence. She also could be referred to a group for both SUD and trauma that is designed specifically to help reduce symptoms of trauma and resolve long-term problems.

Individual, group, and family interventions could be coordinated by the primary counselor from opioid maintenance treatment. The focus of these interventions might be on relapse prevention skills, taking medication as prescribed, and identifying and managing trauma-related symptoms without using.

Considerations in Treatment Matching

A major goal of the screening and assessment process is to ensure the client is matched with appropriate treatment. Acknowledging the overriding importance of this goal, this discussion of the process of clinical assessment for individuals with CODs begins with a fundamental statement of principle: Because clients with CODs are not all the same, program placements and treatment interventions should be matched individually to the needs of each client.

The ultimate purpose of the assessment process is to develop an appropriately individualized integrated treatment plan. In this model, **the consensus panel recommends the following approach:**

- Treatment planning for individuals with CODs and associated problems should follow the principle of mental disorder dual (or multiple) primary treatment, in which a specific intervention is matched to each problem or diagnosis, as well as to stage of change and external contingencies. Exhibit 3.9 shows a sample treatment plan consisting of the problem, intervention, and goal.

- Integrated treatment planning involves helping the client to make the best possible treatment choices for each disorder and adhere to that treatment consistently. At the same time, the counselor needs to help the client adjust the recommended treatment strategies for each disorder as needed in order to take into account problems related to the other disorder.

These principles are best illustrated by using a case example to develop a sample treatment plan. For this purpose, the case example for George T. is used, incorporating the data gathered during assessment (Exhibit 3.9). The problem description presents various factors influencing the problem, including stage of change and client strengths. No specific person is recommended to carry out interventions proposed in the second column, as a range of professionals might carry out each intervention appropriately.

The consensus panel has reviewed research evidence and consensus clinical practice to identify factors critical to the process of matching clients to available treatment. Exhibit 3.10 lists these considerations.

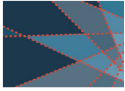


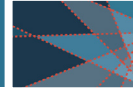
EXHIBIT 3.9. Sample Treatment Plan for Case Example George T.

PROBLEM	INTERVENTION	GOAL
Cocaine use disorder • Work problem, primary reason for referral • Family and work support • Resists mutual support • Mental symptoms trigger use • Action phase	Outpatient treatment • EAP monitoring • Family meetings • Address shame related to disorder • Skill-building to manage symptoms without using • Mutual-support meetings	Abstinence • Negative urinalysis results • Daily recovery plans
Rule out AUD • No clear problem • May trigger cocaine use • Precontemplation phase	• Outpatient motivational enhancement; thorough evaluation of role of alcohol in patient's life, including family education	• Move into contemplation • Willing to consider the risk of use or possible misuse
Bipolar disorder • Long history • On lithium • Some mood symptoms • Maintenance phase	• Medication management • Help taking medication in recovery programs • Bipolar Support Alliance meetings • Advocate/collaborate with prescribing health professional • Identify mood symptoms that are triggers	• Maintain stable mood • Able to manage fluctuating mood symptoms that do occur without using cocaine or other substances to regulate his bipolar disorder

EXHIBIT 3.10. Considerations in Treatment Matching

VARIABLE	KEY DATA
Acute safety needs Determines need for immediate acute stabilization to establish safety prior to routine assessment	• Immediate risk of harm to self or others • Immediate risk of physical harm or abuse from others (Mee-Lee et al., 2013) • Inability to provide for basic self-care • Medically dangerous intoxication or withdrawal • Potentially lethal medical condition • Acute severe mental disorder symptoms (e.g., mania, psychosis) leading to inability to function or communicate effectively

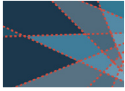
Continued on next page



Continued

Quadrant assignment Guides the choice of the most appropriate setting for treatment	• SPMI vs. non-SPMI • Severely acute or disabling mental disorder symptoms vs. mild-moderate severity symptoms • High-severity SUD (e.g., active SUD) vs. lower severity SUD (e.g., hazardous substance use) • Substance dependence in full vs. partial remission (Mee-Lee et al., 2013; APA, 2013)
Level of care Determines program assignment	• Dimensions of assessment for each disorder using criteria from the LOCUS
Diagnosis Determines the recommended treatment intervention	• Specific diagnosis of each mental disorder and SUD, including distinction of substance-induced symptoms • Information about past and present successful and unsuccessful treatment efforts for each diagnosis • Identification of trauma-related disorders and culture-bound syndromes, in addition to other mental disorders and substance-related problems
Disability Determines case management needs and whether a standard intervention is sufficient—one at the capable or intermediate level—or whether an enhanced-level intervention is essential	• Cognitive deficits, functional deficits, and skill deficits that interfere with ability to function independently or follow treatment recommendations and which may require varying types and amounts of case management or support • Specific functional deficits that may interfere with ability to participate in SUD treatment in a particular program setting and may therefore require a COE setting rather than a COC one • Specific deficits in learning or using basic recovery skills that require modified or simplified learning strategies
Strengths and skills Determines areas of prior success around which to organize future treatment interventions Determines skill-building needs for management of either disorder	• Areas of particular capacity or motivation related to general life functioning (e.g., capacity to socialize, work, or obtain housing) • Ability to manage treatment participation for any disorder (e.g., familiarity and comfort with mutual-support programs, commitment to medication adherence)
Availability and continuity of recovery support Determines availability of existing relationships and whether to establish continuing relationships to provide contingencies to promote learning	• Presence or absence of continuing treatment relationships, particularly mental disorder treatment relationships, beyond the single episode of care • Presence or absence of an existing and ongoing supportive family, peer support, or therapeutic community; quality and safety of recovery environment (Mee-Lee et al., 2013)

Continued on next page



Continued

Cultural context

Determines most culturally appropriate treatment interventions and settings

- Areas of cultural identification and support in relation to:
 - Ethnic or linguistic culture identification (e.g., attachment to traditional Native American cultural healing practices)
 - Cultures that have evolved around treatment of mental disorders and SUDs (e.g., identification with 12-Step and mutual recovery culture, commitment to mental health empowerment movement)
- Gender and gender identity
- Sexual orientation
- Rural vs. urban

Problem domains

Determines specific problems to be solved and opportunities for contingencies to promote treatment participation

Is there impairment, need, or strength in any of the following areas?

- Financial
- Legal
- Employment
- Housing
- Social/family
- Medical, parenting/child protective, abuse/victimization/victimizer

Phase of recovery/stage of change (for each problem)

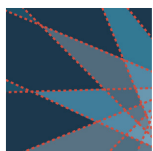
Determines appropriate phase-specific or stage-specific treatment intervention and outcomes

- Requirement for acute stabilization of symptoms, engagement, or motivational enhancement
- Active treatment to achieve prolonged stabilization
- Relapse prevention/maintenance
- Rehabilitation, recovery, and growth
- Within the motivational enhancement sequence, precontemplation, contemplation, preparation, action, maintenance, or relapse (Prochaska & DiClemente, 1992)
- Engagement, stabilization/persuasion, active treatment, or continuing care/relapse prevention (Mueser & Gingerich, 2013; SAMHSA, 2009a)

Conclusion

Assessment is a systematic approach for behavioral health service providers to gather information that supports matched treatment plans for individuals with CODs. It is a required competency and a key component of the counselor–client relationship in which providers learn to better understand their clients; have opportunities to express genuine concern, hope, and empathy for long-term

recovery; and help set the stage for effective treatment. Most of these activities are already a routine component of substance misuse-only assessment; the key additional element is attention to treatment requirements and stage of change for mental disorders, and the possible interference of mental disorder symptoms and disabilities (including personality disorder symptoms) in SUD treatment participation.



Chapter 4—Mental and Substance-Related Disorders: Diagnostic and Cross-Cutting Topics

KEY MESSAGES

- The co-occurrence of mental disorders with substance use disorders (SUDs) is the rule, not the exception. Addiction counselors should expect and prepare to see clients with these disorders in their settings.
- Addiction counselors generally do not diagnose mental disorders. But to engage in accurate treatment planning and to offer comprehensive, efficacious, and responsive services (or referral for such), clinicians must be able to recognize the disorders most likely to be seen in populations who misuse substances.
- It is not always readily apparent whether a co-occurring mental disorder is directly caused by substance misuse or is an independent disorder merely appearing alongside an SUD. This differentiation can be difficult to make but is critically important, as it informs treatment decision making.
- Suicide and trauma are sadly common across most combinations of co-occurring disorders (CODs) and require special attention. Addiction counselors have an ethical and professional responsibility to keep clients safe and to provide services that are supportive, empathic, and person-centered, and that reduce suffering.

Disentangling symptoms of SUDs from those of co-occurring mental disorders is a complex but necessary step in correctly assessing, diagnosing, determining level of service, selecting appropriate and effective treatments, and planning follow-up care. This chapter is designed to facilitate those

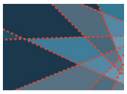
processes by ensuring addiction counselors and other providers have a clear understanding of mental disorder symptoms and diagnostic criteria, their relationships with SUDs, and pertinent management strategies.

This chapter provides an overview for working with SUD treatment clients who also have mental disorders. The audiences for this chapter are counselors, other treatment/service providers, Supervisors, and Administrators. It is presented in concise form so that user can refer to this one chapter to obtain basic information. The material included is not a complete review of all mental disorders and is not intended to be a primer on diagnosis. Rather, it offers a summary of mental disorders with special relevance to co-occurring SUDs (see the section “Scope of the Chapter”).

Since the original publication of this Treatment Improvement Protocol (TIP), updated mental disorder criteria have been published in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013). This chapter contains these latest criteria and, where available, data from prevalence studies and randomized controlled trials in reflection of DSM-5.

Organization of the Chapter

The chapter begins with a brief description of selected mental disorders and their DSM-5 diagnostic criteria. For each disorder, material highlights some of the descriptive and diagnostic features, prevalence statistics, and relationship to SUDs. In general, the mental disorders in this chapter are presented in the following descending order by how commonly they co-occur with SUDs, although this is not applied rigidly: Depressive disorders, bipolar I disorder, posttraumatic stress disorder (PTSD), personality disorders (PDs),



anxiety disorders, schizophrenia and psychosis, attention deficit hyperactivity disorder (ADHD), and feeding and eating disorders.

Because of the greater availability of case histories from the mental health literature, the illustrative material has more emphasis on the mental disorders. Although not intended to offer extensive guidance on treatment, this chapter's coverage of specific mental disorders does include brief information about interventions for and clinical approaches to managing CODs involving each. (Chapter 7 focuses on treatment models for people with CODs.) Case histories illustrate the interaction between mental disorders and SUDs. Each diagnostic topic contains an Advice to the Counselor box containing key considerations related to diagnosis, treatment, or both.

The next main section of this chapter addresses substance-related disorders, including SUDs and substance-induced mental disorders. (DSM-5 uses the term "substance/medication-induced disorders"; this TIP focuses on nonmedication substances and thus will exclude the term "medication.") Because the primary audience for this chapter is addiction counselors, readers are assumed to be highly familiar with SUDs and their diagnostic criteria. Thus, the SUD section is briefer than the mental disorders section. The overall focus remains on substance-induced mental disorders, their relationship to independent co-occurring mental disorders, and what counselors need to know in terms of assessment and treatment.

Licit and illicit drugs of misuse can cause symptoms that are identical to the symptoms of mental illness. Mental disorder diagnoses should be provisional and reevaluated constantly. **Some mental disorders are really substance-induced mental disorders, meaning they are caused by substance use.** Treatment of the SUD and an abstinent period of weeks or months may be required for a definitive diagnosis of an independent, co-occurring mental disorder. A fuller discussion of substance-induced disorders is provided later in this chapter.

The chapter ends with an overview of two concerns that appear across nearly all COD populations: suicidality and trauma. Although suicidality is not strictly speaking a DSM-5-diagnosed mental disorder, it is a high-risk behavior requiring serious attention by providers. The discussion of suicidality highlights key information addiction counselors should know about risk of self-harm in combination with substance misuse, mental disorders, or both. The section offers factual information (e.g., prevalence data), commonly agreed-on clinical practices, and other general information that may be best characterized as "working formulations." Like suicide, trauma itself is not a mental disorder but is extremely common in many psychiatric conditions, frequently coincides with addiction, and increases the odds of negative outcomes, including suicide. Having at least a basic understanding of suicide and trauma is a core competency for addiction counselors working with clients who have CODs and will help improve their ability to not only offer effective services but keep clients safe.

Scope of the Chapter

The mental disorder section of this chapter does not include all DSM-5 mental disorders. The consensus panel acknowledges that people with CODs may have multiple combinations of the various mental disorders presented in this chapter (e.g., a person could have an SUD, bipolar I disorder, and borderline PD [BPD]). However, for purposes of clarity and brevity, the panel chose to focus the discussion on the main disorders primarily seen in people with CODs and not explore the multitude of possible combinations. **This does not mean that other mental disorders excluded from this chapter cannot and do not co-occur with substance misuse.** But the scope of this chapter is such that it focuses only on mental disorders most likely to be seen by SUD treatment professionals.

The consensus panel recognizes that although this chapter covers a broad range of mental disorders and diagnostic material, it cannot and should not replace the comprehensive training necessary for diagnosing and treating clients with specific mental disorders cooccurring with SUDs. Readers of this TIP are assumed to already have working knowledge of mental disorders and their

symptoms. The “Advice to the Counselor” boxes cannot fully address the complexity involved in treating clients with CODs. These boxes distill for counselors the main actions and approaches they can take in working with clients in SUD treatment who have the specific mental disorder being discussed.

The consensus panel recognizes that this chapter cannot cover each mental disorder exhaustively and that **addiction counselors are not expected to diagnose mental disorders**. The panel’s limited goals for this chapter are to increase SUD treatment counselors’ familiarity with mental disorder terminology and criteria and to guide them on how to proceed with clients who have these disorders. The chapter also is meant to stimulate further work in this area and to make this research accessible to the addiction field.

Depressive Disorders

The depressive disorders category in DSM-5 comprises numerous conditions; addiction counselors are most likely to encounter major depressive disorder (MDD) and persistent depressive disorder (PDD; also called dysthymia) among their clients. Common features of all depressive disorders are excessively sad, empty, or irritable mood and somatic and cognitive changes that significantly affect ability to function.

Major Depressive Disorder

MDD is not merely extreme sadness, although sad mood is a defining characteristic. MDD is marked by **either** depressed mood **or** loss of interest in nearly all previously enjoyed activities. At least one of those symptoms must be present and must persist most of the day, almost every day over a 2-week period (Exhibit 4.1). Other core physical, cognitive, and psychosocial features of MDD also must be present nearly every day, with the exception of weight change and suicidal ideation.

MDD is highly associated with suicide risk. A study reported 39 percent of people with a lifetime MDD diagnosis contemplated suicide; nearly 14 percent had a lifetime history of suicide attempt (Hasin et al., 2018). Yet suicide is not isolated to those with depressed mood. **Counselors always should ask clients whether they have been thinking of suicide, whether or not they have, or mention, symptoms of depression.**

Severe depressive episodes can include psychotic features, such as an auditory hallucination of a voice saying that the person is “horrible,” a visual hallucination of a lost relative mocking the person, or a delusion that one’s internal body parts have rotted away. However, most people who have an MDE do not exhibit psychotic symptoms even when the depression is severe (for more information on psychosis, see the section “Schizophrenia and Other Psychotic Disorders”).

WARNING TO COUNSELORS: KNOW YOUR LIMITS OF PRACTICE

This TIP is for addiction counselors in direct clinical contact with clients who have SUDs. Legal titles, levels, types of licenses, certifications, and scopes of practice for addiction counselors differ across all states and the District of Columbia (University of Michigan Behavioral Health Workforce Research Center, 2018). For instance, in certain states, addiction counselors can only conduct assessments and offer treatments for SUDs, limiting their ability to reach clients with CODs. Certification requirements and authorized services also vary by state.

This TIP is intended to benefit all licensed or certified addiction counselors, regardless of their titles.

However, the diagnostic and counseling activities described in this TIP are not necessarily appropriate for all addiction counselors to undertake, especially given that addiction counselors do not normally possess the required training and clinical experience to diagnose mental disorders. Different SUD treatment settings will have different policies and rules about what addiction counselors can and cannot do. Whether certified/licensed or not, **addiction counselors should use these methods only under the supervision of an appropriately trained and certified or licensed SUD treatment provider or other mental health clinician.** Maintaining collaborative relationships with mental health service providers for consultation and referral is recommended, either directly or through clinical supervision.

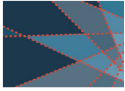


EXHIBIT 4.1. Diagnostic Criteria for MDD

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gain.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A–C represent a major depressive episode (MDE).

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of an MDE in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.*

D. The occurrence of the MDE is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

Continued on next page

Continued

Specify:

- With anxious distress
- With mixed features
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With peripartum onset
- With seasonal pattern (recurrent episode only)

Specify current severity/course:

- Mild
- Moderate
- Severe
- With psychotic features
- In partial remission
- In full remission
- Unspecified

* In distinguishing grief from an MDE, it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in MDE. In grief, self-esteem is generally preserved, whereas in MDE feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about “joining” the deceased, whereas in MDE such thoughts are focused on ending one’s own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

Source: APA (2013, pp. 160–162). Reprinted with permission from the DSM-5 (Copyright ©2013). APA. All Rights Reserved.

MDE must be distinguished from grief or bereavement, which are not mental disorders but rather normal human responses to loss. However, grief and MDD can be experienced at the same time; that is, the presence of grief does not rule out the presence of MDD. DSM-5 provides detailed guidance on diagnosing MDD in people who are bereaved.

Persistent Depressive Disorder

PDD presents as excessively sad or depressed mood that lasts most of the day, more days than not, for at least 2 years. PDD is somewhat of an “umbrella” diagnosis in that it covers two different types of people with depression: people with chronic MDD (i.e., depression lasting at least 2 years) and people who do not meet criteria for an MDD (see Criteria A through C in Exhibit 4.1) but otherwise have had depressive symptoms for at least 2 years. Thus, the criteria for PDD (Exhibit 4.2) are similar to, but less severe than, those of MDD.

Prevalence

Data from a national epidemiological survey indicate the 12-month and lifetime prevalence rates of DSM-5 MDD are 10 percent and 21 percent, respectively (Hasin et al., 2018). Prevalence of MDD in emerging adults (ages 18 to 29 years) is 3 times higher than the prevalence in older adults (ages 60 years and older). Women are 1.5 times as likely to report depression as men (Hasin et al., 2018).

Twelve-month and lifetime prevalence rates for DSM-5 PDD in U.S. samples have not been reported at the time of this publication. Using DSM-IV criteria, 12-month and lifetime prevalence of PDD in U.S. adults are estimated at 1.5 percent and 3 percent, respectively; DSM-IV dysthymia has an estimated 12-month and lifetime prevalence of 0.5 percent and 1 percent, respectively (Blanco et al., 2010).

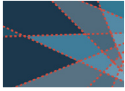


EXHIBIT 4.2. Diagnostic Criteria for PDD

This disorder represents a consolidation of DSM-IV-defined chronic MDD and dysthymic disorder.

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years. **Note:** In children and adolescents, mood can be irritable, and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

1. Poor appetite or overeating
2. Insomnia or hypersomnia
3. Low energy or fatigue
4. Low self-esteem
5. Poor concentration or difficulty making decisions
6. Feelings of hopelessness

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. Criteria for an MDD may be continuously present for 2 years.

E. There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder.

F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of misuse, a medication) or another medical condition (e.g., hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: Because the criteria for an MDE include four symptoms that are absent from the symptom list for persistent depressive disorder (dysthymia), a very limited number of individuals will have depressive symptoms that have persisted longer than 2 years but will not meet criteria for PDD. If full criteria for an MDE have been met at some point during the current episode of illness, they should be given a diagnosis of MDD. Otherwise, a diagnosis of other specified depressive disorder or unspecified depressive disorder is warranted.

Specify if:

- With anxious distress
- With mixed features
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With peripartum onset

Specify if:

- In partial remission
- In full remission

Continued on next page

Continued

Specify if:

- Early onset: If onset is before age 21 years
- Late onset: If onset is at age 21 years or older

Specify if (for most recent 2 years of persistent depressive disorder):

- With pure dysthymic syndrome: Full criteria for MDE have not been met in at least the preceding 2 years
- With persistent MDE: Full criteria for an MDE have not been met throughout the preceding 2-year period
- With intermittent MDEs, with current episode: Full criteria for MDE are currently met, but there have been periods of at least 8 weeks in at least the preceding 2 years with symptoms below the threshold for a full MDE
- With intermittent MDEs, without current episode: Full criteria for an MDE are not currently met, but there has been one or more MDEs in at least the preceding 2 years

Specify current severity:

- Mild
- Moderate
- Major

Source: APA (2013, pp. 168–169). Reprinted with permission from the DSM-5 (Copyright © 2013). APA. All Rights Reserved.

Depressive Disorders and SUDs

Depressive disorders are highly comorbid with SUDs. For instance:

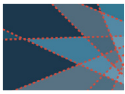
- Presence of a 12-month or lifetime DSM-5 drug use disorder (i.e., a nonalcohol SUD) is associated with a 1.5 to 1.9 increased odds of having any mood disorder, a 1.3 to 1.5 increased odds of having dysthymia, and a 1.2 to 1.3 increased odds of having MDD (Grant et al., 2016).
- Twelve-month alcohol use disorder (AUD) is also associated with an increased risk of MDD and lifetime AUD with persistent depression (Grant et al., 2015).
- A lifetime diagnosis of DSM-5 MDD is more likely to occur in individuals with a history of SUDs (58 percent; for AUD, 41 percent) than in people with a history of any anxiety disorder (37 percent) or PD (32 percent) (Hasin et al., 2018).

People with depression and co-occurring SUDs tend to have more severe mood symptoms (e.g., sleep disturbance, feelings of worthlessness), higher risk of suicidal ideation and suicide attempts, worse functioning, more psychiatric

comorbidities, and greater disease burden (including increased mortality) than people with MDD alone (Blanco et al., 2012; Gadermann, Alonso, Vilagut, Zaslavsky, & Kessler, 2012). They are less likely than people with MDD alone to receive antidepressants—despite strong evidence supporting the efficacy of antidepressant medication in alleviating mood and even some SUD symptoms (Blanco et al., 2012).

Addiction counselors may represent a way to reduce lags in adequate depression care in people with depressive disorders and SUDs.

Among 3.3 million people who reported both MDEs and SUDs between 2008 to 2014, only 55 percent received services for depression in the previous year (Han, Olfson, & Mojtabai, 2017). However, people who had received SUD treatment in the past year were 1.5 times more likely to have received depression care than people who had not engaged in SUD treatment (80 percent vs. 50 percent, respectively) and were 1.6 times more likely to perceive their depressive care as being helpful (48 percent vs. 32 percent) than people who did not access SUD treatment in the previous 12 months (Han, Olfson, & Mojtabai, 2017).



Other facts about depression and SUDs that addiction counselors should know include the following:

- Both substance use and discontinuance can be associated with depressive symptoms.
- During the first months of sobriety, many people with SUDs can exhibit symptoms of depression that fade over time and that are related to acute and protracted withdrawal.
- People with co-occurring depressive disorders and SUDs typically use a variety of drugs.
- Recent evidence suggests there is increasing cannabis use with depression, although cannabinoids have not been shown to be effective in self-management of depression. In fact, cannabis may actually worsen the course of MDD and reduce chances of treatment seeking (Bahorik et al., 2018).

Treatment of MDD and SUD

Psychotherapy (e.g., integrated cognitive–behavioral therapy [CBT], group CBT), with or without adjunct antidepressant use, can effectively reduce frequency of substance use and depressive symptoms and improve functioning briefly and over the long term (Paddock, Hunter, & Leininger, 2014; Vujanovic et al., 2017). In a review examining MDD and AUD specifically (Riper et al., 2014), treatment as usual supplemented with CBT and motivational interviewing had small but significant effects in improving depression and decreasing alcohol use versus treatment as usual alone or other brief psychosocial interventions.

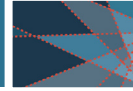
For more extensive guidance about counseling clients with addiction and depression, see TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (Center for Substance Abuse Treatment [CSAT], 2008).

Bipolar I Disorder

Bipolar I disorder, also sometimes termed **manic-depression**, refers to a mental state wherein a person's mood fluctuates wildly between depressive and manic episodes (Exhibit 4.3). During depressive episodes, a person experiences symptoms of MDD (e.g., excessive sadness, loss of interest in normally pleasurable activities, physical and cognitive symptoms). During manic episodes, a person experiences the opposite—extreme euphoria, energy, and activity. Manic episodes vary with intensity and can be manifest in a variety of ways, such as having little or no need for sleep, very fast or “pressured” speech, impulsivity and erratic decision making (especially decisions of major consequence, like spending a large amount of money), and racing thoughts. Some manic episodes are milder in nature; these are known as hypomanic episodes. People with bipolar I disorder can experience both manic and hypomanic episodes. Bipolar II disorder is a related disorder in which the person only experiences hypomania and not full-blown mania. For the purposes of this chapter, only bipolar I disorder, which has ample research strongly linking it to SUDs, will be discussed.

Sometimes, manic episodes can produce symptoms that conflict with reality and are delusional in nature (e.g., a man believing he is going to marry the Queen of England). Because of these delusional and bizarre beliefs, bipolar disorder can sometimes appear similar to schizophrenia and other psychotic disorders (see the section “Schizophrenia and Other Psychotic Disorders”). In fact, increasing research supports a shared genetic risk between the bipolar and psychotic disorders (Cardno & Owen, 2014).

Suicidal thoughts and behaviors are common among people with bipolar disorder (APA, 2013), with **some believing it could have the highest suicide risk of all mental disorders** (Schaffer et



ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH A DEPRESSIVE DISORDER

- Possibly as many as half of the clients an addiction counselor sees will have an MDE (Center for Behavioral Health Statistics and Quality [CBHSQ], 2019). Counselors should expect to encounter depressive symptoms and disorders in their work and proactively familiarize themselves with diagnostic criteria and general treatment approaches.
- Differentiate among commonplace expressions of depression and depression associated with more serious mental illness (SMI), medical conditions and medication side effects, and substance-induced changes. Understand that it is possible to have depressive symptoms without meeting full criteria for MDD or another depressive disorder. Distinguishing MDD from normal moods and depressive symptoms is also important.
- Symptoms of depression can persist for 3 to 6 months following abstinence and need to be treated in counseling. Educate clients about the relationship of depression to substance misuse so that they know what to expect from treatment and the course of recovery.
- Sometimes substance use can mask depressive symptoms, and it may not become apparent that a client has depression until after he or she has stopped using substances. Monitor symptoms continually and respond immediately to any intensification of symptoms.
- Clients with depression often feel hopeless and unmotivated, which can hinder their participation and retention in treatment. If clients seem reluctant to engage in SUD treatment, do not interpret that as a sign of resistance or noncompliance. Alleviating their depressive symptoms could help with this to an extent. But also work with clients on enhancing motivation and self-efficacy so they can develop confidence and internalize the belief that recovery is possible.
- Gradually introduce and teach skills for participation in mutual-support programs.
- Consider CBT and motivational interviewing in place of or in addition to usual psychosocial treatment.
- Combine addiction counseling with medication and mental health services.
- Because antidepressants have such strong efficacy in reducing depressive symptoms, keep on hand the names of local mental health professionals (if one isn't available in the treatment setting) to refer clients for complete assessment and medication review.
- Given that depressive symptoms can result from SUDs and not an underlying mental disorder, careful and continual assessment is essential.
- Because of the increased risk of suicidality with MDD, continually assess and be vigilant for signs of suicidal ideation, gestures/behaviors, and attempts. Use risk mitigation strategies (e.g., safety plans) to protect clients from self-harm. (See the section "Cross-Cutting Topics: Suicide and Trauma" for more guidance.)

al., 2015). An estimated 20 percent of people with bipolar disorder try to commit suicide (Carra, Bartoli, Crocamo, Brady, & Clerici, 2014), leading to a standardized mortality ratio of suicide deaths that is 10 to 30 times greater than that of the general population (Schaffer et al., 2015). People

with bipolar disorder and SUD are significantly more likely to try to commit suicide than people without both conditions (Carra et al., 2014; Schaffer et al., 2015). Interestingly, current or lifetime SUD is a significant risk factor for suicide attempt in bipolar disorder but not suicide death (Schaffer et al., 2015).

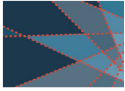


EXHIBIT 4.3. Diagnostic Criteria for Bipolar I Disorder

For a diagnosis of bipolar I disorder, it is necessary to meet the following criteria for a manic episode. The manic episode may have been preceded by and may be followed by hypomanic or MDEs.

Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
3. More talkative than usual or pressure to keep talking
4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) as reported or observed
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity)
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.

Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I disorder.

Note: Criteria A–D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder.

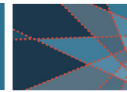
Hypomanic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree:

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
3. More talkative than usual or pressure to keep talking
4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli) as reported or observed.

Continued on next page



Continued

6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).

Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

Note: Criteria A–F constitute a hypomanic episode. Hypomanic episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

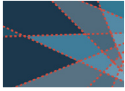
MDE

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gain.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Continued on next page

*Continued*

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A–C constitute an MDE. MDEs are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of an MDE in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.*

Bipolar I Disorder

A. Criteria have been met for at least one manic episode (Criteria A–D under Manic Episode, above).

B. The occurrence of the manic episode and MDE is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

Specify current severity:

- Mild
- Moderate
- Severe

Specify:

- With psychotic features
- In partial remission
- In full remission
- Unspecified

Specify:

- With anxious distress
- With mixed features
- With rapid cycling
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With peripartum onset
- With seasonal pattern

* In distinguishing grief from an MDE, it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of MDE is

Continued on next page

Continued

more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in MDE. In grief, self-esteem is generally preserved, whereas in MDE feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about “joining” the deceased, whereas in MDE such thoughts are focused on ending one’s own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

Source: APA (2013, pp. 123–127). Reprinted with permission from the DSM-5 (Copyright © 2013). APA. All Rights Reserved.

Prevalence

The 12-month and lifetime prevalence rates of DSM-5 bipolar I disorder are 1.5 percent and 2 percent, respectively (Blanco et al., 2017). Rates are nearly equivalent between men and women for both 12-month and lifetime prevalence (Blanco et al., 2017).

Bipolar I Disorder and SUDs

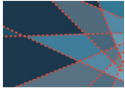
Individuals with bipolar I have high prevalence rates (65 percent) of lifetime SUD, AUD (54 percent), and drug use disorder (32 percent) (McDermid et al., 2015). Presence of a 12-month or lifetime DSM-5 drug use disorder (i.e., an SUD excluding alcohol) is associated with a 1.4 to 1.5 increased odds in having bipolar I disorder (Grant et al., 2016). Similarly, presence of past-year or lifetime bipolar I disorder carries a 2 to 5.8 times greater risk of also having any 12-month or lifetime SUD (Blanco et al., 2017). A systematic review and meta-analysis found strong associations between co-occurring SUDs and bipolar illness in individuals in clinical settings, with the highest prevalence (average: 30 percent) for alcohol use, 20 percent (mean) for cannabis, and 17 percent (mean) for any drug use disorder (Hunt, Malhi, Cleary, Lai, & Sitharthan, 2016b).

Co-occurring bipolar illness and substance misuse are associated with numerous adverse clinical, social, and economic consequences, including increased symptom severity, poorer treatment

outcomes, and greater suicide risk (Ma, Coles, & George, 2018). Presence of a co-occurring SUD with bipolar disorder has been linked to lower SUD treatment adherence and retention, protracted mood episodes, poorer recovery of functional abilities (even after abstaining from substances), increased utilization of emergency services, greater hospitalizations, more variable disease course, greater affective instability, more impulsivity, and poor response to lithium (the standard pharmacotherapy of choice) (Swann, 2010; Tolliver & Anton, 2015).

Treatment of Bipolar I Disorder and SUDs

Substance misuse by people with bipolar disorder complicates diagnosis and treatment. Evidence exists of a bidirectional relationship between bipolar disorder and SUDs, yet the ways in which these conditions influence one another is still unclear (Tolliver & Anton, 2015). Little research has examined nonpharmacological approaches to managing comorbid bipolar I disorder and SUDs. Group CBT, integrated therapy, and relapse prevention techniques may help reduce hospitalizations, increase abstinence, improve medication adherence, reduce addiction severity, and (to a lesser extent) improve mood symptoms (Gold et al., 2018). However, results are inconsistent across studies, underscoring the need for more research.



ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH BIPOLAR I DISORDER

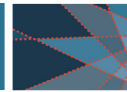
- Although true for most counseling situations, maintaining a calm demeanor and a reassuring presence is especially important with these clients.
- Start low and go slow (that is, start “low” with general and nonprovocative topics and proceed gradually as clients become more comfortable talking about problems).
- Monitor symptoms and respond immediately to any intensification.
- At every session, strongly emphasize and monitor medication compliance and promote medication adherence. The cyclical nature of bipolar disorder is frequently punctuated by bouts of medication noncompliance, and it is crucial to cultivate and convey an understanding of the allure of the manic episode.
- Pay attention to signs of depression or mania, as medication might be able to ward off the worsening of the client's condition. For developing mania, which is virtually nonresponsive to psychosocial interventions, a variety of mood stabilizers have demonstrated remarkable efficacy. Their timely use can avert potentially life-altering, negative events. (See “Pharmacotherapy” in Chapter 7.)
- Although evidence on psychosocial treatments for bipolar I disorder and SUD is inconsistent, the strongest support seems to come from the use of integrated group-based interventions that use multiple treatment components to address both mood and substance-related symptoms. Techniques include counseling, relapse prevention, psychoeducation, medication management, and regular phone or in-person “check-in” sessions to monitor symptoms and treatment progress.
- Gradually introduce and teach skills for participation in mutual-support programs.
- Combine addiction counseling with medication and mental health services.
- Suicide and suicidal behaviors are major ongoing concerns for this client population, and the addiction counselor should have a thorough understanding of her or his role in preventing suicide.

Case Study: Counseling an SUD treatment Client With Bipolar I Disorder

John W. is a 30-year-old man with bipolar I disorder and AUD. He has a history of hospitalizations, both psychiatric and substance related; after the most recent extended psychiatric hospitalization, he was referred for SUD treatment. He told the counselor he used alcohol to facilitate social contact, as well as deal with boredom, because he had not been able to work for some time. The counselor learned that during his early 20s, John W. achieved full-time employment and established an intimate relationship with a nondrinking woman; however, his drinking led to the loss of both.

During one of his AUD treatments, he developed florid manic symptoms, believing himself to be a prophet with the power to heal others. He was transferred to a closed psychiatric unit, where he eventually stabilized on a combination of antipsychotic medications (risperidone) and lithium. Since that time, he has had two episodes of worsening psychiatric symptoms leading to hospitalization; each of these began with drinking, which then led to stopping his medications, then florid mania and psychiatric commitment. However, when he is taking his medications and is sober, John W. has a normal mental status and relates normally to others. Recently, following a series of stressors, John W. left his girlfriend, quit his job, and began using alcohol heavily again. He rapidly relapsed to active mania, did not adhere to a medication regimen, and was rehospitalized.

Continued on next page



Continued

At the point John W. is introduced to the SUD treatment counselor, his mental status is fairly normal; however, he warns the counselor that after manic episodes he tends to get somewhat depressed, even when he is taking medications. The counselor takes an addiction history and finds that John W. has had several periods of a year or two during which he was abstinent from alcohol and drugs of misuse, but he has never had ongoing AUD treatment or attended Alcoholics Anonymous (AA) meetings. John W. replies to the counselor's questions about this with, "Well, if I just take my meds and don't drink, I'm fine. So why do I need those meetings?"

Using a motivational approach, the counselor helps John W. analyze what has worked best for him in dealing with both addiction and mental problems, as well as what has not worked well for him. John W. is tired of the merry-go-round of his life; he certainly acknowledges that he has a major mental disorder, but thinks his drinking is only secondary to the mania. When the counselor gently points out that each of the episodes in which his mental disorder led to hospitalization began with an alcohol relapse, John W. begins to listen. In a group for clients with CODs at the SUD treatment agency, John W. is introduced to another client in recovery with a bipolar disorder, who tells his personal story and how he discovered that both of his problems need primary attention. This client agrees to be John W.'s temporary sponsor and calls John W.'s case manager, who works at the mental health center where John W. gets his medication, and describes the treatment plan. She then makes arrangements for a monthly meeting involving the counselor, case manager, and John W.

Discussion: The SUD treatment counselor has taken the wise step of taking a detailed history and attempting to establish the linkage between CODs. The counselor tries to appreciate the client's own understanding of the relationship between the two. She uses motivational approaches to analyze what John W. did in his previous partially successful attempts to deal with the problem and helps develop connections with other recovering clients to increase motivation. Lastly, she is working closely with the case manager to ensure a coordinated approach to management of each disorder.

Posttraumatic Stress Disorder

PTSD is an exaggerated fear response that occurs following exposure to one or more extremely upsetting events. Such events can include, but are not limited to, war, terrorist attacks, threatened or actual physical or sexual violence, being kidnapped, natural and man-made disasters, and serious motor vehicle accidents. Events may be experienced firsthand, witnessed, experienced through repeated exposure as a part of one's job (e.g., police officers repeatedly hearing details about child abuse, murder, and other violent and upsetting crimes), or by learning about such events occurring to a close loved one (e.g., learning of the murder of one's child). People with PTSD report the most distressing trauma to be sexual abuse before age 18 years (Goldstein et al., 2016).

Symptoms of PTSD are grouped into four categories:

- **Intrusive, persistent re-experiences of the trauma**, including recurrent dreams

or nightmares, flashbacks, and distressing memories

- **Persistent avoidance** of people, places, objects, and events that remind the person of the trauma or otherwise trigger distressing memories, thoughts, feelings, and physiological reactions
- **Negative alterations in cognitions and mood**, such as memory loss (particularly regarding details surrounding the event), self-blame, guilt, hopelessness, social withdrawal, and an inability to experience positive emotions
- **Marked alterations in arousal and reactivity**, such as experiencing sleeplessness or feeling "jumpy," "on edge," easily started, irritable, angry, or unable to concentrate

Exhibit 4.4 lists the DSM-5 criteria for PTSD in adults and children older than age 6; separate criteria are available for children ages 6 years and younger and can be found in DSM-5.

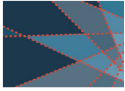


EXHIBIT 4.4. Diagnostic Criteria for PTSD

Note: The following criteria apply to adults, adolescents, and children older than 6 years.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of these ways:

1. Directly experiencing the traumatic event(s)
2. Witnessing, in person, the event(s) as it occurred to others
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse)

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic events(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)

Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s)

Note: In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

Note: In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)

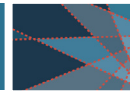
C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)

D. Negative alterations in cognitions and mood associated with the traumatic events(s), beginning or worsening after the traumatic events(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic events(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs)

Continued on next page



Continued

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”)
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame)
5. Markedly diminished interest or participation in significant activities
6. Feelings of detachment or estrangement from others
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings)

E. Marked alterations in arousal and reactivity associated with the traumatic events(s), beginning or worsening after the traumatic events(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects
2. Reckless or self-destructive behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems with concentration
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep)

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

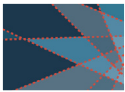
- With dissociative symptoms: The individual's symptoms meet the criteria for PTSD, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:
 1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly)
 2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted)

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizure).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate)

Source: APA (2013, pp. 271–272). Reprinted with permission from the DSM-5 (Copyright © 2013). APA. All Rights Reserved.



Prevalence

Twelve-month and lifetime prevalence rates of DSM-5 PTSD are 4.7 percent and 6.1 percent, respectively (Goldstein et al., 2016). Rates are markedly higher among women than men, about 6 percent and 8 percent for past-year and lifetime PTSD, respectively (Goldstein et al., 2016). Lifetime prevalence is even higher for female veterans (13.9 percent) and younger adults (ages 18 to 29 years, 15.3 percent) (Smith, Goldstein, & Grant, 2016). A 2016 study of veterans using DSM-5 criteria found the lifetime prevalence of PTSD to be 6.9 percent, with significantly higher prevalence rates noted for women and younger age groups (Smith et al., 2016).

Individuals in occupations at risk of exposure to traumatic events (e.g., police, firefighters, emergency medical personnel) have higher rates of PTSD. Among high-risk individuals (those who have survived rape, military combat, and captivity or ethnically or politically motivated internment and genocide), the proportion of those with PTSD ranges from one-third to one-half (APA, 2013).

PTSD and SUDs

A strong association exists between PTSD and substance misuse, including lifetime SUDs (Hasin & Kilcoyne, 2012), lifetime drug use disorders (Grant et al., 2016), and lifetime AUD (Grant et al., 2015). Among people with SUDs, lifetime prevalence of PTSD is thought to range between 26 percent and 52 percent and rates of current PTSD between 15 percent and 42 percent (Vujanovic, Bonn-Miller, & Petry, 2016). Among people with PTSD, lifetime rates of SUD are likely between 36 percent and 52 percent (Vujanovic et al., 2016). Presence of a 12-month or lifetime DSM-5 drug use disorder (i.e., an SUD excluding alcohol) is associated with a 1.5 to 1.6 increased odds of having PTSD (Grant et al., 2016). Similarly, presence of 12-month or lifetime PTSD is associated with a 1.3 to 1.5 increased odds of having a past-year or lifetime SUD (Goldstein et al., 2016).

Comorbid PTSD and addiction are highly complex and associated with worse treatment outcomes (including lower rates of remission and faster relapse), poorer treatment response, more

cognitive difficulties, worse social functioning, greater risk of suicide attempt, and heightened mortality (Flanagan, Korte, Killeen, & Back, 2016; Schumm & Gore, 2016). Compared with people with PTSD or alcohol dependence alone, those with both report more traumatic childhoods, more psychiatric comorbidities, an increased risk of suicide, more severe symptoms, and greater disability (Blanco et al., 2013).

People with PTSD tend to misuse the most serious substances (cocaine and opioids); however, misuse of prescription medications, cannabis, and alcohol also are common.

WARNING TO COUNSELORS: PTSD OR DEPRESSION?

Many people with PTSD are mistakenly diagnosed with depression, particularly in SUD treatment settings where screening for trauma is low. The two conditions are highly comorbid. Symptoms can overlap to an extent, and when occurring together, the combination results in greater symptom severity than either disorder alone (Post, Feeny, Zoellner, & Connell, 2016). Subclinical traumatic stress reactions are commonly expressed as depressive symptoms. However, PTSD has unique treatment needs and a different disease course and treatment response than depression. When working with someone with a depressive disorder diagnosis who also has a history of trauma, consider screening for PTSD to gauge whether a referral for diagnostic assessment might be warranted.

Treatment of PTSD and SUDs

Historically, there has been debate about whether to treat PTSD and addiction concurrently or sequentially, with most providers falling on the side of treating the SUD separately and first (Schumm & Gore, 2016). Some believe that substance misuse among people with PTSD is a means of self-medicating to help manage distressing mood and anxiety symptoms, thus making PTSD the priority target for treatment. Alternatively, others have feared that treating PTSD first could exacerbate SUD symptoms or cause clients to use substances

as a means of coping with the hyperarousal and negative mood that can occur while progressing through PTSD treatment. However, integrated, concurrent treatment that addresses both conditions simultaneously has generated strong empirical support, appears to be preferable to clients, and is increasingly considered the current standard of care, particularly when combining psychosocial and pharmacologic approaches (Flanagan et al., 2016; Schumm & Gore, 2016; Simpson, Lehavot, & Petrakis, 2017).

Despite the evidence that concurrent treatment can be effective, people with PTSD and SUD are frequently only treated for addiction; further, **clients in SUD treatment settings are often not even assessed for PTSD** (Vujanovic et al., 2016). Whereas treating SUD alone rarely leads to improvement in PTSD symptoms, reducing PTSD symptoms can significantly decrease the odds of heavy substance (Hien et al., 2010).

Exposure therapy can be safe and effective at reducing trauma and SUD symptoms—although

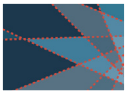
more evidence is needed (Flanagan et al., 2016). Nonexposure-based treatments have been studied more widely for co-occurring PTSD and SUD and may be moderately effective at improving both PTSD and substance symptoms, but the evidence is still premature (Flanagan et al., 2016). A Cochrane Review found individual trauma-focused psychotherapy with adjunctive SUD treatment to be effective at reducing posttreatment PTSD severity and substance use at 5 to 7 months following treatment; however, the authors deemed the current evidence base on psychological treatments for PTSD-SUD to be weak in terms of quality and methodology, underscoring the need for more rigorous research in this area (Roberts, Roberts, Jones, & Bisson, 2016). Studies of pharmacologic treatments for SUD with PTSD, and for AUD specifically, appear encouraging but, again, are understudied, often inconclusive, and require more data (Flanagan et al., 2016; Petrakis & Simpson, 2017).

See the section “Cross-Cutting Topics: Suicide and Trauma” at the end of this chapter for more information about trauma-informed care for people with CODs.

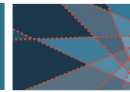
ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH PTSD

- As a counselor, it is important to recognize, and help clients understand, that becoming abstinent from substances does not resolve PTSD; both disorders must be addressed in treatment.
- Treatment of PTSD with cooccurring SUDs requires careful planning and supervision.
 - As the client faces painful trauma memories, the desire for intoxication can be overwhelming. By exploring trauma memories, well-intentioned counselors inadvertently may drive a client back to the substance by urging her to “tell her story” or “let out the abuse.” Even if a client wants to discuss trauma and seems safe during the session, aftereffects may well ensue, including a flood of memories the client is unprepared to handle, increased suicidality, and “retraumatization” (feeling like one is reliving the event).
 - Such treatment approaches should be undertaken only with adequate formal training in both PTSD and substance misuse and only under careful clinical supervision.
- These clients need stability in their primary therapeutic relationship; hence, this work should not be undertaken in settings with high staff turnover and never without training and supervision.

Continued on next page

*Continued*

- Do not try to provide trauma exploration treatment in view of the potential for highly destabilizing effects (including worsening of substance misuse).
- Provide present-focused psychoeducation about PTSD, such as teaching the client to recognize symptoms of the disorder and how to cope with them.
- Clinicians are advised not to overlook the possibility of PTSD in men.
- People with PTSD and substance misuse are more likely to experience further trauma than people with substance misuse alone.
- Repeated trauma is common in domestic violence, child abuse, and some substance-using lifestyles (e.g., the drug trade), so helping the client protect against future trauma may be an important part of treatment.
- Anticipate proceeding slowly with a client who is diagnosed with or has symptoms of PTSD. Consider the effect of a trauma history on the client's current emotional state, such as an increased level of fear, depressed mood, or irritability.
- Trauma begets more trauma, as people with PTSD are at an increased risk of revictimization. Discuss with clients this increased risk, how to recognize and avoid threatening situations, and how substance use plays a role in increasing their vulnerability to revictimization.
- Develop a plan for increased safety if warranted.
- Respond more to the client's behavior than his or her words.
- Limit questioning about details of trauma.
- Recognize that trauma injures an individual's capacity for attachment. The establishment of a trusting treatment relationship will be a goal of treatment, not a starting point.
- Recognize the importance of one's own trauma history and countertransference.
- Help the client learn to deescalate intense emotions.
- Help the client understand the link between PTSD and substance use by providing psychoeducation.
- Teach coping skills to control PTSD symptoms.
- Recognize that PTSD/SUD treatment clients may have a more difficult time in treatment and that treatment for PTSD may be long term, especially for those who have a history of serious trauma.
- Help the client access long-term PTSD treatment and refer to trauma experts for trauma exploratory work.
- Given the high prevalence of self-harm in this population, counselors should screen for suicide risk early on in treatment and throughout the course of care. Risk of suicide in people with PTSD is correlated with a history of childhood maltreatment and more severe PTSD symptoms—especially ones concerning negative mood and cognitions (Criterion D in DSM-5 diagnostic criteria).



CASE STUDY: COUNSELING AN SUD TREATMENT CLIENT WHO BINGE DRINKS AND HAS PTSD

Caitlin P. is a 17-year-old Native American woman admitted to an inpatient SUD treatment program after she tried to kill herself during a drunken episode. She has been binge drinking since age 12 and also has tried a wide variety of pills without caring what she is taking. She has a history of depression and burning her arms with cigarettes. She was the victim of a date rape at age 15 and did not tell anyone but a close friend. She did not tell her family for fear that they would think less of her for not preventing or fighting off the attack.

In treatment, she worked with staff to try to gain control over her repeated self-destructive behavior. Together they worked on developing compassion for herself, created a safety plan to encourage her to reach out for help when in distress, and began a log to help her identify her PTSD symptoms so that she could recognize them more clearly. When she had the urge to drink, use drugs, or burn herself, she was guided to try to “bring down” the feelings through grounding, rethink the situation, and reassure herself that she could get through it. She began to see that her substance use had been a way to numb the pain.

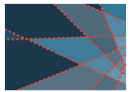
Discussion: Counselors can help clients gain control over PTSD symptoms and self-destructive behavior associated with trauma. Providing specific coping strategies and lots of encouragement typically appeals to PTSD/SUD treatment clients, who may want to learn how to overcome the emotional rollercoaster of their disorders. Notice that in such early-phase treatment, detailed exploration of the past is not generally advised.

For more information about working with American Indian and Alaska Native clients who have SUDs or CODs, see TIP 61, *Behavioral Health Services for American Indians and Alaska Natives* (SAMHSA, 2018a).

Personality Disorders

A PD refers to a person’s lifelong inability to form healthy, functional relationships with others and a failure to develop an adaptive sense of self. These are manifest as (a) destructive or otherwise problematic patterns of thinking and feeling about oneself, one’s place in the world, and others and (b) negative ways of behaving toward others. People with PDs often lack insight into their dysfunctional cognitive, emotional, and behavioral patterns and often blame others or the world in

general for their difficulties. Many people with PDs struggle to develop strong, positive relationships, because they view reality from the perspective of their own needs and therefore have a difficult time understanding, empathizing with, and connecting with others. PDs are lifelong conditions that develop in adolescence or early adulthood. They are frequently resistant to change and result in significant impairments in interpersonal functioning, work/school performance, and self-concept.



There are several types of PDs, and the precise symptoms someone exhibits will depend on which type of PD he or she has. For instance, depending on the PD type, an individual might think of himself/herself in overly negative ways or in grandiose ways, might be overly attached to others or completely indifferent to others, might constantly try to be the center of attention or might be socially reclusive. People with PDs must first meet the diagnostic criteria for a general PD (Exhibit 4.5) and then must meet additional diagnostic criteria for whatever PD type is most appropriate given their symptoms. Many individuals with PDs have features of, or meet full criteria for, other PDs.

This TIP provides details about the two PD types that are commonly comorbid with addiction—BPD and antisocial PD (ASPD). Before exploring BPD and ASPD in detail, an overview of PDs in general follows. Readers should be aware that the diagnostic approach to PDs continues to undergo refinement, as researchers in psychopathology have expressed many concerns about the meaningfulness, gender bias, accuracy, and utility of the current categorical diagnostic system for PDs (see Section III of DSM-5

for more information on alternative PD classification and diagnostic criteria).

PD Clusters

Once a person meets criteria for a general PD, his or her diagnosis is further categorized based on several specific PD types, including paranoid PD, schizoid PD, schizotypal PD, histrionic PD, narcissistic PD, ASPD, BPD, avoidant PD, dependent PD, and obsessive-compulsive PD. If the symptoms do not meet any of the types, he or she can be diagnosed with either unspecified PD or other specified PD. Detailed descriptions and criteria for all 10 PD types can be found in DSM-5. BPD and ASPD most frequently co-occur with substance misuse (Köck & Walter, 2018). Thus, they are included in this chapter and discussed in respective subsections.

In DSM5, PD types are categorized into three distinct clusters based on their common features:

- **Cluster A PDs** describe people who may be seen as odd or eccentric. This eccentricity can express itself in many ways (e.g., paranoia and suspicion, extreme social withdrawal/lack of

EXHIBIT 4.5. Diagnostic Criteria for General PD

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events)
2. Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)
3. Interpersonal functioning
4. Impulse control

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

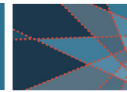
C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., head trauma).

Source: APA (2013, pp. 646–647). Reprinted with permission from the DSM-5 (Copyright © 2013). APA. All Rights Reserved.



WARNING TO COUNSELORS: PDS AND PROVIDER STIGMA

PDs are among the most stigmatized of all mental disorders (Sheehan, Nieweglowski, & Corrigan, 2016). Primary care, mental health, and SUD treatment professionals sometimes have contemptuous attitudes toward PDs and the people who live with them. They may think or say things such as:

- “These people cannot be treated, so why bother?”
- “I see PDs all the time, especially in women.”
- “Most people with addiction also have a PD.”
- “It is not worth the time to try to diagnose or treat someone with a PD because nothing can be done for them anyway.”
- “I don’t accept referrals for clients like that because they’re too much work and can’t be helped.”
- “Most antisocial people are criminals and are just going to end up in prison.”
- “People with ASPD are ‘psychopaths’ (or ‘sociopaths’).”
- “These people are just manipulative liars; they don’t really want to get better or want my help.”
- “That wasn’t a real suicide attempt. She’s borderline—she’s just seeking attention.”

It is true that PDs are lifelong disorders, can be challenging to work with, and may be more resistant to change than other mental disorders or SUDs. But that does not mean that counselors cannot offer people with these conditions any relief, and it does not mean that people with PDs cannot improve their symptoms. Addiction professionals can help clients with PDs reduce substance misuse, which in turn can indirectly help improve functioning and quality of life by reducing risky behavior and enhancing health.

Counselors can combat stigma and prejudice by:

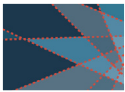
- Becoming familiar with the latest evidence in support of PD treatment. The notion that these disorders are completely intractable is untrue. Even in the absence of validated treatments for the PD itself, interventions can still help reduce disabling symptoms and CODs, including co-occurring addiction.
- Engaging in honest self-reflection about their own views of and attitudes about PDs. Talking to a clinical supervisor, or even engaging in brief counseling themselves, can foster self-awareness and behavior change.
- Remembering that stereotypes can be dangerous and affect how counselors serve (or do not serve) the clients who need them. All people, regardless of symptoms or diagnoses, deserve health and happiness.

interest in interpersonal relationships, unusual beliefs or behaviors). PD types included in this cluster are:

- Paranoid PD.
- Schizoid PD.
- Schizotypal PD.
- **Cluster B PDs** are characterized by dramatic, overly emotional, and erratic and unpredictable behavior. PD types included in this cluster are:
 - Histrionic PD.
 - Narcissistic PD.
 - ASPD.
 - BPD.
- **Cluster C PDs** are marked by anxious and fearful behaviors. PD types included in this cluster are:
 - Obsessive-compulsive PD.
 - Avoidant PD.
 - Dependent PD.

Prevalence

Prevalence estimates for PDs among the general population are difficult to ascertain, given lack of research examining large samples from the community (as opposed to clinical samples, in which PDs are far more common and frequently studied). Estimates are 9.1 percent for any PD, 5.7 percent for any Cluster A PD, 1.5 percent for any Cluster B, and 6 percent for Cluster C (APA, 2013). In one analysis of the National Epidemiologic Survey on Alcohol



and Related Conditions (NESARC), the prevalence of lifetime DSM-IV PDs varied from 0.5 percent to 7.9 percent, depending on the PD type (Hasin & Grant, 2015). Prevalence rates for BPD and ASPD are discussed in separate sections.

Diagnostic criteria for PDs have long been debated among psychopathology researchers and clinicians, given multiple problems with the way PDs are classified and diagnosed (Paris, 2014; Sarkar & Duggan, 2010). Problems include a lack of empirical evidence supporting PDs; the extensive overlap between diagnostic criteria among the specific types of PDs as well as overlap with other mental disorders; the fact that PD criteria are insufficiently discriminant, which has resulted in many individuals who exhibit PD pathology receiving a DSM-IV “personality disorder not otherwise specified” diagnosis after failing to “fit in” to any of the specified PD types; and the difficulty mental health professionals have in distinguishing PD traits from variants of normal personality, which means that deciding whether a person meets PD criteria is often a subjective judgment. **Thus, it is hard to know exactly how many people have a PD, including how many people with addiction have co-occurring PDs** (Paris, 2014).

PDs and SUDs

SUD counselors frequently see people with PD diagnoses in their treatment settings. A review found the prevalence of PDs among people with SUDs to be wide ranging but nonetheless extremely high, varying from about 35 percent to 65 percent; rates of ASPD ranged from about 14 percent to almost 35 percent (Köck & Walter,

For most people with SUDs, drugs eventually become more important than jobs, friends, and family. These changes in priorities often appear similar to a PD, but diagnostic clarity for PDs in general is difficult. For clients with substance-related disorders, the true diagnostic picture might not emerge for weeks or months. It is not unusual for PD symptoms to clear with abstinence, sometimes even fairly early in recovery.

2018). Similarly, among people undergoing detoxification for AUD, rates of co-occurring PDs vary widely from 5 percent to 87 percent (Newton-Howes & Foulds, 2018). PDs may be present in as much as 24 percent of people with AUD in the general population (Newton-Howes & Foulds, 2018).

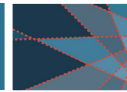
People with PDs and SUDs differ from those with PDs only or SUDs only in important ways (Köck & Walter, 2018), including more severe mental and substance-related symptoms, longer persisting substance use, a greater likelihood of other co-occurring mental disorders (e.g., anxiety, depressive, and eating disorders), increased mortality, and higher SUD treatment dropout.

Treatment for PDs and SUDs

No evidence-based treatments exist for PDs themselves (Bateman, Gunderson, & Mulder, 2015), but effective treatments are available to address a variety of PD symptoms, including risk of suicide and self-harm, affective dysregulation, maladaptive thought patterns, and poor interpersonal functioning. Psychotherapy is the primary form of intervention, as no medications have been approved for the treatment of PDs. Pharmacotherapy may be useful as an adjunctive treatment for certain symptoms like affective lability, impulsivity, and psychosis, but it is not useful as a primary intervention. (See the section “Pharmacotherapy” in Chapter 7 for more information.) Dialectical behavioral therapy, dynamic deconstructive psychotherapy, and dual-focused schema therapy appear promising, particularly for BPD, and have shown to positively affect psychiatric and addiction-related outcomes, although, in general, the research literature on effective treatments for PDs, with or without co-occurring SUD, is sparse and requires further evidence (Bateman et al., 2015; Köck & Walter, 2018).

BPD

The essential feature of BPD is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, along with marked impulsivity, that begins by early adulthood and is present in a variety of contexts (Exhibit 4.6). Relationships with others are likely to be unstable—for instance, people with BPD might remark how wonderful an



ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH A PD

- Clients with PDs tend to be limited in their ability to receive, accept, or benefit from corrective feedback.
- A further difficulty is the strong countertransference providers can have in working with these clients, who may be adept at igniting reactions in a variety of ways. Specific concerns will, however, vary according to the specific PD and other individual circumstances.
- PDs may cause difficulty forming genuinely positive therapeutic alliances. Some clients tend to frame reality in terms of their own needs and perceptions and not to understand the perspectives of others.
- The course and severity of PDs can be worsened by the presence of other mental disorders, such as depressive, anxiety, and psychotic disorders. Be sure to offer empirical treatments for co-occurring conditions as well as the primary PD and SUD.
- To get the best outcomes possible for clients with PDs and co-occurring SUDs, treatment should address both conditions to the extent possible and should not neglect one disorder over the other.

EXHIBIT 4.6. Diagnostic Criteria for BPD

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in various contexts, as indicated by five (or more) of the following:

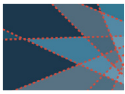
1. Frantic efforts to avoid real or imagined abandonment (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating) (**Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation or severe dissociative symptoms

Source: APA (2013, p. 663). Reprinted with permission from the DSM-5 (Copyright © 2013). APA. All Rights Reserved.

individual is one day but express intense anger, disapproval, condemnation, and even hate toward that same individual a week later. The severe instability people with BPD experience includes fluctuating views and feelings about themselves. Those with BPD often feel good about themselves and their progress and optimistic about their future for a few days or weeks, only to have a seemingly

minor experience turn their world upside down, with concomitant plunging self-esteem and depressing hopelessness. This instability often extends to work and school.

When experiencing emotional states they cannot handle, clients with BPD can be at high risk of suicidal, self-mutilating, or brief psychotic states.



About three-fourths of people with BPD have a history of self-harm, and the disorder carries a 10-percent lifetime risk of completed suicide (Antai-Otong, 2016).

Prevalence

BPD has a prevalence of 1.6 percent to 5.9 percent in the general population but is more common in mental health settings (about a 10-percent prevalence rate for outpatient mental health clinics, about 20 percent among psychiatric inpatients, and 6 percent in primary care settings) (APA, 2013). Lifetime prevalence of DSM-IV BPD is 5.9 percent (Hasin & Grant, 2015).

Women are much more likely to be diagnosed with BPD, generally at 3 times the rate of men (i.e., about 75 percent of cases are women) (APA, 2013). However, the accuracy of this pattern is dubious as epidemiologic surveys of the U.S. general

population have found the lifetime prevalence of BPD does not actually differ significantly between men and women (Hasin & Grant, 2015).

BPD and SUDs

BPD is highly prevalent in SUD treatment settings (and especially inpatient and residential treatment), with rates averaging about 22 percent across multiple studies but as high as 53 percent in some research (Trull et al., 2018). Presence of a 12-month or lifetime DSM-5 drug use disorder (i.e., an SUD excluding alcohol) is associated with a 1.7 to 1.8 increased odds of having BPD (Grant et al., 2016). Approximately 45 percent of individuals with BPD also have a current SUD, and about 75 percent have a lifetime SUD (Trull et al., 2018). Opioids, cocaine, and alcohol are the substances with the strongest associations with BPD (Trull et al., 2018).

Treatment of BPD and SUDs

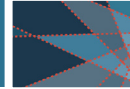
People with BPD typically seek behavioral health services based on their current life conditions and emotional state. Those who seek mental health services tend to be acutely emotionally distraught, needing some relief from how they feel. Similarly, those who choose (or are directed to choose) a program are likely experiencing the SUD as the immediate target for treatment. Consequently, the average admission of a person with BPD to a mental health program may be considerably different from the average admission of a person with BPD to an SUD treatment program.

In inpatient mental health service settings, dialectical behavior therapy for BPD is recommended to help reduce suicide risk, stabilize behavior, and help clients regulate emotions (Ritter & Platt, 2016). SUD treatment for people with BPD can be complicated, and progress may be slow, but effective interventions are available to help reduce symptoms and improve functioning. A systematic review of 10 studies on treatments for BPD and co-occurring SUDs found good support for dialectical behavior therapy, dynamic deconstructive therapy, and dual-focused schema therapy in improving outcomes of substance use, suicidal gestures and self-harm, global and social functioning, treatment utilization, and treatment retention (Lee, Cameron, & Jenner, 2015).

WARNING TO COUNSELORS: THE MISDIAGNOSIS OF BPD

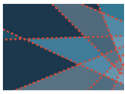
PDs can be difficult to diagnose. BPD is especially prone to misdiagnosis, particularly among women. Reasons for incorrect diagnosis (or, alternatively, failure to diagnose) are numerous and include (Fruzzetti, 2017):

- Stigma surrounding the disorder may lead providers to refuse to diagnose it or to be overzealous in diagnosing it (the latter, especially in women who are “emotional,” unstable, argumentative, or in crisis).
- Symptoms of BPD—including emotional lability, suicidality, and impulsive behaviors—that are also present in full or in part in many other disorders, including MDD, bipolar disorder, PTSD, SUDs, and more. This makes it difficult to disentangle BPD from other illnesses.
- The incorrect belief that BPD is not treatable, which may make clinicians less likely to give the diagnosis, especially when they believe that symptoms reflect a different disorder, like depression or PTSD.
- Women being significantly more likely to receive a BPD diagnosis because of gender bias.



ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH BPD

- Anticipate that client progress will be slow and uneven.
- Assess the risk of self-harm by asking about what is wrong, why now, whether the client has specific plans for suicide, past attempts, current feelings, and protective factors. (See the discussion of suicidality at the end of this chapter.)
- Maintain a positive but neutral professional relationship, avoid overinvolvement in the client's perceptions, and monitor the counseling process frequently with supervisors and colleagues.
- Set clear boundaries and expectations regarding limits and requirements in roles and behavior.
- Understand that clients with BPD may be inconsistent in their attendance to sessions; anticipate and discuss these interruptions with the client.
- Assist the client in developing skills (e.g., deep breathing, meditation, cognitive restructuring) to manage negative memories and emotions.
- Help the client understand the connections between their feelings and their behaviors.
- Monitor newly abstinent individuals with BPD for compulsive sexual behavior, compulsive gambling, compulsive spending/shopping, or other behaviors that result in negative or even dangerous consequences.
- Medication management and monitoring should be included in the treatment plan. Individuals with BPD often are skilled in seeking multiple sources of medication that they favor, such as benzodiazepines. Once they are prescribed this medication in a mental health system, they may demand to be continued on the medication to avoid dangerous withdrawal.
- Help clients manage their daily lives and responsibilities by focusing on work, family, and social functioning.
- At the beginning of a crisis episode, a client with BPD may take a drink or use a different substance in an attempt to quell the growing sense of tension or loss of control. The client must learn that at this point, substance use increases harm and real loss of control. The client needs to develop positive coping strategies to put into play immediately upon experiencing a desire to use substances.
- Educate clients about their SUDs and mental disorders. Clients should learn that treatment for and recovery from their SUD may progress at a different rate than their treatment for and recovery from BPD. In addition, although many clients appear to fully recover from their SUDs, the degree of long-term recovery from BPD is less understood and characterized.
- Written and oral contracts that are simple, clear, direct, and time limited can be a useful part of the treatment plan. Contracts can help clients create structure and safe environments for themselves, prevent relapse, or promote appropriate behavior in therapy sessions and in mutual-support meetings.
- To treat people with BPD, pay attention to several areas, such as violence to self or others, transference and countertransference, boundaries, treatment resistance, symptom substitution, and somatic complaints.
- Therapists should be realistic in their expectations and know that clients might try to test them. To respond to such tests, therapists should maintain a matter-of-fact, businesslike attitude, and remember that people with PDs often display maladaptive behaviors that have helped them to survive in difficult situations, sometimes called “survivor behaviors.” (See TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* [CSAT, 2000c]).



CASE STUDY: COUNSELING AN SUD TREATMENT CLIENT WITH BPD

Ming L., an Asian woman, was 32 years old when she was taken by ambulance to the local hospital's emergency department (ED). Ming L. had taken 80 Tylenol capsules and an unknown amount of Ativan in a suicide attempt. Once medically stable, Ming L. was evaluated by the hospital's social worker to determine her clinical needs.

The social worker asked Ming L. about her family of origin. Ming L. gave a cold stare and said, "I don't talk about that." Asked if she had ever been sexually abused, Ming L. replied, "I don't remember." Ming L. acknowledged previous suicide attempts as well as a history of cutting her arm with a razor blade during stressful episodes. She reported that the cutting "helps the pain."

Ming L. denied having "a problem" with substances but admitted taking "medication" and "drinking socially." A review of Ming L.'s medications revealed the use of Ativan "when I need it." It soon became clear that Ming L. was using a variety of benzodiazepines (anxiety medications) prescribed by several doctors and probably was taking a daily dose indicative of severe SUD. She reported using alcohol "on weekends with friends" but was vague about the amount. Ming L. did acknowledge that before her suicide attempts, she drank alone in her apartment. This last suicide attempt was a response to a breakup with her boyfriend.

The counselor reads through notes from an evaluating psychiatrist and reviews the social worker's report of his interview with Ming. She notes that the psychiatrist describes the client as having a severe BPD, major recurrent depression, and SUDs involving both benzodiazepines and alcohol.

Discussion: Knowing the limits of what an SUD treatment counselor or agency can and cannot realistically do is important. A client with problems this serious is unlikely to do well in standard SUD treatment unless she is also enrolled in a program qualified to provide treatment to clients with BPD, and preferably in a program that offers treatment designed especially for this disorder, such as dialectical behavior therapy (Linehan et al. 1999) (although SUD treatment programs are increasingly developing their capacities to address specialized mental disorders). She is likely to need detoxification either on an inpatient basis or in a long-term outpatient program that knows how to address clients with PDs.

ASPD

The core features of ASPD are a pervasive disregard for the rights, feelings, and needs of others and a failure to form long-term, fulfilling, adaptive relationships (Exhibit 4.7). Individuals with ASPD often display a host of challenging traits: deceitfulness, remorselessness, aggression, disregard for rules and laws, low conscientiousness, impulsivity, failure to adhere to social norms,

delinquency, and recklessness. As a result, these individuals often lead unstable lives and are at high risk of increased mortality, violence/aggression, suicide and suicidal behavior, accidents, criminality, incarceration, and chronic illnesses (e.g., cancer, HIV) (Black, 2015; Black, 2017; Dykstra, Schumacher, Mota & Coffey, 2015; Krasnova, Eaton, & Samuels, 2018; McCloskey & Ammerman, 2018). Many people with ASPD have experienced traumatic or disruptive childhoods (Sher et al., 2015).

EXHIBIT 4.7. Diagnostic Criteria for ASPD

A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:

1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest
2. Deceitfulness, indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
3. Impulsivity or failure to plan ahead
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults
5. Reckless disregard for safety of self or others
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
7. Lack of remorse, indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least age 18 years.

C. There is evidence of conduct disorder with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

Source: APA (2013, p. 659). Reprinted with permission from the DSM-5 (Copyright © 2013). APA. All Rights Reserved.

A particularly stigmatizing aspect of ASPD is its history of being equated with derisive terms like “sociopath” and “psychopath.” ASPD thus carries extremely negative connotations that might well be accurate in only a small percentage of those people with the disorder. Psychopathy and sociopathy are personality traits, not mental disorders. They are related to ASPD but are usually manifest in more extreme ways than ASPD (e.g., criminal behavior). In short, **psychopathy and sociopathy are not the same as ASPD.** (See the TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System*

[CSAT, 2005b] for a full discussion of psychopathy and its relationship to ASPD.)

Prevalence

Twelve-month prevalence rates for DSM-IV ASPD fall between 0.2 percent and 3.3 percent (APA, 2013). Lifetime DSM-IV ASPD is estimated at 3.6 percent (Hasin & Grant, 2015). Much higher prevalence rates (up to 70 percent) have been found in studies of men in treatment for AUD and SUD treatment clinics, prisons, and other forensic settings (APA, 2013).

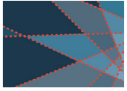
Men are 2 to 8 times more likely to have an ASPD diagnosis than women (Black, 2017). Lifetime prevalence of DSM-IV ASPD is estimated at 1.9 percent in women and 5.5 percent in men (Hasin & Grant, 2015).

ASPD and SUDs

Presence of a 12-month or lifetime DSM-5 drug use disorder (i.e., an SUD excluding alcohol) is linked with 1.4 to 2 increased odds of having ASPD (Grant et al., 2016). Prevalence of ASPD is 7 percent to 40 percent in men with existing SUDs. ASPD is significantly associated with persistent SUDs (Grant et al., 2015; Grant et al., 2016).

An analysis of NESARC data (using DSM-IV diagnoses) revealed gender differences in comorbidities with ASPD (Alegria et al., 2013). Men with ASPD were more likely to have AUD, any drug use disorder, and narcissistic PD. Women with ASPD were more likely to have any mood disorder, MDD, dysthymia, any anxiety disorder, panic disorder, specific phobia, PTSD, and generalized anxiety disorder (GAD). Women were also more likely to report childhood adverse events, such as sexual abuse.

Another study of treatment-seeking individuals assessing gender differences in individuals with an ASPD diagnosis similarly found that women with ASPD tended to be younger, had fewer episodes of antisocial behavior and higher scores on measures of trauma, including emotional and sexual abuse, than men with an ASPD (Sher et al., 2015). Both women and men with ASPD had comorbid alcohol (43.6 percent for women and 50 percent for men) and cannabis use disorders (21.8 percent and 29.7



percent, respectively), and men had higher rates of comorbid cocaine use disorder (22 percent) than women (7.3 percent). Many people with ASPD use substances in a polydrug pattern involving alcohol, marijuana, heroin, cocaine, and methamphetamine.

People with ASPD and SUDs have higher rates of aggression, impulsivity, and psychopathy than people with SUDs alone (Alcorn et al., 2013).

Disregard for others' rights is a key diagnostic feature of ASPD. Yet most clients who are actively using substances display behaviors at some point that show such disregard, so perceiving the distinction between SUD and ASPD can be difficult for the mental health and the SUD treatment fields.

Treatment of ASPD and SUDs

As with most PDs, no empirically supported treatments exist for ASPD, much less ASPD combined with SUDs (Bateman et al., 2015). Various therapies for ASPD with addiction (e.g., CBT, contingency management) may help ameliorate substance-related outcomes, like substance misuse and number of urine-negative specimens over time, but studies are few and sample sizes are small (Brazil, van Dongen, Maes, Mars, & Baskin-Sommers, 2018).

Anxiety Disorders

The distinguishing feature of anxiety disorders is excessive fear and worry along with behavioral disturbances, usually out of attempts to avoid or manage the anxiety. Anxiety disorders are highly

ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH ASPD

- As with CODs in general, clients with ASPD and those with both an SUD and ASPD may be seen as particularly hard to treat, having poor prognoses, and warranting exclusion from treatment programs or group counseling. Counselors should maintain a realistic but hopeful, optimistic attitude toward helping clients improve symptoms and functioning.
- Be aware of the stigma that surrounds ASPD. Many mental health professionals have strongly negative feelings about working with clients who have ASPD, or any PD. Some may even refuse to accept ASPD referrals. Treating ASPD can be challenging, but people with ASPD have the same rights to quality, ethical treatment as anyone else with any other mental disorder.
- Empirical support for interventions to effectively manage ASPD itself is lacking, but effective treatments exist to address certain symptoms (e.g., risk of suicide or self-harm, affective instability), especially those of co-occurring depression, anxiety, and SUDs. For instance, CBT can be useful in restructuring negative thought patterns and reducing impulsivity, improving interpersonal functioning, and providing general support.
- Heed the warning signs of countertransference and transference. Because many mental health professionals have negative attitudes or misperceptions about ASPD, countertransference can occur and prevent counselors from forming an empathic and effective therapeutic alliance with the client.
- Use a positive and empathetic attitude but remain firm in enforcing the structure, rules, and boundaries of psychotherapy and therapeutic relationship.
- Differentiate true ASPD from substance-related antisocial behavior. This can best be done by looking at how the person relates to others throughout the course of his or her life. People with this disorder will have evidence of antisocial behavior preceding substance use and even during periods of enforced abstinence.
- It also is important to recognize that people with substance-related antisocial behavior may be more likely to have MDD than other typical PDs. However, the type and character of depression that may be experienced by those with true ASPD have been less well characterized, and their treatment is unclear.

comorbid with each other but differ in the types of situations that arouse fear and the content of the anxiety-provoking thoughts and beliefs. Panic attacks are a common fear response in anxiety disorders but are not limited to these disorders.

Three of the more prevalent anxiety disorders in the adult population that are likely to co-occur with addiction are GAD, panic disorder, and social anxiety disorder (SAD).

GAD

GAD is marked by excessive anxiety and worry (apprehensive expectation) about a range of topics or events, like everyday living, finances, relationships, or work/school performance (Exhibit 4.8). Anxiety is intense, frequent, chronic (i.e., lasting at least 6 months), and disproportionate to the actual threat posed by the subject of worry.

The worry is accompanied by additional cognitive/physical symptoms.

Panic Disorder

Panic disorder is diagnosed in people who experience repeated panic attacks that are distressing and disabling (Exhibit 4.9). A **panic attack** is an abrupt but very intense occurrence of extreme fear. It often only lasts for a few minutes but the symptoms can be extremely uncomfortable and upsetting, such as hyperventilation, palpitations, trembling, sweating, dizziness, hot flashes or chills, numbness or tingling, and the sensation or fear of nausea or choking. People experiencing panic attacks also can experience psychological symptoms, like feeling as though they are going to die, as though they are “losing their mind,” as though things are not real (derealization), or as if they have left their body

EXHIBIT 4.8. Diagnostic Criteria for GAD

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

Note: Only one item is required in children.

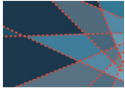
1. Restlessness or feeling keyed up or on edge
2. Being easily fatigued
3. Difficulty concentrating or mind going blank
4. Irritability
5. Muscle tension
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in SAD [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in PTSD, gaining weight in anorexia nervosa [AN], physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

Source: APA (2013, pp. 222). Reprinted with permission from the DSM-5 (Copyright © 2013). APA. All Rights Reserved



(depersonalization). Because of the distressing nature of panic attacks, people with panic disorder may constantly worry about having subsequent attacks or engage in behaviors in an attempt to control the attacks (like avoiding places where they have previously had a panic attack or fear they might have one).

Panic disorder often is underdiagnosed at the beginning of treatment or else is seen as secondary to the more significant disorders, which are the primary focus of treatment. However, panic disorder can significantly impede a person's ability to take certain steps toward recovery, such as getting on a bus to go to a meeting or sitting in a 12-Step meeting. **Sometimes counselors can erroneously identify these behaviors as manipulative or treatment-resistant behaviors.**

EXHIBIT 4.9. Diagnostic Criteria for Panic Disorder

A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:

Note: The abrupt surge can occur from a calm state or an anxious state.

1. Palpitations, pounding heart, or accelerated heart rate
2. Sweating
3. Trembling or shaking
4. Sensations of shortness of breath or smothering
5. Feelings of choking
6. Chest pain or discomfort
7. Nausea or abdominal distress
8. Feeling dizzy, unsteady, light-headed, or faint
9. Chills or heat sensations
10. Paresthesias (numbness or tingling sensations)
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself)
12. Fear of losing control or "going crazy"
13. Fear of dying

Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:

1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, "going crazy").
2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

C. The disturbance is not attributable to the physiological effects of a substance (e.g. a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).

D. The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in SAD; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in obsessive-compulsive disorder; in response to reminders of traumatic events, as in PTSD; or in response to separation from attachment figures, as in separation anxiety disorder).

Source: APA (2013, pp. 208–209). Reprinted with permission from the DSM-5 (Copyright © 2013). APA. All Rights Reserved.

Agoraphobia

One of the changes in DSM-5 concerns the separation of agoraphobia from panic disorder. Although now two distinct conditions, they are closely related and many of their symptoms overlap. In agoraphobia, people exhibit a strong fear of being in certain places or situations where escape could be difficult should the person experience panic-like symptoms or otherwise feel anxious or a loss of control. Situations typically include being in crowds, on public transportation, in open spaces (like bridges), in closed spaces (such as the movie theater), or away from home. People with agoraphobia avoid these situations for fear of having panic attacks or similar incapacitating or embarrassing symptoms (e.g., vomiting, incontinence), or they tolerate them but with great distress and discomfort.

Agoraphobia often occurs without panic disorder in community settings but frequently occurs with panic disorder in clinical settings; the two conditions are distinct yet intertwined (APA, 2013; Asmundson, Taylor, & Smits, 2014). SUDs can and do co-occur with agoraphobia (Goodwin & Stein, 2013; Marmorstein, 2012), but literature on this co-occurrence is relatively small compared with other anxiety disorders or has been examined as occurring with panic disorder (Cogle, Hakes, Macatee, Chavarria, & Zvolensky, 2015) rather than occurring alone. Furthermore, research is more focused on its co-occurrence with nicotine than other substances.

The linkage of agoraphobia with addiction may be explained by its relationship with panic disorder and not with SUD. Thus, agoraphobia is not a subject of focus for this chapter but is mentioned here because of its interrelationship with panic disorder, which addiction counselors are likely to see in their clients.

SAD

Social phobia describes the persistent and recognizably irrational fear of embarrassment and humiliation in social situations (Exhibit 4.10). The social phobia may be quite specific (e.g., public speaking) or may become generalized to all social situations. SAD, also called social phobia in DSM-5, involves intense anxiety or fear in social or performance situations. Individuals may fear being judged by others (e.g., being perceived as stupid, awkward, or boring); being embarrassed or humiliated; accidentally offending someone; or being the center of attention. As a result, the individual will often avoid social or performance situations; when a situation cannot be avoided, they experience significant anxiety and distress. Many people with SAD have strong physical symptoms (e.g., rapid heart rate, nausea, sweating) and may experience full-blown attacks when confronting a feared situation. They recognize that their fear is excessive and unreasonable, but people with SAD often feel powerless against their anxiety.

EXHIBIT 4.10. Diagnostic Criteria for SAD

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).

Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.

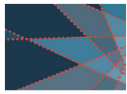
B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others).

C. The social situations almost always provoke fear or anxiety.

Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.

D. The social situations are avoided or endured with intense fear or anxiety.

Continued on next page



Continued

E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

F. The fear, anxiety or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.

J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

Specify if:

- Performance only: If the fear is restricted to speaking or performing in public

Source: APA (2013, pp. 202–203). Reprinted with permission from the DSM-5 (Copyright © 2013). APA. All Rights Reserved.

Prevalence

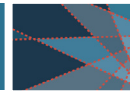
The lifetime prevalence of any anxiety disorder is estimated at over 30 percent; 12-month prevalence estimates are approximately 19 percent (Harvard Medical School, 2005). A recent World Health Organization (WHO) survey and analysis using DSM-5 diagnostic criteria found the community lifetime prevalence of GAD in the U.S. is 7.8 percent, and 12-month prevalence is 4 percent (Ruscio et al., 2017). Women are twice as likely as men to experience the disorder (APA, 2013). Lifetime prevalence of panic attacks (ascertained as part of an analysis of data collected worldwide and defined per DSM-5 criteria) with or without panic disorder is almost 28 percent (de Jonge et al., 2016). The 12-month prevalence in the general population for panic disorder is about 2.4 percent; lifetime prevalence is 6.8 percent (Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012). The 12-month prevalence for SAD is approximately 7 percent; rates in the community trend higher in women (1.5 times) than men, especially in young adults (APA, 2013).

Anxiety Disorders and SUDs

The relationship between substance use and anxiety disorders is complex and multifaceted, and the two disorders commonly co-occur. Presence of

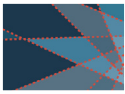
a 12-month or lifetime DSM-5 drug use disorder (i.e., an SUD excluding alcohol) is associated with a 1.2 to 1.3 increased odds of having any anxiety disorder, a 1.0 to 1.3 increased odds of having panic disorder, a 1.2 to 1.3 increased odds of having GAD, and a 1.1 to 1.3 increased odds of having SAD (Grant et al., 2016). Recent analyses indicate lifetime (but not 12-month) diagnosis of drug and alcohol use disorders is associated with GAD (Grant et al., 2015; Grant et al., 2016). Twelve-month prevalence of panic disorder with co-occurring SUD is 11 percent, and lifetime co-occurrence is 28 percent (de Jonge et al., 2016).

When anxiety and SUDs co-occur, the disorders affect development and maintenance of comorbidity, and each disorder modifies the presentation and treatment outcomes for the other (Brady, Haynes, Hartwell, & Killeen, 2013). Consequently, people with anxiety disorders and co-occurring SUDs experience worse outcomes than those with either disorder alone, including greater disability, more hospitalizations and healthcare utilization, poorer functioning, more difficulties in interpersonal relationships, more severe symptoms, worse health-related quality of life, and poorer treatment response (Buckner, Heimberg, Ecker, & Vinci, 2013; Magidson, Liu, Lejuez, & Blanco, 2012). GAD and addiction are



ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH AN ANXIETY DISORDER

- Treating only one disorder is usually insufficient, as is treating disorders in isolation (e.g., sequentially). Clients with both anxiety and addictions need concurrent treatment that equally targets both conditions.
- Pharmacotherapies can effectively reduce anxiety symptoms (especially if combined with psychotherapy) and may need to be a part of clients' treatment plans. But prescribing psychotropic medication in someone with an SUD can be tricky. As needed, refer the client to a mental health professional for a full assessment to determine whether medication is warranted and how to safely integrate it into the treatment plan.
- People in recovery from SUDs may have conflicting feelings about taking medication. Not all clients with anxiety disorders will need pharmacotherapy, but in many cases it can help and, when combined with psychotherapy, is frequently more effective at reducing anxiety symptoms and improving functioning than either medication or psychotherapy alone. That said, do not “push” medications on clients; instead, invite them to explore their feelings about taking medications and discuss advantages and disadvantages of such.
- Selective serotonin reuptake inhibitors are commonly used to help manage GAD, panic disorder, and SAD but should not be taken with alcohol. Addiction counselors must educate clients taking anxiolytics (especially benzodiazepines) about the indications, contraindications, adverse effects, and dangers of medication–alcohol interactions. For clients with anxiety and AUD specifically, referral to a mental health professional to discuss medication management may be needed.
- Be mindful of the increased risk of dependence and abuse liability with benzodiazepines. This risk might be heightened in people who misuse substances to self-medicate their anxiety symptoms or in people with SUDs in general. Use CBT known to effectively treat anxiety disorders to minimize or augment the use of medications.
- Educate clients on the dangers of using substances to self-medicate and control anxiety symptoms, and make distress tolerance, self-regulation, and adaptive coping skills major focuses of treatment.
- Assess for (and advise against) over-the-counter substances that can cause or exacerbate anxiety symptoms, like caffeine pills and weight loss supplements.
- Understand the special sensitivities of clients with SAD to social situations. Although group CBT can help people with SAD learn to become more comfortable in social environments, individual CBT can be equally effective and should be an option for clients who decline group treatment.
- When clients do not improve as expected, the cause is not necessarily treatment failure or client noncompliance. Clients may be compliant and plans may be adequate, but disease processes remain resistant.
- Expect a longer treatment duration compared with treatment for either anxiety or addiction alone.
- Clients with severe and persistent SUDs and anxiety disorders should not be seen as resistant, manipulative, or unmotivated but in need of intensive support.
- Symptoms may result from SUDs, not underlying mental disorders; careful, continual assessment is key.
- Anxiety symptoms and disorders are risk factors for suicidal ideation and suicide attempt. Use suicide risk mitigation (e.g., routine assessment, thorough documentation) and collaborate with clients to implement safety plans.



CASE STUDY: GAD AND PROTRACTED WITHDRAWAL

Ray Y., a 50-year-old husband and father of teenagers, is going through protracted alcohol withdrawal. He appears “edgy” and irritable, sometimes sad, and complains to his SUD treatment counselor of insomnia, headaches, and an upset stomach. He tells the counselor he can barely stand not to drink: “I’m jumping out of my skin.” Although these symptoms are common during protracted withdrawal, because they have persisted for over a month the counselor begins a more detailed exploration.

The counselor asks Ray Y. whether he had these symptoms before he used alcohol, and Ray Y. says he’s “always been this way.” He worries about everything, even events that are weeks away. His family vacations are nightmares because every aspect of vacation planning troubles him and keeps him awake. During family therapy, it becomes apparent that his daughter deeply resents his controlling and distrustful behavior, as well as his overprotective stance toward all her social commitments. The counselor refers Ray Y. to a psychiatrist, who diagnoses GAD, begins a course of medication, and initiates mental health counseling. The family receives help coping with Ray Y.’s disorder, and his daughter is referred for short-term counseling to help her address the mental problems she is beginning to develop as a result of her father’s excessive control.

Discussion: Anxiety symptoms are quite common during protracted withdrawal, but counselors should consider the possibility that an anxiety disorder is indicated. Symptoms should be tracked to see whether they persist beyond the normal time that might be expected for protracted withdrawal. Protracted withdrawal can occur up to a few months to a year, particularly with antianxiety medication. It varies according to severity, duration, and type of medication. Most protracted withdrawal is between 1 and 3 months. Counselors should also be aware of the effect of such disorders on close family members. Children and adolescents may not understand that a parent has a mental disorder and may be relieved to have a way of understanding and coping with difficult behavior.

associated with higher rates of heavy alcohol use, hospitalizations, relapse, and leaving treatment against medical advice compared with people with SUDs but no GAD (Domenico, Lewis, Hazarika, & Nixon, 2018).

Anxiety symptoms and anxiety disorders are predictors of suicidal ideation and suicide attempt (Bentley et al., 2016); given that SUDs also elevate risk of suicide (Yuodelis-Flores & Ries, 2015), the combination of the two suggests efforts to mitigate suicide risk mitigation are warranted with these clients.

Treatment of Anxiety Disorders and SUDs

SUD treatment for people with anxiety should include interventions that address the anxiety as well as the addiction. Clients may report a reduction in some anxiety symptoms during detoxification or early in recovery (McHugh, 2015). **That said, SUD treatment alone is not sufficient to address the co-occurring anxiety.** Further,

the presence of an anxiety disorder complicates SUD treatment and can make achieving and sustaining abstinence and preventing relapse more problematic (McHugh, 2015).

Concurrent, integrated treatments that include CBT or exposure therapy can safely, effectively reduce psychiatric and SUD symptoms but in some studies are no more effective than placebo (McHugh, 2015).

Schizophrenia and Other Psychotic Disorders

Psychotic Disorders

Psychotic disorders are characterized by a severely incapacitated mental and emotional state involving a person’s thinking, perception, and emotional control. Key features include distorted thoughts in which an individual has false beliefs, sensations, or perceptions that are imagined, are very extreme, or both; and unusual emotional and behavioral states with deterioration in thinking, judgment,

self-control, or understanding. Psychotic disorders are usually expressed clinically as a combination of:

- **Delusions:** Beliefs that are fixed, resistant to change, and are directly contradicted by evidence or otherwise not grounded in reality (e.g., the belief that one is being followed by people from Mars, or that one is a very important person to whom the President wants to speak right away).
- **Hallucinations:** Hearing, seeing, tasting, or feeling things that are not there and being unable to recognize that what is being experienced is not real (such as hearing voices that say self-condemning or other disturbing things, or seeing a person who isn't really there).
- **Disorganized thinking:** This is reflected in speech that is incoherent ("word salad"), illogical, uses unconventional or made-up words (neologisms and word approximations), fluctuates from topic to topic (loose associations), or is completely unrelated to subject matter at hand (tangential speech).
- **Grossly disorganized or abnormal motor behavior:** This includes a wide range of odd behaviors, such as laughing or smiling inappropriately, grimacing, staring, talking to oneself, purposeless or peculiar movements and mannerisms, mimicking others' speech or movements (echolalia and echopraxia), and random agitation. A specific psychomotor disturbance called **catatonia**—which includes immobility, stupor, and holding rigid body positions against gravity over extended periods of time (catalepsy)—can occur in schizophrenia but is also present in other mental disorders (like bipolar disorder) and some medical conditions.
- **Negative symptoms:** A constellation of symptoms reflecting diminished emotional expression and self-motivated purposeful activities (avolition). Negative symptoms also may include diminished speech output (alogia) or poverty of speech (e.g., one-word answers), motivation, ability to experience pleasure (anhedonia), or interest in social activities (asociality).

Although schizophrenia is perhaps the most well known psychotic disorder, people with bipolar disorders may experience psychotic states

during periods of mania—the heightened state of excitement, little or no sleep, impulsiveness, and poor judgment (see the section "Bipolar I Disorder"). Other conditions also can be accompanied by a psychotic state, including toxic poisoning, other metabolic difficulties (infections [e.g., latestage AIDS]), and other mental disorders (MDD, dementia, PTSD, alcohol withdrawal states, brief reactive psychoses, and others).

SUD treatment counselors typically do not see clients in the throes of an acute psychotic episode, as such psychotic patients more likely present, or are referred to, EDs and mental health services facilities. Counselors are more likely to encounter such clients in a "residual" or later and less active phase of the illness, the time at which these individuals may receive treatment for their SUDs in an SUD treatment agency. Even if the SUD treatment counselor never sees a client during an actively psychotic period, knowing what the client experiences as a psychotic episode will enable the counselor to understand and assist the client more effectively. On the other hand, counselors are increasingly treating clients with methamphetamine dependence who often have residual paranoid and psychotic symptoms and may need antipsychotic medications.

Schizophrenia

No single symptom specifically indicates or characterizes schizophrenia. Symptoms include a range of cognitive, behavioral, and emotional dysfunctions (Exhibit 4.11). Thus, schizophrenia is a heterogeneous clinical syndrome. Symptoms of schizophrenia include delusions, hallucinations, disorganized speech (e.g., frequent derailment or incoherence), grossly disorganized or catatonic behavior, and deficits in certain areas of functioning—for example, the inability to initiate and persist in goal-directed activities. These symptoms regularly develop before the first episode of a schizophrenic breakdown, sometimes stretching back years and often intensifying prior to reactivations of an active, acutely psychotic state. Clinicians generally divide schizophrenia symptoms into positive and negative symptoms. Acute course schizophrenia is characterized by positive symptoms like hallucinations, delusions, excitement, motor manifestations (such as agitated

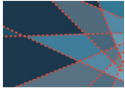


EXHIBIT 4.11. Diagnostic Criteria for Schizophrenia

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be 1, 2, or 3:

1. Delusions
2. Hallucinations
3. Disorganized speech (e.g., frequent derailment or incoherence)
4. Grossly disorganized or catatonic behavior
5. Negative symptoms, (i.e., diminished emotional expression or avolition)

B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).

C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective disorder and depressive or bipolar with psychotic features have been ruled out because either (1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or (2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, also are present for at least 1 month (or less if successfully treated).

Specify if:

The following course specifiers are only to be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria.

- First episode, currently in acute episode: First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An acute episode is a time period in which the symptom criteria are fulfilled.
- First episode, currently in partial remission: Partial remission is a period of time during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.
- First episode, currently in full remission: Full remission is a period of time after a previous episode during which no disorder-specific symptoms are present.
- Multiple episodes, currently in acute episode: Multiple episodes may be determined after a minimum of two episodes (i.e., after a first episode, a remission and a minimum of one relapse).
- Multiple episodes, currently in partial remission
- Multiple episodes, currently in full remission
- Continuous: Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods being very brief relative to the overall course.

Continued on next page

Continued

- Unspecified

Specify if:

- With catatonia

Specify current severity:

- Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe).

Note: Diagnosis of schizophrenia can be made without using this severity specifier.

Source: APA (2013, pp. 99–100). Reprinted with permission from the DSM-5 (Copyright © 2013). APA. All Rights Reserved.

behavior or catatonia), disorganized speech, relatively minor thought disturbances, and positive response to neuroleptic medication. Chronic course schizophrenia is characterized by negative symptoms, such as lack of enjoyment (anhedonia), apathy, lack of emotional expressiveness (flat affect), and social isolation. Some clients will live their entire lives exhibiting only a single psychotic episode; others may have repeated episodes separated by varying durations of time.

Prevalence

Community prevalence rates for schizophrenia using DSM-5 criteria are not available at the time of this publication. The lifetime prevalence rate for adults with DSM-IV schizophrenia is between 0.3 percent and 0.7 percent (APA, 2013). The National Institute of Mental Health (NIMH; 2018) reports similar but slightly lower numbers, ranging between 0.25 percent and 0.64 percent. Although its prevalence is very low, schizophrenia is very burdensome and considered one of the top 15 leading causes of global disability (GBD 2016 Disease and Injury Incidence and Prevalence Collaborators, 2017).

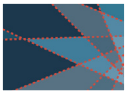
Schizophrenia/Other Psychotic Disorders and SUDs

Substance misuse often occurs in people with schizophrenia and other psychotic disorders. In a study of more than 1,200 people with schizophrenia (Kerner, 2015), lifetime SUD prevalence was 55 percent, including alcohol abuse

Individuals with SMI (including schizophrenia, schizoaffective disorder, and bipolar disorder with psychotic features) die approximately 10 to 25 years earlier than the general population, mostly because of the effects of physical illnesses caused at least in part by SUDs (e.g., heart disease, lung disease, infectious disease) (Hartz et al., 2014; WHO, n.d.).

at 17 percent, alcohol dependence at 26 percent, illicit drug abuse at 13 percent, and illicit drug dependence at 14 percent. The most commonly used substances were alcohol (43 percent), cannabis (35 percent), and other illegal substances (27 percent). Compared with the general population, people with severe psychotic disorders have 4 times greater risk of heavy alcohol use, 3.5 times the risk of heavy cannabis use, and 4.6 times the risk of recreational drug use (Hartz et al., 2014).

The combination of substance misuse in people with schizophrenia or other psychotic disorders contributes to shortened mortality and an increased likelihood of deleterious health and functional outcomes, including a higher risk for self-destructive and violent behaviors, victimization, suicide, housing instability, poor physical health, cognitive impairment, employment problems, legal difficulties, and unstable social relationships (Bennett, Bradshaw, & Catalano, 2017; Trudeau et al., 2018). Further, substance misuse in schizophrenia can worsen disease course and may reduce adherence to antipsychotic medication (Werner & Covenas, 2017).



CASE STUDY: COUNSELING AN SUD TREATMENT CLIENT WITH SCHIZOPHRENIA

Adolfo M. is a 40-year-old Latino man who began using cannabis and alcohol at 15. He was diagnosed as having schizophrenia when he was 18 and began using cocaine at 19. Sometimes, he lives with his sister or with temporary girlfriends; sometimes, on the street. He has never had a sustained relationship, and he has never held a steady job. He has few close friends. He has had periods of abstinence and freedom from hallucinations and major delusions, but he generally has unusual views of the world that emerge quickly in conversation.

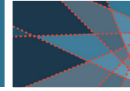
Adolfo M. has been referred to an SUD treatment counselor, who was hired by the mental health center to do most of the group and individual drug/alcohol work with clients. The first step the counselor takes is to meet with Adolfo M. and his case manager together. This provides a clinical linkage and allows them to get the best history. The clinical history reveals that Adolfo M. does best when he is sober and on medications, but there are times when he will be sober and not adhere to a medical regimen, or when he is both taking medications and drinking (although these periods are becoming shorter in duration and less frequent). His case manager often is able to redirect him toward renewed sobriety and adherence to medications, but Adolfo M. and the case manager agree that the cycle of relapse and the work of pulling things back together is wearing them both out. After the meeting, the case manager, counselor, and Adolfo M. agree to meet weekly for a while to see what they can do together to increase the stable periods and decrease the relapse periods. After a month of these planning meetings, the following plan emerges. Adolfo M. will attend SUD treatment groups for people with CODs (run by the counselor three times a week at the clinic), see the team psychiatrist, and attend local dual disorder AA meetings. The SUD treatment group he will be joining is one that addresses not only addiction problems but also difficulties with treatment follow-through, life problems, ways of dealing with stress, and the need for social support for clients trying to get sober. When and if relapse happens, Adolfo M. will be accepted back without prejudice and supported in recovery and treatment of both his substance misuse and mental disorders; however, part of the plan is to analyze relapses with the group. His goal is to have as many sober days as possible with as many days adhering to a medical regimen as possible. Another aspect of the group is that monthly, 90-day, 6-month, and yearly sobriety birthdays are celebrated. Part of the employment program at the center is that clients need to have a minimum of 3 months of sobriety before they will be placed in a supported work situation, so this becomes an incentive for sobriety as well.

Discussion: SUD treatment counselors working within mental health centers should be aware of the need not only to work with the client but also to form solid working relationships with case managers, the psychiatrist, and other personnel. Seeing clients with case managers and other team members is a good way to establish important linkages and a united view of the treatment plan. In Adolfo M.'s case, the counselor used his ties with the case manager to good effect and also is using relapse prevention and contingency management strategies appropriately (see Chapter 5 for a discussion of relapse prevention).

ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH SCHIZOPHRENIA OR ANOTHER PSYCHOTIC DISORDER

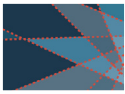
- Understand that what looks like resistance or denial may in reality be a manifestation of negative symptoms of schizophrenia.
- Use a recovery perspective and a compassionate attitude toward the client. This can convey hope and allow the clients to envision significant recovery and improvement in his or her life.
- Obtain a working knowledge of the signs and symptoms of the disorder.

Continued on next page

*Continued*

- Be aware that an accurate understanding of the role of SUDs in the client's psychotic disorder requires a multiple-contact, longitudinal assessment.
- Work closely with a psychiatrist or mental health professional.
- Expect crises associated with the mental disorder and have available resources (e.g., crisis intervention, psychiatric consultation) to facilitate stabilization.
- As appropriate, assist the client to obtain Medicare, Medicaid, Temporary Assistance to Needy Families, disability payments, and other social services.
- Make available psychoeducation on the psychiatric condition and use of medication. The psychoeducational component of treatment should include information about mental disorders and SUDs, from causes and the natural histories of the disorders to the recovery process and how the illnesses can interact.
- Understand that medication adherence is critical to control positive symptoms and maintain stability/functionality. Yet nonadherence is common. Make medication monitoring and adherence a part of treatment by:
 - Providing psychoeducation about its importance.
 - Checking in with clients about the status of their symptoms (given that nonresponsiveness to medication may be a reason for nonadherence).
 - Discussing with clients their reasons for not taking the medication (e.g., unpleasant side effects, high cost, failing to remember to take them).
 - Using motivational interviewing techniques to explore clients' expectations and beliefs about taking (and not taking) medication, which can help identify barriers to behavior change.
 - Working with clients to develop helpful reminders, alerts, or other solutions to practical obstacles. If cost is an issue, connect the client to a prescription assistance program (offered by numerous nonprofit organizations, state/county/federal agencies, and pharmaceutical companies) or consult with the client's prescriber about the possibility of switching the client to a lower cost medication.
 - Enlisting, when appropriate, the help of family or loved ones to aid in giving positive reinforcement and supporting clients in adhering to their medication.
- Ensure that the treatment program philosophy is based on a multidisciplinary team approach. Ideally, team members should be cross-trained, and there should be representatives from the medical, mental health service, and addiction systems. The overall goals of long-term management should include:
 - Providing comprehensive and integrated services for both the mental disorders and SUDs.
 - Taking a long-term focus that addresses biopsychosocial matters in accord with a treatment plan with goals specific to a client's situation.
- Provide frequent breaks and shorter sessions or meetings.
- Use structure and support.
- Present material in simple, concrete terms with examples and use multimedia methods.
- Encourage participation in social clubs with recreational activities.
- Teach the client skills for detecting early signs of relapse for both mental illness and substance use.
- Consider including family members and community supports, when appropriate, in overall treatment.

Continued on next page



Continued

- Involve family in psychoeducational groups that specifically focus on education about SUDs and psychotic disorders; establish support groups of families and significant others.
- Understand that psychotic disorders and SUDs tend to be chronic disorders with multiple relapses and remissions, requiring long-term treatment. For clients with CODs involving psychotic disorders, a long-term approach is imperative.
- Monitor clients for signs of substance misuse relapse and a return of psychotic symptoms.
- Remember that suicide is a significant risk in schizophrenia, more so when co-occurring with SUDs. Ongoing monitoring/ assessment of suicidal ideation, gestures, plans, and attempts throughout treatment is imperative. Work with clients to form safety plans/contracts; make positive coping skills part of interventions.

Treatment of Schizophrenia/Other Psychotic Disorders and SUDs

Antipsychotic medication is the standard of care for reducing positive symptoms (e.g., delusions, hallucinations) whereas various psychosocial interventions and approaches can help address addiction recovery. Specifically, integrated CBT, group behavioral therapy, contingency management, 12-Step facilitation, motivational enhancement, motivational interviewing, assertive community treatment, or (preferably) a combination thereof may all help reduce substance use (quantity, frequency, and severity), increase abstinence, reduce number of drinking days, lower relapse rates, reduce the number of positive urine samples, and decrease negative consequences of substance use in people with SUDs and schizophrenia or other SMI (including psychotic disorders) (Bennett et al., 2017; De Witte, Crunelle, Sabbe, Moggi, & Dom, 2014). These approaches have also been associated with improvements in psychiatric symptoms (including negative symptoms), scores of global functioning, hospitalizations, and achieving stable housing (De Witte et al., 2014). Integrated treatments appear to yield more positive results than single interventions and are the recommended approach (De Witte et al., 2014).

Attention Deficit Hyperactivity Disorder

ADHD is marked by a chronic inability to direct, control, or sustain attention; hyperactivity; or both (Exhibit 4.12). People with ADHD often have

difficulty concentrating for even short periods of time. They may be disorganized and restless or seem always “on the go,” constantly moving and fidgeting. Some people with ADHD behave impulsively.

Although ADHD is frequently associated with children, the disorder can persist into adulthood and for some individuals can begin in adulthood. In adults, symptoms can include having a short temper, difficulty being productive at work, and an inability to sustain relationships.

The three types of ADHD are combined type (person has difficulty paying attention and hyperactivity); predominantly inattentive; and predominantly hyperactive/impulsive.

Prevalence

At the time of this publication, 12-month and lifetime ADHD prevalence rates among all age groups in the general population using DSM-5 criteria are not readily available. However, data from the National Survey of Children’s Health show that 6.1 million children and adolescents ages 2 to 17 years had ever been diagnosed with ADHD (Danielson et al., 2018).

The prevalence of ADHD in adults is less studied than in children. The overall current prevalence of adult ADHD (using DSM-IV criteria) is around 2.5 percent (APA, 2013; Simon, Czobor, Balint, Meszaros, & Bitter, 2009). Epidemiological population-based survey data on U.S. adults with ADHD (Kessler et al., 2005) suggest the estimated

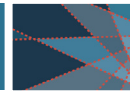


EXHIBIT 4.12. Diagnostic Criteria for ADHD

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):

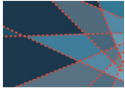
1. Inattention: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities. **Note:** The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

- a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate)
- b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading)
- c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction)
- d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked)
- e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet demands)
- f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers)
- g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile phones)
- h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts)
- i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments)

2. Hyperactivity and impulsivity: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities. **Note:** The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (ages 17 and older), at least five symptoms are required.

- a. Often fidgets with or taps hands or feet or squirms in seat
- b. Often leaves seat in situations in which remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place)
- c. Often runs about or climbs in situations in which it is inappropriate. (**Note:** In adolescents or adults, may be limited to feeling restless.)
- d. Often unable to play or engage in leisure activities quietly
- e. Is often “on the go,” acting as if “driven by a motor” (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with)
- f. Often talks excessively
- g. Often blurts out an answer before a question has been completed (e.g., completes people’s sentences; cannot wait for turn in conversation)

Continued on next page



Continued

- h. Often has difficulty awaiting his or her turn (e.g., while waiting in line)
- i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing)

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.

C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).

D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, PD, substance intoxication or withdrawal).

Specify whether:

- Combined presentation: If both Criterion A1 (inattention) and Criterion A2 (hyperactivity-impulsivity) are met for the past 6 months
- Predominantly inattentive presentation: If Criterion A1 (inattention) is met but Criterion A2 (hyperactivity-impulsivity) is not met for the past 6 months
- Predominantly hyperactive/impulsive presentation: If Criterion A2 (hyperactivity-impulsivity) is met and Criterion A1 (inattention) is not met for the past 6 months

Specify if:

- In partial remission: When full criteria were previously met, fewer than the full criteria have been met for the past 6 months, and the symptoms still result in impairment in social, academic, or occupational functioning.

Specify current severity:

- Mild: Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning.
- Moderate: Symptoms or functional impairment between “mild” and “severe” are present.
- Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

Source: APA (2013, pp. 59–61). Reprinted with permission from the DSM-5 (Copyright © 2013). APA. All Rights Reserved.

lifetime prevalence of DSM-IV ADHD in people ages 18 to 44 years is 8.1 percent.

ADHD and SUDs

SUDs are among the most common comorbidities of ADHD (Katzman, Bilkey, Chokka, Fallu, & Klassen, 2017), and data from clinical and epidemiological studies support this linkage (Martinez-Raga, Szerman, Knecht, & de Alvaro, 2013). Among adults with substance misuse, the prevalence of ADHD is approximately 23 percent,

although this estimate is dependent on substance of misuse and assessment instrument used (van Emmerik-van Oortmerssen et al., 2012). Among a sample of more than 500 children with and without ADHD who were followed throughout adolescence and early adulthood (Molina et al., 2018), early substance use in adolescence was greater and escalated more quickly in the children with ADHD. Further, weekly and daily cannabis use and daily smoking in adulthood were significantly more prevalent in the ADHD group than the non-ADHD

group. Adults with ADHD have been found primarily to use alcohol, nicotine, cannabis, and cocaine (Lee, Humphreys, Flory, Liu, & Glass, 2011; Luo & Levin, 2017).

People with addiction who have co-occurring ADHD have a heightened risk for suicide attempts, hospitalizations, earlier onset of addiction, impulsivity, more severe disease course (for both ADHD and the SUD) and polysubstance use as well as lower rates of abstinence and treatment adherence (Egan, Dawson, & Wymbs, 2017; Katzman et al., 2017). ADHD and SUDs carry an enhanced risk of comorbidity with depression, conduct disorder, bipolar disorders, anxiety disorders, and PDs (Luo & Levin, 2017; Martinez-Raga et al., 2013; Regnart, Truter, & Meyer, 2017; Young & Sedgwick, 2015; Zulauf, Sprich, Safren, & Wilens, 2014). Symptoms of ADHD hyperactivity and impulsivity are more strongly seen with substance misuse and SUDs than ADHD symptoms of inattention (De Alwis, Lynskey, Reiersen, & Agrawal, 2014).

Although it is important to rule out other causes of inattention or hyperactivity, including substance misuse, **misattribution of ADHD symptoms to SUDs increases the likelihood of underdiagnosis** (Crunelle et al., 2018). People with SUDs who are newly abstinent or those in active or protracted withdrawal may experience some impairments similar to ADHD. Many of the behavioral symptoms of ADHD also appear during substance intoxication

and withdrawal, and functional consequences of ADHD, such as poor job performance or job loss, are also evident in people with addiction. Both alcohol and cannabis can produce symptoms that mimic ADHD. This underscores the importance of conducting a thorough assessment (see Chapter 3) to fully investigate symptoms in childhood, family history of addiction and psychiatric illness, and other biopsychosocial factors that can inform whether a diagnosis of ADHD, SUD, or both are warranted.

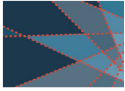
Treatment of ADHD and SUDs

ADHD complicates SUD treatment because clients with these CODs may have more difficulty engaging in treatment and learning abstinence skills, be at greater risk for relapse, and have poorer substance use outcomes. The most common attention problems in SUD treatment populations are secondary to short-term toxic effects of substances, and these should be substantially better with each month of sobriety.

Only a limited number of studies explore treatment of ADHD with comorbid SUDs (De Crescenzo, Cortese, Adamo, & Janiri, 2017). Treatment of adults with ADHD often involves use of stimulant or nonstimulant medication; although efficacious in reducing psychiatric symptoms, these medications generally do not alleviate SUD symptoms (Cunill, Castells, Tobias, & Capella, 2015; De Crescenzo et al., 2017; Luo & Levin, 2017). Thus, ADHD medication alone is an insufficient treatment approach for clients with these CODs (Crunelle et

A consensus statement by an international panel of ADHD and addiction experts (including from the U.S.) on the treatment of ADHD and SUDs recommends (Crunelle et al., 2018):

- Using a combined treatment approach comprising psychoeducation, pharmacotherapy, individual or group CBT, and peer support.
- Integrating ADHD treatment into SUD treatment; integrating SUD treatment into mental health services.
- Treating both disorders, but addressing the SUD first and then the ADHD shortly afterwards.
- Considering residential treatment for cases of severe addiction.
- Providing pharmacotherapy for ADHD (particularly with psychotherapy), but clinicians should be aware that medication alone is usually not sufficient to treat the SUD.
- Prescribing ADHD medication as needed but understand that this is a controversial topic because of the misuse liability of stimulants. Clinicians should consider all risks and weigh them against potential benefits when deciding whether to prescribe stimulant medications for people with ADHD-SUD.



al., 2018; Zulauf et al., 2014). Stimulant medications have misuse potential, and counselors should be vigilant for signs of diversion. Use of long-acting or extended-release medication or use of antidepressants instead of stimulants can attenuate diversion and misuse liability. The advised approach to treatment involves a combination of psychoeducation, behavioral coaching, CBT, and nonstimulant or extended-release stimulant medication (De Crescenzo et al., 2017).

Little research supports concurrent treatment of these conditions. Some researchers recommend first addressing whichever condition is most debilitating to the client (Katzman et al., 2017; Klassen, Bilkey, Katzman, & Chokka, 2012). Others suggest that, to stabilize the client, treating the SUD should be prioritized (Crunelle et al., 2018). A systematic literature review and meta-analysis of pharmacotherapy for ADHD and SUD (Cunill et al., 2015) found no effect of timing of initiation of treatment but warns that treatment of ADHD symptoms may need to be delayed until after abstinence is achieved, given possible harmful interactions that can occur between ADHD medications and substances of misuse.

Feeding and Eating Disorders

Feeding and eating disorders have as their common core a persistent disturbance of eating or eating-related behavior, resulting in changes in consumption or absorption of food that significantly impair physical health or psychosocial functioning. The primary eating disorders linked to SUD and discussed in this section are AN, bulimia nervosa (BN), and binge eating disorder (BED).

Anorexia Nervosa

AN, the most visible eating disorder, is marked by a refusal to maintain body weight above the minimally normal weight for age and height because of an intense fear of weight gain (Exhibit 4.13). The term **anorexia nervosa** means “nervous loss of appetite,” a misnomer; only in extreme stages of inanition (i.e., exhaustion as a result of lack of nutrients in the blood) is appetite actually lost.

Individuals with AN have a dogged determination to lose weight and can achieve this in several ways. Individuals with the restricting subtype of AN severely limit their food intake, engage in excessive exercise, and fast. Those with the binge-eating/purging subtype engage in episodes of binge eating or purging with self-induced vomiting,

CASE STUDY: COUNSELING AN SUD TREATMENT CLIENT WITH ADHD

John R., a 29-year-old White man, is seeking treatment. He has been in several treatment programs but always dropped out after the first 4 weeks. He tells the counselor he dropped out because he would get cravings and that he just could not concentrate in the treatment sessions. He mentions the difficulty of staying focused during 3-hour intensive group sessions. A contributing factor in his quitting treatment was that group leaders always seemed to scold him for talking to others. The clinician evaluating him asks how John R. did in school and finds that he had difficulty in his classwork years before he started using alcohol and drugs; he was restless and easily distracted. He had been evaluated for a learning disability and ADHD and took Ritalin for about 2 years (in the 5th and 6th grades), then stopped. He was not sure why, but he did terribly in school, eventually dropping out about the time he started using drugs regularly in the 8th grade.

Discussion: The SUD treatment provider reviewed John R.’s learning history and asked about anxiety or depressive disorders. The provider referred him to the team’s psychiatrist, who uncovered more history about the ADHD and also contacted John R.’s mother. When the provider reviewed a list of features commonly associated with ADHD, she agreed that John R. had many of these features and that she had noticed them in childhood. John R. was started on bupropion and moved to a less intensive level of care (1 hour of group therapy, 30 minutes of individual counseling, and AA meetings 3 times weekly). Over the next 2 months, John R.’s ability to tolerate a more intensive treatment improved. Although he was still somewhat intrusive to others, he was able to benefit from more intensive group treatment.

EXHIBIT 4.13. Diagnostic Criteria for AN

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. **Significantly low weight** is defined as a weight that is less than minimally normal or, for children and adolescents, less than minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Specify whether:

- Restricting type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.
- Binge-eating/purging type: During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Specify if:

- In partial remission: After full criteria for AN were previously met, Criterion A (low body weight) has not been met for a sustained period, but either Criterion B (intense fear of gaining weight or becoming fat or behavior that interferes with weight gain) or Criterion C (disturbances in self-perception of weight and shape) is still met.
- In full remission: After full criteria for AN were previously met, none of the criteria have been met for a sustained period of time.

Continued in next column

Continued

Specify current severity:

The minimum level of severity is based, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, BMI percentile. The ranges below are derived from WHO categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

- Mild: BMI ≥ 17 kg/m²
- Moderate: BMI 16–16.99 kg/m²
- Severe: BMI 15–15.99 kg/m²
- Extreme: BMI < 15 kg/m²

Source: APA (2013, pp. 338–339). Reprinted with permission from the DSM-5 (Copyright © 2013). APA. All Rights Reserved.

laxatives, diuretics, or enemas. They engage in these behaviors out of a marked fear of weight gain, which is reinforced by distorted perceptions of their body shape (e.g., believing oneself to be “fat” even though bodyweight is extremely low).

Bulimia Nervosa

The core symptoms of BN are bingeing and purging (Exhibit 4.14). A binge is a rapid consumption of an unusually large amount of food, by comparison with social norms, in a discrete period of time (e.g., over 2 hours). Integral to the notion of a binge is feeling out of control; thus, a binge is not merely overeating. An individual with BN may state that he or she is unable to postpone the binge or stop eating willfully once the binge has begun. The binge may only end when the individual is interrupted, out of food, exhausted, or physically unable to consume more.

The second feature of BN is purging. Individuals with BN compensate in many different ways for overeating. Ninety percent of people with BN self-induce vomiting or misuse laxatives as their form of purging (Westmoreland, Krantz, & Mehler, 2016). Other methods of purgation include the

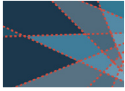


EXHIBIT 4.14. Diagnostic Criteria for BN

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances
2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain includes self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of AN.

Specify if:

- In partial remission: After full criteria for BN were previously met, some, but not all, of the criteria have been met for a sustained period of time.
- In full remission: After full criteria for BN were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based on the frequency of inappropriate compensatory behaviors (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

- Mild: An average of 1–3 episodes of inappropriate compensatory behaviors per week
- Moderate: An average of 4–7 episodes of inappropriate compensatory behaviors per week
- Severe: An average of 8–13 episodes of inappropriate compensatory behaviors per week
- Extreme: An average of 14 or more episodes of inappropriate compensatory behaviors per week

Source: APA (2013, p. 345). Reprinted with permission from the DSM-5 (Copyright © 2013). APA. All Rights Reserved.

misuse of diuretics and emetics; saunas; excessive exercise; fasting; and other idiosyncratic methods that people believe will lead to weight loss (such as “mono” dieting, in which a person eats only a single food for extended periods of time and nothing else, like apples or eggs). Many of these auxiliary methods are dangerous and ineffective because they promote loss of water and valuable electrolytes. As with AN, individuals with BN place an undue emphasis on shape and weight in their sense of identity. To meet criteria, bingeing and purging must occur, on average, at least once per week for 3 months.

Binge Eating Disorder

BED involves recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances, with episodes marked by feelings of lack of control (Exhibit 4.15). Someone with BED may eat too quickly, even when he or she is not hungry. The person may feel guilt, embarrassment, or disgust and may binge eat alone to hide the behavior. This disorder is linked with marked distress and occurs, on average, at least once a week over 3 months. Unlike in BN, the binge is not followed by compensatory behaviors to rid the body of food.

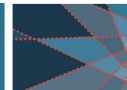


EXHIBIT 4.15. Diagnostic Criteria for BED

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances
2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. The binge-eating episodes are associated with three (or more) of the following:

1. Eating much more rapidly than normal
2. Eating until feeling uncomfortably full
3. Eating large amounts of food when not feeling physically hungry
4. Eating alone because of feeling embarrassed by how much one is eating
5. Feeling disgusted with oneself, depressed, or very guilty afterward

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in BN and does not occur exclusively during the course of BN or AN.

Specify if:

- In partial remission: After full criteria for binge-eating disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time.
- In full remission: After full criteria for binge-eating disorder were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based on the frequency of episodes of binge eating (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

- Mild: 1–3 binge-eating episodes per week
- Moderate: 4–7 binge-eating episodes per week
- Severe: 8–13 binge-eating episodes per week
- Extreme: 14 or more binge-eating episodes per week

Source: APA (2013, p. 350). Reprinted with permission from the DSM-5 (Copyright © 2013). APA. All Rights Reserved.

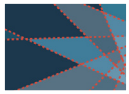
Prevalence

Feeding and eating disorders in the general population are rare. Twelve-month estimates of DSM-5 AN, BN, and BED are 0.05 percent, 0.14 percent, and 0.44 percent, respectively; lifetime prevalence rates are 0.80 percent, 0.28 percent, and 0.85 percent, respectively (Udo & Grilo, 2018). These rates are generally lower than previously reported estimates using DSM-IV criteria (APA, 2013) but were drawn from a sample roughly 12 times larger than the samples used in other survey studies (Udo & Grilo, 2018).

Eating disorders are far more prevalent in women than men. Women have 12 times the odds of having AN, 5.8 times the odds of having BN, and about 3 times the odds of having BED (Udo & Grilo, 2018).

Feeding and Eating Disorders and SUDs

Feeding and eating disorders are highly coincident with substance misuse (SAMHSA, 2011a), likely because the conditions share numerous physical, mental, and social risk factors (Brewerton, 2014). Most studies observe comorbidity rates that



exceed the general population of women of similar age. A meta-analysis (Bahji et al., 2019) found lifetime prevalence of any SUD among people with eating disorders to be 25 percent, including 20 percent for AUD, about 20 percent for any illicit drug use disorder, almost 14 percent for cocaine and cannabis use disorder (each), and 6 percent for opioid use disorder (OUD). **Even if not rising to the level of addiction, licit and illicit substance use is elevated in people with eating disorders, especially individuals with bulimic features.** In a sample of almost 3,000 people, 80 percent of those with BN reported using alcohol, and 50 percent used other substances; 65 percent of those with BED used alcohol, and nearly 24 percent used other substances; and 60 percent of those with AN (binge/purge subtype) used alcohol, and 44 percent used other substances (Fouladi et al., 2015).

SUD treatment-seeking women have higher rates of BN than any other feeding and eating disorder, and SUDs are more common alongside BN or AN with bulimic features than they are comorbid with restrictive AN (APA, 2013; CSAT, 2009; Fouladi et al., 2015). Some have suggested that the most common comorbidity among feeding and eating disorders and SUDs is BN (or AN with bulimic features) and AUD (Gregorowski, Seedat, & Jordaan, 2013; Munn-Chernoff et al., 2015).

Treatment outcomes of people with eating disorders and SUDs are worse than those of people without both conditions. They have higher odds of

early mortality, co-occurring physical and mental illness, and delayed recovery (Root et al., 2010). People in SUD treatment with feeding/eating disorder symptoms have higher risk of treatment dropout and discharge against medical advice (Elmquist, Shorey, Anderson, & Stuart, 2015). Alcohol misuse more than doubles mortality risk in AN (Franko et al., 2013).

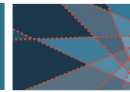
Treatment of Feeding and Eating Disorders and SUDs

Feeding or eating disorders can make SUD assessment and treatment more complex—such as by raising risk of stopping SUD treatment against medical advice (Elmquist et al., 2015). Heightened mortality with feeding and eating disorders means that multidisciplinary care should include primary care providers and dietary/nutritional rehabilitation professionals in addition to SUD treatment professionals, mental health professionals (e.g., psychiatric and mental health nurses), and social workers (SAMHSA, 2011a).

The literature does not currently describe randomized controlled trials for treatment of these CODs. In general, concurrent treatment is recommended; sequential interventions can increase likelihood of relapse or otherwise hinder recovery from the untreated CODs (Gregorowski et al., 2013). If integrated care is not possible, SUD treatment should proceed first to halt active substance use and allow the client to fully participate in further care (SAMHSA, 2011a).

“DRUNKOREXIA”: A NEW AND DANGEROUS COMBINATION OF EATING DISORDERS AND ALCOHOL MISUSE

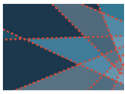
Researchers are noticing a disturbing trend of college students (particularly women) engaging in inappropriate compensatory behaviors prior to consuming alcohol in order to avoid or mitigate weight gain from drinking. For instance, a woman might fast all day or drastically reduce her caloric intake prior to going out to a party where she knows she will be drinking. This trend has been colloquially termed “drunkorexia” (Barry & Piazza-Gardner, 2012; Bryant, Darkes, & Rahal, 2012; Burke, Cremeens, Vail-Smith, & Woolsey, 2010; Hunt & Forbush, 2016; Wilkerson, Hackman, Rush, Usdan, & Smith, 2017) and is very serious given that excess consumption of alcohol on an empty stomach raises the risk of alcohol poisoning and damage to the brain and other organs. In light of high rates of binge and hazardous drinking in college-aged populations, this makes the combination of disordered eating and alcohol misuse potentially very dangerous.



ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH AN EATING DISORDER

- When possible, work closely with a professional who specializes in eating disorders. Programs that specialize in eating disorders and SUDs are rare, so parallel treatment by different providers may be necessary.
- Screen for eating disorders both at intake and intermittently throughout SUD treatment (e.g., during medical history, as a part of SUD assessment, as a part of daily or weekly meetings).
- Many symptoms and features of eating disorders overlap with those of SUDs as well as other mental disorders, such as reduced food intake, low energy, depressed affect, difficulty concentrating, and sleep disturbance. This underscores the importance of early screening and a thorough differential diagnosis.
- Addiction counselors may have a hard time detecting feeding and eating disorders because clients are often adept at concealing their symptoms. Contrary to popular belief, many people with feeding and eating disorders are not exceedingly thin. In fact, most people with BN are of normal weight or even overweight. Learn the symptoms of AN, BN, and BED, and have screening tools and referral information on hand for mental health professionals who can thoroughly assess clients for possible eating disorders and symptoms. Do not merely look for clients who “look like” they have an eating disorder.
- The stereotypical picture of someone with an eating disorder is a young, heterosexual, White woman, but these conditions occur in both genders, among diverse ethnic/racial groups, across cultures, throughout the lifespan, and in people of all sexual orientations and gender identities.
- Co-occurring depression and anxiety are common in people with eating disorders and SUDs. Assess for these (or their symptoms) and treat accordingly, because failure to do so can reduce overall treatment success.
- Some clients may be hesitant to address their SUD out of fear that doing so will cause them to gain weight.
- Medical stabilization is critical, as people with feeding and eating disorders are at high risk for serious health complications, including electrolyte imbalances, cardiovascular dysfunction (e.g., low blood pressure, arrhythmias), withdrawal from laxative use, and dehydration. Treatment should include continual collaboration with healthcare providers to ensure client safety and stability.
- People actively using substances need to be treated for their addiction before treatment for their eating disorder can proceed. Ideally, both conditions would be managed concurrently using an integrated, continuous care approach. But given that integrated programs for these CODs are uncommon, SUD treatment may need to be the primary focus, assuming the client is already medically stable.
- Family dynamics often play a prominent role in the lives of people with eating disorders. As appropriate, include family in the treatment process, including referral to a marriage and family therapist if needed.
- Document through a comprehensive assessment the individual’s full repertoire of weight loss behaviors, as people with eating disorders will often go to dangerous extremes to lose weight.
- Conduct a behavioral analysis of foods and substances of choice; high-risk times and situations for engaging in disordered eating and substance misuse; and the nature, pattern, and interrelationship of disordered eating and substance use. Develop a treatment plan for both the eating disorder and the SUD.
- Use psychoeducation and CBT techniques.

Continued on next page

*Continued*

- Use adjunctive strategies such as nutritional consultation, the setting of a weight range goal, and observations at and between mealtimes for disordered eating behaviors.
- Incorporate relapse prevention strategies for a long course of treatment and several treatment episodes.
- In addition to “traditional” drugs of misuse and alcohol, women with eating disorders are unique in their misuse of pharmacological agents ingested for the purpose of weight loss, appetite suppression, and purging. Among these drugs are prescription and over-the-counter diet pills, laxatives, diuretics, and emetics. Nicotine and caffeine also must be considered when assessing substance use in women with eating disorders.
- Drugs related to purging (e.g., diuretics, laxatives, emetics), are ineffective and potentially dangerous methods of accomplishing weight loss or maintenance. The literature suggests that, like more common drugs of misuse, tolerance and withdrawal occur with laxatives, diuretics, and possibly diet pills and emetics.
- Alcohol and substances such as cannabis can disinhibit appetite (i.e., remove normal restraints on eating) and increase the risk of binge eating as well as relapse in individuals with BN.
- Clients with feeding and eating disorders have craving, tolerance, and withdrawal from drugs linked with purging (e.g., laxatives, diuretics) and urges (or cravings) for binge foods similar to urges for substances.
- Feeding and eating disorders are quite serious and can be fatal. Treat them accordingly.
- Suicide risk in this population is perilously high. Regularly assess for suicidal thoughts, gestures, and attempts and develop methods for safety monitoring and harm prevention (e.g., safety plans).

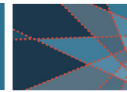
Only 51 percent of SUD treatment programs report screening clients for feeding and eating disorders (Kanbur & Harrison, 2016).

Regardless of treatment modality, providers must first ensure medical and weight stabilization

so clients are healthy and able to physically and cognitively participate in and benefit from therapy (Harrop & Marlatt, 2010). Some clients with AN or BN may require inpatient treatment or partial hospitalization to stabilize weight. Depending on the facility, staff may not be equipped to address any co-occurring substance misuse simultaneously.

The primary treatment for these disorders is psychosocial intervention, including individual,

group, family therapy, or a combination thereof. CBT can be effective for feeding and eating disorders but has not been researched thoroughly in populations with co-occurring addiction (Gregorowski et al., 2013). Dialectical behavior therapy also can be useful in promoting mindfulness, improving management of negative emotions, and teaching affective and behavioral self-regulation skills in feeding and eating disorders and in SUDs separately (Ritschel, Lim, & Stewart, 2015) but, again, has not been studied extensively in both concurrently. Pharmacotherapy may be warranted for BN and BED (SAMHSA, 2011a) but is not a first-line treatment. Further studies are needed to clarify how the presence of a feeding or eating disorder affects SUD treatment and how best to integrate treatment for both conditions.



Substance-Related Disorders

The primary aim of this section of the chapter is to describe substance-induced mental disorders and to clarify how to differentiate them from mental disorders that co-occur with SUDs.

Substance-related disorders include two subcategories: SUDs and substance-induced disorders. SUDs identify the cluster of cognitive, behavioral, and physical symptoms that occur as a result of continued and frequent use of substances. These consequences are not immediate. Rather, they occur over time as addiction progresses. Substance-induced mental disorders refer to the immediate effects of substance use (intoxication), the immediate effects of discontinuing a substance (substance withdrawal), and other substance-induced mental disorders (APA, 2013).

SUDs

The essential feature of an SUD is a cluster of cognitive, behavioral, and physical symptoms indicating that the individual continues using the substance despite significant substance-related problems. All DSM-5 SUDs have their own diagnostic criteria, but criteria are largely the same across substances. Addiction counselors should be familiar with SUD diagnostic criteria and refer to DSM-5 as needed.

Prevalence

Lifetime and 12-month prevalence rates of DSM-5 drug use disorders (i.e., non-alcohol-related SUDs) are nearly 10 percent and 4 percent, respectively (Grant et al., 2016). Lifetime and 12-month prevalence rates of AUD are about 29 percent and 14 percent, respectively (Grant et al., 2015). Past-month prevalence rates of misuse of other substances by adults ages 26 and older include (CBHSQ, 2019):

- 8.6 percent for cannabis.
- 0.7 percent for cocaine.
- 1.0 percent for pain relievers.

- 0.5 for tranquilizers.
- 0.4 percent for stimulants.
- 0.1 percent for prescription sedatives.
- 0.4 percent for hallucinogens.
- 0.2 percent for heroin.
- 0.1 percent for inhalants.

Substance-Induced Mental Disorders

The toxic effects of substances can mimic mental disorders in ways that can be difficult to distinguish from mental illness. This section focuses on a general description of symptoms of mental illness that are the result of substances or medications—a condition called **substance-induced mental disorders**.

DSM-5 substance-induced mental disorders include:

- Substance-induced depressive disorders.
- Substance-induced bipolar and related disorders.
- Substance-induced anxiety disorders.
- Substance-induced psychotic disorders.
- Substance-induced obsessive-compulsive and related disorders.
- Substance-induced sleep disorders.
- Substance-induced sexual dysfunctions.
- Substance-induced delirium.
- Substance-induced neurocognitive disorder.

The first four of the listed substance-induced mental disorders are the most common in addiction, discussed further in the section, “Specific Substance-Induced Mental Disorders.” Exhibit 4.16 summarizes substances and the substance-induced mental disorders associated with each.

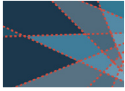


EXHIBIT 4.16. Substances and Corresponding Substance-Induced Mental Disorders

SUBSTANCE	SUBSTANCE-INDUCED MENTAL DISORDER	
Alcohol	• Psychotic disorders • Bipolar disorders • Depressive disorders	• Anxiety disorders • Sleep disorders
Caffeine	• Anxiety disorders	• Sleep disorders
Cannabis	• Psychotic disorders	• Anxiety disorders
Hallucinogens	• Psychotic disorders • Bipolar disorders	• Depressive disorders • Anxiety disorders
Inhalants	• Psychotic disorders • Depressive disorders	• Anxiety disorders
Opioids	• Depressive disorders • Anxiety disorders	• Sleep disorders
Sedatives	• Psychotic disorders • Bipolar disorders • Depressive disorders	• Anxiety disorders • Sleep disorders
Stimulants (e.g., cocaine, amphetamines)	• Psychotic disorders • Bipolar disorders • Depressive disorders	• Anxiety disorders • Sleep disorders

WARNING TO COUNSELORS: INDEPENDENT VERSUS SUBSTANCE-INDUCED MENTAL DISORDERS

The symptoms of substance-induced mental disorders may be identical to those of independent but co-occurring mental disorders. Accurate assessment of a mental disorder cannot occur while an individual is actively using substances. Knowing the difference between the two is key because they may (or may not) need to be treated differently and will have different prognoses. Mental disorder symptoms resulting from intoxication or withdrawal often need no formal treatment and will resolve on their own and quickly.

Also keep in mind the bidirectional and unstable temporal relationship between mental disorders and SUDs. Whether a substance is causing psychiatric symptoms or vice versa is often unclear, and the answer can change over time. Each disorder can affect the other reciprocally. **Even when a substance clearly is responsible for the emergence of a mental disorder/psychiatric symptoms, that does not preclude the possibility of an independent mental disorder developing in the future. In fact, an individual can have both a substance-induced and an independent mental disorder.** For example, a client may present with well-established independent and controlled bipolar I disorder and AUD in remission, but the same client could be experiencing amphetamine-induced auditory hallucinations and paranoia from an amphetamine misuse relapse over the last 3 weeks.

Even when the psychiatric diagnosis has not been established, the client's co-occurring symptoms should still be treated (with nonmedication). **Counselors should not withhold treatment simply because a determination about the origin of the mental disorder has not yet been made.**

General Considerations

Substance-induced mental disorders are distinct from independent co-occurring mental disorders in that all or most of the psychiatric symptoms are the direct result of substance use. This does not mean that substance-induced disorders preclude co-occurring mental disorders, only that the specific symptom cluster at a specific point in time is more likely the result of substance use, misuse, intoxication, or withdrawal than of underlying mental illness.

Even when the psychiatric diagnosis has not been established, the client's co-occurring symptoms should still be treated (with nonmedication). Counselors should not withhold treatment simply because a determination about the origin of the mental disorder has not yet been made.

Symptoms of substance-induced mental disorders run the gamut from mild anxiety and depression (these are the most common across all substances) to full-blown manic and other psychotic reactions (much less common). For example, acute withdrawal symptoms from physiological depressants such as alcohol and

benzodiazepines are hyperactivity, elevated blood pressure, agitation, and anxiety (i.e., “the shakes”). On the other hand, those who “crash” from stimulants are tired, withdrawn, and depressed.

Because clients vary greatly in how they respond to both intoxication and withdrawal given the same exposure to the same substance, and also because different substances may be taken at the same time, prediction of any particular substance-related syndrome has its limits. **What is most important is to continue to evaluate psychiatric symptoms and their relationship to abstinence or ongoing substance misuse over time.** Most substance-induced symptoms begin to improve within hours or days after substance use has stopped. Notable exceptions to this are psychotic symptoms caused by heavy and longterm amphetamine misuse and dementia (e.g., problems with memory, concentration, problem solving) caused by using substances directly toxic to the brain, which most commonly include alcohol, inhalants like gasoline, and amphetamines.

Exhibit 4.17 offers an overview of the most common classes of misused substances and the accompanying psychiatric symptoms seen in intoxication and withdrawal.

EXHIBIT 4.17. Substance-Induced Mental Disorder Symptoms (by Substance)

ALCOHOL

Intoxication. In most people, moderate to heavy consumption is associated with euphoria, mood lability, decreased impulse control, and increased social confidence (i.e., getting high). Symptoms may appear hypomanic but are often followed by next-day mild fatigue, nausea, and dysphoria.

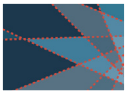
Withdrawal. Following acute withdrawal (a few days), some people will experience continued mood instability, fatigue, insomnia, reduced sexual interest, and hostility for weeks or months, so-called “protracted withdrawal.” Symptoms of alcohol withdrawal include agitation, anxiety, tremor, malaise, hyperreflexia (exaggeration of reflexes), mild tachycardia (rapid heartbeat), increasing blood pressure, sweating, insomnia, nausea or vomiting, and perceptual distortions. More severe withdrawal is characterized by severe instability in vital signs, agitation, hallucinations, delusions, and often seizures.

Alcohol-induced deliriums after high-dose drinking are characterized by fluctuating mental status, confusion, and disorientation and are reversible once both alcohol and its withdrawal symptoms are gone.

CANNABIS

Intoxication. Consumption typically results in a “high” feeling followed by symptoms including euphoria, sedation, lethargy, impairment in short-term memory, difficulty carrying out complex mental processes, impaired judgement, distorted sensory perceptions, impaired motor performance, and the sensation that time is passing slowly. Occasionally, the individual experiences anxiety (which may be severe), dysphoria, or social withdrawal.

Continued on next page



Continued

Withdrawal. Cessation or substantial reduction in heavy or prolonged cannabis use may result in fatigue, yawning, difficulty concentrating, and rebound periods of increased appetite and hypersomnia that follow initial periods of loss of appetite and insomnia.

HALLUCINOGENS

Intoxication. Hallucinogens produce visual distortions and frank hallucinations. Some people who use hallucinogens experience a marked distortion of their sense of time and feelings of depersonalization. Hallucinogens may also be associated with drug-induced panic, paranoia, and even delusional states in addition to the hallucinations. Hallucinogen hallucinations usually are more visual (e.g., enhanced colors and shapes) as compared with schizophrenic-type hallucinations, which tend to be more auditory (e.g., voices). Phencyclidine (PCP) causes dissociative and delusional symptoms and may lead to violent behavior and amnesia of the intoxication.

OPIOIDS

Intoxication. Opioid intoxication is characterized by intense euphoria and feelings of well-being.

Withdrawal. Withdrawal can result in agitation, severe body aches, gastrointestinal symptoms, dysphoria, and craving to use more opioids. Symptoms during withdrawal vary—some will become acutely anxious and agitated, whereas others will experience depression and anhedonia. Even with abstinence, anxiety, depression, and sleep disturbance can persist as a protracted withdrawal syndrome.

SEDATIVES

Intoxication. Acute intoxication with sedatives like diazepam is similar to what is experienced with alcohol.

Withdrawal. Withdrawal symptoms are also similar to alcohol and include mood instability with anxiety or depression, sleep disturbance, autonomic hyperactivity, tremor, nausea or vomiting, and, in more severe cases, transient hallucinations or illusions and grand mal seizures. There are reports of a protracted withdrawal syndrome characterized by anxiety, depression, paresthesias, perceptual distortions, muscle pain and twitching, tinnitus, dizziness, headache, derealization and depersonalization, and impaired concentration. Most symptoms resolve in weeks, but some symptoms, such as anxiety, depression, tinnitus, and paresthesias (sensations such as prickling, burning, etc.), have been reported to last a year or more after withdrawal for some.

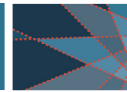
STIMULANTS (INCLUDES COCAINE AND AMPHETAMINES)

Intoxication. Mild to moderate intoxication from cocaine, methamphetamine, or other stimulants is associated with euphoria, and a sense of internal well-being, and perceived increased powers of thought, strength, and accomplishment. In fact, low to moderate doses of amphetamines may actually increase certain test-taking skills temporarily in those with ADHD and even in people who do not have ADHD. However, as more substance is used and intoxication increases, attention, ability to concentrate, and function decrease.

With cocaine and methamphetamines, dosing is almost always beyond the functional window. As dosage increases, the chances of impulsive dangerous behaviors, which may involve violence, promiscuous sexual activity, and others, also increases.

Withdrawal. After intoxication comes a crash in which the person is desperately fatigued, depressed, and often craves more stimulant to relieve these withdrawal symptoms. This dynamic is why it is thought that people who misuse stimulants often go on week- or month-long binges and have a hard time stopping.

Even with several weeks of abstinence, many people who are addicted to stimulants report a dysphoric state that is marked by anhedonia (absence of pleasure) or anxiety. Heavy, long-term amphetamine use appears to cause long-term changes in the functional structure of the brain, and this is accompanied by long-term problems with concentration, memory, and, at times, psychotic symptoms.



INDUCED VERSUS INDEPENDENT MENTAL DISORDERS: THE IMPORTANCE OF TREATMENT

It will not always be clear whether a client's mental disorder or symptoms are independent or caused by long-term substance use or withdrawal. But withholding treatment until this determination is made is inhumane and unethical. **Individuals should be engaged in treatment that addresses their co-occurring psychiatric symptoms, even if the origin of the co-occurring mental disorder is unclear.**

If counselors struggle to differentiate an independent from a substance-induced mental disorder, they should:

- Observe the client and watch for changes in symptoms (e.g., do symptoms abate once the person is abstinent from the substance for a length of time?).
- Reevaluate the client to help discern whether the symptoms/disorder is caused by withdrawal, protracted withdrawal, or the neurological effects of chronic substance use.
- Offer nonmedication treatment (e.g., SUD interventions or mental health services) for all symptoms, regardless of whether a formal diagnosis has been established.

Diagnoses of substance-induced mental disorders will typically be provisional and will require reevaluation—sometimes repeatedly. Many apparent acute mental disorders may really be substance-induced disorders, such as in those clients who use substances and who are acutely suicidal.

Some people who appear to have substance-induced mental disorders turn out to have a substance-induced mental disorder and independent mental disorder. Consider preexisting mood state, personal expectations, drug dosage, and environmental surroundings in understanding of how a particular client might experience a substance-induced disorder. Treatment of the SUD and an abstinent period of weeks or months may be required for a definitive diagnosis of an independent, co-occurring mental disorder. As described in Chapter 3, SUD treatment programs and clinical staff can concentrate on screening for mental disorders and determining the severity and acuity of symptoms, along with an understanding of the client's support network and overall life situation.

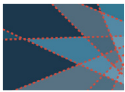
Specific Substance-Induced Mental Disorders

This section briefly discusses the most common substance-induced mental disorders in clinical populations: substance-induced depressive, anxiety, bipolar, and psychotic disorders. Diagnostic criteria for all substance-induced mental disorders, including the four mentioned, are nearly identical and comprise five general characteristics (Exhibit 4.18).

EXHIBIT 4.18. Features of DSM-5 Substance-Induced Mental Disorders

- A. The disorder represents a clinically significant symptomatic presentation of a relevant mental disorder.
- B. There is evidence from the history, physical examination, or laboratory findings of both of the following:
 1. The disorder developed during or within 1 month of a substance intoxication or withdrawal or taking a medication; and
 2. The involved substance/medication is capable of producing the mental disorder.
- C. The disorder is not better explained by an independent mental disorder (i.e., one that is not substance- or medication-induced). Such evidence of an independent mental disorder could include the following:
 1. The disorder preceded the onset of severe intoxication or withdrawal or exposure to the medication; or

Continued on next page



Continued

2. The full mental disorder persisted for a substantial period of time (e.g., at least 1 month) after the cessation of acute withdrawal or severe intoxication or taking the medication. This criterion does not apply to substance-induced neurocognitive disorders or hallucinogen persisting perception disorder, which persist beyond the cessation of acute intoxication or withdrawal.

D. The disorder does not occur exclusively during the course of a delirium.

E. The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Source: APA (2013, p. 488). Reprinted with permission from the DSM-5 (Copyright © 2013). APA. All Rights Reserved.

EXHIBIT 4.19. Substances That Precipitate or Mimic Common Mental Disorders

MENTAL DISORDER	SUBSTANCES THAT MIMIC MENTAL DISORDERS DURING USE (INTOXICATION)	SUBSTANCES THAT MIMIC MENTAL DISORDERS AFTER USE (WITHDRAWAL)
Depression and dysthymia	Alcohol, benzodiazepines, opioids, barbiturates, cannabis, steroids (chronic), stimulants (chronic)	Alcohol, benzodiazepines, barbiturates, opioids, steroids (chronic), stimulants (chronic)
Anxiety disorders	Alcohol, amphetamine and its derivatives, cannabis, cocaine, hallucinogens, intoxicants and PCP, inhalants, stimulants	Alcohol, cocaine, opioids, sedatives, hypnotics, anxiolytics, stimulants
Bipolar disorders and mania	Stimulants, alcohol, hallucinogens, inhalants (organic solvents), steroids (chronic, acute)	Alcohol, benzodiazepines, barbiturates, opioids, steroids (chronic)
Psychosis	Alcohol, anxiolytics, cannabis, hallucinogens (e.g., PCP), inhalants, sedatives, hypnotics, stimulants	Alcohol, sedatives, hypnotics, anxiolytics

Exhibit 4.19 lists substances most likely to induce/mimic depressive, anxiety, bipolar, and psychotic disorders.

Substance-induced depressive disorders

The lifetime prevalence of substance-induced depressive disorders in the general community is

0.26 percent (Blanco et al., 2012). Observed rates among clinical populations are much higher. For instance, in a study of people seeking treatment for co-occurring depressive disorders and SUDs, 24 percent had substance-induced depression; rates varied by substance. Among those with 12-month alcohol dependence, prevalence of

substance-induced MDD was 22 percent; for past-year cocaine dependence, 22 percent; and for past-year heroin dependence, nearly 37 percent (Samet et al., 2013). In another study of people with SUDs, 60 percent of people with depression had a substance-induced rather than independent depressive disorder (Conner et al., 2014). DSM-5 notes that although about 40 percent of people with AUD develop MDD, only about one-third to one-half are cases of independent depression, meaning **as much as 75 percent of occurrences of depressive disorders in the context of AUD could be because of intoxication or withdrawal** (APA, 2013). Depressive disorders or their symptoms could also be because of the long-term effects of substance use.

Diagnosis of a substance-induced versus independent depressive disorder can be difficult given that many people with SUDs do have mood symptoms, like depressed affect, and **intoxication and withdrawal from substances can mirror symptoms of depression**. During the first months of abstinence, many people with SUDs may exhibit symptoms of depression that fade over time and are related to acute withdrawal. Because depressive symptoms during withdrawal and early recovery may result from SUDs and not an underlying depression, a period of time should elapse before depression is diagnosed. This does not preclude the importance of addressing depressive symptoms during the early stage of recovery, before diagnosis. Further, even if an episode of depression is substance induced, that does not mean that it should not be treated. Overall, the process of addiction can result in biopsychosocial disintegration, leading to PDD or depression often lasting from months to years.

Substance-induced mood alterations can result from acute and chronic drug use as well as from drug withdrawal. Substance-induced depressive disorders, most notably acute depression lasting from hours to days, can result from sedative–hypnotic intoxication. Similarly, prolonged or subacute withdrawal, lasting from weeks to months, can cause episodes of depression, and sometimes is accompanied by suicidal ideation or attempts.

Stimulant withdrawal may provoke episodes of depression lasting from hours to days, especially

following high-dose, chronic use. Acute stimulant withdrawal generally lasts from several hours to 1 week and is characterized by depressed mood, agitation, fatigue, voracious appetite, and insomnia or hypersomnia (oversleeping). Depression resulting from stimulant withdrawal may be severe and can be worsened by the individual’s awareness of substance use–related adverse consequences. Symptoms of craving for stimulants are likely and suicide is possible. Protracted stimulant withdrawal often includes sustained episodes of anhedonia (absence of pleasure) and lethargy with frequent ruminations and dreams about stimulant use.

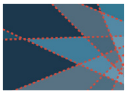
Stimulant cessation may be followed for several months by bursts of dysphoria, intense depression, insomnia, and agitation. These symptoms may be either worsened or lessened depending on the provider’s treatment attitudes, beliefs, and approaches. It is a delicate balance—between allowing time to observe the direction of symptoms to treating the client’s presenting symptoms regardless of origin.

Substance-Induced Anxiety Disorders

The prevalence of substance-induced anxiety disorders in the community is unreported and thought to be quite low (less than 0.1 percent), although likely higher in clinical samples (APA, 2013).

Licit and illicit substances can cause symptoms that are identical to those in anxiety. In addition, many medications, toxins, and medical procedures can cause or are associated with an eruption of anxiety. Moreover, these reactions vary greatly from mild manifestations of shortlived symptoms to full-blown manic and other psychotic reactions, which are not necessarily short lived.

Symptoms that look like anxiety may appear either during use or withdrawal. Alcohol, amphetamine and its derivatives, cannabis, cocaine, hallucinogens, intoxicants and phencyclidine and its relatives have been reported to cause the symptoms of anxiety during intoxication. Withdrawal from alcohol, cocaine, illicit opioids, and also caffeine and nicotine can also cause manifestations of anxiety. Similarly, withdrawal from depressants, opioids, and stimulants invariably includes potent anxiety symptoms.

**Substance-Induced Bipolar Disorders**

Epidemiologic data on substance-induced mania or bipolar disorders in the U.S. general population are not readily available.

A number of substances of misuse (as well as prescribed medications and several medical conditions) are also associated with manic-like phenomena. Acute manic symptoms may be induced or mimicked by intoxication with stimulants, steroids, hallucinogens, or polydrug combinations. They may also be caused by withdrawal from depressants such as alcohol. Individuals experiencing acute mania with its accompanying hyperactivity, psychosis, and often aggressive and impulsive behavior should be referred to emergency mental health professionals.

Stimulant-induced episodes of mania may include symptoms of paranoia lasting from hours to days. Stimulants such as cocaine and amphetamines cause potent psychomotor stimulation. Stimulant intoxication generally includes increased mental and physical energy, feelings of well-being and grandiosity, and rapid, pressured speech. Chronic, high-dose stimulant intoxication, especially with sleep deprivation, may prompt a manic episode. Symptoms may include euphoric, expansive, or irritable mood, often with flight of ideas, severe social functioning impairment, and insomnia.

Substance-Induced Psychosis

This condition is very rare; exact prevalence rates are unknown (APA, 2013). In first-episode psychosis, 7 percent to 25 percent of cases are substance induced (APA, 2013).

CASE STUDIES: IDENTIFYING DISORDERS

George M. is a 37-year-old divorced man who was brought to the ED intoxicated. His blood alcohol level was 0.27, and the toxicology screen was positive for cocaine. He was also suicidal ("I'm going to do it right this time!"). He has a history of three psychiatric hospitalizations and two inpatient SUD treatments. Each psychiatric admission was preceded by substance use.

George M. never followed through with mental health services. He sometimes attended AA, but not recently.

Teresa G. is a 37-year-old divorced woman who was brought into a detoxification unit 4 days ago with a blood alcohol level of 0.21. She is observed to be depressed, withdrawn, with little energy, fleeting suicidal thoughts, and poor concentration, but states she is just fine, not depressed, and life was good last week before her relapse. She has never used substances (other than alcohol) and began drinking alcohol only 3 years ago. However, she has had several alcohol-related problems since then. She has a history of three psychiatric hospitalizations for depression, at ages 19, 23, and 32. She reports a positive response to antidepressants. She is currently not receiving mental health services or SUD treatment. She is diagnosed with AUD (relapse) and substance-induced depressive disorder, with a likely history of, but not active, major depression.

Discussion: Many factors must be examined when making initial diagnostic and treatment decisions. For example, if George M.'s psychiatric admissions were 2 or 3 days long, usually with discharges related to leaving against medical advice, decisions about diagnosis and treatment would be different (i.e., this is likely a substance-induced suicidal state and referral at discharge should be to an SUD treatment agency rather than a mental health center) than if two of his psychiatric admissions were 2 or 3 weeks long with clearly defined manic and psychotic symptoms continuing throughout the course, despite aggressive use of mental health services and medication (this is more likely a person with both bipolar disorder and AUD who requires integrated treatment for both his severe AUD and bipolar disorder).

Similarly, if Teresa G. became increasingly depressed/withdrawn in the past 3 months, and had for a month experienced disordered sleep, poor concentration, and suicidal thoughts, she would be best diagnosed with MDD with acute alcohol relapse, not substance-induced depressive disorder secondary to alcohol relapse.

Heavy users of psychoactive substances, like cannabis, amphetamines, and cocaine, are vulnerable to substance-induced psychosis, especially clients with cooccurring schizophrenia and bipolar disorders. Antidepressants can also precipitate psychotic episodes, as can medications like prescribed steroids and nonsteroidal anti-inflammatory drugs, antiviral agents, antibiotics, anticholinergics, antihistamines, muscle relaxants, and opioids. Any number of physical illnesses or medication reactions, from brain tumors to steroid side effects, can cause a psychotic episode or psychotic behavior. **Virtually any substance taken in very large quantities over a long enough period can lead to a psychotic state.**

Differential diagnosis among psychotic disorders can be challenging, even for experienced clinicians and diagnosticians, especially when substances are involved. When a client presents in a psychotic state, any immediate or recent substance use is difficult to determine, and it may be impossible to discern whether the hallucinations or delusions are caused by substance use. If the hallucinations or delusions can be attributed to substance use but are prominent and beyond what one might expect from intoxication alone, the episode would be described as a substance-induced psychotic disorder. Hallucinations that the person knows are solely the result of substance use are not considered indicative of a psychotic episode; instead, they are diagnosed as substance intoxication or substance withdrawal with the specifier “with perceptual disturbances” (APA, 2013).

Cross-Cutting Topics: Suicide and Trauma

Suicide risk and trauma status are relevant to care planning, client safety, and treatment outcomes across many CODs. This section briefly addresses each issue and offers guidance to help addiction counselors understand why both need to be actively considered as part of assessment and treatment.

Ample literature discusses suicide, mental disorders, and addiction. This section is not intended to thoroughly review all aspects of

suicide-related assessment, management, and prevention techniques for COD populations; readers instead are directed to TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009) for more information. The aim of this text is to ensure that readers have a broad and general understanding of the high risk of suicidal thoughts and behaviors in clients with CODs and feel confident in knowing how to prevent and respond to such events.

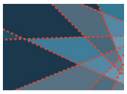
Similarly, trauma has been a significant topic of research in the behavioral health literature. What follows is an abbreviated summary of the link between trauma and mental disorders and SUDs and how addiction counselors can offer trauma-informed services. Readers should consult TIP 57, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA, 2014b) for more guidance in this area.

For both suicide and trauma, readers are reminded to review Chapter 3 for assessment techniques and tools, Appendix B for links to suicide prevention materials and other resources, and Appendix C for counselor tools like trauma screeners.

Suicide

Suicide is a common risk factor that pertains to nearly all CODs and particularly those involving addiction and MDD, bipolar disorder, schizophrenia, PTSD, or PDs (Yuodelis-Flores & Ries, 2015). Suicidality itself is not a mental disorder, but it is considered a high-risk behavior of significant public health concern (Hogan & Grumet, 2016). Substance-induced or exacerbated suicidal ideations, intentions, and behaviors are possible complications of SUDs, especially for clients with co-occurring mental disorders.

The topic of suicidality is critical for SUD treatment counselors working with clients who have CODs. SUDs alone increase suicidality (Yuodelis-Flores & Ries, 2015), whereas the added presence of some mental disorders doubles the already heightened risk (O'Connor & Pirkis, 2016). The risk of suicide is greatest when relapse occurs after a substantial



These populations (Department of Health and Human Services, 2012) are vulnerable to suicide risk; many are susceptible to addiction or CODs as well:

- American Indians/Alaska Natives
- Individuals who have lost a loved one to suicide
- Clients involved in criminal justice/child welfare systems
- Clients who engage in nonsuicidal self-injury
- Individuals with a history of previous suicide attempt
- Individuals with debilitating physical conditions
- Clients with mental disorders, SUDs, or both
- Individuals in the LGBTQ community
- Members of the armed forces and veterans
- Middle-aged and older men

period of abstinence—especially if there is concurrent financial or psychosocial loss. **Every agency that offers SUD counseling must also have a clear protocol in place that addresses the recognition and treatment (or referral) of people who may be suicidal.**

Prevalence

Suicide is the 10th leading cause of death in the United States among people ages 10 and older (Stone et al., 2019). Suicide is the second leading cause of death for people ages 10 to 34 and the fourth leading cause of death for those ages 35 and 54 (NIMH, 2019). Per the Centers for Disease Control and Prevention (CDC), from 1999 to 2018, suicide rates in the United States increased 41 percent, from 10.5 to 14.8 per 100,000 people (CDC, 2019). Suicide rates among men remain more than 3 times higher (23.4 per 100,000 in 2018) than among women (6.4 per 100,000 in 2018) (CDC, 2020).

Almost half (46 percent) of all individuals in the United States who died by suicide between 2014 and 2016 had a known mental health condition, and 54 percent were in treatment at the time of death (Stone et al., 2019). Depression

was the most common mental disorder diagnosis among those who completed suicide (75 percent); other major mental disorder diagnoses included anxiety (17 percent), bipolar disorders (15 percent), schizophrenia (5 percent), and PTSD (4 percent) (Stone et al., 2019).

Suicide and SUDs

Substance misuse makes people susceptible to self-harm; indeed, **suicide is the leading cause of death among people with addiction** (CSAT, 2009). From 2014 to 2016, 28 percent of people who died by suicide had problematic substance use, including 32 percent of people with a known mental health disorder (Stone et al., 2019). Of these individuals with known psychiatric problems, 39 percent tested positive for alcohol, 39 percent for benzodiazepines, 29 percent for opioids, 23 percent for cannabis, 10 percent for amphetamines, and 6 percent for cocaine (Stone et al., 2019).

Alcohol factors prominently into suicide (Darvishi, Farhadi, Haghtalab, & Poorolajal, 2015). **Acute alcohol intoxication increases the risk of suicide attempt by nearly 7 times and in some studies, if use is heavy, by as much as 37 times** (Borges et al., 2017). This risk appears to increase with corresponding increases in consumption; as such, populations with AUD have higher rates of suicide than people without problematic alcohol use (Yuodelis-Flores & Ries, 2015).

Other substances also carry an increased risk of self-harm, as suicidal behavior is prominent in OUD, cocaine use disorder, and polysubstance use (Yuodelis-Flores & Ries, 2015). Among

According to NSDUH data (CBHSQ, 2019), in 2018:

- About 10.7 million U.S. adults ages 18 or older thought seriously of dying by suicide (4.3 percent of adults).
- 3.3 million U.S. adults made suicide plans (1.3 percent).
- 1.4 million U.S. adults made nonfatal suicide attempts (0.6 percent).

individuals with a history of substance misuse who died by suicide in 2014 (Fowler, Jack, Lyons, Betz, & Petrosky, 2018), the most commonly involved nonmedication substances were alcohol (51 percent), opioids (23 percent), and cannabis (almost 14 percent). Furthermore, among all suicide cases that year, opioids were the direct cause of death in 27 percent of people and alcohol in 13 percent (Fowler et al., 2018). The overall suicide rate of U.S. veterans with an SUD is estimated at 75.6 per 100,000 people and is highest among those who misuse sedatives, followed by amphetamines, opioids, cannabis, alcohol, and cocaine (Bohnert, Ilgen, Louzon, McCarthy, & Katz, 2017). People who report misusing prescription medication, and in particular pain relievers, also appear to be vulnerable to suicidal ideation (Ford & Perna, 2015).

The link between substance misuse and suicide may relate to the capacity of substances, especially alcohol, to quell inhibition, leading to poor judgment, mood instability, and impulsiveness. Depression, comorbid with suicide risk and substance misuse, may moderate this relationship. A population-based sample of people currently using alcohol and with a history of depressed mood (Sung et al., 2016) found that those with a positive history of suicide attempt were significantly more likely than those without such a history to have problematic substance use, including 21 percent with alcohol abuse or dependence and nearly 40 percent with illicit drug abuse or dependence. Yet alcohol dependence in this sample significantly increased the odds of suicidal ideation and suicide attempt even among people without a history of depressed mood. This suggests that depressed mood alone cannot account for the relationship between alcohol misuse and risk of suicide, although it undoubtedly increases the odds.

Many psychiatric illnesses have a heightened risk of suicidal thoughts and behaviors further exacerbated in the presence of co-occurring addiction. Risk factors for suicide that have been identified in the general population, such as a family history of suicide attempt or completion and access to firearms, also apply to people with CODs and make self-harm more likely. Additionally, **certain individuals with CODs may be at even further risk based on the presence**

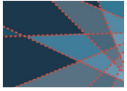
of contributing factors that frequently appear in populations with mental disorders and SUDs. For instance, having a chronic physical health condition (such as traumatic brain injury or infectious disease), experiencing homelessness, being a military veteran, and past involvement in the criminal justice system are all associated with suicide-related ideation, gestures, attempts, or deaths (Ahmedani et al., 2017; Cook, 2013; Jahn et al., 2018; Kang et al., 2015; Tsai & Cao, 2019) and may further compromise the safety of people with CODs. A history of adverse life experiences, like childhood maltreatment or intimate partner violence, also significantly increases risk of self-harm (especially in people with CODs) and is addressed in the section “Trauma.”

Prevention and Management of Suicidal Behaviors

Although a rare event, suicide is often—but not always—preventable. **All SUD treatment clients should receive at least a basic screening for suicidality, and all SUD treatment professionals should know how to conduct at least basic screening and triage.** (To learn more about suicide screening, see Chapter 3 of this TIP.) SAMHSA's Five-Step Evaluation and Triage (SAMHSA, 2009b) recommends using the following process for identifying and responding to threat of self-harm:

1. **Identify risk factors.**
2. **Identify protective factors.**
3. **Conduct a suicidal inquiry** into the client's thoughts, plans, behaviors, and intents.
4. **Determine the level of risk** and appropriate interventions.
5. **Document** risk, rationale, intervention, and follow-up procedures.

Addiction counselors should regularly assess and monitor all clients with CODs for suicidal ideation, gestures, plans, and attempts and especially clients with depressive disorders, bipolar disorders, PTSD, schizophrenia, or PDs. Routine assessment should be an integral part of treatment but is especially critical during times of high stress or increased substance use (including relapse) as well as at intake, following any suicidal behavior, following reports of suicidal ideation,



and just before discharge. Information should be collected on the client's:

- Personal and family history of suicidal thoughts and behaviors.
- Plan for suicide.
- Reasons for not following through with past plans for suicide.
- Reasons for not following through with the current plan for suicide.
- Current support system.
- Means and access to lethal methods (e.g., firearms).
- History and current symptoms of impulsivity.
- Depressed mood, feelings of hopelessness, or both.
- Protective factors (e.g., coping skills, spiritual/religious beliefs).

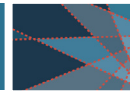
Asking a client directly about his or her desire to die by suicide does not make self-harm more likely and in fact can yield helpful information.

Note that people may deny such thoughts or plans despite having them. Thus, **direct questioning alone is an insufficient risk mitigation strategy.** Suicide risk assessment scales might be useful in this regard (see Chapter 3 and Appendix C for suicide risk and self-harm screening tools) but often lack the specificity and sensitivity to adequately detect impending suicidal behaviors (Bolton, Gunnell, & Turecki, 2015). **Providers also should not rely solely on suicide measures.** Instead, suicide screening should include thorough investigation of all major signs, symptoms, and risk factors associated with self-harm in mental health, addiction, or COD populations.

Safety planning is critical in suicide risk mitigation. Suicide "contracts" are written statements in which the person who is suicidal states that he or she will not kill himself but rather call for help, go to an ED, or other seek other assistance if he or she becomes suicidal. These contracts are not effective alone for a client who is suicidal. Such contracts often help make clients and therapists less anxious

RESOURCE ALERT: SUICIDE PREVENTION RESOURCES FOR COUNSELORS

- American Counseling Association (ACA):
 - Suicide Prevention Tip Sheet (<https://www.counseling.org/docs/default-source/Communications-/suicide-prevention-final.pdf?sfvrsn=2>)
 - Counselor Training in Suicide Assessment, Prevention, and Management (www.counseling.org/docs/default-source/vistas/article_65d15528f16116603abcacff0000bee5e7.pdf?sfvrsn=4f43482c_6)
 - Developing Clinical Skills in Suicide Assessment, Prevention, and Treatment (www.counseling.org/publications/frontmatter/72861-fm.pdf)
- International Association for Suicide Prevention's Guidelines for Suicide Prevention (www.iasp.info/suicide_guidelines.php)
- SAMHSA:
 - Suicide Prevention Resource Center (www.sprc.org/)
 - Suicide Assessment Five-Step Evaluation and Triage for Mental Health Professionals (<https://store.samhsa.gov/system/files/sma09-4432.pdf>)
 - TIP 50, Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment (<https://store.samhsa.gov/product/TIP-50-Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/SMA15-4381>)
 - Video companion to TIP 50, Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment (www.youtube.com/watch?v=1n2Qzlheuzc&feature=youtu.be)



about a suicidal condition, but studies have never shown these contracts to be effective at preventing suicide. Rather, safety contracts help focus on the key elements that are most likely to keep clients safe, such as agreeing to remove the means a client is most likely to use to commit suicide.

Counselors and other providers should know their own skills and limitations in engaging, screening, assessing, and intervening with suicidal clients and work out these problems with a supervisor before an emergency. Providers also should know what immediate onsite and offsite resources are available to help with someone identified as suicidal. To learn more about suicide prevention, see “Resource Alert: Suicide Prevention Resources for Counselors.”

No empirical treatments for suicide exist. However, **interventions that reduce symptoms of SUDs and mental illness can help mitigate suicide risk and**

decrease self-harm behaviors by improving mood and enhancing support and coping skills. Some research supports the use of psychotherapies such as CBT and dialectical behavior therapy in reducing parasuicidal behavior and suicide attempts, but the overall evidence base is small (Bolton et al., 2015). Pharmacotherapy—particularly antidepressants—can reduce suicidal behavior in people ages 25 years and older. Yet paradoxically, some studies show that it actually increases suicide in people ages 25 and younger (Bolton et al., 2015). Certain mood stabilizers and antipsychotic medications also may reduce self-harm in people with bipolar disorder, schizophrenia, and other psychotic disorders (Bolton et al., 2015).

The first steps in suicide intervention, and thus crisis stabilization, are contained in the process of a good engagement and evaluation. **Asking suicide-related questions, exploring the context**

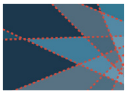
CASE STUDY: COUNSELING AN SUD TREATMENT CLIENT WHO IS SUICIDAL

Beth, a 44-year-old woman, comes to the SUD treatment center complaining that drinking too much causes problems for her. She has tried to stop drinking before but always relapses. The counselor finds that she has been sleeping and eating poorly and calling in sick to work. She spends much of the day crying and thinking of how alcohol, which destroyed her latest significant relationship, has ruined her life. She takes pain medication for a chronic back problem, which complicates her situation. The counselor tells her of a therapy group that is a good fit, tells her how to register, and arranges some individual counseling to set her on the right path. The counselor tells her she has done the right thing by coming in for help and offers encouragement about her ability to stop drinking.

Beth misses her next appointment. The counselor calls her home and learns from her roommate that Beth tried to commit suicide after leaving the SUD treatment center. She took an overdose of opioids and is recovering in the hospital. The ED staff had found Beth under the influence of alcohol upon admission.

Discussion: Although Beth provided information that showed she was depressed, the counselor did not explore the possibility of suicidal thinking. **Counselors always should ask if the client has been thinking of suicide, whether or not the client mentions depression.** Clients, in general, may not answer a very direct question or may hint at something darker without mentioning it directly. Interpreting the client's response requires sensitivity on the part of the counselor. It is important to realize that such questions do not increase the likelihood of suicide. Clients who, in fact, are contemplating suicide are more likely to feel relieved that the subject has now been brought into the light and can be addressed with help from someone who cares.

The client reports taking alcohol and pain medications. Alcohol impairs judgment and, like pain medications, depresses brain and body functions. The combination of substances increases the risk of suicide or accidental overdose. Readers are encouraged to think through this case and apply the risk assessment strategy included in Chapter 3 and use the tools in Appendix C, imagining what kind of answers the counselor might have received. Readers could consider interventions and referrals that would have been possible in their treatment settings.



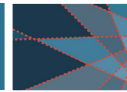
of those impulses, evaluating support systems, considering the lethality of means, and assessing the client's motivation to seek help are in themselves an intervention. Such an interview will often elicit the client's own insight and problem solving and may result in a decrease in suicidal impulses.

If, however, the client experiences little or no relief after this process, psychiatric intervention is required, especially if the client has a cooccurring mental disorder or medical disorder in which the risk of suicide is elevated or if the client has a history of suicide attempts. If either or both is true, **arrangements should be made for transfer to a facility that can provide more intensive psychiatric evaluation and treatment. Emergency**

ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WHO IS SUICIDAL

- All SUD treatment clients should receive at least a brief screening for suicide, such as: "In the past, have you ever been suicidal or made a suicide attempt? Do you have any of those feelings now?"
- All SUD treatment staff should be able to screen for suicidality and basic mental disorders (e.g., depression, anxiety disorders, PTSD).
- Screen for suicidal thoughts or plans with anyone who makes suicidal references, appears seriously depressed, or who has a history of suicide attempts. Treat all suicide threats with seriousness.
- Inquire directly about a client's depressed mood or agitation. For example:
 - "You know, you seem to be pretty down. How depressed are you?"
 - The issue may arise via general questions. For example, a client may state, "I don't use crack much anymore. I get really down when I'm coming off it." The counselor may then ask, "How down have you gotten? Were you ever suicidal? How are you doing now?"
- The suicidal client is more likely to engage with the counselor and reveal suicidality if the counselor responds to clues given by the client and inquires sensitively about them. Saying, "You seem pretty uncomfortable and nervous—is there something I can do to help?" to an agitated client opens a door to further assessment.
- If the client screens positive, use the risk assessment strategy described in Chapter 3 to more thoroughly investigate suicide intent. Further screening/assessment should be documented to protect both the client and the counselor. This means writing information on evaluation forms or making additional notes, even if suicide-related items are not included on the form used.
- Assess the client's risk of self-harm by asking about what is wrong, why now, whether specific plans have been made to commit suicide, past attempts, current feelings, and protective factors. (See Chapter 3 and Appendix C for a risk assessment protocol and screening measures.)
- Develop a safety and risk management process with the client that involves a commitment on the client's part to follow advice, remove the means to commit suicide (e.g., a gun), and agree to seek help and treatment. Avoid sole reliance on "no suicide contracts."
- Assess the client's risk of harm to others.
- Clients who are actively suicidal should be evaluated by a psychiatrist onsite immediately, or a case manager or counselor should escort the client to emergency psychiatric services. Where available, mobile crisis service, including a psychiatrist, is a quick-response resource for management of the client who is suicidal.

Continued on next page



Continued

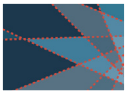
- Be caring and supportive. The seriously suicidal client should have someone to contact 24 hours a day, and frequent telephone contact between the client and the contact person usually is indicated.
- Provide availability of contact 24 hours per day until psychiatric referral is realized. Refer clients with serious plans, previous attempts, or SMI for psychiatric intervention or obtain the assistance of a psychiatric consultant for the management of these clients.
- Monitor and develop strategies to ensure medication adherence.
- Interventions should seek to increase support available to the client from family and community, and should provide immediate interventions, including medication to stabilize the client's mental state, if needed.
- Families and individuals often benefit from education about depression and suicidality, including warning signs, resources for help, and the importance of addressing this problem. Education often provides individuals with a sense of hope and realistic expectations.
- Develop long-term recovery plans to treat substance misuse. Longer term treatment concerns for a client who has been suicidal focus on long-term treatment strategies for CODs or on other risk factors that have culminated in a suicidal event. In this case, treatment becomes long-term prevention.
- In people with serious and persistent mental disorders (e.g., bipolar disorder), long-term medication compliance is key in preventing suicide. Just as essential as medication and medication compliance, however, is the need to rebuild hope in the future and engender the belief that recovery from co-occurring disorders is possible and that one has a sense of purpose, value, empowerment, and role in one's own recovery.
- Review all such situations with the supervisor or treatment team members.
- Document thoroughly all client reports and counselor suggestions.

procedures should be in place so the counselor can accomplish this transfer even when a psychiatrist or clinical supervisor/director is not available. Once the client is stabilized and is safe to return to a less restrictive setting, he or she should return to the program.

Trauma

DSM-5 defines trauma as “as exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways: (a) directly experiencing the traumatic event; (b) witnessing, in person, an event as it occurred to others; (c) learning that the traumatic event occurred to a close family member or close friend; and (d) experiencing repeated or extreme exposure to aversive details of the traumatic event(s)” (APA, 2013, p. 271).

For many people with mental disorders, SUDs, or both, past or current trauma is a prominent driver of negative outcomes such as psychiatric hospitalizations; suicide attempts; self-harm behaviors; arrest; aggression; and substance use initiation, escalation (from occasional use, to regular use, to misuse/heavy use/addiction), treatment dropout, and relapse (Kumar, Stowe Han, & Mancino, 2016; Lijffijt, Hu, & Swann, 2014; Stinson, Quinn, & Levenson, 2016). Data from the National Longitudinal Study of Adolescent to Adult Health (Quinn et al., 2016) confirm that exposure to childhood trauma (e.g., sexual/emotional/physical abuse, neglect, witnessing violence) significantly increases the risk of adulthood prescription pain reliever misuse (PPRM) and injection drug use. This risk only grows as the number of traumas experienced increases; in the study, exposure to one trauma increased the risk of PPRM by



WARNING TO COUNSELORS: RETHINKING TRAUMA

When providers hear the term “trauma,” they probably get a specific picture in their mind of what a client with trauma looks like—a woman who has been physically abused by her husband, a man who faced combat as a Marine, a woman who was date raped while in college. These are indeed common examples of trauma, but addiction counselors who only think of trauma in prototypical terms will overlook clients who have faced adversities and are in need of help. When thinking about clients with trauma:

Do not think only of women. Men experience trauma, and although at lower rates than women, their adversities are just as serious and potentially damaging.

Do not think only of military veterans or of people who served in combat. Rates of trauma and PTSD are certainly high in military populations, but trauma happens to people from all walks of life. Among active duty military personnel and veterans, people can experience trauma even if they were not directly involved in combat. (See the section “Special Considerations: Trauma and Military Personnel.”)

Do not think only of physical violence. Emotional abuse and neglect are damaging and can have just as serious an impact as physical or sexual abuse (Norman et al., 2012).

Do not think only of young people. PTSD is less prevalent in older adults, but up to 52 percent of people ages 50 and older have had at least one traumatic event in their lives (Choi, DiNitto, Marti, & Choi, 2017).

Remember that someone may not have a PTSD diagnosis but still have PTSD symptoms, a history of trauma, or both. These people may be just as much in need of treatment as someone with a full-blown diagnosis. Also, PTSD and its symptoms are easily mistaken for other disorders, such as BPD and depressive disorders (especially MDD). Although the person may not meet sufficient criteria for PTSD, he or she may have traumatic stress reactions that need to be addressed. Subclinical traumatic stress reactions are more commonly expressed through depressive symptoms. **Do not assume that just because someone does not have a PTSD diagnosis that he or she is not in need of trauma-informed care.**

34 percent; two traumas, by 50 percent; three traumas, by 70 percent; and four traumas, by 217 percent. Emotional and physical abuse nearly doubled the risk of injection drug use.

Prevalence

Traumatic events are common in people with CODs in part because they are so widely prevalent in the general population. Almost 90 percent of people in the United States have a lifetime history of exposure to at least one traumatizing event, typically the death of family/close friend because of violence/accident/disaster; physical or sexual assault; disaster; or accident/fire (Kilpatrick et al., 2013).

Trauma and CODs

As noted in the section “PTSD,” **trauma in people with addiction, mental illness, or both is the norm rather than the exception** (SAMHSA, 2014b). In more than 600 people receiving SUD treatment, 49 percent reported a lifetime history of physical or sexual abuse, and women were 5 times more likely than men to report lifetime trauma

(Keyser-Marcus et al., 2015). In people with SMI, trauma exposure is common, with prevalence rates ranging from 25 percent to 72 percent for physical abuse, 24 percent to 49 percent for sexual abuse, and 20 percent to 47 percent for PTSD (Mauritz, Goossens, Draijer, & van Achterberg, 2013). Twelve-month or lifetime rates of DSM-5 drug use disorder (i.e., an SUD excluding alcohol) carries increased odds of having PTSD (Grant et al., 2016), and 12-month or lifetime PTSD increases the odds of having a past-year or lifetime SUD (Goldstein et al., 2016).

Adverse life experiences are highly coincident with SUDs and mental disorders, and vice versa:

- Current PTSD prevalence in addiction populations is likely 15 percent to 42 percent (Vujanovic et al., 2016).
- In active duty military personnel, prevalence rates of various comorbid mental disorders and SUDs in people with PTSD have been estimated at 49 percent for depressive disorders, 36

percent for GAD, and almost 27 percent for AUD (Walter, Levine, Highfill-McRoy, Navarro, & Thomsen, 2018).

- Among a sample of U.S. adults with any lifetime trauma, 47 percent screened positive for PTSD, almost 47 percent for GAD, and 42 percent for depression (Ghafoori, Barragan, & Palinkas, 2014).
- Between 28 percent and 43 percent of people with PTSD have an SMI (Lu et al., 2013).
- People with past-year or lifetime PTSD are at significant risk of developing any number of comorbid mental disorders, including any mood disorder (2.4 to 3 times the odds), bipolar I disorder (2.1 to 2.2 times), any anxiety disorder (2.6 to 2.8 times), GAD (2 to 2.2 times), panic disorder (2.1 times), and BPD (2.8 to 3.3 times) (Goldstein et al., 2016).
- People with adverse childhood events (e.g., abuse, neglect) are more likely to report lifetime drug use, past-year moderate-to-heavy alcohol use, lifetime suicide attempt, and past-year depressed mood than people without such a history (Merrick et al., 2017). Emotional abuse in childhood is linked with 6 times the odds for a lifetime suicide attempt (Merrick et al., 2017).

Trauma-Informed Treatment of CODs

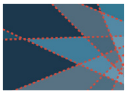
Historically, trauma has not been adequately addressed in SUD treatment, given provider fear that doing so would worsen mental and addiction problems. However, research indicates the opposite—that **failing to address trauma in people with SUDs leads to worse outcomes** (Brown, Harris, & Fallot, 2013).

Trauma-informed care means attending to trauma-related symptoms and also creating a treatment environment that is responsive to the unique needs of individuals with histories of trauma. Treatment is focused on reducing specific symptoms and restoring functioning but also broader goals like building resiliency, reestablishing trust, preventing retraumatization, and offering hope for the future. Creating a supportive, safe treatment environment is crucial. Counselors must realize how the setting and their interactions with clients who have trauma can affect treatment adherence, retention, and outcomes.

Trauma-informed care for people with mental disorders, SUDs, or both often includes (SAMHSA, 2014b):

- Psychoeducation, especially about the relationship between trauma, mental health, and addiction. Psychoeducation is also needed to help normalize symptoms and reassure clients that their experiences are not unusual, “wrong,” or “bad.”
- Teaching coping and problem-solving skills to foster effective stress management.
- Discussing retraumatization and developing strategies to prevent further victimization.
- Helping clients feel empowered and in control of their lives.
- Establishing a sense of safety in clients’ daily lives and in treatment.
- Promoting resilience and offering hope for change and improvement.
- Identifying and responding adaptatively to triggers, like intrusive thoughts, feelings, and sensations.
- Building a therapeutic alliance, which fosters trust, confidence, and self-worth—all keys to healing.
- Using trauma-specific interventions, like:
 - CBT.
 - Cognitive processing therapy.
 - Exposure therapy.
 - Eye movement desensitization/reprocessing.
 - Affective regulation.
 - Distress tolerance and stress inoculation.
 - Peer support services from other people who have a trauma history and are thriving.

TIP 57, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA, 2014b) and SAMHSA’s “Concept of Trauma and Guidance for a Trauma-Informed Approach” (SAMHSA, 2014c) will help addiction and mental health professionals tailor their services in a way that is respectful of and sensitive to clients’ trauma-related needs. Chapter 6 discusses adapting treatments for CODs to female clients with trauma.



ADVICE TO THE COUNSELOR: COUNSELING A CLIENT WITH TRAUMA

- Clients need not only to feel safe in the treatment environment, but also to feel safe from their trauma symptoms, many of which are intrusive, overwhelming, and distressing.
- Ensure interventions/interactions do not distress or traumatize clients. Avoid:
 - Being overly confrontational or argumentative with clients.
 - Discounting and dismissing clients' experiences and feelings.
 - Minimizing or ignoring clients' responses and needs.
 - Pushing clients to talk in greater detail about their trauma.
 - Violating clients' physical boundaries.
- Educate clients about the link between trauma and mental disorders, SUDs, or both.
- Normalize clients' reactions and feelings; this helps validate their experiences and offers a sense of relief.
- Help clients identify triggers and learn more adaptive ways to cope and respond to them. This reduces maladaptive distress management strategies like substance use, self-injurious behaviors, and avoidance.
- Although trauma is an important focus of treatment, it does not need to be the sole focus. In fact, constantly focusing on the trauma can be overwhelming and emotionally draining for clients.
- Include specific SUD treatment approaches and techniques to address addiction symptoms.
- Use an integrated trauma and SUD recovery model that fully addresses mental and substance-related needs.
- Explore with clients their readiness for change using the Stages of Change Model. This aids treatment matching, fosters better adherence/completion rates, and increases clients' chances for long-term recovery.

Special Considerations: Trauma and Military Personnel

Active duty and veteran members of the military are highly susceptible to trauma and all of its deleterious aftereffects. PTSD prevalence is significantly higher than that of the general population and civilian clinical samples, including 9 percent among a sample of more than 4 million veterans in primary care settings (Trivedi et al., 2015), 23 percent among Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) veterans (Fulton et al., 2015), 21 percent in Gulf War veterans (Dursa, Barth, Schneiderman, & Bossarte, 2016), and 8.5 percent to 12.2 percent of Vietnam War veterans (Marmar et al., 2015).

About 20 percent of veterans have CODs (Trivedi et al., 2015); 16 percent have PTSD and SUDs specifically (Mansfield, Greenbaum, Schaper, Banducci, & Rosen, 2017). In a sample of (OEF/

OIF) veterans, 63 percent of people with SUD also had PTSD (Seal et al., 2011). Other common mental disorders in this population include SMI, depression, and anxiety; all tend to co-occur often (Exhibit 4.20). These illnesses are linked with increased hospitalizations, ED use, and mortality, with SMI and SUDs being particularly damaging (Trivedi et al., 2015).

Many veterans seek treatment outside of the Veterans Health Administration, so community addiction counselors should prepare to work with them. **Counseling veteran or active duty military populations requires a slightly different knowledge base, clinical approach, and skillset than civilian populations.** SUD counselors should note that (Briggs & Reneson, 2010; Teeters, Lancaster, Brown, & Back, 2017):

- War zone stress reactions often require specialized care and an understanding of the experiences faced by soldiers in combat.

EXHIBIT 4.20. Veterans and CODs

COMORBID MENTAL ILLNESSES	SUD	21.9 percent	23.2 percent	22.1 percent	29.0 percent	—
	SMI	8.8 percent	8.0 percent	10.2 percent	—	12.8 percent
	Anxiety	13.9 percent	19.4 percent	—	13.3 percent	12.7 percent
	Depression	48.1 percent	—	55.0 percent	29.5 percent	37.8 percent
	PTSD	—	33.2 percent	27.1 percent	22.4 percent	24.6 percent
	Specific Disorder	PTSD	Depression	Anxiety	SMI	SUD
PRIMARY MENTAL ILLNESS						

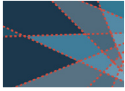
Source: Trivedi et al. (2015).

- Military-related trauma exposure does not include only direct combat. For instance, people working in intelligence gathering and medical personnel are often deployed to war zones where they witness horrific acts of violence and are potential targets of violence themselves.
- Female veterans often have specific service needs, such as those to address military sexual trauma (e.g., sexual assault, harassment), intimate partner violence, and child care. (Note that men also can be victims of military sexual trauma, albeit at far lower rates than reported by women. Do not assume that military sexual trauma is solely a women's issue.)
- Many veterans are hesitant to seek SUD treatment or mental health services because of fear that doing so could negatively affect their career advancement. Concerns about confidentiality are thus understandably very high in these clients.
- Shame, embarrassment, and stigma over mental health and addiction are prominent. Military culture fosters some behaviors and mindsets that can be adaptive in combat—like independence, being “masculine,” and not showing “weakness”—but make seeking treatment much harder.
- Suicide risk is high in veterans. It requires active monitoring and management throughout treatment, particularly for military personnel with childhood trauma, PTSD, military sexual trauma, or depression (Carroll, Currier, McCormick, & Drescher, 2017; Cunningham et al., 2017; Kimerling, Makin-Byrd, Louzon,

Ignacio, & McCarthy, 2016; McKinney, Hirsch, & Britton, 2017; Pompili et al., 2013).

Indepth discussions about prevention programming and treatment for military populations with trauma, suicide risk, SUDs, mental disorders, or a combination thereof is beyond the scope of this TIP. However, ample information is available elsewhere. The following resources offer helpful guidance about working with military professionals who engage in substance misuse or have mental illness, including trauma, suicidality, and CODs:

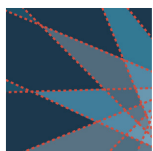
- ACA:
 - *Suicide Among Veterans and the Implications for Counselors* (www.counseling.org/docs/default-source/vistas/suicide-among-veterans-and-the-implications-for-counselors.pdf?sfvrsn=3803a659_11)
 - *Comparison of Civilian Trauma and Combat Trauma* (<https://pdfs.semanticscholar.org/eff2/8af43d3feaac7bac3cc5bb789bd4d5f100ec.pdf>)
 - *Counseling Addicted Veterans: What to Know and How to Help* (<https://pdfs.semanticscholar.org/9742/967aac-815ca02c4f599b36be996d0b10d3d9.pdf>)
- The Department of Veterans Affairs' National Center for PTSD (www.ptsd.va.gov/):
 - *Practice Recommendations for Treatment of Veterans with Comorbid Substance Use Disorder and Posttraumatic Stress Disorder* (www.mentalhealth.va.gov/providers/sud/docs/SUD_PTSD_Practice_Recommendations.pdf)



- Veteran Outreach Toolkit: Preventing Veteran Suicide Is Everyone's Business (www.va.gov/ve/docs/outreachToolkitPreventingVeteran-SuicidesEveryonesBusiness.pdf)
- National Strategy for Preventing Veteran Suicide, 2018–2028 (www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf)
- SAMHSA's *Addressing the Substance Use Disorder Service Needs of Returning Veterans and Their Families* (www.samhsa.gov/sites/default/files/veterans_report.pdf)
- Community Anti-Drug Coalitions of America's *Strategies for Addressing Substance Abuse in Veteran Populations* (www.cadca.org/sites/default/files/mckesson_toolkit_1.pdf)

Conclusion

The material in this chapter is intended to increase SUD treatment counselors' and other providers' familiarity with mental disorders terminology and criteria, as well as to provide advice on how to proceed with clients who demonstrate these disorders. The consensus panel encourages counselors to continue to increase their understanding of mental disorders by using the resource material referenced in each section (and in Appendix C), attending courses and conferences in these areas, and engaging in dialog with mental health professionals who are involved in treatment. At the same time, the panel urges continued work to develop improved treatment approaches that address substance use in combination with specific mental disorders, as well as better translation of that work to make it more accessible to the SUD treatment field.



Chapter 5—Strategies for Working With People Who Have Co-Occurring Disorders

KEY MESSAGES

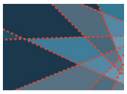
- Building a positive therapeutic alliance is a cornerstone of effective, high-quality, person-centered care for all clients, especially those with co-occurring disorders (CODs). Clients with CODs often experience stigma, mistrust, and low treatment engagement.
- CODs are complex and are associated with certain clinical challenges that, if unaddressed, can compromise the counselor–client relationship and impinge on quality of care, potentially leading to suboptimal outcomes.
- Strategies and approaches like empathic support, motivational enhancement, relapse prevention techniques, and skill building help strengthen clients' ability to succeed and make long-term recovery more likely.
- Certain mental disorders are complex, chronic, and difficult to treat, including major depressive disorder (MDD), anxiety disorders, posttraumatic stress disorder (PTSD), and serious mental illness² (SMI). Clients with these disorders may have unique symptoms and limitations in function.
- Empirically based substance use disorder (SUD) treatment approaches can help counselors address these unique symptoms and functional limitations in ways that will minimize their potential to disrupt the therapeutic relationship and impede positive treatment outcomes.

Establishing and maintaining a successful therapeutic relationship with clients can enhance treatment engagement, participation, and outcomes. Building a good therapeutic relationship with clients who have CODs is especially important, yet doing so can be difficult. The first part of this chapter reviews guidelines and techniques for building rapport and optimizing outcomes when providing SUD treatment to clients who have CODs. The chapter also describes how to modify general treatment principles to suit the needs of clients with COD—particularly useful when working with clients in Quadrants II and III. (Chapter 3 addresses the Four Quadrants Model of service provision.) The second part describes evidence-based techniques for building therapeutic rapport and effectively counseling clients with CODs involving specific mental disorders—MDD, anxiety disorders, PTSD, and SMI.

The material in this chapter is consistent with national or state consensus practice guidelines for COD treatment and consonant with many recommendations therein:

- Counselors must be able to **address common clinical challenges**, like managing feelings and biases that could arise when working with clients who have CODs (sometimes called countertransference).
- Together, providers and clients should **monitor clients' disorders and symptoms** by examining the status of each disorder and alerting each other to signs of relapse.
- Counselors can help clients with functional deficits in areas such as understanding instructions by **using repetition, skill-building strategies, and other accommodations to aid progress**.

² SMI: A diagnosable mental, behavioral, or emotional disorder (other than developmental disorders or SUDs) that persists long enough to meet diagnostic criteria and that causes functional impairment sufficient to substantially disrupt major life activities (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017).



- The consensus panel recommends that counselors **primarily use a supportive, empathic, and culturally responsive approach** when working with clients who have CODs. Counselors need to distinguish behaviors and beliefs of cultural origin from those that may indicate a mental disorder.
- Counselors and other service providers should **use motivational enhancement and relapse prevention strategies consistent with each client's specific stage of recovery**. These strategies are helpful regardless of the severity of a client's mental disorder.

This chapter is intended for counselors and other behavioral health service providers, supervisors, and administrators. Throughout this chapter, "Advice to the Counselor" boxes highlight practical guidance for counselors.

Competencies for Working With Clients Who Have CODs

Before establishing therapeutic rapport with clients who have CODs, treatment providers first must ensure that they possess integrated competencies for working with the COD population. This means having the specific attitudes, values, knowledge, and skills needed to provide appropriate services to individuals with CODs in the context of the providers' job and program setting.

Just as other types of integration exist on a continuum, so too does integrated competency. Some interventions or programs require only basic competency in welcoming, screening, and assessing individuals with CODs to identify their treatment needs. Other interventions, programs, or job functions (e.g., those of supervisory staff) may require more advanced integrated competency. Clients with more complex or unstable disorders require providers with higher levels of integrated competency. They also require more formal mechanisms within programs to coordinate various staff members, providing effective integrated treatment.

The mental health service and SUD treatment systems are moving toward identification of a basic, required level of integrated competency for all providers. Many states are developing curriculums for initial and ongoing training and

supervision to help providers achieve competency. Other states have created career ladders and certification pathways to encourage providers to achieve greater competency and to reward them for this achievement. (See Chapter 8 for further discussion of counselor competencies.)

Guidelines for a Successful Therapeutic Relationship

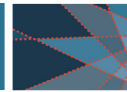
This section reviews 10 guidelines for forming a good therapeutic relationship with clients who have CODs, thereby increasing their chances of successful long-term recovery.

Develop and Use a Therapeutic Alliance To Engage Clients in Treatment

Research suggests that a therapeutic alliance is a strong, if not essential, factor in supporting recovery from mental disorders and SUDs (Kelly, Greene, & Bergman, 2016; Shattock, Berry, Degnan, & Edge, 2018; Zugai, Stein-Parbury, & Roche, 2015). The therapeutic alliance can foster desirable outcomes by improving symptoms, functioning, treatment engagement, treatment satisfaction, and quality of life (Dixon, Holoshitz, & Nossel, 2016; Kidd,

10 GUIDELINES FOR DEVELOPING SUCCESSFUL THERAPEUTIC RELATIONSHIPS WITH CLIENTS WHO HAVE CODS

1. Develop and use a therapeutic alliance to engage clients in treatment.
2. Maintain a recovery perspective.
3. Ensure continuity of care.
4. Address common clinical challenges (e.g., countertransference, confidentiality).
5. Monitor psychiatric symptoms (including symptoms of self-harm).
6. Use supportive and empathic counseling; adopt a multiproblem viewpoint.
7. Use culturally responsive methods.
8. Use motivational enhancement.
9. Teach relapse prevention techniques.
10. Use repetition and skill building to address deficits in functioning.



Given the proliferation of research over the past few decades on technology-based interventions in behavioral health services, some researchers have explored how technology can affect client–counselor relationships in COD treatment. A pilot study from Ben-Zeev, Kaiser, and Krzos (2014) examined the use of mobile phone technology to monitor clients with SMI and SUDs. Using daily text messages over 12 weeks, team members routinely texted clients (in what the study authors termed “hovering”) reminders of upcoming appointments, inquiries about medication adherence, general suggestions about managing symptoms, and, as needed, crisis management. At the end of the trial, participant ratings of therapeutic alliance with providers who “hovered” were significantly higher than those for providers who did not use the intervention. Most clients were satisfied with the technology, and 87 percent said it helped them feel more in control of their lives.

Davidson, & McKenzie, 2017). For clients with SMI (e.g., bipolar disorder, schizophrenia), better therapeutic alliance has been linked to a reduction in symptoms, fewer hospitalizations, greater antipsychotic medication adherence, and improved client self-esteem (Garcia et al., 2016; Shattock et al., 2018). Studies of people with SUDs or CODs also suggest that a strong therapeutic alliance is a significant predictor of treatment retention, symptom reduction, enhanced abstinence-related self-efficacy, and more days of abstinence (Campbell, Guydish, Le, Wells, & McCarty, 2015; Connors et al., 2016; Maisto et al., 2015).

However, the personal beliefs of individuals with CODs, such as mistrust of treatment providers and fear of stigma, can be barriers to treatment seeking, access, and engagement (Priester et al., 2016) and can make establishing a close, trusting client–provider relationship challenging. Developing an effective relationship with clients who have SMI and SUDs can be especially difficult. Some individuals have little insight, lower motivation to change, and less ability to seek/access care than people without CODs (Pierre, 2018). Challenges may be more apparent in clients with SUDs and co-occurring psychosis, as they may have emotional/cognitive dysfunctions inhibiting their ability to participate in treatment (Priester et al., 2016). The presence and level of clinical and functional deficits varies widely from one person with CODs to the next, and among all people with CODs over the course of their illness and lifetime.

To foster treatment engagement for clients with CODs, therapeutic relationships must build on clients’ existing capacities. The therapeutic alliance is the cornerstone of the COD recovery process.

Once established, the alliance is rewarding for both client and provider and facilitates their joint participation in a full range of therapeutic activities. Counselors should document alliance-building activities to help manage risk.

Maintain a Recovery Perspective

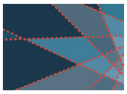
Varied Meanings of “Recovery”

The word “recovery” has different meanings in different contexts. SUD treatment providers may think of clients who have changed their substance use behavior as being “in recovery” for the rest of their lives (but not necessarily in formal treatment forever). Mental health clinicians may think of

ADVICE TO THE COUNSELOR: FORMING A THERAPEUTIC ALLIANCE

The consensus panel recommends these approaches to form a therapeutic alliance with clients who have CODs:

- Demonstrate an understanding and acceptance of clients.
- Help clients clarify the nature of their difficulties.
- Indicate that you will work together with clients.
- Communicate to clients that you will help them help themselves.
- Express empathy and a willingness to listen to clients’ understanding of their problems.
- Assist clients in solving external problems directly and immediately.



ADVICE TO THE COUNSELOR: MAINTAINING A RECOVERY PERSPECTIVE

The consensus panel recommends these approaches for maintaining a recovery perspective in treating CODs:

- Assess each client's stage of change (see the section "Using Motivational Enhancement Consistent With Clients' Specific Stage of Change").
- Ensure that treatment stage and expectations are consistent with each client's stage of change.
- Use client empowerment to motivate change.
- Foster continuous support.
- Provide continuity of treatment.
- Acknowledge that recovery is a long-term process; support and applaud even small gains by clients.

recovery as a process in which the client moves toward specific behavioral goals in stages; in this conceptualization, recovery is assessed by whether these goals are achieved. In mutual-support programs, recovery implies not only abstinence from substances but also a commitment to "working the program," which includes group members changing the way they act with others and taking responsibility for their actions. People with mental disorders may see recovery as the process of reclaiming a meaningful life beyond mental illness, with symptom control and positive life activity.

Generally, it is recognized that **recovery does not refer solely to a change in substance use but also to a change in an unhealthy way of living**. Markers such as improved health, better ability to care for oneself and others, increased independence, and enhanced self-worth indicate progress in recovery.

Implications of the Recovery Perspective

The recovery perspective as developed in the SUD treatment field has two main features:

1. It acknowledges that recovery is a long-term process of internal change.
2. It recognizes that these internal changes proceed through various stages (see De Leon [1996] and Prochaska et al. [1992] for a detailed description).

The recovery perspective generates two main principles for practice:

- **Develop a treatment plan that provides for continuity of care over time.** In preparing

this plan, the provider should recognize that treatment may occur in different settings over time (e.g., residential, outpatient). The plan should reflect that much of the recovery process is client driven and typically occurs outside of, or following, professional treatment (e.g., through participation in mutual support). Providers should reinforce long-term participation in these settings.

- **Use interventions that match the tasks and challenges specific to each stage of the COD recovery process.** Doing so enables providers to use sensible stepwise approaches in developing and using treatment protocols. Markers that are unique to individuals—such as those related to their cultural, social, or spiritual context—should be considered. Providers should engage clients in defining markers of progress that are meaningful to them in each stage of recovery.

Stages of Change and Stages of Treatment

Working within the recovery perspective requires a thorough understanding of the interrelationship between stages of change (as originally defined by Prochaska et al., 1992, and built upon by De Leon, 1996) and stages of treatment (see the section "Using Motivational Enhancement Consistent With Clients' Specific Stage of Change"). De Leon developed a measure of motivation for change and readiness for treatment—Circumstances, Motivation, and Readiness Scales—and provided scores for samples of people with CODs (De Leon, Sacks, Staines, & McKendrick, 2000). The

scales have a demonstrated relationship with retention in general SUD treatment populations and programs (Ali, Green, Daughters, & Lejuez, 2017). A meta-analysis (Krebs, Norcross, Nicholson, & Prochaska, 2018) found that client stage or readiness level of change predicted psychotherapy outcomes among people with SUDs, eating disorders, anxiety disorders, depressive disorders, borderline personality disorder, and CODs (e.g., PTSD and alcohol dependence). The authors suggest tailoring goal setting, treatment processes, and resources to each client's stage of change to optimize outcomes. Expectations for clients' progress through treatment stages (e.g., outreach, stabilization, early-middle-late primary treatment, continuing care, long-term care) should be consistent with clients' stages of change.

Client Empowerment and Responsibility

The recovery perspective emphasizes clients' empowerment and responsibility and their network of family and significant others. Per Green, Yarborough, Polen, Janoff, and Yarborough (2015), achieving sobriety can be a major step in building clients' feelings of self-efficacy and confidence to further achieve recovery in SMI and can be a turning point in advancing their personal growth, improving functioning, and meeting recovery goals.

Continuous Support

The recovery perspective highlights the need for continuing recovery support. Providers encourage clients to build a support network that offers respect, acceptance, and appreciation. For example, an important element of long-term participation in Alcoholics Anonymous (AA) is the sense of belonging or a "home." AA offers this supportive environment without producing overdependence because members are expected to contribute, as well as receive, support.

Ensure Continuity of Care

Continuity of treatment flows from a recovery perspective and is a guiding principle in its own right. Continuity of treatment implies that COD services are constant. Treatment continuity for clients with CODs begins with proper, thorough

identification, assessment, and diagnosis. Per a review by McCallum et al. (2015), continuity of care for people with CODs means providing:

- Care that is regular and consistent over time.
- Care that is continually adjusted to the client's needs.
- Continuity in the counselor–client relationship, such as through ongoing and reliable contact.
- Continuity across services via case management, coordination of care, and linkage to resources.
- Continuity in the transfer of care, including maintaining contact (as appropriate) even after handoff.

On a program level (Padwa, Larkins, Crevecoeur-MacPhail, & Grella, 2013), continuity of care for clients with CODs can include having structures, procedures, and training in place that enables providers to:

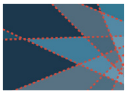
- Assess and monitor mental disorder and SUD symptoms.
- Develop discharge planning that continually supports clients through community resources (e.g., peer recovery support services, mutual support).
- Ensure medication needs are met (e.g., medication checks are scheduled, prescription refill procedures are in place) for people on pharmacotherapy.

More discussion of how counselors can ensure continuity of care for clients with CODs across different treatment settings can be found in Chapters 2 and 7.

Address Common Clinical Challenges

Ease Discomfort and Reluctance

Providers' ease in working toward a therapeutic alliance is affected by their comfort level in working with clients who have CODs. SUD counselors may find some clients with SMI or severe SUDs to be threatening or unsettling. This discomfort may result from lack of experience, training, or mentoring. Likewise, some mental health clinicians may feel uncomfortable or intimidated by clients with SUDs. Providers need to recognize certain



ADVICE TO THE COUNSELOR: MITIGATING RELAPSE BY MANAGING THE RECOVERY ENVIRONMENT

To guide clients through recovery and ensure delivery of comprehensive, recovery-oriented care, counselors must help clients establish and maintain a supportive recovery environment. This environment is more than where clients live; it compasses clients' entire physical, emotional, social, educational, and vocational world.

Understanding limitations in clients' recovery environments is critical to helping them prevent relapse and problem solve barriers. Environmental obstacles and lack of support can sabotage clients' recovery efforts and can be difficult to overcome without assistance from a mental health or addiction professional.

Counselors can help clients with CODs create a life conducive to recovery by assessing areas of functioning and symptoms and offering services relevant to the American Society of Addiction Medicine's Patient Placement Criteria, Third Revision, Domain 6 (Mee-Lee et al., 2013). This means working with clients to identify and explore:

- The client's current living situation, including the physical living space, the people who co-occupy their home, and the surrounding community (e.g., Is it safe? Is it disruptive to recovery? Does the client live in an area where illicit substances are easily accessible?).
- The client's available supports for all biopsychosocial needs, whether related to illness or broader areas of living, like social life, work, and relationships. For instance, does the client have reliable transportation? What about child care? Does the client have people in his or her life to rely on for tangible and emotional support? Is the client able to maintain primary care and behavioral health appointments?
- Threats to support in the client's life, such as friends or loved ones who actively misuse substances or family members who are unsupportive of SUD treatment?
- Whether the client engages in peer support, 12-Step support, or other mutual-support programs.
- Educational or occupational matters that facilitate or hinder recovery. For instance, is the client employed? Does his or her supervisor know that the client is in recovery (and supportive of this)? Is the client working to complete his or her degree, and does the client value degree completion as a recovery goal?
- Whether the client is engaged in meaningful activities with family, friends, partners, coworkers, classmates, or peers. Also, does the client have hobbies or otherwise regularly engage in pleasant activities?
- Whether the client is involved in the criminal justice system, child welfare system, or both.
- Whether the client needs financial assistance (e.g., applying for Social Security Disability Insurance).

patterns that invite these feelings and not let them interfere with clients' treatment. Providers who find it challenging to form a therapeutic alliance with clients who have CODs should consider whether their difficulty is related to:

- The client's difficulties.
- A limitation in their own experience and skills.
- Demographic differences between themselves and their clients in areas such as age, gender,

education, socioeconomic status, race, or ethnicity.

- Countertransference (see the section "Manage Countertransference").

A consultation with a supervisor or peer to discuss this issue is important. Often these reactions can be overcome with further experience, training, supervision, and mentoring.

Individuals with CODs may also feel challenged

in forming a therapeutic relationship with their treatment providers. They often experience demoralization and despair, given the complexity of having multiple behavioral health concerns and the difficulty of achieving treatment success. Inspiring hope often is a necessary precursor that allows clients to give up short-term relief for long-term work, even when there is some uncertainty in timeframe and benefit.

Manage Countertransference

Providers should understand difficulties related to countertransference and be familiar with strategies to manage it. Although the concept of **countertransference** is somewhat dated and infrequently used in the COD literature, it can help providers understand how their past experiences can influence current attitudes toward certain clients. **Transference** describes the process whereby clients project attitudes, feelings, reactions, and images from the past onto their providers. For example, the client may regard the provider as an “authoritative father,” “know-it-all older brother,” or “interfering mother.”

Countertransference is now understood to be a normal part of providers’ treatment experience. Particularly when working with clients who have

multiple, complicated problems, providers are as vulnerable as clients to feelings of pessimism, despair, and anger, as well as desires to abandon treatment. Less experienced providers may find it harder to identify countertransference, access feelings evoked by interactions with clients, name those feelings, and keep feelings from interfering with the counseling relationship.

SUDs and mental disorders are stigmatized by the general public. Stigma can also be present among providers. Mental health clinicians who usually do not treat people with SUDs may not have worked out their own responses to substance misuse, which can influence their interactions with these clients. Providers working with clients who have SMI may have more negative beliefs about and express more negative attitudes toward clients with SMI than those without such diagnoses (Smith, Mittal, Chekuri, Han, & Sullivan, 2017; Stone et al., 2019). Providers who treat clients with SMI can benefit from working with supervisors to uncover and correct underlying harmful thoughts and attitudes.

Similarly, SUD treatment providers may be unaware of their own reactions to people with specific mental disorders and may have difficulty preventing these reactions from influencing treatment. Their negative attitudes or beliefs may be communicated, directly or subtly, to the client—for example, through thoughts like, “I was depressed too, but I never took medications for it—I just worked the Steps and got over it. So why should this guy need medication?”

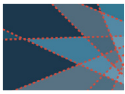
Negative feelings generated by countertransference can worsen over time. Some research indicates that providers treating clients with CODs may feel less satisfied with their jobs and increasingly frustrated with their clients the longer they stay in practice (Avery et al., 2016).

Providers’ negative attitudes toward clients with CODs can have a significant impact on treatment services and outcomes. For example, countertransference may result in providers failing to offer timely, appropriate treatment and having poor communication with their clients (Avery et al., 2016). (For a full discussion of countertransference in SUD treatment, see Powell & Brodsky, 2004.) Countertransference

ADVICE TO THE COUNSELOR: MANAGING COUNTERTRANSFERENCE

The consensus panel recommends this approach to manage countertransference with clients who have CODs:

- Be aware of strong personal reactions and biases toward clients.
- Get further supervision when countertransference is suspected and may be interfering with counseling.
- Receive formal and periodic clinical supervision; counselors should have opportunities to discuss countertransference with their supervisors and with other staff at clinical team meetings.



Providers have a duty to be aware of federal rules under the Health Insurance Portability and Accountability Act and any additional regulations in their states dictating what information they can and cannot share with other providers (as well as caregivers and family members) and under which circumstances.

problems are particularly significant when working with people who have CODs, because people with **SUDs and mental disorders may evoke strong feelings in providers that could become barriers to treatment if providers allow such feelings to interfere.** Providers may feel angry, used, overwhelmed, confused, anxious, uncertain how to proceed with a case, or just worn out.

Cultural concerns may cause strong yet unspoken feelings, creating countertransference and transference. Counselors working with clients in their area of expertise may be familiar with countertransference, but working with an unfamiliar population will introduce different kinds and combinations of feelings.

Protect Confidentiality

Confidentiality and privacy are relevant to every clinical situation and are especially important for clients with SMI, SUDs, or both. These conditions can be complex and debilitating, and they are associated with an increased risk of harm to self and others. Furthermore, people receiving SUD treatment in federally funded programs are protected by additional regulations that affect information sharing, privacy, and consent. More information about these regulations is available online (www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs).

However, confidentiality is not absolute. **Contexts in which to be mindful of protections related to client privacy and confidentiality—and the limitations of those protections—include:**

- **When collaborating with other providers, especially those outside of the behavioral health field.** All clients have a right to privacy and confidentiality. There are federal as well

RESOURCE ALERT: FEDERAL AND STATE MENTAL HEALTH PRIVACY AND CONFIDENTIALITY REGULATIONS

Mental health regulations regarding privacy, confidentiality, and information sharing (including duty to warn laws) vary by state. Counselors can stay up-to-date on regulations in the state(s) in which they practice by accessing information and resources available online:

- SAMHSA's *Directory of Single State Agencies for Substance Abuse Services* (<https://www.samhsa.gov/sites/default/files/single-state-agencies-directory-08232019.pdf>)
- National Conference of State Legislatures' Mental Health Professionals Duty to Warn (www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx)

General resources about the protection of mental health clients' and SUD treatment clients' rights include:

- Department of Health and Human Services' Mental Health Information Privacy FAQs (www.hhs.gov/hipaa/for-professionals/faq/mental-health/index.html)
- SAMHSA's Laws and Regulations (www.samhsa.gov/about-us/who-we-are/laws-regulations)
- SAMHSA's Substance Abuse Confidentiality Regulations FAQs (www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs)

as state regulations that dictate the type of information providers can share with other providers while upholding those rights for their clients. Remember that counselors who practice in more than one location must follow the regulations in each of the states in which they see clients. (See "Resource Alert: Federal and State Mental Health Privacy and Confidentiality Regulations.")

- **When working in a setting with electronic health records (EHRs).** The proliferation of EHRs has helped foster easier record sharing between mental health and general medical clinicians but also poses a risk to confidentiality that, if breached, could seriously damage client trust in the counselor and in the psychotherapy process in general (Shenoy & Appel, 2017).
- **When working with clients who verbalize specific threats of harm to a third party.** If the counselor has reason to believe a violent act is foreseeable and is directed at a specific person, breach of confidentiality may be appropriate or even required by the state's duty to warn mandate. Counselors should seek consultation, as needed and as appropriate given the volatility of the situation. If employed by an agency, follow required treatment facility policies/procedures as well.
- **When treating clients with trauma/PTSD.** Trauma survivors may be mistrustful and concerned about privacy, posing barriers to treatment (Kantor, Knefel, & Lueger-Schuster, 2017). Trauma in the context of ongoing intimate partner violence, child maltreatment, sexual assault, or elder abuse raises ethical and legal concerns about breaching confidentiality under duty to warn laws.
- **When working with clients ages 18 and under, including students.** Discussion of pediatric and adolescent mental disorders and substance misuse is beyond the scope of this TIP. Information on laws affecting mental health clinicians and addiction counselors is available via American Academy of Pediatrics' Confidentiality Laws Tip Sheet (www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Confidentiality_Laws.pdf) and in the resource alert about federal and state privacy and confidentiality regulations.

Providers must understand how to involve family members, when appropriate, without jeopardizing client privacy and confidentiality. Families often want to be involved in the care of a loved one with CODs—especially if the individual has a history of nonadherence to medication and other treatment and does not have other support

systems in place. Sometimes, family members or caregivers must be involved because the client lacks capacity to make independent healthcare decisions.

Recommended practices for involving families (Rowe, 2012) in a client's COD treatment include:

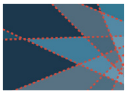
- Involving family members in planning and implementing treatments to the extent possible (after discussing their involvement with the client and obtaining his or her written consent).
- Conveying the same respect and empathy toward family members as toward clients to build rapport.
- Developing a contract that spells out what type of information families will and will not receive and what role they can play in their loved one's treatment.

Monitor Psychiatric Symptoms

Joint Treatment Planning

When SUD counselors work with clients who have CODs, especially those who need medications or are receiving mental health services separately from SUD treatment, it is especially important that they participate in developing client treatment plans and monitoring clients' psychiatric symptoms. The SUD counselor should, at minimum, be knowledgeable of the overall treatment plan to permit reinforcement of the plan's mental health aspects as well as aspects specific to recovery from SUDs. It is equally important for clients to participate in developing their COD treatment plans.

For example, for a client with bipolar disorder and alcohol use disorder (AUD) who is receiving treatment at both an SUD treatment agency and a local mental health center, the treatment plan might include individual SUD treatment counseling, medication management, and group therapy. In another example, for a client taking lithium, the SUD treatment provider may assist in medication monitoring by asking such questions as, "How are your meds helping you? Are you remembering to take them? Are you having any problems with them? Do you need to check in with the prescribing doctor?"



Psychiatric Medications

Providers should ask clients with CODs to bring in all medications to counseling sessions. Providers can then ask clients in what manner, when, and how they are taking medications. They can also ask whether clients feel that the medication is helping them, and how. Doing so presents an opportunity for providers and their clients to review and discuss attitudes toward medication and clients' typical patterns in taking medication. Some clients may not disclose that they have discontinued their medications, but when asked to bring in their medications, they may bring medication bottles that are completely full. **Providers should help educate clients about the effects of medication, teach clients to monitor themselves (if possible), and consult with clients' physicians whenever appropriate.**

ADVICE TO THE COUNSELOR: MONITORING PSYCHIATRIC SYMPTOMS

The consensus panel recommends these approaches to monitoring psychiatric symptoms in clients with CODs:

- Obtain a mental status examination to evaluate clients' overall mental health and danger profile. Ask about clients' symptoms and use of medication and look for signs of mental disorders regularly.
- Keep track of changes in symptoms.
- Ask clients directly and regularly about the extent of their depression and associated suicidal thoughts.

Status of Psychiatric Symptoms

SUD counselors should monitor changes in severity and number of psychiatric symptoms over time. For example, most clients present for SUD treatment with anxiety or depressive symptoms. Such symptoms are substance induced (see Chapter 4) if they occur within 30 days of intoxication or withdrawal.

Substance-induced symptoms tend to follow the principle of "what goes up, must come down," and vice versa. Clients who have just ended a binge on stimulants will seem tired and depressed (clients using methamphetamines may present with psychotic symptoms that require medication). Conversely, those who recently stopped taking depressants (e.g., alcohol, opioids) will likely seem agitated and anxious. These substance-induced symptoms result from substance withdrawal and usually persist for days or weeks. Substance-related depression may follow (which can be seen as a neurotransmitter depletion state) and may begin to improve within a few weeks. If depressive or other symptoms persist, then a co-occurring (additional) mental disorder is likely, and a differential diagnostic process should ensue. Such symptoms may be appropriate targets for establishing a diagnosis or determining treatment choices.

SUD treatment providers can use various tools to help monitor psychiatric symptoms. Some tools consist only of questions and require no formal instrument. For example, to gauge the status of depression quickly, providers can ask a client: "On a scale of 0 to 10, with 0 being your best day and 10 your worst, how depressed are you?" This simple scale, used from session to session, can provide much useful information. SUD treatment providers should also monitor adherence to prescribed medication by asking clients regularly for information about their use of these medications and their effects.

To identify changes, providers should track psychiatric symptoms clients mention at the outset of treatment from week to week. For example, one may ask, "Last week you mentioned low appetite, sleeplessness, and feeling hopeless—are these symptoms better or worse now?" Providers should also ascertain whether clients follow their suggestions to alleviate symptoms, and if so, with what result.

Chapter 3 and Appendix C also address screening and assessment tools for mental disorders and SUDs.

Potential for Harm to Self or Others

According to the Centers for Disease Control and Prevention (2018), 46 percent of people who die by suicide have a known mental health issue; 28 percent have problematic substance

use. Individuals with CODs are at increased risk of self-harm (e.g., cutting, suicide attempt) or harm to others compared with people who do not have CODs (Carra et al., 2014; Haviland, Banta, Sonne, & Przekop, 2016; Tiet & Schutte, 2012).

Providers should always ask explicitly about suicide or the intention to harm someone else when client assessment indicates that either is an issue. For clients who mention or seem to be experiencing depression or sadness, explore the extent to which suicidal thinking is present. (To learn about duty to warn laws in each state, see “Resource Alert: Federal and State Mental Health Privacy and Confidentiality Regulations” in the previous section of this chapter.)

Follow-up services for clients who screen positive for suicide risk or have tried to commit suicide or other self-injurious behaviors may effectively prevent future harmful behaviors (including completed suicides), but more research in this area is needed (Brown & Green, 2014). Follow-up services can include:

- Conducting a full suicide risk assessment (see Chapter 3).
- Contacting the client (e.g., sending letters or postcards) to express care and concern.
- Scheduling follow-up appointments in person or by phone to discuss the treatment plan.
- Making home visits (as appropriate).
- Administering follow-up psychiatric and suicide risk assessments throughout the course of care.

Chapter 4 covers general approaches to preventing suicide and managing clients who have tried to commit suicide or are at risk for self-harm. Instructions on screening for risk of harm to self or others appear in Chapter 3 and Appendix C.

Use Supportive and Empathic Counseling

A supportive and empathic counseling style is one of the keys to establishing an effective therapeutic alliance with clients who have CODs. According to Lockwood, empathy is “the ability to vicariously experience and to understand the affect of other people”; it is the foundation adults use for relating to and interacting with other adults (Lockwood, 2016, p. 256).

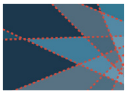
ADVICE TO THE COUNSELOR: USING AN EMPATHIC STYLE

Empathy is a key skill for the SUD counselor, without which little could be accomplished. Bell (2018, p. 111) notes that “it is the job of counselor educators and supervisors to instill and nourish the trait of empathy, while building skills that relay empathy to the client.” An empathic style is one that:

- Involves taking the client’s perspective and trying to see life from his or her worldview.
- Tries to connect with clients who are difficult or are engaging in behaviors the counselor disagrees with or cannot otherwise relate to (e.g., misusing substances, breaking the law).
- Is mindful, compassionate, and warm rather than judgmental and accusatory.
- Is focused on listening to—rather than talking at—the client.
- Includes nonverbal communication (e.g., open body positioning, direct eye contact, nodding along).
- Conveys reflective listening via techniques like repetition and parroting, using verbal cues like “I see” or “Tell me more about that,” and paraphrasing content and feelings (“So, you’re saying that he left, and then you decided to go to the bar. Do I have that right?” or “I hear that you were extremely angry about that”).
- Demonstrates comfort by expressing sympathy, consolation, and reflexive reassurance (i.e., phrasing designed to alleviate anxiety and worry without promising a certain outcome—such as saying, “Just give it your best shot, and let’s see how things play out” instead of saying, “Everything will be just fine”).

See also Treatment Improvement Protocol (TIP) 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* (SAMHSA, 2019c).

Sources: Bell (2018); Kelley & Kelley (2013).



In empathic counseling, providers model behaviors that can help clients build more productive relationships. Providers' empathy helps clients begin to recognize and own their feelings, which is an essential step toward managing them. In learning to recognize and manage their own feelings, clients will also learn to empathize with the feelings of others.

Empathic counseling must be consistent over time to keep the alliance intact, especially for clients with CODs. Clients with CODs often have lower motivation to address mental illness or substance misuse, find it harder to understand and relate to others, and need strong support and understanding to make major lifestyle changes such as adopting abstinence. Support and empathy from providers can help maintain the therapeutic alliance, increase client motivation, and assist with medication adherence.

Confrontation and Empathy

Historically, addiction research defined confrontation as an aggressive, argumentative communication tactic to pressure people who misused substances into treatment. Confrontation has more recently come to be seen as a supportive, honest approach to warning or advising at-risk individuals about harmful behaviors (Polcin, Galloway, Bond, Korcha, & Greenfield, 2010; Polcin, Mulia, & Laura, 2012).

SUD treatment providers often feel tension between offering clients empathic support and addressing clients' potential minimization, evasion, dishonesty, and denial. However, providers can be empathic and firm at once. Straightforward, factual presentation of conflicting material or problematic behavior in an inquisitive, caring manner can be confrontational yet supportive. **Achieving a balance of empathy and firmness is critical for providers to maintain therapeutic alliances with clients who have CODs.**

Structure and Support

Clients with CODs benefit from a careful balance of structured versus free time. Free time is both a trigger for substance use cravings and a negative influence for many individuals with mental disorders. Thus, management of free time is of

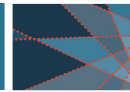
particular concern for clients with CODs. Clients with CODs need strategies to better manage their free time, such as by structuring one's day to include meaningful activities and to avoid activities that are risky. Providers can help clients plan their free time (especially weekends) to introduce new pleasurable activities that may alleviate symptoms and offer satisfaction through means other than substance use. Other activities that can help structure clients' time are working on vocational and relationship matters in treatment.

In addition to structure, clients' daily activities need to have opportunities for receiving support and encouragement. Counselors should work with clients to create a healthy support system of friends, family, and activities.

Mutual support is a key tool providers can introduce to clients with CODs. Dual recovery mutual supports are increasingly available in most large communities. Providers play an important role in helping clients with CODs access and benefit from such resources. (Chapter 7 has more information on mutual-support approaches for people with CODs.) If groups for clients who do not speak English are unavailable locally, providers can seek resources in nearby communities or, if the number of clients in need warrants, organize a group for those who speak the same non-English language.

A provider can assist a client with CODs in accessing mutual support by:

- **Helping the client locate an appropriate group.** The provider should be aware of available local mutual-support programs and dual recovery mutual-support groups, especially those that are friendly to clients with CODs, have other members with CODs, or are designed specifically for people with CODs. The provider can gain awareness by visiting groups to see how they are conducted, discussing groups with colleagues, updating personal lists of groups periodically, and gathering information from clients. The provider should ensure that the group selected is a good fit for the client in terms of its members' ages, genders, and cultural characteristics. Some communities offer alternatives to



CASE STUDY: HELPING A CLIENT FIND A SPONSOR

Linda, a 24-year-old woman, had attended her mutual-support group for about 3 months. Although she knew she should ask someone to sponsor her, she was shy and afraid of rejection. She had identified a few women who might be good sponsors, but each week in counseling, she stated that she was afraid to reach out. No one had approached her about sponsorship either, although the group members seemed “friendly enough.” The counselor suggested that Linda share, in the next group meeting, that she’d like a sponsor but has been feeling shy and hadn’t wanted to be rejected. The counselor and Linda role-played this act of sharing during a counseling session. The counselor reminded Linda that it was okay to feel afraid and reassured her that, if she couldn’t share at the next meeting, they would talk about what had stopped her.

After the next meeting, Linda related that she almost shared but got scared at the last minute. She felt bad that she had missed an opportunity. She and the counselor talked about getting it over with, and Linda resolved to reach out, starting her sharing statement with, “It’s hard for me to talk in public, but I want to work this program, so I’m telling you all that I know it’s time to get a sponsor.” This counseling work helped Linda convey her need to the group. The response from group members was helpful to Linda, as several women offered to meet with her and talk about sponsorship. This experience also helped Linda become more attached to the group and learn a new skill for seeking help. Although Linda was helped through counseling strategies alone, others who are anxious in social settings may need medications in addition to counseling.

mutual-support groups, such as Secular Organizations for Sobriety.

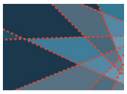
- **Helping the client prepare to participate appropriately in the group.** Some clients, particularly those with SMI or anxiety about group participation, benefit when providers offer an explanation of the group process in advance. The provider should inform the client of the structure of a meeting, expectations of sharing, and how to participate. The client may need to rehearse the kinds of things that are and are not appropriate to share at such meetings. The provider should also teach the client how to politely decline to participate and when this would be appropriate. The counselor should be familiar enough with group function and dynamics to walk the client through the meeting process before attending.
- **Helping overcome barriers to group participation.** The provider should be aware of the genuine difficulties the client may have in connecting with a group. Although clients with CODs, like any clients, may have some ambivalence about change, they also may have legitimate barriers they cannot remove on their own. For example, a client with cognitive difficulties may need help working out how he or she can physically get to the meeting. The provider may need to write down detailed

instructions for this client that another would not need (e.g., “Catch the number 9 bus on the other side of the street from the treatment center, get off at Main Street, and walk 3 blocks to the left to the white church. Walk in at the basement entrance and go to Room 5.”)

- **Debriefing the client after he or she has attended a mutual-support group to help process reactions and prepare for future attendance.** The provider’s work does not end with referral to a mutual-support group. The provider must be prepared to help the client overcome any obstacles after attending the first group to ensure engagement. Often, this involves a discussion of the client’s reaction to the group and a clarification of how he or she can participate in future groups.

Use Culturally Appropriate Methods

Research is lacking on the ethnic/racial diversity of populations with CODs. Limited published studies suggest that **although CODs are more frequently observed among Whites, non-White Americans also experience CODs.** A report (Mericle, Ta Park, Holck, & Arria, 2012) estimated lifetime prevalence of CODs at 5.8 percent among Latinos, 5.4 percent among African Americans, and 2.1 percent among Asians. Whites, by comparison, had a lifetime prevalence of 8.2 percent.



Notable gaps exist in the rates of behavioral health service access, utilization, and completion among diverse racial and ethnic groups compared with Whites (Cook, Trinh, Li, Hou, & Progovac, 2017; Holden et al., 2014; Maura & Weisman de Mamani, 2017; Nam, Matejkowski, & Lee, 2017; Saloner & Le Cook, 2013; Sanchez, Ybarra, Chapa, & Martinez, 2016). This is attributable to multiple factors such as underassessment, underdiagnosis, and underreferral (Priester et al., 2016) as well as cultural barriers like language differences, fear of stigma, and shame (Holden et al., 2014; Keen, Whitehead, Clifford, Rose, & Latimer, 2014; Masson et al., 2013; Maura & Weisman de Mamani, 2017; Pinedo, Zemore, & Rogers, 2018). Culturally responsive care and cultural competence training among behavioral health staff are needed to help break down barriers to service access and improve treatment outcomes for diverse populations with CODs.

Understanding Clients' Cultural Backgrounds

Population shifts are resulting in increasing numbers of diverse racial and ethnic groups in the United States (Colby & Ortman, 2014). Each geographic area has its own cultural mix. **To provide effective COD treatment to people of various cultural groups, providers should learn as much as possible about characteristics of their clients' cultural groups.**

Of particular importance are culturally based conventions of social interaction, styles of interpersonal communication, concepts of healing, views of mental illness, and perceptions of substance use. For example, some cultures may tend to somaticize symptoms of mental disorders, and clients from such groups may expect treatment providers to offer relief for physical complaints. These clients may be offended by too many probing, personal questions early in treatment and never return.

Similarly, COD treatment providers need to understand culturally based concepts of and expectations surrounding families. Providers should learn each client's role in the family and its cultural significance (e.g., expectations of the oldest son, a daughter's responsibilities to her parents, the role of a grandmother as matriarch).

Providers should not make assumptions about clients based on their perception of the clients' culture. An individual client's level of acculturation and specific experiences may result in that person identifying with the dominant culture or other cultures. For example, a person from India adopted by African American parents at an early age may know little about the cultural practices in his birth country. A provider working with this client would need to acknowledge the birth country and explore the client's associations with it as well as what those associations might mean. The client's country of origin may have little influence on his cultural beliefs or practices.

Chapter 6 of this TIP further discusses culture-related topics in COD treatment, including how counselors can reduce racial/ethnic disparities and use culturally adapted services. For more information about cultural competence in general behavioral health services, see TIP 59, *Improving Cultural Competence* (SAMHSA, 2014a), which is available free of charge online (<https://store.samhsa.gov/system/files/sma14-4849.pdf>).

Using Motivational Enhancement Consistent With Clients' Specific Stage of Change

Motivational interviewing (MI) is a **client-centered approach that enhances clients' internal motivation to change by exploring and resolving ambivalence** (Miller & Rollnick, 2013). MI involves accepting a client's level of motivation, whatever it is, as the only possible starting point for change. For example, if a client says she has no interest in changing the amount or frequency of her drinking, but is interested in complying with an SUD assessment to be eligible for something else (such as the right to return to work or a housing voucher), the SUD treatment provider would avoid arguing with or confronting her. Instead, the provider would focus on establishing a positive rapport with the client—even remarking on the positive aspects of the client's desire to return to work or take care of herself by obtaining housing. The provider would work with available openings to probe the areas in which the client does have motivation to change in hopes of eventually affecting the client's drinking or drug use.

For an indepth discussion of MI and how to apply its principles to stages of change in clients with SUD, see TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* (SAMHSA, 2019c).

Guiding Processes of MI

Four overlapping processes guide the practice of MI (Miller & Rollnick, 2013).

1. **Engaging:** The counselor uses strategies to establish rapport and help build a trustful relationship with the client. Techniques include asking open- rather than close-ended questions, using reflective listening, summarizing statements from the client, and determining his or her readiness to change.
2. **Focusing:** The counselor helps direct the conversation and process as a whole through agenda setting and identifying a target behavior of change.
3. **Evoking:** The counselor helps clients express their motivations or reasons for change. Use of change talk (expressing a desire to change) is core to this process and helps clients recognize how their substance use is affecting their lives. It helps clients recognize and respond to sustain talk (expressing a desire not to change), which creates ambivalence and should be minimized. Use of open-ended questions and reflective listening by the counselor will facilitate this process.
4. **Planning:** The counselor collaborates with the client to develop a plan for change. The plan is critical for putting ideas about and reasons for change into action. The counselor works with clients to identify a specific change goal (like reducing the number of drinks per day), explore possible strategies that will lead to the change, create steps to make the change, and problem-solve possible obstacles to achieving lasting behavior change.

The details of these strategies and techniques are presented in TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* (SAMHSA, 2019c) and in Miller and Rollnick's manual, *Motivational Interviewing: Helping People Change* (2013).

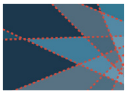
Matching Motivational Strategies to Clients' Stage of Change

The motivational strategies providers use should be consistent with their clients' stage of change (i.e., precontemplation, contemplation, preparation, action, maintenance, termination). A client with CODs could be at one stage of recovery or change for his or her mental disorder and another for his or her SUD, which can complicate selection of strategies. Furthermore, a client may be at one stage of change for one substance and another stage of change for another substance. For example, a client who has combined alcohol and cocaine use disorders with co-occurring panic disorder may be in the contemplation stage (i.e., aware that a problem exists and considering overcoming it, but not committed to taking action) in regard to alcohol use, precontemplation (i.e., unaware that a problem exists, with no intention of changing behavior) in regard to cocaine use, and action (i.e., actively modifying behavior, experiences, or environment to overcome the problem) for the panic disorder.

Evaluating clients' motivational state is an ongoing process. Court mandates, rules for clients engaged in group therapy, the treatment agency's operating restrictions, and other factors may act as barriers to implementing specific MI strategies in particular situations.

MI and CODs

MI has been shown to be effective or efficacious in improving behavior change—such as treatment engagement, attendance, and resistance—as well as enhancing motivation and confidence in people with mental or substance misuse problems, including comorbid conditions (Baker, Thornton, Hiles, Hides, & Lubman, 2012; Keeley et al., 2016; Laakso, 2012; Romano & Peters, 2015). MI also appears to be effective in helping clients with SUD reduce substance misuse and associated behaviors and consequences (DiClemente, Corno, Graydon, Wiprovnick, & Knoblach, 2017). For instance, a review of studies on COD interventions for people involved in the criminal justice system found MI helpful in reducing self-reported substance misuse (Perry et al., 2015). In a sample of people with PTSD seeking SUD treatment (Coffey et al., 2016), trauma-focused motivational enhancement therapy was associated



with significantly greater reductions in PTSD symptoms versus a control condition (12 sessions of healthy lifestyle education). At 6 months after treatment, just 6 percent of participants in the motivational enhancement therapy group had a positive urine drug screen for at least one illicit substance, compared with almost 13 percent in the healthy lifestyle control group.

Motivational strategies may be helpful with people who have SMI, but more research is needed. A 3-week MI intervention yielded improvements in medication adherence, self-efficacy, and motivation to change among clients receiving outpatient treatment for bipolar disorder (McKenzie & Chang, 2015). Results concerning MI and improved adherence to pharmacotherapy for clients with schizophrenia are generally negative, but some research suggests that MI reduces psychotic symptoms and hospitalization rates (Vanderwaal, 2015). A meta-analysis of MI plus cognitive-behavioral therapy (CBT) as an adjunct to or replacement for treatment as usual for co-occurring AUD and depression (Riper et al., 2014) found small but positive effects in decreasing alcohol consumption and improving depressive symptoms.

Although more research is warranted, it appears that MI strategies may be applied successfully to the treatment of clients with CODs, especially in:

- Assessing clients' perceptions of their problems.
- Exploring clients' understanding of their disorders.
- Examining clients' desire for continued treatment.
- Ensuring client attendance at initial sessions.
- Expanding clients' willingness to take responsibility for change.

Teaching Relapse Prevention Techniques

SAMHSA (2011) considers relapse prevention a critical component of integrated programming for effective COD treatment. The long-term course of comorbid mental illness and addiction is often marked by (sometimes multiple) instances of relapse and remission (Luciano, Bryan, et al., 2014; Xie, Drake, McHugo, Xie, & Mohandas, 2010). Per the National Institute on Drug Abuse (NIDA), relapse is "a return to drug use after an attempt to stop" (NIDA, 2018c). Others define relapse as "a setback that occurs during the behavior change

In relapse prevention, providers recognize that lapses (single episodes or brief returns to substance use) are an expected part of overcoming SUDs. Lapses do not signal failure or loss of all treatment progress.

process, such that progress toward the initiation or maintenance of a behavior change goal (e.g., abstinence from drug use) is interrupted by a reversion to the target behavior" (Hendershot, Witkiewitz, George, & Marlatt, 2011, p. 2).

A variety of SUD relapse prevention models are described in the literature (Hendershot et al., 2011; Melemis, 2015). However, **all relapse prevention approaches include anticipating problems likely to arise in maintaining change, acknowledging them as high-risk situations for resumed substance use, and helping clients develop strategies to cope with those situations without having a lapse.**

To prevent relapse, providers and clients must understand the types of triggers and cues that precede it. These warning signs precede exposure to events, environments, or internal processes (high-risk situations) where or when resumed substance use is likely. A lapse may occur in response to these high-risk situations unless the client is able to implement effective coping strategies quickly and adequately.

For clients with CODs who require medication to manage disruptive or disorganizing mental disorder symptoms, providers must address lapses in medication regimen adherence. In these cases, a "lapse" is defined as not taking prescribed medication. This type of lapse is different from lapses that involve returns to substance misuse for self-medication or pleasure seeking.

Counseling for relapse prevention can occur individually or in small groups, and may include practice or role-play to help clients learn how to cope effectively with high-risk situations. Relapse prevention approaches have many common elements (Daley & Marlatt, 1992) that highlight the need for clients to:

1. Have a range of cognitive and behavioral coping strategies to handle high-risk situations and relapse warning signs.

2. Make lifestyle changes that decrease the need for alcohol, drugs, or tobacco.
3. Increase healthy activities.
4. Be prepared to interrupt lapses so that they do not end in full-blown relapse.
5. Resume or continue to practice relapse prevention skills even when a full-blown relapse does occur by renewing their commitment to abstinence rather than giving up the goal of living a drug-free life.

NIDA (2018) includes relapse prevention therapy (RPT) in its list of effective SUD treatment approaches. RPT helps people maintain health behavior changes by teaching them to anticipate and cope with relapse. RPT strategies fall into five categories (Marlatt, 1985):

- **Assessment procedures** help clients appreciate the nature of their problems in objective terms, to measure motivation for change, and to identify risk factors that increase the probability of relapse.
- **Insight/awareness-raising techniques** help clients adjust their beliefs about the behavior change process (e.g., viewing it as a learning process). Via self-monitoring, RPT also helps clients identify patterns of emotion, thought, and behavior related to SUDs and co-occurring mental disorders.
- **Coping-skills training** strategies teach clients behavioral and cognitive strategies to avoid relapse.
- **Cognitive strategies** help clients manage urges and craving, identify early warning signals of relapse, and reframe reactions to an initial lapse.
- **Lifestyle modifications** (e.g., meditation, exercise) strengthen clients' overall coping capacity.

The goal of RPT is to teach clients to recognize increasing relapse risk and to intervene at earlier points in the relapse process. Thus, RPT fosters client progress toward maintaining abstinence and living a life in which lapses occur less often and are less severe. RPT frames a lapse as a "fork in the road," or a crisis. Each lapse has elements of danger (progression to full-blown relapse) and opportunity (reduced relapse risk in the future because of the lessons learned from debriefing the lapse).

RPT encourages clients to create a balanced lifestyle that will help them manage their CODs more effectively and fulfill their needs without using substances to cope with life's demands and opportunities. In delivering RPT, providers can:

- Explore with clients the positive and negative consequences of continued substance use ("decisional balance," as discussed in the motivational interviewing section of this chapter).
- Help clients recognize high-risk situations for returning to substance use.
- Teach clients skills to avoid high-risk situations or cope effectively with them.
- Develop a relapse emergency plan for damage control to limit lapse duration/severity.
- Support clients in learning how to identify and cope with substance-related urges and cravings.

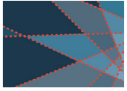
Empirical Evidence Supporting Use of RPT in COD Treatment

Much of the empirical literature on RPT addresses its application in SUD treatment. In this context, RPT has demonstrated strong and consistent efficacy versus no treatment and similar efficacy to other active treatments on outcomes like reduced relapse risk and severity, increased treatment gains, and greater use of treatment matching (Bowen et al., 2014; Hendershot et al., 2011). **Research also supports RPT for enhancing substance use outcomes among people with CODs.**

In treating people with bipolar disorder and AUD (Farren, Hill, & Weiss, 2012), integrated group therapy focused on relapse prevention strategies was associated with greater abstinence, fewer days of substance misuse, and fewer days of alcohol use to intoxication than controls/treatment as usual. RPT with prolonged exposure therapy is linked to marked improvement in client- and provider-reported SUD and PTSD symptom severity and past-week substance use (Ruglass et al., 2017).

RPT Adaptations for Clients With CODs

RPT adaptations for clients with CODs should address their full range of symptoms and circumstances. Adapted RPT should support adherence to treatment (including medication



adherence—particularly critical for people with psychotic or bipolar disorders), improve social functioning, and help clients meet basic living needs (e.g., finding housing, gaining stable employment). The aspects of RPT most useful for improving recovery from CODs (Subodh, Sharma, & Shah, 2018; Weiss & Connery, 2011) include:

- Encouraging abstinence.
- Promoting adherence to mood-stabilizing medication.
- Supporting habits associated with stable mood, like good sleep hygiene.
- Promoting recovery by teaching clients strategies for:
 - Avoiding, recognizing, and responding to high-risk situations that are likely to exacerbate substance- or mood-related symptoms and problems.
 - Using substance-refusal skills.
- Addressing multiple areas of functioning, including interpersonal functioning.
- Using family-focused interventions, especially for clients who have demonstrated difficulty with adhering to treatment/medication or who have problems with cognition or insight.
- Facilitating engagement in mutual-support groups.

In a small qualitative analysis of men with CODs (Luciano, Bryan, et al., 2014), client-reported relapse prevention strategies deemed helpful for maintaining at least 1 year of sobriety included:

- Building a supportive community, including peers in treatment.
- Establishing a meaningful daily routine (e.g., going to work, attending school, exercising).
- Adopting a healthy mindset that helped individuals stay mindful of cravings and other symptoms, develop insight about the relationship between substance use and mental illness, and maintain a sense of responsibility (to themselves and to others) to live a life of recovery.

RPT-based SUD interventions with integrated components to address PTSD are supported by a growing number of studies, reflecting the field's recognition that trauma commonly co-occurs with addiction (Swopes, Davis, & Scholl, 2017; Vrana, Killeen, Brant, Mastrogiovanni, & Baker, 2017; Vujanovic, Smith, Green, Lane, & Schmitz, 2018). In just one example of trauma-informed RPT adaptations to address CODs, Vallejo and Amaro (2009) adapted a mindfulness-based stress reduction program for relapse prevention among women with SUDs and trauma/PTSD to better address trauma sensitivity and risk of relapse. Modifications included:

- Centrally focusing on stress management as a key skill in preventing relapse.
- Using shorter and more structured sessions.
- Altering body scan activities during mindfulness exercises to reduce anxiety and promote feelings of safety (e.g., having participants perform body scans with eyes open rather than

ADVICE TO THE COUNSELOR: USING RELAPSE PREVENTION METHODS IN COD TREATMENT

The consensus panel recommends using the following relapse prevention methods with clients who have CODs:

- Provide relapse prevention education on both mental disorders and SUDs and their interrelations.
- Teach clients skills to resist pressure to stop psychotropic medication and to increase medication adherence.
- Encourage attendance at dual recovery groups and teach social skills necessary for participation.
- Use daily inventory to monitor psychiatric symptoms and symptom changes.

If relapse occurs, use it as a learning experience to investigate triggers with the client. Reframe the relapse as an opportunity for self-knowledge and a step toward ultimate success.

closed; avoiding a detailed focus on scanning parts of the body that could be triggering or retraumatizing, like the pelvic area).

- Using a more flexible curriculum that emphasized early identification of warning signs of relapse.
- Having counselors available to work with clients on uncomfortable feelings that arose in sessions.
- PTSD-related adaptations may be particularly important when providing RPT for women, in whom trauma-related symptoms have been shown to predict returns to substance use (Heffner, Blom, & Anthenelli, 2011).

Integrated Treatment

RPT and other CBT approaches to mental health counseling and SUD treatment allow providers to treat CODs in an integrated way by:

1. Conducting a detailed functional analysis of the relationships between substance use, mental disorder symptoms, and any reported criminal conduct.
2. Evaluating unique and common high-risk factors for each problem and gauging how they interrelate.
3. Assessing cognitive and behavioral coping skills deficits.
4. Implementing cognitive and behavioral coping skills training tailored to the specific needs of each client with respect to substance use, symptoms of mental disorder, and criminal conduct.

Chapter 7 further discusses integrated treatments and their outcomes for clients with CODs.

Use Repetition and Skill Building To Address Deficits in Functioning

In applying the approaches described previously, **providers should keep in mind that clients with CODs often have cognitive limitations, including difficulty concentrating.** Sometimes, these limitations are transient and improve during the first several weeks of treatment. Other times, symptoms persist for long periods. In some cases, individuals with specific disorders (e.g., schizophrenia, attention deficit hyperactivity disorder) may manifest these symptoms as part of their disorder.

General treatment strategies to address cognitive limitations in clients with CODs include:

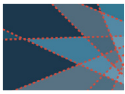
- Being more concrete and less abstract in communicating ideas.
- Using simpler concepts.
- Having briefer discussions.
- Repeating core concepts many times.
- Presenting information in multiple formats (verbally; visually; affectively through stories, music, and experiential activities).
- Using role-playing to practice real-life situations with clients who have cognitive limitations (e.g., having a client practice “asking for help” by phone using a prepared script individually with the counselor, or in a group to obtain feedback from the members).

Compared with individuals who have no additional disorders or disabilities, people with CODs and additional deficits require more SUD treatment to attain and maintain abstinence.

Abstinence requires clients to develop and use a set of SUD recovery skills. Clients with co-occurring mental disorders face additional challenges that require learning yet more diverse skills. They also may require more support that provides treatment in smaller steps with more practice, rehearsal, and repetition. **The challenge is not to provide more intensive or complicated treatment for clients**

CASE STUDY: USING REPETITION AND SKILL BUILDING WITH A CLIENT WHO HAS CODs

In individual counseling sessions with Susan, a 34-year-old White woman with bipolar disorder and AUD, the counselor observes that she frequently forgets details of her recent past, including discussions and decisions made in recent counseling sessions. Conclusions the counselor thought were clear in one session seem fuzzy by the next. The counselor adjusts course, starting sessions with a brief review of the last session. The counselor allows time at the end of each session for a review. Susan has difficulty remembering appointment times and other responsibilities, so the counselor also helps her devise a system of reminders.



with CODs, but rather to tailor the skill acquisition process to the needs and abilities of each client.

Guidance for Working With Clients Who Have Specific Co-Occurring Mental Disorders

Clients with certain mental disorders may have specific treatment needs and do best with particular counseling approaches tailored to their diagnosis and levels of functioning. This is especially true for mental disorders known to be highly disabling, distressing, longstanding, or difficult to treat—such as depression, anxiety, PTSD, and SMI. These mental disorders are also the most likely to co-occur with substance misuse. This section of Chapter 5 offers guidance for SUD treatment, mental health service, and other providers on how best to deliver SUD treatment and build rapport with clients who have these disorders. Chapter 4 covers diagnosis and management of the specific mental disorders discussed.

MDD

Depression commonly co-occurs with SUDs (Lai et al., 2015), and each can exacerbate the other. To optimize treatment outcomes, counselors working with clients who have an SUD and MDD should:

- **Use integrated CBT treatment approaches.** Review studies and meta-analyses confirm CBT's effectiveness in improving symptoms and decreasing substance misuse among people with depression and SUDs, particularly when integrated with additional treatment strategies such as RPT or MI (Baker et al., 2012; Riper et al., 2014; Vujanovic et al., 2017). CBT treatment elements most helpful for clients with depression and SUDs include (Vujanovic et al., 2017):
 - Functional analysis of situations in which substance use is likely to occur and of situations associated with depressive symptoms.
 - Cognitive training to identify and reframe maladaptive thoughts associated with increased substance use as well as with negative mood.
 - Behavioral skills to address craving, coping with stressful situations, and improving mood.
- **Incorporate behavioral activation (BA) techniques into CBT treatment.** BA techniques are often used in CBT to help clients improve their mood by reengaging in pleasant and rewarding behaviors. BA supports clients in identifying rewarding activities and goals, barriers to engaging in those activities (e.g., avoidance triggers), and solutions for reducing avoidance. Research on BA for depression and SUDs is still growing, but early evidence suggests that CBT with BA is feasible and efficacious in reducing negative mood, increasing activation of pleasant behaviors, and improving treatment retention (Daughters, Magidson, Lejuez, & Chen, 2016; Martínez-Vispo, Martínez, López-Durán, Fernández del Río, & Becoña, 2018; Vujanovic et al., 2017).
- **Remain vigilant for double depression.** Not all clients with depression and SUDs will meet criteria for MDD, but they may still have distressing, impairing depressive symptoms that would benefit from treatment. Counselors need to look for clients with “double depression,” or the occurrence of persistent depressive disorder and intermittent major depressive episodes. In a sample of clients seeking SUD treatment, 14 percent had double depression (Diaz, Horton, & Weiner, 2012) and reported higher levels of alcohol dependence and lower quality of life than participants with dysthymia only or MDD only.
- **Perform (or give referrals for) medication evaluations.** Antidepressants can be highly effective in treating MDD, but not all clients will need medication. Evaluation by a psychiatrist can help determine whether pharmacotherapy is warranted.
- **Be mindful of the unclear temporal relationship between depression and substance misuse, as this can affect treatment planning.** Providers may be tempted to assume that a client is misusing substances to self-medicate for depression or that a client's depression is substance induced. But the relationship between substance misuse and depression is multifactorial, with more research needed to clarify those factors. Although the

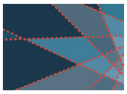
self-medication hypothesis has some support, several factors affect the temporal-causal relationship between depression and substance misuse, like sociocultural factors (e.g., income-to-poverty ratio) and demographics (Lo, Cheng, & de la Rosa, 2015). Counselors should not make treatment decisions based on assumptions that alleviating depressive symptoms will reduce substance misuse or vice versa. CODs tend to be intertwined in complex ways and often require multiple trials of various approaches to treatment.

Anxiety Disorders

Despite high rates of elevated anxiety among SUD populations, research on the complex relationship between substance misuse and anxiety is still developing. The emerging picture suggests that anxiety can be a risk for substance misuse (such as through avoidance coping or self-medication) and that substance use, craving, and withdrawal can lead to increases in anxiety.

Counselors treating clients for anxiety disorders and SUDs should be mindful that:

- **Anxiety needs to be assessed early in treatment.** Anxiety is related to more severe substance dependence and is associated with higher rates of treatment dropout and posttreatment relapse (McHugh, 2015; Smith & Randall, 2012; Vorspan, Mehtelli, Dupuy, Bloch, & Lépine, 2015). Identifying clients with elevated anxiety early in SUD treatment could help providers better address risks for premature treatment termination or posttreatment relapse. Screening for elevated anxiety early in treatment can also identify clients who may require additional skills to help them manage elevated distress related to stopping or decreasing their substance use (e.g., distress associated with withdrawal, worsening of anxiety symptoms previously self-managed with drugs or alcohol).
- **The type of anxiety disorder can affect treatment engagement, participation, and retention.** For instance, individuals with elevated social anxiety may be reluctant to speak during group treatment or to share their social worries with their counselors for fear of being judged or ridiculed. This can impede their ability to participate in and benefit from group or even individual SUD treatments. Counselors should discuss with anxious clients their reasons for treatment noncompliance when relevant. Sometimes, anxious clients have difficulty adhering to treatment because of their symptoms or anxiety-related avoidance, not because of low motivation.
- **Anxiety symptoms can mimic or occur as a part of withdrawal from substances:**
 - Anxiety is a commonly reported withdrawal symptom (Craske & Stein, 2016). When clients reduce or stop using substances, their anxiety may increase as a result of withdrawal.
 - Anxiety sensitivity (fear of anxiety-related sensations) is related to premature treatment termination (Belleau et al., 2017), in part because clients with this sensitivity face additional difficulty tolerating physical symptoms of withdrawal. People may misinterpret physical symptoms of withdrawal (e.g., increased heart rate, sweating, sleep problems, irritability) as signs of a medical problem. Anxiety symptoms and anxiety sensitivity can also evolve into full-blown anxiety disorders if left untreated, making clients vulnerable for returns to substance use.
- **Integrated treatments are highly recommended:**
 - Given the worse outcomes associated with treating anxiety and SUDs in isolation, clients may benefit from an integrated approach. Given the bidirectional relationship between the two conditions, addressing both simultaneously in integrated counseling can mitigate relapse and provide a holistic approach to treatment.
 - Effective techniques include psychoeducation about the nature of anxiety (e.g., the relationship between thoughts, feelings, and behaviors; normalizing anxiety), CBT (including anxiety monitoring, thought restructuring, clarifying cognitive distortions, exposure therapy, and relaxation training), medication, motivational enhancement, mindfulness, and encouraging a healthy lifestyle (e.g., good sleep hygiene, engaging in physical activity).



PTSD

People with PTSD or histories of trauma are susceptible to substance misuse, often as a coping mechanism. People with both PTSD and SUDs tend to have worse clinical symptoms than people with either disorder alone, including a higher risk of suicide (SAMHSA, 2014b). Providers whose clients have PTSD and SUDs can improve treatment success if they:

- **Treat disorders concurrently.** Integrated, concurrent treatments are effective; clients may prefer them over sequential treatment (Banerjee & Spry, 2017; Flanagan et al., 2016; SAMHSA, 2014b). Additionally, some symptoms of PTSD may worsen during abstinence. Do not make the mistake of thinking that treating the SUD will necessarily alleviate the PTSD. Both must be treated jointly. In some instances, medication for PTSD may also be needed.
- **Help clients increase their feelings of safety at the outset of treatment** through techniques such as grounding exercises, establishing routines in treatment, discussing safety-promoting behaviors, and developing a safety plan to help the client feel confident, prepared, and in control (SAMHSA, 2014b).
- **Take steps to help prevent retraumatization of clients.** This includes being sensitive to clients' triggers (e.g., allowing a client to sit facing the door instead of with his or her back to it), sensitively addressing clients acting out in response to triggering events, listening for cues that cause reactions and behaviors, and teaching clients to identify and manage trauma-related triggers (SAMHSA, 2014b).
- **Adjust the pace, timing, and length of sessions to the needs of clients.** Do not rush clients into talking about their trauma, and stay alert for signs of clients feeling overwhelmed by the intensity or speed of the intervention (SAMHSA, 2014b). Creating safety and enhancing coping skills to manage traumatic stress reactions are key aspects of helping clients heal from trauma.
- **Recognize the cyclical relationship between trauma and substance use.** Using substances places people at greater risk for additional traumatic events. These traumas increase risks of substance misuse. Counselors need to

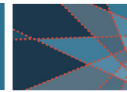
educate clients about this to help safeguard them from harm.

Chapter 4 provides more information about trauma-informed care for people with CODs.

SMI

People with SMI and SUDs often have complex recovery trajectories with drastic shifts in symptoms and functioning, employment, housing, family life, social relationships, and physical health. Counselors working with clients who have SMI and SUDs should be aware that:

- **Although integrated treatments work for many clients with SMI and SUDs, this approach has different levels of success.** Integrated treatment for SMI and SUDs has demonstrated mixed results in the empirical literature (Chow et al., 2013; Hunt, Siegfried, Morley, Sitharthan, & Cleary, 2013). It may help improve psychiatric symptoms better than nonintegrated treatment in outpatient and residential settings and may be better at reducing alcohol consumption, but not drug use, in residential settings compared with outpatient settings. However, some studies have found no significant effects of integrated versus nonintegrated treatments. For some clients with SMI and SUDs, parallel treatment may be preferable and should not be ruled out as an option after first trying to treat concurrently.
- **Many SMI symptoms, like psychosis, apathy, and cognitive dysfunction, can undermine treatment participation and adherence.** Treatment should address (Horsfall, Cleary, Hunt, & Walter, 2009):
 - Managing positive and negative symptoms of psychosis.
 - Increasing coping skills.
 - Improving social skills, including communication with others.
 - Enhancing problem-solving abilities.
 - Building distress tolerance.
 - Increasing motivation.
 - Learning how to set and achieve goals.
 - Expanding social support networks (including peer supports).



Given these potential cognitive, social, and functional challenges, counselors may need to use sessions that are shorter, more flexible, adapted to client impairments, and lower in intensity.

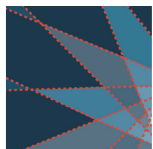
- **SMI often requires medication for symptom stabilization.** Counselors should consider referring clients not currently on medication or not being followed by a psychiatrist for a medication evaluation, especially for clients who are unstable or experiencing positive psychiatric symptoms (e.g., hallucinations, delusions).
- **Clients may need assistance with basic living needs.** Securing reliable housing and gainful employment are often among the greatest stressors people with SMI experience (Horsfall et al., 2009). Vocational rehabilitation and housing assistance should be provided as a part of comprehensive COD care to help increase the chances of long-term recovery. Certain clients may also need help from counselors in connecting with the criminal justice system.
- **Encouraging abstinence may indirectly help improve psychiatric symptoms.** Stopping substance use can give clients a sense of accomplishment and self-efficacy that can fuel their confidence in being able to recover from their mental illness as well (Green, Yarborough, et al., 2015).

Conclusion

Therapeutic alliance is a critical component of counseling essential to clients' success and long-term recovery. People with CODs often face numerous difficulties in managing complex and fluctuating symptoms as well as the effects of symptoms on everyday living, including their ability to function as a productive and healthy member of society, hold down a job, maintain housing, and have fulfilling relationships. Experiences of stigma and feelings of hopelessness can contribute to clients' mistrust or low motivation to initiate, engage in, and complete treatment.

Providers working with people who have CODs should be aware of basic approaches that can support the therapeutic relationship and make interventions more effective. Although there is no one-size-fits-all approach for treating CODs, the techniques, skills, and interventions described in this chapter should help counselors contribute to the recovery process in a way that is evidence based, person centered, and maximally beneficial to clients.

This page intentionally left blank.



Chapter 6—Co-Occurring Disorders Among Special Populations

KEY MESSAGES

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

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

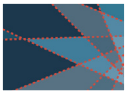
and is intended for counselors, other treatment/service providers, supervisors, and administrators. It describes unique aspects of CODs among specific populations and offers recommendations to SUD treatment providers, other behavioral health service providers, program supervisors/administrators, and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

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

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

MILITARY PERSONNEL

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



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

People Experiencing Homelessness

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

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

Homelessness, Mental Health, and Substance Misuse

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

Further statistics paint a similar picture:

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

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

The Importance of Housing

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

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

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

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

Service Models for People With CODs Who Are Experiencing Homelessness

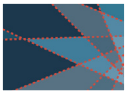
To address substance misuse, mental illness, or both in clients who lack housing, providers can choose among several service models, including:

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

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

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

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



Supportive Housing Model

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

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

Housing First

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

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

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

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

RESOURCE ALERT: IMPLEMENTING SUPPORTIVE HOUSING PROGRAMS

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

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

Pathways to Housing

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

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

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

Linear Housing Model

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

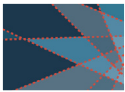
approach to produce less favorable housing retention outcomes than supportive housing (Kertesz et al., 2009; Polcin, 2016). **Linear models often require completion of an SUD treatment program (typically residential treatment) in addition to abstinence before housing is provided, yet SUD treatment completion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

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

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

THE ROLE OF RECOVERY HOUSING FOR PEOPLE WITH CODs

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



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

Integrated Housing and Treatment Models

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

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

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

The consensus panel recommends that providers:

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

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

People Involved in the Criminal Justice System

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

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

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

Rationale for Treatment

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

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

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

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

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

Treatment Features, Approaches, and Empirical Evidence

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

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

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

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

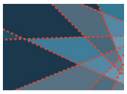
IDDT treatments can be adapted for incarcerated populations to address criminal thinking and reduce risk of recidivism.

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

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

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

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



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

Evidence in Support of Postrelease Treatment and Follow-Up

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

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

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

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

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

Women

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

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

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

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

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

Substance Misuse and Mental Illness in Women

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

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

Treatment Approaches for Women

SUD treatment

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

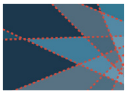
Program (<https://idph.iowa.gov/substance-abuse/programs/ppw>), funded through a SAMHSA grant, reported a 76-percent treatment completion rate and 90.5-percent abstinence rate from drugs and alcohol at 5 to 8 months after admission (Jones & Arndt, 2017).

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

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

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

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



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

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

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

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

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

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

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

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

COD Treatment

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

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

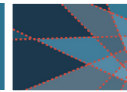


EXHIBIT 6.1. Adapting Treatment Services to Women's Needs

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

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

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

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

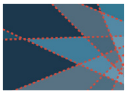
Women receiving treatment for SUDs or CODs often benefit from trauma-informed approaches. Trauma is present in an overwhelming majority of women with CODs (SAMHSA, 2015c), regardless of their age. Most women have a history of at least one adverse childhood experience, often abuse (Choi et al., 2017).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

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

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

Pregnancy and CODs

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



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

Topics To Address With Co-Occurring Mental Illness

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

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

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

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

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

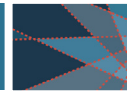
When women are parenting, it can often retrigger their own childhood traumas. Therefore, providers need to balance growth and healing with coping and safety. Focusing on women's desire to be good mothers, the sensitive counselor will be alert to guilt, shame, denial, and resistance related to dealing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

Pharmacological Considerations

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

Postpartum Depression and Psychosis

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



PREGNANCY AND MAT FOR OUD

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

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

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

Source: SAMHSA (2018c).

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

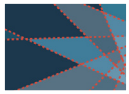
PPD prevalence estimates vary, given differences in timeframes researchers use to define the postpartum period. According to DSM-5 (APA, 2013), 3 percent to 6 percent of women will experience a major depressive episode either during pregnancy or in the weeks and months following childbirth. In a sample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

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

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

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

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



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

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

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

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

PPD and Substance Misuse

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

Women, Trauma, and Violence

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

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

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

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

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

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

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

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

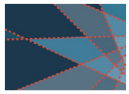
People of Diverse Racial/Ethnic Backgrounds

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

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

Cultural Perceptions of Substance Misuse, Mental Disorders, and Healing

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



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

Cultural Perceptions and Diagnosis

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

Treatment Access and Utilization

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

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

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

RACIAL/ETHNIC DISPARITIES AND SMI

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

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

Source: Maura & Weisman de Mamani (2017).

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

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

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

Reducing Racial/Ethnic Disparities

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

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

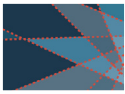
- Using bilingual case managers.
- Maintaining a diverse workforce.
- Ensuring staff are trained in culturally responsive care.
- Using multilingual mutual-support programs.
- Using patient navigators to help clients access community resources and overcome logistical barriers (e.g., keeping appointments).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

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

Cultural Differences and Treatment: Empirical Evidence on Effectiveness

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

- Culturally tailored psychosocial interventions increase treatment engagement and



ADVICE TO THE COUNSELOR: USING CULTURALLY APPROPRIATE METHODS

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

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

Source: Healey et al. (2017).

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

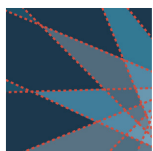
- Cultural competence training for staff is associated with improved communication, more accurate diagnosis, a positive therapeutic alliance, and greater client satisfaction.
- Providing treatment in a client's native language or dialect can lead to better treatment outcomes and may be more influential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

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

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

Conclusion

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



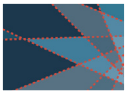
Chapter 7—Treatment Models and Settings for People With Co-Occurring Disorders

KEY MESSAGES

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

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

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



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

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

Treatment Overview

Treatment Programs

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

An SUD treatment program offers an organized array of services and interventions focused on treating SUDs, providing both stabilization and ongoing treatment. SUD treatment programs more advanced in treating people with CODs may offer a variety of interventions for mental

disorders (e.g., symptom management training, psychopharmacology,) in the context of the ongoing SUD treatment.

Program Types

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

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

Levels of Service

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

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

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

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

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

Treatment Matching to Levels of Service Using the Quadrants of Care

Effective treatment matching is an essential component of quality care for people with CODs that benefits the healthcare system as a whole. Treatment matching not only ensures clients receive the appropriate type and dose of service

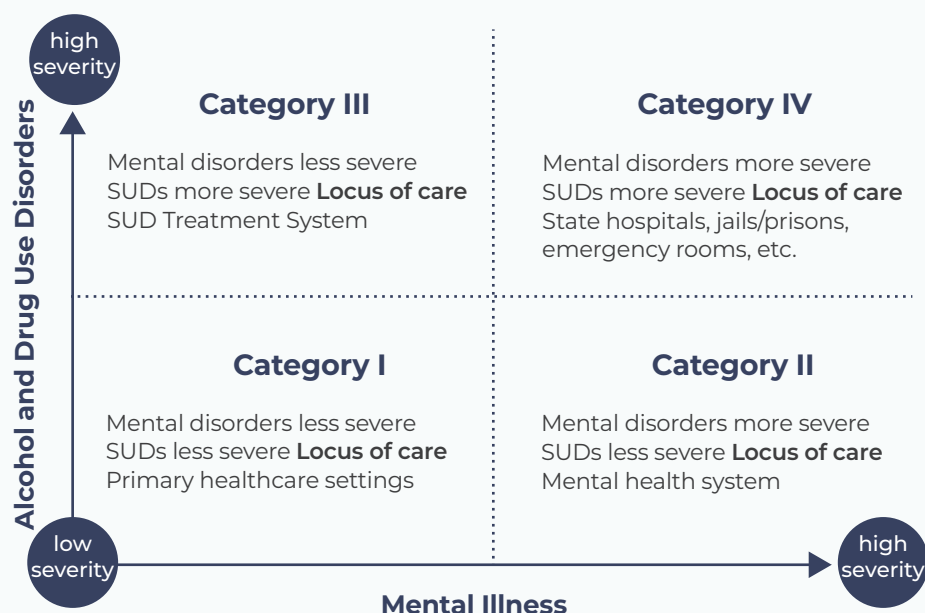
needed, it can help reduce unnecessary lengths of stay for residential treatment and helps reserve use of costly healthcare resources for those who truly require complex interventions. The widely used Four Quadrant Model (Ries, 1993; Exhibit 7.1) provides a framework for treatment decision making and prioritizing service needs for clients with CODs based on symptom/disorder severity. It has good concurrent and predictive validity (McDonnell et al., 2012).

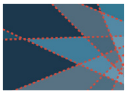
Under this conceptualization, clients are categorized accordingly:

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

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

EXHIBIT 7.1. The Four Quadrants of Care





Episodes of Treatment

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

Integrated Versus Nonintegrated Treatment

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

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

Integrated treatments for people with CODs have demonstrated superiority to nonintegrated approaches and help improve substance use, mental illness symptoms, treatment retention,

cost effectiveness, and client satisfaction (Kelly & Daley, 2013; Morisano et al., 2014). For an indepth discussion, see the section “Integrated Care” later in this chapter.

Culturally Responsive Treatment

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

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

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

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

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

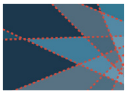
Barriers to Treatment

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

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

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

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



RESOURCE ALERT: FINDING QUALITY TREATMENT FOR SUBSTANCE USE DISORDERS

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

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

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

- Organizational "red tape" leading to delays in care and lack of service provision.

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

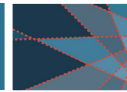
Treatment Models

Integrated Care

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

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

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



INTEGRATED CARE: PARTNERSHIPS FOR PHARMACOTHERAPY

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

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

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

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

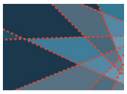
For more guidance about medication treatments for CODs, see the section "Pharmacotherapy" at the end of this chapter. Also see the text box "Knowing When To Refer for Medication Management" within that section.

Empirical Evidence of Integrated Care for CODs

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

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

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



RESOURCE ALERT: IMPLEMENTING INTEGRATED CARE FOR PEOPLE WITH CODs

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

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

Assertive Community Treatment

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

Program Model

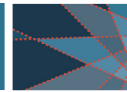
ACT programs typically use intensive outreach activities, active and continued engagement with clients, and a high intensity of services. Multidisciplinary teams, including specialists in key areas of treatment, provide a range of services to clients. Members typically include mental health and SUD treatment counselors, case managers, nursing staff, and psychiatric consultants. The ACT team provides the client with practical assistance in life management as well as direct treatment, often within the client's home environment, and remains responsible and available 24 hours a day (SAMHSA, 2008). The team has the capacity to intensify services as needed and may make several visits

each week (or even per day) to a client. Caseloads are kept smaller than other community-based treatment models to accommodate the intensity of service provision (a 1:10 staff-to-client ratio is typical).

ACT Activities and Interventions

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

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



NINE ESSENTIAL FEATURES OF ACT

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

Source: Bond & Drake (2015).

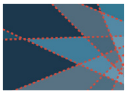
- Crisis assessment and intervention. This is provided during extended service hours (24 hours a day, ideally through a system of on-call rotation).

Key Modifications for Integrating COD Treatment

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

housing needs, criminal justice-related needs). Key elements in this evolution have been (Neumiller et al., 2009):

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



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

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

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

Populations Served

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

Empirical Evidence for ACT

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

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

RESOURCE ALERT: IMPLEMENTING ACT FOR PEOPLE WITH CODs

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

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

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

Examples of ACT Programs

The University of Washington Program for ACT

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

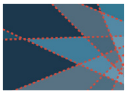
RESOURCE ALERT: UNIVERSITY OF WASHINGTON PACT IMPLEMENTATION AND ENGAGEMENT TOOLS

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

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

Mercy Maricopa ACT Program

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



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

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

Integrated Case Management

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

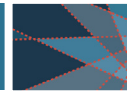
ICM is not a precisely defined term but rather is used in the literature to describe an alternative to both traditional case management and ACT. The goals of the ICM model are to engage individuals in a trusting relationship, assist in meeting their basic needs (e.g., housing), and help them access

and use brokered services in the community. The fundamental element of ICM is a low caseload per case manager, which translates into more intensive and consistent services for each client. TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT], 2000b), contains more information on the history of case management, both how it has developed to meet the needs of clients in SUD treatment (including clients with CODs) and specific guidelines about how to implement case management services.

Program Model

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

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



ADVICE TO ADMINISTRATORS: TREATMENT PRINCIPLES FROM ICM

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

Treatment Activities and Interventions

Examples of ICM activities and interventions include:

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

Key Modifications of ICM for CODs

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

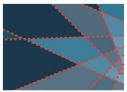
- Using direct interventions for clients with CODs, such as enhancing motivation for treatment and discussing the interactive effects of mental disorders and SUDs.
- Making referrals to providers of integrated SUD treatment and mental health services or, if integrated services are not available or accessible,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

Empirical Evidence

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

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

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



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

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

Malte, Cox, and Saxon (2017) also examined veterans receiving ICM but with a focus on promoting housing stability and addiction recovery. Almost 60 percent of program participants had a comorbid depressive disorder, 43 percent PTSD, 31 percent an anxiety disorder, 21 percent a psychotic disorder, and 19 percent a bipolar disorder. Over time, participants increased their percentage of days spent in their own home or in transitional housing; decreased days spent homeless or living with others; increased rates of 30-day abstinence; and improved their Addiction Severity Index (ASI) scores (legal, drug, and psychiatric composite scales). However, none of these improvements

were significantly different from those observed in the control condition (a housing support group). Nevertheless, the addiction/housing ICM program was associated with more days spent in SUD treatment (almost 53 days longer than controls), greater treatment participation, and higher treatment satisfaction.

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

Examples of ICM Programs

SAMHSA's Cooperative Agreement to Benefit Homeless Individuals

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

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

The program includes:

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

Pathways to Housing, Inc.’s HF Programs

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

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

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

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

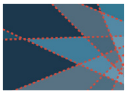
Comparison of ACT and ICM

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

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

Differences Between ACT and ICM

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



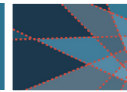
The ACT multidisciplinary team shares responsibility for the entire defined caseload of clients and meets frequently (ideally, teams meet daily) to ensure that all members are fully up-to-date on clinical matters. Although team members may play different roles, all are familiar with every client on the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

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

Recommendations for Extending ACT and ICM in SUD Treatment Settings

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

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



VOCATIONAL SERVICES AND TREATMENT MODELS

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

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

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

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

Dual Recovery Mutual-Support Programs

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

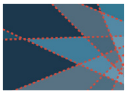
In the past decade, mutual-support approaches have emerged for people with CODs. Mutual-support programs apply a broad spectrum of personal responsibility and peer support principles, usually including 12-Step programs. These programs are gaining recognition as more meetings are being held in both agency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

In recent years, dual recovery mutual-support organizations have emerged as a source of support for people in recovery from CODs (Bogenschutz

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

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

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



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

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

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

Dual Recovery Mutual-Support Approaches

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

Mutual-Support Groups

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

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

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

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

Dual recovery mutual-support program fellowships do not provide specific clinical or counseling interventions, classes on psychiatric symptoms, or any services similar to case management. Dual recovery fellowships maintain a primary purpose of members helping one another achieve and maintain dual recovery, prevent relapse, and carry the message of recovery to others who experience dual

disorders. Dual recovery mutual-support program members who take turns chairing their meetings are members of their fellowship as a whole. Anonymity of meeting attendees is preserved because group facilitators do not record the names of their fellow members or newcomers. Fellowship members carry out the primary purpose through the service work of their groups and meetings.

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

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

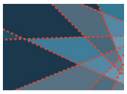
Outreach by fellowship members may provide information about their organization to agencies and institutions through inservice programs, workshops, or other types of presentations.

Access and Linkage

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

Referral to dual recovery fellowships is informal:

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



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

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

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

Common Features of Dual Recovery Mutual-Support Fellowships

Dual recovery fellowships tend to have the following in common:

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

Empirical Evidence

Empirical evidence suggests that participation in mutual-support programs contributes substantially

to members’ progress in dual recovery and should be encouraged. Specifically, studies have found the following positive outcomes:

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

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

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

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

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

Peer Recovery Support Services

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

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

- Rates of abstinence.
- Number of days abstinent.
- Relapse rates.
- Treatment engagement.
- Treatment retention.
- Residential treatment use.
- Rehospitalization.
- Adherence to treatment plan.
- Treatment completion.
- Treatment satisfaction.
- Relationships with treatment providers.
- Housing stability.
- Probation/parole status.
- Number of criminal justice charges.
- Recovery capital.

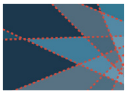
- Mental disorder symptoms.
- Knowledge about mental illness and SUDs.
- Family functioning, including parenting abilities.
- Access to social supports.

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

Treatment Settings

Therapeutic Communities

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



In a definitive book titled *The Therapeutic Community: Theory, Model, and Method*, De Leon (2000) provided a full description of the TC for SUD treatment to advance research and guide training, practice, and program development. Descriptions of TCs also appear in the National Institute on Drug Abuse (NIDA, 2015) Research Report titled *Therapeutic Communities* (https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/therapeuticcomm_rrs_0723.pdf).

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

Modified TCs for Clients With CODs

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

WHAT MAKES TCs WORK?

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

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

Treatment Activities/Interventions

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

EXHIBIT 7.2. TC Activities and Components

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

Source: NIDA (2015).

Key Modifications

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

- Staff led and staff guided throughout
- Three highly structured and often formalized phases:
 - Feedback on behavior from one participant to another
 - Opportunity for both participants to explain their position
 - Resolution between participants with plans for behavior change

- Substantially reduced emotional intensity; emphasis on instruction and learning of new behaviors
- Persuasive appeal for personal honesty, truthfulness in dealing with others, and responsible behavior to self and others

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

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

More recent adaptations also can include:

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

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

Role of the Family

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

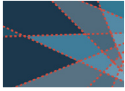
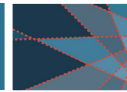


EXHIBIT 7.3. TC Modifications for People With CODs

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

Source: Sacks & Sacks (2011).



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

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

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

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

Empirical Evidence

A series of studies has established that:

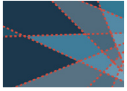
- MTCs affect a wide range of clinical and functional variables, including substance use, mental disorder symptoms, criminal behavior, employment, and housing (Sacks, McKendrick, Sacks, & Cleland, 2010). For instance, a review of TCs and MTCs (Magor-Blatch, Bhullar, Thomson, & Thorsteinsson, 2014) reported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

compared with traditional TCs (Magor-Blatch et al., 2014; Peters et al., 2017). MTCs also appear to reduce reincarceration better than parole supervision (Sacks, Chaple, Sacks, McKendrick, & Cleland, 2012).

- People with CODs and HIV receiving MTC continuing care had a greater decrease in SUD and mental illness symptoms at 6 months than people receiving standard continuing care (Sacks, McKendrick, Vazan, Sacks, & Cleland, 2011). Larger improvements were observed in MTC clients who had higher levels of psychosocial functioning and health at the start of treatment.
- MTCs can meet the various needs of pregnant and parenting women with SUDs—many of whom have co-occurring mental disorders, experiences with homelessness, criminal justice involvement, or a combination thereof. One such program (Bromberg, Backman, Krow, & Frankel, 2010) reduced recidivism, promoted long-term abstinence (about 90 percent of clients remained abstinent for 2 years after program completion), and facilitated drug-free births and healthy infant development.

Outpatient SUD Treatment

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



RESOURCE ALERT: HOW TO IMPLEMENT TC/MTC PROGRAMMING

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

- NIDA's *Therapeutic Communities Research Report* (https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/therapeuticcomm_rrs_0723.pdf)
- The Arkansas Department of Human Services' *Therapeutic Communities Certification Manual* (https://humanservices.arkansas.gov/images/uploads/dpsqa/DBHS_Therapeutic_Communities_Certification_-_FINAL.pdf)
- Missouri Department of Corrections and Maryville *Treatment Center's Therapeutic Community Program Handbook* (www.law.umich.edu/special/policyclearinghouse/Documents/MO%20-%20Maryville%20Treatment%20Center%20Therapeutic%20Community%20Program%20Handbook.pdf)
- National Institute of Justice's *Program Profile: Modified Therapeutic Community for Offenders With Mental Illness and Chemical Abuse Disorders* (www.crimesolutions.gov/ProgramDetails.aspx?ID=90)
- University of Delaware Center for Drug and Alcohol Studies. *Therapeutic Community Treatment Methodology: Treating Chemically Dependent Criminal Offenders in Corrections* (www.cdhs.udel.edu/content-sub-site/Documents/CDHS/CTC/Treating%20Chemically%20Dependent%20Criminal%20Offenders%20in%20Corrections.pdf)

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

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

Many individuals with CODs have multiple health and social problems that complicate their treatment. Evidence from prior studies indicates that a mental disorder often makes effective SUD treatment harder because of cognitive, psychosocial, and economic barriers that hinder

engagement and retention (Priester et al., 2016). Outpatient treatment programs are available widely and serve the most clients (Cohen et al., 2013; SAMHSA, 2019a), so using current best practices from the SUD treatment and mental health fields is vital. Doing so enables these programs to use the best available treatment models to reach the greatest possible number of people with CODs.

Prevalence

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

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

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

Empirical Evidence of Effectiveness

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

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

Outpatient treatment can also be leveraged as a form of continuing care, such as following discharge from hospitalization or release from jail/prison, to help clients maintain long-term recovery and wellness (Grella & Shi, 2011). Six-month outpatient ACT for men with SMI and

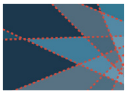
SUD (Noel, Woods, Routhier, & Drake, 2016) was effective in sustaining improvements clients experienced during the previous 6 months in residential treatment, including improvements in mental health, substance use, housing, education, employment, family functioning, spirituality, and sleep hygiene. Outpatient mental health services focused on supporting community reintegration following release from jail were associated with 12-month declines in number of arrests and number of days in jail among people with CODs and people with mental disorders only (Alarid & Rubin, 2018).

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

Designing Outpatient Programs for Clients With CODs

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

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

**RESOURCE ALERT: OUTPATIENT SUD TREATMENT**

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

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

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

Referral and Placement

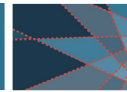
Careful assessment will help identify those clients who require more secure inpatient treatment settings (e.g., clients who are actively suicidal or homicidal), as well as those who require 24-hour medical monitoring, those who need detoxification, and those with serious SUDs who may require a period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

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

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

Engagement and Retention

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



IMPROVING ENGAGEMENT AND ADHERENCE OF CLIENTS WITH CODS IN OUTPATIENT SETTINGS

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

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

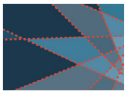
the ACT and ICM models provide techniques that enable clients to access services and foster the development of treatment relationships.

Discharge Planning

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

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

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



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

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

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

Residential SUD Treatment

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

Prevalence

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

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

Empirical Evidence of Effectiveness

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

Designing Residential Programs for Clients With CODs

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

Intake

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

1. **Written referral.** Referral information from other programs or services can include the client's psychiatric diagnosis, history, current level of mental functioning, medical status (including results of screening for tuberculosis, HIV, sexually transmitted disease, hepatitis), and assessment of functional level. Referrals also may include a psychosocial history and a physical examination.
2. **Intake interview.** An intake interview is conducted at the program site by a counselor or clinical team. At this time, the referral material is reviewed for accuracy and completeness, and each client is interviewed to determine if the referral is appropriate in terms of the history of mental and substance use problems. The client's residential and treatment history is reviewed to assess the adequacy of past treatment attempts. Furthermore, each client's motivation and readiness for change are assessed, and the client's willingness to accept the current placement as part of the recovery process is evaluated. Screening instruments, such as those described in Chapter 3 and located in Appendix C, can be used in conjunction with this intake interview.
3. **Program review.** Each client should receive a complete description of the program and a tour of the facility to ensure that both are acceptable. This review includes a description of the daily operation of the program in terms of groups, activities, and responsibilities; a tour of the physical site (including sleeping arrangements and communal areas); and an introduction to some of the clients who are already enrolled in the program.
4. **Team meeting.** At the end of the intake interview and program review, the team meets with the client to decide whether to proceed with admission to the program. The client's receptivity to the program is considered, and additional information (e.g., involvement with the justice system, suicide attempts) is obtained

as needed. It should be noted that the decision-making process is inclusive; that is, a program accepts referrals as long as the clients meet the eligibility criteria, are not currently a danger to self or others, do not refuse medication, express a readiness and motivation for treatment, and accept the placement and the program as part of their recovery process.

Engagement and Retention

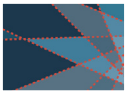
Clients with CODs need to be engaged in treatment so they can fully use available services. Successful engagement helps clients view the treatment program as an important resource. To accomplish this, the program must meet essential needs and ensure psychiatric stabilization. Residential treatment programs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

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

Discharge Planning

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

- Discharge planning begins upon entry into the program.



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

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

Acute Care and Other Medical Settings

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

opposed to specialty care settings. People going to EDs for treatment for mental disorders and SUDs is also on the rise.

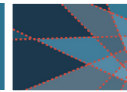
The integration of SUD treatment with primary medical care can be effective in reducing both medical problems and levels of substance use. Clients can be more readily engaged and retained in SUD treatment if that treatment is integrated with medical care than if clients are referred to a separate SUD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

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

RECOMMENDATIONS FOR CONTINUING CARE FOLLOWING DISCHARGE FROM RESIDENTIAL TREATMENT

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

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



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

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

Prevalence

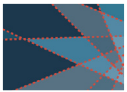
In 2018, 5 percent of SUD treatment facilities in the United States were hospital-based inpatient services (SAMHSA, 2019a). Specifically, 4 percent of facilities offered hospital-based treatment and 5 percent offered hospital-based detoxification. In 2018, 40 percent of general hospitals offered COD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

Empirical Evidence of Effectiveness

Over the past two decades, significant research has emerged in support of team-based, integrated behavioral health services in acute medical care settings (e.g., EDs, primary care clinics). Collaborative behavioral health service models are feasible and can be as effective as (and in some cases even more effective than) usual care in identifying and managing SMI, SUDs, or CODs (Chan, Huang, Bradley, & Unutzer, 2014; Chan, Huang, Sieu, & Unutzer, 2013; Kumar & Klein, 2013; Park, Cheng, Samet, Winter, & Saitz, 2015; Walley et al., 2015). Integrated, collaborative behavioral health services can improve mental

disorder symptoms (including remission and recovery), treatment adherence, treatment satisfaction, quality of life (mental and physical), medication adherence, and social functioning and are cost-effective and valued by clients (Epstein, Barry, Fiellin, & Busch, 2015; Goodrich, Kilbourne, Nord, & Bauer, 2013). Most of these studies are focused on mental health services, with comparatively fewer examining integrated SUD treatment, but research suggests addiction models also are feasible and can produce positive outcomes (Goodrich et al., 2013), including long-term abstinence (Savic, Best, Manning, & Lubman, 2017). Primary care-based SUD treatment may also help reduce length of inpatient stay and ED utilization while also increasing recovery coach contacts and use of addiction pharmacotherapy (i.e., buprenorphine and naltrexone) (Wakeman et al., 2019).

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



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

treatment and physical healthcare needs in one location (Barry et al., 2016).

Designing Acute Medical and Primary Care Programs for Clients With CODs

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

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

Screening and Assessment in Acute and Other Medical Settings

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

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

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

Source: Crowley & Kirschner (2015).

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

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

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

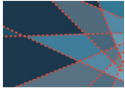
These data are worrisome, given feedback from the

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

Interventions

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

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



limits to confidentiality at intake and their consent documented.

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

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

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

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

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

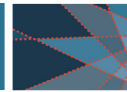


EXHIBIT 7.5. Redesigning Addiction Services for Integration With Primary Care: Questions for Addiction Providers and Administrators To Consider

Administrative Questions

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

Capacity/Resource Questions

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

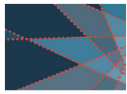
Financing Questions

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

Clinical Supports Questions

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

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



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

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

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

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

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

preventing overdose and substance use over time has yet to be borne out (Hawk & D'Onofrio, 2018).

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

Pharmacotherapy

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

Medication for Mental Illness

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

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

Medication Management

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

KNOWING WHEN TO REFER FOR MEDICATION MANAGEMENT

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

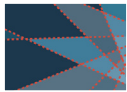
- Has not had success improving symptoms or functioning after trying multiple psychotherapies.
- Has had limited success improving symptoms or functioning with psychotherapy but is still experiencing symptoms that are distressing or interfere with the person's functioning.
- Wants to be abstinent but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

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

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

Considerations for the SUD Treatment Provider

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



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

Medication for Depression

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

Several classes of medications have been approved for treating depression (FDA, 2017), including selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), and monoamine oxidase inhibitors (MAOIs). Each works in different ways but ultimately treats depression by changing the balance of chemicals (neurotransmitters) in the brain that regulate mood, such as serotonin, norepinephrine, and dopamine. Sometimes medication not specifically approved for depression, such as mood stabilizers or 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, in a matter of hours. Its release represents the first time FDA has approved a new antidepressant since the medication Prozac entered the market in 1988.

Side Effects

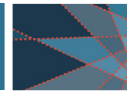
Common side effects when antidepressants are started or when the dose is increased are nausea, vomiting, and diarrhea (Exhibit 7.6). These usually improve in a few weeks. Side effects such as weight gain, sleep disturbances, and sexual dysfunction can be longer lasting. Some medication side effects may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

Medication for Anxiety Disorders

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

EXHIBIT 7.6. Side Effects of Antidepressants

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



A NOTE ABOUT SEROTONIN SYNDROME

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

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

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

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

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

Medication for PTSD

Medication combined with psychotherapy can be effective in relieving symptoms of PTSD (VA/DoD, 2017). The FDA has approved two SSRIs for the

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.

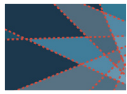
treatment of PTSD. Studies are also underway to explore the benefit of using certain antipsychotics in PTSD.

Medication for Bipolar Disorder

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

Mood Stabilizers

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



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

Antiseizure Medication

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

Antipsychotic Medication

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

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

Medication for Schizophrenia and Other Psychotic Disorders

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

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

Side Effects

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

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

Medication for Attention Deficit Hyperactivity Disorder

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

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

No specific guidelines exist on whether stimulants should be prescribed for co-occurring ADHD in people with SUDs. Available research is unclear as to whether stimulants are effective for ADHD in the presence of an SUD. Although efficacious in reducing ADHD symptoms, stimulant medications generally do not alleviate SUD symptoms (Cunill et al., 2015; De Crescenzo et al., 2017; Luo & Levin, 2017). Thus, ADHD medication alone, if used at all, is an insufficient treatment approach for ADHD-SUD (Crunelle et al., 2018; Zulauf et al., 2014). Stimulants do have misuse potential, but current evidence suggests that most people

with ADHD and SUD generally do not divert or misuse stimulant medication for ADHD (e.g., to experience euphoria) (Luo & Levin, 2017). However, diversion can and does occur in some people. Use of long-acting or extended-release medication or of antidepressants instead of stimulants can help reduce the chances of diversion and misuse.

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

Medication for PDs

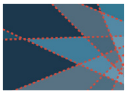
No medications are FDA approved to treat any PD. Antidepressants, mood stabilizers, antipsychotics, and antianxiety medications can be prescribed to target symptoms/improve function.

Medication for Feeding and Eating Disorders

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

Medication for SUDs

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



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

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

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

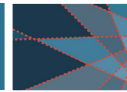
Medication is not a cure for addiction and is not right for everyone. But the science is clear: in certain instances (e.g., for OUD), pharmacotherapy can not only help improve lives, it can help save them as well.

Medication for AUD

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

Medication for OUD

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

**RESOURCE ALERT: LEARNING MORE ABOUT PHARMACOTHERAPY AND CODs**

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

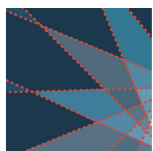
- SAMHSA's TIP 63, Medications for Opioid Use Disorder (<https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder>)
- SAMHSA's Medication for the Treatment of Alcohol Use Disorder: A Brief Guide (<https://store.samhsa.gov/system/files/sma15-4907.pdf>)
- APA's Practice Guideline for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

Conclusion

CODs are exceedingly common in both the SUD population and the mental illness population, and addiction counselors should expect to see both conditions in their work. A wide range of treatment approaches are available and can be adapted to the specific needs of people with CODs, including their symptoms as well as their stages of change and readiness to engage in services. Because the

disease course of SUDs and mental disorders is often unstable and unpredictable, counselors must be ready to offer COD-appropriate interventions across all settings, including nontraditional settings like jails and prisons. Continuous, integrated treatment modalities that link clients with resources and supports in the community give people with addiction the best chances at achieving lasting recovery.

This page intentionally left blank.



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

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 leads to high rates of staff burnout and turnover.
- Professional education and accreditation, 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.

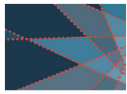
Availability, quality, and cost of SUD treatment and mental health services are intricately tied to the current state of the behavioral health workforce. Without a robust, sizeable labor force, how will

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—addressed primarily to supervisors and administrators—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 high-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. Toward that end, the chapter contains links to practical, web-based resources for programs and administrators, including toolkits and manuals.
- The second half of this chapter focuses on ensuring the competency and professional development of program staff. 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 March 2020, the Health Resources and Services Administration (HRSA) has identified approximately 5,537 mental health professional shortage areas in the United States, requiring 6,387 mental health practitioners to fill the shortage (HRSA, 2020). **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

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.

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.

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

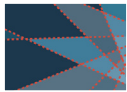
media, at job fairs, in newspapers, and within the community, can increase exposure and widen the potential pool of applications. Less traditional but nonetheless effective places to advertise include churches, synagogues, and other faith-based organizations; community welfare agencies and housing offices; shopping centers; and health clinics and senior centers. Staff referral incentives encourage current employees to act as recruiters and also help increase retention.

Exhibit 8.1 outlines steps from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Recruitment and Retention Toolkit, designed to aid behavioral health service 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 Resources for the Behavioral Health Workforce").

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 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 finalize 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)
- National Association for Alcoholism and Drug Abuse Counselors (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, February 11, 2020). 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), 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 "Avoiding 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, less support from supervisors or coworkers, and poor role manageability (Garner & Hunter, 2014). These factors are largely modifiable and are

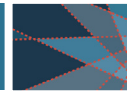


EXHIBIT 8.2. Reducing Staff Turnover in Programs for Clients With CODs

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.

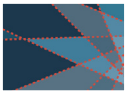
important targets for monitoring and implementing programmatic changes to help providers feel satisfied, supported, and competent on the job (Yanchus et al., 2017). Exhibit 8.2 offers methods for reducing staff turnover.

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. Program administrators must maintain awareness of the problem of burnout and the benefits of reducing turnover. Program administrators must demonstrate interest in staff well-being to sustain morale and team cohesion.

To lessen burnout among counselors working with a demanding caseload that includes clients with CODs, behavioral health service organizations should (Atkinson, Rodman, Thuras, Shiroma, &



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>)

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.

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 five 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. Together these elements help create an environment in which high-quality service can thrive.

In support of all behavioral health service providers embodying the “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

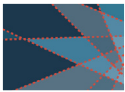
Attitudes and values guide the way providers meet client needs and affect the overall treatment climate. They not only determine how the client is viewed by the provider (thereby generating assumptions that could either facilitate or deter achievement of the highest standard of care), but also profoundly 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 training. 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
- 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
- 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 with experience working with CODs.

Provider Competencies

Provider competencies are the specific and measurable skills providers 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). Still, the groupings within each category reflect, 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.

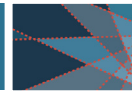
Basic, intermediate, and advanced competencies are discussed further in the following sections. See also “Resource Alert: Oregon Health Authority’s Competency Checklists for COD Providers” and Technical Assistance Publication (TAP) 21, *Addiction Counseling Competencies* (CSAT, 2006a) for more examples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

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 be able to carry out the mental health–related activities shown in Exhibit 8.4.

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.



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

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 to determine 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.
- Deescalate 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.

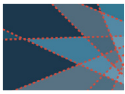


EXHIBIT 8.5. Six Intermediate Competencies for Treating People With CODs

- 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,³ 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 of 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

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).

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

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* (5th ed.; 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.
- 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.

therapies and treatment interventions, assessment and diagnosis procedures, and basic knowledge of pharmacotherapies (SAMHSA, 2011b). Exhibit 8.6 gives examples of advanced skills.

Supervision

Staff working in COD programs need relational skills (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 help processes for treating clients with CODs become part of the culture of the organization, 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:

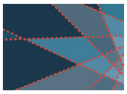
- Is provided by professionals with licensure/certification in the addiction field, such as licensed/certified addiction counselors, clinical psychologists, psychiatrists, clinical social workers, psychological counselors, marriage and family therapists, and specialty practice nurse practitioners (psychiatric 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.

Continuing Professional Development

The consensus panel is aware that many providers in the SUD treatment and mental health services fields have effectively performed the difficult task of providing services for clients with CODs, often without much guidance from established research and knowledge or systematized 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

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>)



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 program staff who treat clients with CODs 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 symptoms 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 knowledge of and comfort with 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 SUD-related needs.
- Education about the availability of different SUD treatment options.
- Quick and easy access to as-needed

The scope of practice that addiction counselors must follow legally and under which they can be reimbursed varies 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.

consultations (e.g., phone-based consultations with peers with experience in treating SUDs).

Discipline-Specific Education

Staff education and training are fundamental to all SUD treatment programs. Few university-based programs offer a formal curriculum on CODs, despite some improvement during the past decade. Many professional organizations are promoting the development of competencies and practice standards for intervening with substance use problems, including the American Psychiatric Association, American Psychological Association, American Society of Addiction Medicine, National Association of Social Workers, and 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, medical students, internal medicine and general practice residents, and general psychiatry residents all need to be educated in the problems of CODs. Too few hours of medical education are devoted to the problems

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.

of addiction and mental disorders. Medication can play a critical role in the treatment of CODs, so having adequately trained physicians who can manage medication therapies for clients with CODs is important.

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. Ideally, 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.

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.

Cross-training facilitates interaction and communication between the counselors from each discipline. 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.

A recent survey (SAMHSA, 2018e) that asked approximately 13,600 SUD treatment facilities nationwide about their quality assurance practices found that 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.

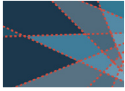


EXHIBIT 8.7. Certification for Health Professions

PROFESSION	CERTIFICATION IN SUDS OR CODS
Physicians	Physicians from any specialty, including primary care, psychiatry, and internal medicine can become certified by the American Society of Addiction Medicine (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/carn-exam) • Certified Addictions Registered Nurse–Advanced Practice (www.cnetnurse.com/ap-carn-exam)
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	The National Association of Social Workers 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/).

National Training Resources

Curriculums 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.)

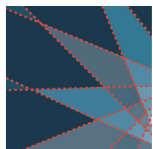
COD/Addiction Certification in Health Disciplines

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/).

Conclusion

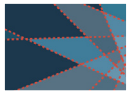
The consensus panel strongly encourages counselors to acquire competencies specific to working effectively with clients who have CODs. Juggling a high-stress, demanding workload with continuing professional development is difficult. The panel urges agency and program administrators, including line-level 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.

This page intentionally left blank.



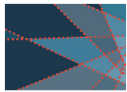
Appendix A—Bibliography

- Abroms, M., & Sher, L. (2016). Dual disorders and suicide. *Journal of Dual Diagnosis*, 12(2), 148–149. doi:10.1080/15504263.2016.1172898
- Aciri, M., Hooley, C. D., Richardson, N., & Moaba, L. B. (2017). Peer models in mental health for caregivers and families. *Community Mental Health Journal*, 53(2), 241–249. doi:10.1007/s10597-016-0040-4
- Afful, S. E., Strickland, J. R., Cottler, L., & Bierut, L. J. (2010). Exposure to trauma: A comparison of cocaine-dependent cases and a community-matched sample. *Drug and Alcohol Dependence*, 112(1–2), 46–53. doi:10.1016/j.drugalcdep.2010.05.012
- Ahmedani, B. K., Peterson, E. L., Hu, Y., Rossom, R. C., Lynch, F., Lu, C. Y., . . . Simon, G. E. (2017). Major physical health conditions and risk of suicide. *American Journal of Preventive Medicine*, 53(3), 308–315. doi:10.1016/j.amepre.2017.04.001
- Ait-Daoud, N., Blevins, D., Khanna, S., Sharma, S., & Holstege, C. P. (2017). Women and addiction. *Psychiatric Clinics of North America*, 40(2), 285–297. doi:10.1016/j.psc.2017.01.005
- Akbar, M., Egli, M., Cho, Y., Song, B., & Noronha, A. (2018). Medications for alcohol use disorders: An overview. *Pharmacology & Therapeutics*, 185, 64–85. doi: 10.1016/j.pharmthera.2017.11.007.
- Alam, D. A., & Martorana, A. (2011). Addiction treatment: Level of care determination. *Primary Care*, 38(1), 125–136. doi:10.1016/j.pop.2010.11.009
- Alarid, L. F., & Rubin, M. (2018). Misdemeanor arrestees with mental health needs: Diversion and outpatient services as a recidivism reduction strategy. *International Journal of Offender Therapy and Comparative Criminology*, 62(3), 575–590. doi:10.1177/0306624x16652892
- Alcorn, J. L., 3rd, Gowin, J. L., Green, C. E., Swann, A. C., Moeller, F. G., & Lane, S. D. (2013). Aggression, impulsivity, and psychopathic traits in combined antisocial personality disorder and substance use disorder. *Journal of Neuropsychiatry and Clinical Neurosciences*, 25(3), 229–232. doi:10.1176/appi.neuropsych.12030060
- Alegria, A. A., Blanco, C., Petry, N. M., Skodol, A. E., Liu, S. M., Grant, B., & Hasin, D. (2013). Sex differences in antisocial personality disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Personality Disorders*, 4(3), 214–222. doi:10.1037/a0031681
- Alexander, M., Layman, D., & Haugland, G. (2013). Validating the Modified Mini Screen (MMS) as a mental health referral screen for public assistance recipients in New York State. Annual Meeting of the American Public Health Association, Boston, MA.
- Alexander, M. J., Haugland, G., Lin, S. P., Bertollo, D. N., & McCorry, F. A. (2008). Mental health screening in addiction, corrections and social service settings: Validating the MMS. *International Journal of Mental Health and Addiction*, 6(1), 105–119.
- Ali, B., Green, K. M., Daughters, S. B., & Lejuez, C. W. (2017). Distress tolerance interacts with circumstances, motivation, and readiness to predict substance abuse treatment retention. *Addictive Behaviors*, 73, 99–104. doi:10.1016/j.addbeh.2017.04.016
- Al-Rousan, T., Rubenstein, L., Sieleni, B., Deol, H., & Wallace, R. B. (2017). Inside the nation's largest mental health institution: A prevalence study in a state prison system. *BMC Public Health*, 17(1), 342. doi:10.1186/s12889-017-4257-0
- American Association of Community Psychiatrists. (2016). *LOCUS: Level of Care Utilization System for Psychiatric and Addiction Services: Adult version 20*. Retrieved from <https://drive.google.com/file/d/0B89glzXJnn4cV1dESWI2eFEzc3M/view>
- American College of Emergency Physicians. (January 2017). *Alcohol screening in the emergency department*. Policy statement. Retrieved from www.acep.org/globalassets/new-pdfs/policy-statements/alcohol-screening-in-the-emergency-department.pdf
- American Psychiatric Association. (2010). *Practice guideline for the treatment of patients with major depressive disorder*. Retrieved from https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Association.
- Antai-Otong, D. (2016). Evidence-based care of the patient with borderline personality disorder. *Nursing Clinics of North America*, 51(2), 299–308. doi:10.1016/j.cnur.2016.01.012
- Arkins, B., Begley, C., & Higgins, A. (2016). Measures for screening for intimate partner violence: A systematic review. *Journal of Psychiatric Mental Health Nursing*, 23(3–4), 217–235. doi:10.1111/jpm.12289
- Arnold, L. E., Hodgkins, P., Caci, H., Kahle, J., & Young, S. (2015). Effect of treatment modality on long-term outcomes in attention-deficit/hyperactivity disorder: A systematic review. *PLoS ONE*, 10(2), e0116407. doi:10.1371/journal.pone.0116407
- Arunogiri, S., & Lubman, D. I. (2015). Anxiety and substance use disorders: A worrying combination. *Australasian Psychiatry*, 23(4), 382–387. doi:10.1177/1039856215590053



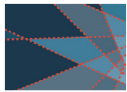
- Ashford, R. D., Meeks, M., Curtis, B., & Brown, A. M. (2018). Utilization of peer-based substance use disorder and recovery interventions in rural emergency departments: Patient characteristics and exploratory analysis. *Journal of Rural Mental Health, 43*(1), 17–29. doi:10.1037/rmh0000106
- Asmundson, G. J., Taylor, S., & Smits, J. A. (2014). Panic disorder and agoraphobia: An overview and commentary on DSM-5 changes. *Depression and Anxiety, 31*(6), 480–486. doi:10.1002/da.22277
- Atkinson, D. M., Rodman, J. L., Thuras, P. D., Shiroma, P. R., & Lim, K. O. (2017). Examining burnout, depression, and self-compassion in Veterans Affairs mental health staff. *Journal of Alternative and Complementary Medicine, 23*(7), 551–557. doi:10.1089/acm.2017.0087
- Avery, J., Han, B. H., Zerbo, E., Wu, G., Mauer, E., Avery, J., ... Penzner, J. B. (2017). Changes in psychiatry residents' attitudes towards individuals with substance use disorders over the course of residency training. *American Journal on Addictions, 26*(1), 75–79. doi: 10.1111/ajad.12406
- Avery, J., & Zerbo, E. (2015). Improving psychiatry residents' attitudes toward individuals diagnosed with substance use disorders. *Harvard Review of Psychiatry, 23*(4), 296–300. doi:10.1097/hrp.0000000000000047
- Avery, J., Zerbo, E., & Ross, S. (2016). Improving psychiatrists' attitudes towards individuals with psychotic disorders and co-occurring substance use disorders. *Academic Psychiatry, 40*(3), 520–522. doi:10.1007/s40596-015-0361-6
- Ayangbayi, T., Okunade, A., Karakus, M., & Nianogo, T. (2017). Characteristics of hospital emergency room visits for mental and substance use disorders. *Psychiatric Services, 68*(4), 408–410. doi:10.1176/appi.ps.201600125
- Babor, T. F., Higgins-Biddle, J. C., Saunders, J. B., & Monteiro, M. G. (2001). *AUDIT: The alcohol use disorders identification test: Guidelines for use in primary care* (2nd ed.). Retrieved from https://apps.who.int/iris/bitstream/handle/10665/67205/WHO_MSD_MSB_01.6a.pdf?sequence=1&isAllowed=y
- Bahji, A., Mazhar, M. N., Hudson, C. C., Nadkarni, P., MacNeil, B. A., & Hawken, E. (2019). Prevalence of substance use disorder comorbidity among individuals with eating disorders: A systematic review and meta-analysis. *Psychiatry Research, 273*, 58–66. doi:10.1016/j.psychres.2019.01.007
- Bahorik, A. L., Sterling, S. A., Campbell, C. I., Weisner, C., Ramo, D., & Satre, D. D. (2018). Medical and non-medical marijuana use in depression: Longitudinal associations with suicidal ideation, everyday functioning, and psychiatry service utilization. *Journal of Affective Disorders, 241*, 8–14. doi:10.1016/j.jad.2018.05.065
- Baillargeon, J., Penn, J. V., Knight, K., Harzke, A. J., Baillargeon, G., & Becker, E. A. (2010). Risk of reincarceration among prisoners with co-occurring severe mental illness and substance use disorders. *Administration and Policy in Mental Health, 37*(4), 367–374. doi:10.1007/s10488-009-0252-9
- Baker, A. L., Thornton, L. K., Hiles, S., Hides, L., & Lubman, D. I. (2012). Psychological interventions for alcohol misuse among people with co-occurring depression or anxiety disorders: A systematic review. *Journal of Affective Disorders, 139*(3), 217–229. doi:10.1016/j.jad.2011.08.004
- Baker, J. H., Mitchell, K. S., Neale, M. C., & Kendler, K. S. (2010). Eating disorder symptomatology and substance use disorders: Prevalence and shared risk in a population based twin sample. *International Journal of Eating Disorders, 43*(7), 648–658. doi:10.1002/eat.20856
- Bandelow, B., & Michaelis, S. (2015). Epidemiology of anxiety disorders in the 21st century. *Dialogues in Clinical Neuroscience, 17*(3), 327–335.
- Bandelow, B., Michaelis, S., & Wedekind, D. (2017). Treatment of anxiety disorders. *Dialogues in Clinical Neuroscience, 19*(2), 93–107.
- Banerjee, S., & Spry, C. (2017). CADTH Rapid Response Reports. In *Concurrent treatment for substance use disorder and trauma-related comorbidities: A review of clinical effectiveness and guidelines*. Ottawa (ON): Canadian Agency for Drugs and Technologies in Health.
- Barry, A. E., & Piazza-Gardner, A. K. (2012). Drunkorexia: Understanding the co-occurrence of alcohol consumption and eating/exercise weight management behaviors. *Journal of American College Health, 60*(3), 236–243. doi: 10.1080/07448481.2011.587487
- Barry, C. L., Epstein, A. J., Fiellin, D. A., Fraenkel, L., & Busch, S. H. (2016). Estimating demand for primary care-based treatment for substance and alcohol use disorders. *Addiction, 111*(8), 1376–1384. doi:10.1111/add.13364
- Bartlett, D. (2017). Drug-induced serotonin syndrome. *Critical Care Nurse, 37*(1), 49–54. doi:10.4037/ccn2017.169
- Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016). Peer-delivered recovery support services for addictions in the United States: A systematic review. *Journal of Substance Abuse Treatment, 63*, 1–9.
- Bateman, A. W., Gunderson, J., & Mulder, R. (2015). Treatment of personality disorder. *Lancet, 385*(9969), 735–743. doi:10.1016/s0140-6736(14)61394-5
- Batterham, P. J., Ftanou, M., Pirkis, J., Brewer, J. L., Mackinnon, A. J., Beautrais, A., ... Christensen, H. (2015). A systematic review and evaluation of measures for suicidal ideation and behaviors in population-based research. *Psychological Assessment, 27*(2), 501–512. doi:10.1037/pas0000053

- Baum, N. (2016). Secondary traumatization in mental health professionals: A systematic review of gender findings. *Trauma, Violence, & Abuse*, 17(2), 221–235. doi:10.1177/1524838015584357
- Beck, A. T., & Steer, R. A. (1987). *Beck Depression Inventory manual*. San Antonio, TX: The Psychological Corporation, Harcourt Brace Jovanovich.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory-II manual*. San Antonio, TX: Psychological Corporation.
- Becker, M. A., Boaz, T. L., Andel, R., & Hafner, S. (2017). Risk of early rehospitalization for non-behavioral health conditions among adult Medicaid beneficiaries with severe mental illness or substance use disorders. *Journal of Behavioral Health Services & Research*, 44(1), 113–121. doi:10.1007/s11414-016-9516-9
- Beidas, R. S., Marcus, S., Wolk, C. B., Powell, B., Aarons, G. A., Evans, A. C., . . . Mandell, D. S. (2016). A prospective examination of clinician and supervisor turnover within the context of implementation of evidence-based practices in a publicly-funded mental health system. *Administration and Policy in Mental Health and Mental Health Services Research*, 43(5), 640–649.
- Bell, H. (2018). Creative interventions for teaching empathy in the counseling classroom. *Journal of Creativity in Mental Health*, 13(1), 106–120. doi:10.1080/15401383.2017.1328295
- Belleau, E. L., Chin, E. G., Wanklyn, S. G., Zambrano-Vazquez, L., Schumacher, J. A., & Coffey, S. F. (2017). Pre-treatment predictors of dropout from prolonged exposure therapy in patients with chronic posttraumatic stress disorder and comorbid substance use disorders. *Behaviour Research and Therapy*, 91, 43–50.
- Benich, J. J., 3rd, Bragg, S. W., & Freedy, J. R. (2016). Psychopharmacology in primary care settings. *Primary Care*, 43(2), 327–340. doi:10.1016/j.pop.2016.01.002
- Bennett, A. C., Gibson, C., Rohan, A. M., Howland, J. F., & Rankin, K. M. (2018). Mental health and substance use-related hospitalizations among women of reproductive age in Illinois and Wisconsin. *Public Health Reports*, 134(1), 17–26.
- Bennett, M. E., Bradshaw, K. R., & Catalano, L. T. (2017). Treatment of substance use disorders in schizophrenia. *American Journal of Drug and Alcohol Abuse*, 43(4), 377–390. doi:10.1080/00952990.2016.1200592
- Benningfield, M. M., Arria, A. M., Kaltenbach, K., Heil, S. H., Stine, S. M., Coyle, M. G., . . . Martin, P. R. (2010). Co-occurring psychiatric symptoms are associated with increased psychological, social, and medical impairment in opioid dependent pregnant women. *American Journal on Addictions*, 19(5), 416–421. doi:10.1111/j.1521-0391.2010.00064.x
- Benston, E. A. (2015). Housing programs for homeless individuals with mental illness: Effects on housing and mental health outcomes. *Psychiatric Services*, 66(8), 806–816. doi:10.1176/appi.ps.201400294
- Bentley, K. H., Franklin, J. C., Ribeiro, J. D., Kleiman, E. M., Fox, K. R., & Nock, M. K. (2016). Anxiety and its disorders as risk factors for suicidal thoughts and behaviors: A meta-analytic review. *Clinical Psychology Review*, 43, 30–46. doi:10.1016/j.cpr.2015.11.008
- Ben-Zeev, D., Kaiser, S. M., & Krzos, I. M. (2014). Remote “hovering” with individuals with psychotic disorders and substance use: Feasibility, engagement, and therapeutic alliance with a text-messaging mobile interventionist. *Journal of Dual Diagnosis*, 10(4), 197–203.
- Berenz, E. C., & Coffey, S. F. (2012). Treatment of co-occurring posttraumatic stress disorder and substance use disorders. *Current Psychiatry Reports*, 14(5), 469–477. doi:10.1007/s11920-012-0300-0
- Bergink, V., Rasgon, N., & Wisner, K. L. (2016). Postpartum psychosis: Madness, mania, and melancholia in motherhood. *American Journal of Psychiatry*, 173(12), 1179–1188. doi:10.1176/appi.ajp.2016.16040454
- Bergman, B. G., Greene, M. C., Hoepfner, B. B., Slaymaker, V., & Kelly, J. F. (2014). Psychiatric comorbidity and 12-step participation: A longitudinal investigation of treated young adults. *Alcoholism: Clinical and Experimental Research*, 38(2), 501–510. doi:10.1111/acer.12249
- Bernert, R. A., Hom, M. A., & Roberts, L. W. (2014). A review of multidisciplinary clinical practice guidelines in suicide prevention: Toward an emerging standard in suicide risk assessment and management, training and practice. *Academic Psychiatry*, 38(5), 585–592. doi:10.1007/s40596-014-0180-1
- Bernstein, J., Derrington, T. M., Belanoff, C., Cabral, H. J., Babakhanlou-Chase, H., Diop, H., . . . Kotelchuck, M. (2015). Treatment outcomes for substance use disorder among women of reproductive age in Massachusetts: A population-based approach. *Drug and Alcohol Dependence*, 147, 151–159. doi:10.1016/j.drugalcdep.2015.06.002
- Bhugra, D. (2005). The global prevalence of schizophrenia. *PLoS Medicine*, 2(5), e151. doi:10.1371/journal.pmed.0020151
- Black, D. W. (2015). The natural history of antisocial personality disorder. *Canadian Journal of Psychiatry*, 60(7), 309–314. doi:10.1177/070674371506000703
- Black, D. W. (2017). The treatment of antisocial personality disorder. *Current Treatment Options in Psychiatry*, 4(4), 295–302.



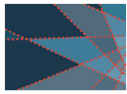
- Blanco, C., Alegria, A. A., Liu, S. M., Secades-Villa, R., Sugaya, L., Davies, C., & Nunes, E. V. (2012). Differences among major depressive disorder with and without co-occurring substance use disorders and substance-induced depressive disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry*, 73(6), 865–873. doi:10.4088/JCP.10m06673
- Blanco, C., Compton, W. M., Saha, T. D., Goldstein, B. I., Ruan, W. J., Huang, B., & Grant, B. F. (2017). Epidemiology of DSM-5 bipolar I disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions – III. *Journal of Psychiatric Research*, 84, 310–317. doi:10.1016/j.jpsychires.2016.10.003
- Blanco, C., Okuda, M., Markowitz, J. C., Liu, S. M., Grant, B. F., & Hasin, D. S. (2010). The epidemiology of chronic major depressive disorder and dysthymic disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry*, 71(12), 1645–1656. doi:10.4088/JCP.09m05663gry
- Blanco, C., Xu, Y., Brady, K., Perez-Fuentes, G., Okuda, M., & Wang, S. (2013). Comorbidity of posttraumatic stress disorder with alcohol dependence among US adults: Results from National Epidemiological Survey on Alcohol and Related Conditions. *Drug and Alcohol Dependence*, 132(3), 630–638. doi:S0376-8716(13)00145-2 [pii];10.1016/j.drugalcdep.2013.04.016 [doi]
- Blodgett, J. C., Maisel, N. C., Fuh, I. L., Wilbourne, P. L., & Finney, J. W. (2014). How effective is continuing care for substance use disorders? A meta-analytic review. *Journal of Substance Abuse Treatment*, 46(2), 87–97. doi:10.1016/j.jsat.2013.08.022
- Boden, M. T., & Hoggatt, K. J. (2018). Substance use disorders among veterans in a nationally representative sample: Prevalence and associated functioning and treatment utilization. *Journal of Studies on Alcohol and Drugs*, 79(6), 853–861.
- Bogenschutz, M. P., Donovan, D. M., Mandler, R. N., Perl, H. I., Forcehimes, A. A., Crandall, C., . . . Douaihy, A. (2014a). Brief intervention for patients with problematic drug use presenting in emergency departments: A randomized clinical trial. *JAMA Internal Medicine*, 174(11), 1736–1745. doi:10.1001/jamainternmed.2014.4052
- Bogenschutz, M. P., Rice, S. L., Tonigan, J. S., Vogel, H. S., Nowinski, J., Hume, D., & Arenella, P. B. (2014b). 12-step facilitation for the dually diagnosed: A randomized clinical trial. *Journal of Substance Abuse Treatment*, 46(4), 403–411. doi:10.1016/j.jsat.2013.12.009
- Boggs, J. M., Beck, A., Hubley, S., Peterson, E. L., Hu, Y., Williams, L. K., . . . Ahmedani, B. K. (2018). General medical, mental health, and demographic risk factors associated with suicide by firearm compared with other means. *Psychiatric Services*, 69(6), 677–684. doi:10.1176/appi.ps.201700237
- Bohnert, K. M., Ilgen, M. A., Louzon, S., McCarthy, J. F., & Katz, I. R. (2017). Substance use disorders and the risk of suicide mortality among men and women in the US Veterans Health Administration. *Addiction*, 112(7), 1193–1201. doi:10.1111/add.13774
- Bolton, J. M., Gunnell, D., & Turecki, G. (2015). Suicide risk assessment and intervention in people with mental illness. *BMJ*, 351, h4978. doi:10.1136/bmj.h4978
- Bond, G. R., & Drake, R. E. (2015). The critical ingredients of assertive community treatment. *World Psychiatry*, 14(2), 240–242. doi:10.1002/wps.20234
- Bonsack, C., Gibellini Manetti, S., Favrod, J., Montagrin, Y., Besson, J., Bovet, P., & Conus, P. (2011). Motivational intervention to reduce cannabis use in young people with psychosis: A randomized controlled trial. *Psychotherapy and Psychosomatics*, 80(5), 287–297. doi:10.1159/000323466
- Boothroyd, R. A., Peters, R. H., Armstrong, M. I., Rynearson-Moody, S., & Caudy, M. (2015). The psychometric properties of the simple screening instrument for substance abuse. *Evaluation and the Health Professions*, 38(4), 538–562. doi:10.1177/0163278713490165
- Borges, G., Bagge, C. L., Cherpitel, C. J., Conner, K. R., Orozco, R., & Rossow, I. (2017). A meta-analysis of acute use of alcohol and the risk of suicide attempt. *Psychological Medicine*, 47(5), 949–957. doi:10.1017/s0033291716002841
- Bowen, S., Witkiewitz, K., Clifasefi, S. L., Grow, J., Chawla, N., Hsu, S. H., . . . Larimer, M. E. (2014). Relative efficacy of mindfulness-based relapse prevention, standard relapse prevention, and treatment as usual for substance use disorders: A randomized clinical trial. *JAMA Psychiatry*, 71(5), 547–556. doi:10.1001/jamapsychiatry.2013.4546
- Bradizza, C. M., Stasiewicz, P. R., & Dermen, K. H. (2014). Behavioral interventions for individuals dually-diagnosed with a severe mental illness and a substance use disorder. *Current Addiction Reports*, 1(4), 243–250. doi:10.1007/s40429-014-0032-9
- Brady, K. T., Back, S. E., & Coffey, S. F. (2004). Substance abuse and posttraumatic stress disorder. *Current Directions in Psychological Science*, 13(5), 206–209. doi:10.1111/j.0963-7214.2004.00309.x
- Brady, K. T., Haynes, L. F., Hartwell, K. J., & Killeen, T. K. (2013). Substance use disorders and anxiety: A treatment challenge for social workers. *Social Work in Public Health*, 28(3–4), 407–423. doi:10.1080/19371918.2013.774675
- Brazil, I. A., van Dongen, J. D. M., Maes, J. H. R., Mars, R. B., & Baskin-Sommers, A. R. (2018). Classification and treatment of antisocial individuals: From behavior to biocognition. *Neuroscience and Biobehavioral Reviews*, 91, 259–277. doi:10.1016/j.neubiorev.2016.10.010

- Brewerton, T. D. (2014). Are eating disorders addictions? In T. Brewerton & A. Baker Dennis (Eds.), *Eating disorders, addictions and substance use disorders: Research, clinical and treatment perspectives* (pp. 267–299). New York: Springer-Verlag Publishing.
- Briggs, C. A., & Reneson, S. (2010). Counseling addicted veterans: What to know and how to help. Retrieved from <https://pdfs.semanticscholar.org/9742/967aac815ca02c4f599b36be996d0b10d3d9.pdf>
- Brockington, I. (2017). Suicide and filicide in postpartum psychosis. *Archives of Women's Mental Health*, 20(1), 63–69. doi:10.1007/s00737-016-0675-8
- Broderick, K. B., Kaplan, B., Martini, D., & Caruso, E. (2015). Emergency physician utilization of alcohol/substance screening, brief advice and discharge: A 10-year comparison. *Journal of Emergency Medicine*, 49(4), 400–407. doi:10.1016/j.jemermed.2015.05.014
- Bromberg, S. R., Backman, T. L., Krow, J., & Frankel, K. A. (2010). The Haven Mother's House Modified Therapeutic Community: Meeting the gap in infant mental health services for pregnant and parenting mothers with drug addiction. *Infant Mental Health Journal*, 31(3), 255–276. doi:10.1002/imhj.20255
- Brook, J. S., Zhang, C., Rubenstone, E., Primack, B. A., & Brook, D. W. (2016). Comorbid trajectories of substance use as predictors of antisocial personality disorder, major depressive episode, and generalized anxiety disorder. *Addictive Behaviors*, 62, 114–121. doi:10.1016/j.addbeh.2016.06.003
- Brooner, R. K., Kidorf, M. S., King, V. L., Peirce, J., Neufeld, K., Stoller, K., & Kolodner, K. (2013). Managing psychiatric comorbidity within versus outside of methadone treatment settings: A randomized and controlled evaluation. *Addiction*, 108(11), 1942–1951.
- Brown, C. H., Bennett, M. E., Li, L., & Bellack, A. S. (2011). Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors*, 36(5), 439–447. doi:10.1016/j.addbeh.2010.12.001
- Brown, G. K., & Green, K. L. (2014). A review of evidence-based follow-up care for suicide prevention: Where do we go from here? *American Journal of Preventive Medicine*, 47(3)(Suppl. 2), S209–S215. doi:10.1016/j.amepre.2014.06.006
- Brown, V. B., Harris, M., & Fallot, R. (2013). Moving toward trauma-informed practice in addiction treatment: A collaborative model of agency assessment. *Journal of Psychoactive Drugs*, 45(5), 386–393. doi:10.1080/02791072.2013.844381
- Bryant, J. B., Darkes, J., & Rahal, C. (2012). College students' compensatory eating and behaviors in response to alcohol consumption. *Journal of American College Health*, 60(5), 350–356. doi:10.1080/07448481.2011.630702
- Buck, K. D., & Lysaker, P. H. (2010). Clinical supervision for the treatment of adults with severe mental illness: Pertinent issues when assisting graduate nursing students. *Perspectives in Psychiatric Care*, 46(3), 234–243. doi:10.1111/j.1744-6163.2010.00258.x
- Buckner, J. D., Heimberg, R. G., Ecker, A. H., & Vinci, C. (2013). A biopsychosocial model of social anxiety and substance use. *Depression and Anxiety*, 30(3), 276–284. doi:10.1002/da.22032
- Bukach, A. M., Ejaz, F. K., Dawson, N., & Gitter, R. J. (2017). Turnover among community mental health workers in Ohio. *Administration and Policy in Mental Health and Mental Health Services Research*, 44(1), 115–122. doi:10.1007/s10488-015-0706-1
- Bureau of Labor Statistics. (2019, March 7). *Labor force statistics from the Current Population Survey. Databases, tables & calculators by subject*. Retrieved from <https://data.bls.gov/timeseries/lms14000000>
- Bureau of Labor Statistics (BLS). (2020, February 11). *Job openings and labor turnover—August 2019*. Retrieved from www.bls.gov/news.release/pdf/jolts.pdf
- Bureau of Labor Statistics. (2020, March 3). *Databases, tables & calculators by subject. Labor force statistics from the Current Population Survey*. Retrieved from <https://data.bls.gov/timeseries/LNS14000000>
- Burke, S. C., Cremeens, J., Vail-Smith, K., & Woolsey, C. (2010). Drunkorexia: Calorie restriction prior to alcohol consumption among college freshman. *Journal of Alcohol and Drug Education*, 54(2), 17–34.
- Bush, K., Kivlahan, D. R., McDonell, M. B., Fihn, S. D., & Bradley, K. A. (1998). The AUDIT alcohol consumption questions (AUDIT-C): An effective brief screening test for problem drinking. *Archives of Internal Medicine*, 158(16), 1789–1795.
- Buttner, M., O'Hara, M. W., & Watson, D. (2012). The structure of women's mood in the early postpartum. *Assessment*, 19, 247–256.
- Cabassa, L. J., & Baumann, A. A. (2013). A two-way street: Bridging implementation science and cultural adaptations of mental health treatments. *Implementation Science: IS*, 8, 90. doi:10.1186/1748-5908-8-90
- Campbell, B. K., Guydish, J., Le, T., Wells, E. A., & McCarty, D. (2015). The relationship of therapeutic alliance and treatment delivery fidelity with treatment retention in a multisite trial of twelve-step facilitation. *Psychology of Addictive Behaviors*, 29(1), 106–113. doi:10.1037/adb0000008
- Cardno, A. G., & Owen, M. J. (2014). Genetic relationships between schizophrenia, bipolar disorder, and schizoaffective disorder. *Schizophrenia Bulletin*, 40(3), 504–515. doi:10.1093/schbul/sbu016



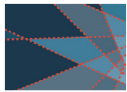
- Carpenter, R. W., Wood, P. K., & Trull, T. J. (2016). Comorbidity of borderline personality disorder and lifetime substance use disorders in a nationally representative sample. *Journal of Personality Disorders*, 30(3), 336–350. doi:10.1521/pedi_2015_29_197
- Carra, G., Bartoli, F., Crocamo, C., Brady, K. T., & Clerici, M. (2014). Attempted suicide in people with co-occurring bipolar and substance use disorders: Systematic review and meta-analysis. *Journal of Affective Disorders*, 167, 125–135. doi:10.1016/j.jad.2014.05.066
- Carroll, J. F. X., & McGinley, J. J. (2000). Mental health screening form-iii (MHSF-III). Unpublished screening instrument, Project Return Foundation, Inc., New York, NY.
- Carroll, J. F. X., & McGinley, J. J. (2001). A screening form for identifying mental health problems in alcohol/other drug dependent persons. *Alcoholism Treatment Quarterly*, 19(4), 33–47. doi:10.1300/J020v19n04_02
- Carroll, T. D., Currier, J. M., McCormick, W. H., & Drescher, K. D. (2017). Adverse childhood experiences and risk for suicidal behavior in male Iraq and Afghanistan veterans seeking PTSD treatment. *Psychological Trauma*, 9(5), 583–586. doi:10.1037/tra0000250
- Carter, A. C., Capone, C., & Short, E. E. (2011). Co-occurring posttraumatic stress disorder and alcohol use disorders in veteran populations. *Journal of Dual Diagnosis*, 7(4), 285–299. doi:10.1080/15504263.2011.620453
- Center for Behavioral Health Statistics and Quality (CBHSQ). (2019). *2018 National Survey on Drug Use and Health: Detailed tables*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>
- Center for Mental Health Services. (1998). Cooccurring psychiatric and substance disorders in managed care systems: Standards of care, practice guidelines, workforce competencies, and training curricula. Retrieved from <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.493.5621&rep=rep1&type=pdf>
- Center for Quality Assessment and Improvement in Mental Health. (2007). *The Suicide Behaviors Questionnaire-Revised (SBQ-R) – Overview*. Retrieved from http://www.cqaimh.org/pdf/tool_sbq-r.pdf
- Center for Substance Abuse Treatment. (1994). *Simple screening instruments for outreach for alcohol and other drug abuse and infectious diseases*. Treatment Improvement Protocol (TIP) Series 11 (DHHS Publication No. (SMA) 94-2094). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1995). *Alcohol and other drug screening of hospitalized trauma patients*. Treatment Improvement Protocol (TIP) Series 16 (DHHS Publication No. (SMA) 95-3041). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (1997). *A guide to substance abuse services for primary care clinicians*. Treatment Improvement Protocol (TIP) Series 24 (DHHS Publication No. (SMA) 97-3139). Rockville, MD: Center for Substance Abuse Treatment.
- Center for Substance Abuse Treatment. (1998a). *Comprehensive case management for substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 27 (DHHS Publication No. (SMA) 15-4215). Rockville, MD: Center for Substance Abuse Treatment.
- Center for Substance Abuse Treatment. (1998b). *Substance use disorder treatment for people with physical and cognitive disabilities*. Treatment Improvement Protocol (TIP) Series 29 (DHHS Publication No. (SMA) 98-3249). Rockville, MD: Center for Substance Abuse Treatment.
- Center for Substance Abuse Treatment. (1999a). *Brief interventions and brief therapies for substance abuse*. Treatment Improvement Protocol (TIP) Series 34 (DHHS Publication No. (SMA) 99-3353). Rockville, MD: Center for Substance Abuse Treatment.
- Center for Substance Abuse Treatment. (1999b). *Enhancing motivation for change in substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 35 (DHHS Publication No. (SMA) 99-3354). Rockville, MD: Center for Substance Abuse Treatment.
- Center for Substance Abuse Treatment. (2000a). *Changing the conversation: Improving substance abuse treatment*. The National Treatment Improvement Plan. Panel reports, public hearings, and participant acknowledgements. HHS Publication No. (SMA) 003479. Rockville, MD: Center for Substance Abuse Treatment.
- Center for Substance Abuse Treatment. (2000b). *Comprehensive case management for substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 27 (DHHS Publication No. (SMA) 15-4215). Rockville, MD: Center for Substance Abuse Treatment.
- Center for Substance Abuse Treatment. (2000c). *Substance abuse treatment for persons with child abuse and neglect issues*. Treatment Improvement Protocol (TIP) Series 36 (DHHS Publication No. (SMA) 00-3357). Rockville, MD: Center for Substance Abuse Treatment.
- Center for Substance Abuse Treatment. (2005a). 9 substance-induced disorders. In *Substance abuse treatment for persons with co-occurring disorders*. Treatment Improvement Protocol (TIP) Series, No. 42. Rockville, MD: Center for Substance Abuse Treatment.
- Center for Substance Abuse Treatment. (2005b). *Substance abuse treatment for adults in the criminal justice system*. Treatment Improvement Protocol (TIP) Series 44 (DHHS Publication No. (SMA) 05-4056). Rockville, MD: Center for Substance Abuse Treatment.

- Center for Substance Abuse Treatment. (2006a). *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice*. Technical Assistance Publication (TAP) Series 21 (DHHS Publication No. (SMA) 06-4171). Rockville, MD: Center for Substance Abuse Treatment.
- Center for Substance Abuse Treatment. (2006b). *Detoxification from alcohol and other drugs*. Treatment Improvement Protocol (TIP) Series 45 (DHHS Publication No. (SMA) 06-4131). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (2008). *Managing depressive symptoms in substance abuse clients during early recovery*. Treatment Improvement Protocol (TIP) Series 48. (DHHS Publication No. (SMA) 08-4353). Rockville, MD: Center for Substance Abuse Treatment.
- Center for Substance Abuse Treatment. (2009). *Addressing suicidal thoughts and behaviors in substance abuse treatment*. Treatment Improvement Protocol (TIP) Series 50 (HHS Publication No. (SMA) 09-4381). Rockville, MD: Center for Substance Abuse Treatment.
- Centers for Disease Control and Prevention (CDC). (2014). *Healthy People 2020*. Retrieved from www.cdc.gov/dhbsp/hp2020.htm
- Centers for Disease Control and Prevention. (2018). *Suicide rising across the US*. Retrieved from www.cdc.gov/vitalsigns/suicide/index.html
- Centers for Disease Control and Prevention. (2020). Underlying Cause of Death 1999–2018 on CDC WONDER Online Database. Retrieved from <https://wonder.cdc.gov/ucd-icd10.html>
- Chan, Y. F., Huang, H., Bradley, K., & Unutzer, J. (2014). Referral for substance abuse treatment and depression improvement among patients with co-occurring disorders seeking behavioral health services in primary care. *Journal of Substance Abuse Treatment*, 46(2), 106–112. doi:10.1016/j.jsat.2013.08.016
- Chan, Y. F., Huang, H., Sieu, N., & Unutzer, J. (2013). Substance screening and referral for substance abuse treatment in an integrated mental health care program. *Psychiatric Services*, 64(1), 88–90. doi:10.1176/appi.ps.201200082
- Chaple, M., Sacks, S., Randell, J., & Kang, B. (2016). A technical assistance framework to facilitate the delivery of integrated behavioral health services in Federally Qualified Health Centers (FQHCs). *Journal of Substance Abuse Treatment*, 60, 62–69. doi:10.1016/j.jsat.2015.08.006
- Chapman, S. A., Blash, L. K., Mayer, K., & Spetz, J. (2018). Emerging roles for peer providers in mental health and substance use disorders. *American Journal of Preventive Medicine*, 54(6S3), S267–S274. doi:10.1016/j.amepre.2018.02.019
- Chapman, S. L., & Wu, L. T. (2013). Postpartum substance use and depressive symptoms: A review. *Women and Health*, 53(5), 479–503. doi:10.1080/03630242.2013.804025
- Charzynska, K., Kucharska, K., & Mortimer, A. (2015). Does employment promote the process of recovery from schizophrenia? A review of the existing evidence. *International Journal of Occupational Medicine and Environmental Health* 28(3), 407–418. doi:10.13075/ijom.1896.00341
- Cherry, D., Albert, M., & McCaig, L. F. (2018). Mental health-related physician office visits by adults aged 18 and over: United States, 2012–2014. *NCHS Data Brief*, June (311), 1–8.
- Chhatre, S., Cook, R., Mallik, E., & Jayadevappa, R. (2017). Trends in substance use admissions among older adults. *BMC Health Services Research*, 17(1), 584. doi:10.1186/s12913-017-2538-z
- Chinman, M., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Swift, A., & Delphin-Rittmon, M. E. (2014). Peer support services for individuals with serious mental illnesses: Assessing the evidence. *Psychiatric Services*, 65(4), 429–441.
- Choi, N. G., DiNitto, D. M., Marti, C. N., & Choi, B. Y. (2017). Association of adverse childhood experiences with lifetime mental and substance use disorders among men and women aged 50+ years. *International Psychogeriatrics*, 29(3), 359–372. doi:10.1017/s1041610216001800
- Choi, S., Adams, S. M., MacMaster, S. A., & Seiters, J. (2013). Predictors of residential treatment retention among individuals with co-occurring substance abuse and mental health disorders. *Journal of Psychoactive Drugs*, 45(2), 122–131. doi:10.1080/02791072.2013.785817
- Chow, C. M., Wieman, D., Cichocki, B., Qvicklund, H., & Hiersteiner, D. (2013). Mission impossible: Treating serious mental illness and substance use co-occurring disorder with integrated treatment: A meta-analysis. *Mental Health and Substance Use: Dual Diagnosis*, 6(2), 150–168. doi:10.1080/17523281.2012.693130
- Clark, C., Guenther, C. C., & Mitchell, J. N. (2016). Case management models in permanent supported housing programs for people with complex behavioral issues who are homeless. *Journal of Dual Diagnosis*, 12(2), 185–192. doi:10.1080/15504263.2016.1176852
- Clark, R. E., Samnaliev, M., & McGovern, M. P. (2007). Treatment for co-occurring mental and substance use disorders in five state Medicaid programs. *Psychiatric Services*, 58(7), 942–948. doi:10.1176/ps.2007.58.7.942
- Cleary, M., Hunt, G. E., Matheson, S., & Walter, G. (2009). Psychosocial treatments for people with co-occurring severe mental illness and substance misuse: Systematic review. *Journal of Advanced Nursing*, 65(2), 238–258. doi:10.1111/j.1365-2648.2008.04879.x



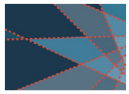
- Coffey, S. F., Schumacher, J. A., Nosen, E., Littlefield, A. K., Henslee, A. M., Lappen, A., & Stasiewicz, P. R. (2016). Trauma-focused exposure therapy for chronic posttraumatic stress disorder in alcohol and drug dependent patients: A randomized controlled trial. *Psychology of Addictive Behaviors, 30*(7), 778–790. doi:10.1037/adb0000201
- Cohen, A., Freeborn, B., & McManus, B. (2013). Competition and crowding out in the market for outpatient substance abuse treatment. *International Economic Review, 54*(1), 159–184. doi:10.1111/j.1468-2354.2012.00729.x
- Cohen, L. R., Field, C., Campbell, A. N., & Hien, D. A. (2013). Intimate partner violence outcomes in women with PTSD and substance use: A secondary analysis of NIDA Clinical Trials Network “Women and Trauma” multi-site study. *Addictive Behaviors, 38*(7), 2325–2332. doi:10.1016/j.addbeh.2013.03.006
- Colby, S. L., & Ortman, J. M. (2014). Projections of the size and composition of the U.S. population: 2014 to 2060. *Current Population Reports, P25-1143*, Washington, DC: U.S. Census Bureau.
- Collins, S. E., Malone, D. K., & Clifasefi, S. L. (2013). Housing retention in single-site housing first for chronically homeless individuals with severe alcohol problems. *American Journal of Public Health, 103*(Suppl. 2), S269–S274. doi:10.2105/ajph.2013.301312
- Conner, K. R., Gamble, S. A., Bagge, C. L., He, H., Swogger, M. T., Watts, A., & Houston, R. J. (2014). Substance-induced depression and independent depression in proximal risk for suicidal behavior. *Journal of Studies on Alcohol and Drugs, 75*(4), 567–572.
- Connors, G. J., Maisto, S. A., Schlauch, R. C., Dearing, R. L., Prince, M. A., & Duerr, M. R. (2016). Therapeutic alliances predict session by session drinking behavior in the treatment of alcohol use disorders. *Journal of Consulting and Clinical Psychology, 84*(11), 972–982. doi:10.1037/ccp0000130
- Cook, B. L., Trinh, N. H., Li, Z., Hou, S. S., & Progovac, A. M. (2017). Trends in racial-ethnic disparities in access to mental health care, 2004–2012. *Psychiatric Services, 68*(1), 9–16. doi:10.1176/appi.ps.201500453
- Cook, T. B. (2013). Recent criminal offending and suicide attempts: A national sample. *Social Psychiatry and Psychiatric Epidemiology, 48*(5), 767–774. doi:10.1007/s00127-012-0567-9
- Cogle, J. R., Hakes, J. K., Macatee, R. J., Chavarria, J., & Zvolensky, M. J. (2015). Quality of life and risk of psychiatric disorders among regular users of alcohol, nicotine, and cannabis: An analysis of the National Epidemiological Survey on Alcohol and Related Conditions (NESARC). *Journal of Psychiatric Research, 66–67*, 135–141. doi: 10.1016/j.jpsychires.(2015). .05.004
- Cox, K. B., Malte, C. A., & Saxon, A. J. (2017). Characteristics and service utilization of homeless veterans entering VA substance use treatment. *Psychological Services, 14*(2), 208–213. doi:10.1037/ser0000133
- Craske, M. G., & Stein, M. B. (2016). Anxiety. *Lancet, 388*(10063), 3048–3059. doi:10.1016/s0140-6736(16)30381-6
- Creswell, K. G., Bachrach, R. L., Wright, A. G., Pinto, A., & Ansell, E. (2016). Predicting problematic alcohol use with the DSM-5 alternative model of personality pathology. *Personality Disorders, 7*(1), 103–111. doi:10.1037/per0000131
- Crisanti, A. S., Duran, D., Greene, R. N., Reno, J., Luna-Anderson, C., & Altschul, D. B. (2017). A longitudinal analysis of peer-delivered permanent supportive housing: Impact of housing on mental and overall health in an ethnically diverse population. *Psychological Services, 14*(2), 141–153. doi:10.1037/ser0000135
- Crits-Christoph, P., Hamilton, J. L., Ring-Kurtz, S., Gallop, R., McClure, B., Kulaga, A., & Rotrosen, J. (2011). Program, counselor, and patient variability in the alliance: A multilevel study of the alliance in relation to substance use outcomes. *Journal of Substance Abuse Treatment, 40*(4), 405–413. doi:10.1016/j.jsat.2011.01.003
- Crowley, R. A., & Kirschner, N. (2015). The integration of care for mental health, substance abuse, and other behavioral health conditions into primary care: Executive summary of an American College of Physicians position paper. *Annals of Internal Medicine, 163*(4), 298–299. doi:10.7326/m15-0510
- Crunelle, C. L., van den Brink, W., Moggi, F., Konstenius, M., Franck, J., Levin, F. R., . . . Matthys, F. (2018). International consensus statement on screening, diagnosis and treatment of substance use disorder patients with comorbid attention deficit/hyperactivity disorder. *European Addiction Research, 24*(1), 43–51. doi:10.1159/000487767
- Cunill, R., Castells, X., Tobias, A., & Capella, D. (2015). Pharmacological treatment of attention deficit hyperactivity disorder with co-morbid drug dependence. *Journal of Psychopharmacology, 29*(1), 15–23. doi:10.1177/0269881114544777
- Cunningham, K. C., Farmer, C., LoSavio, S. T., Dennis, P. A., Clancy, C. P., Hertzberg, M. A., . . . Beckham, J. C. (2017). A model comparison approach to trauma-related guilt as a mediator of the relationship between PTSD symptoms and suicidal ideation among veterans. *Journal of Affective Disorders, 221*, 227–231. doi:10.1016/j.jad.2017.06.046
- Curtis, M. A., Garlington, S., & Schottenfield, L. S. (2013). Alcohol, drug, and criminal history restrictions in public housing. *Cityscape, 15*, 37–52.

- Cusack, K. J., Morrissey, J. P., Cuddeback, G. S., Prins, A., & Williams, D. M. (2010). Criminal justice involvement, behavioral health service use, and costs of forensic assertive community treatment: A randomized trial. *Community Mental Health Journal, 46*(4), 356–363. doi:10.1007/s10597-010-9299-z
- Cusack, M., & Montgomery, A. E. (2017). Examining the bidirectional association between veteran homelessness and incarceration within the context of permanent supportive housing. *Psychological Services, 14*(2), 250–256. doi:10.1037/ser0000110
- Cutcliffe, J. R., Travale, R., Richmond, M. M., & Green, T. (2016). Considering the contemporary issues and unresolved challenges facing therapeutic communities for clients with alcohol and substance abuse. *Issues in Mental Health Nursing, 37*(9), 642–650. doi:10.3109/01612840.2016.1169465
- Daley, D. C., & Marlatt, G. A. (1992). Relapse prevention: Cognitive and behavioral interventions. In J. G. Lowinson, P. Ruiz, R. B. Millman, & J. G. Langrod (Eds.), *Substance abuse: A comprehensive textbook* (pp. 533–542). Baltimore, MD: Williams and Wilkins.
- Danielson, M. L., Bitsko, R. H., Ghandour, R. M., Holbrook, J. R., Kogan, M. D., & Blumberg, S. J. (2018). Prevalence of parent-reported ADHD diagnosis and associated treatment among US children and adolescents, 2016. *Journal of Clinical Child & Adolescent Psychology, 47*(2), 199–212.
- Darvishi, N., Farhadi, M., Haghtalab, T., & Poorolajal, J. (2015). Alcohol-related risk of suicidal ideation, suicide attempt, and completed suicide: A meta-analysis. *PLoS ONE, 10*(5), e0126870. doi:10.1371/journal.pone.0126870
- Dass-Brailsford, P., & Safilian, C. M. (2017). Integrated approaches to treating psychological trauma and substance abuse in women: An update. *Trauma & Acute Care, 2*(2), 41.
- Daughters, S. B., Magidson, J. F., Lejuez, C. W., & Chen, Y. (2016). LETS ACT: A behavioral activation treatment for substance use and depression. *Advances in Dual Diagnosis, 9*(2–3), 74–84. doi:10.1108/ADD-02-2016-0006
- Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry, 11*(2), 123–128.
- Davies, W. (2017). Understanding the pathophysiology of postpartum psychosis: Challenges and new approaches. *World Journal of Psychiatry, 7*(2), 77–88. doi:10.5498/wjp.v7.i2.77
- Davis, H., & Attia, E. (2017). Pharmacotherapy of eating disorders. *Current Opinion in Psychiatry, 30*(6), 452–457. doi:10.1097/YCO.0000000000000358
- Dawson, D. A., Smith, S. M., Saha, T. D., Rubinsky, A. D., & Grant, B. F. (2012). Comparative performance of the AUDIT-C in screening for DSM-IV and DSM-5 alcohol use disorders. *Drug and Alcohol Dependence, 126*(3), 384–388. doi:10.1016/j.drugalcdep.2012.05.029
- De Alwis, D., Lynskey, M. T., Reiersen, A. M., & Agrawal, A. (2014). Attention-deficit/hyperactivity disorder subtypes and substance use and use disorders in NESARC. *Addictive Behaviors, 39*(8), 1278–1285. doi:10.1016/j.addbeh.2014.04.003
- De Crescenzo, F., Cortese, S., Adamo, N., & Janiri, L. (2017). Pharmacological and non-pharmacological treatment of adults with ADHD: A meta-review. *Evidence Based Mental Health, 20*(1), 4–11. doi:10.1136/eb-2016-102415
- De Hert, M., Cohen, D., Bobes, J., Cetkovich-Bakmas, M., Leucht, S., Ndeti, D. M., . . . Correll, C. U. (2011). Physical illness in patients with severe mental disorders. II. Barriers to care, monitoring and treatment guidelines, plus recommendations at the system and individual level. *World Psychiatry, 10*(2), 138–151.
- de Jonge, P., Roest, A. M., Lim, C. C., Florescu, S. E., Bromet, E. J., Stein, D. J., . . . Scott, K. M. (2016). Cross-national epidemiology of panic disorder and panic attacks in the world mental health surveys. *Depression and Anxiety, 33*(12), 1155–1177. doi:10.1002/da.22572
- de la Sierra, L. R. (2002). Countertransference: Our difficulties in the treatment of substance abuse. In *The psychodynamics of addiction* (pp. 141–152). Philadelphia, PA: Whurr Publishers.
- De Leon, G. (1996). Integrative recovery: A stage paradigm. *Substance Abuse, 17*(1), 51–63. doi:10.1080/08897079609444728
- De Leon, G. (2000). Modified therapeutic community for homeless mentally ill chemical abusers: Treatment outcomes. *American Journal of Drug and Alcohol Abuse, 26*(3), 461–480.
- De Leon, G. (2015). “The gold standard” and related considerations for a maturing science of substance abuse treatment. Therapeutic communities; a case in point. *Substance Use and Misuse, 50*(8–9), 1106–1109. doi:10.3109/10826084.2015.1012846
- De Leon, G., Sacks, S., Staines, G., & McKendrick, K. (2000). Modified therapeutic community for homeless mentally ill chemical abusers: Treatment outcomes. *American Journal of Drug and Alcohol Abuse, 26*(3), 461–480.
- DeMarce, J. M., Lash, S. J., Stephens, R. S., Grambow, S. C., & Burden, J. L. (2008). Promoting continuing care adherence among substance abusers with co-occurring psychiatric disorders following residential treatment. *Addictive Behaviors, 33*(9), 1104–1112. doi:10.1016/j.addbeh.2008.02.008



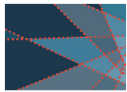
- Department of Veterans Affairs & Department of Defense. (2015). *VA/DoD clinical practice guideline for the management of substance use disorders*. Version 3. 0. Retrieved from www.healthquality.va.gov/guidelines/MH/sud/VADODSUDCPGRevised22216.pdf
- Department of Veterans Affairs & Department of Defense. (2017). *VA/DoD clinical practice guideline for the management of posttraumatic stress disorder and acute stress disorder*. Version 3.0. Retrieved from www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal012418.pdf
- Detweiler, M. B., Pagadala, B., Candelario, J., Boyle, J. S., Detweiler, J. G., & Lutgens, B. W. (2016). Treatment of post-traumatic stress disorder nightmares at a Veterans Affairs medical center. *Journal of Clinical Medicine*, 5(12). pii: E117. doi:10.3390/jcm5120117
- De Witte, N. A., Crunelle, C. L., Sabbe, B., Moggi, F., & Dom, G. (2014). Treatment for outpatients with comorbid schizophrenia and substance use disorders: A review. *European Addiction Research*, 20(3), 105–114. doi:10.1159/000355267
- Diaz, N., Horton, E. G., & Weiner, M. (2012). Dysthymia, major depression, and double depression among individuals receiving substance abuse treatment. *Health*, 4(12), 1–9. doi:10.4236/health.2012.412181
- Dickey, B., & Ware, N. C. (2008). Therapeutic communities and mental health system reform. *Psychiatric Rehabilitation Journal*, 32(2), 105–109. doi:10.2975/32.2.2008.105.109
- DiClemente, C. C., Corno, C. M., Graydon, M. M., Wiprovnick, A. E., & Knoblach, D. J. (2017). Motivational interviewing, enhancement, and brief interventions over the last decade: A review of reviews of efficacy and effectiveness. *Psychology of Addictive Behaviors*, 31(8), 862–887. doi:10.1037/adb0000318
- Dieterich, M., Irving, C. B., Bergman, H., Khokhar, M. A., Park, B., & Marshall, M. (2017). Intensive case management for severe mental illness. *Schizophrenia Bulletin*, 43(4), 698–700. doi:10.1093/schbul/sbx061
- Ding, K., Slate, M., & Yang, J. (2017). History of co-occurring disorders and current mental health status among homeless veterans. *BMC Public Health*, 18, 751.
- Ding, K., Yang, J., Cheng, G., Schiltz, T., Summers, K. M., & Skinstad, A. H. (2011). Hospitalizations and hospital charges for co-occurring substance use and mental disorders. *Journal of Substance Abuse Treatment*, 40(4), 366–375. doi:10.1016/j.jsat.2010.12.005
- Dixon, L. B., Holoshitz, Y., & Nossel, I. (2016). Treatment engagement of individuals experiencing mental illness: Review and update. *World Psychiatry*, 15(1), 13–20. doi:doi:10.1002/wps.20306
- Domenico, L. H., Lewis, B., Hazarika, M., & Nixon, S. J. (2018). Characterizing anxiety among individuals receiving treatment for alcohol and substance use disorders. *Journal of the American Psychiatric Nurses Association*, 24(4), 343–351. doi:10.1177/1078390317739106
- Doucet, S., Jones, I., Letourneau, N., Dennis, C. L., & Blackmore, E. R. (2011). Interventions for the prevention and treatment of postpartum psychosis: A systematic review. *Archives of Women's Mental Health*, 14(2), 89–98. doi:10.1007/s00737-010-0199-6
- Drainoni, M. L., Farrell, C., Sorensen-Alawad, A., Palmisano, J. N., Chaisson, C., & Walley, A. Y. (2014). Patient perspectives of an integrated program of medical care and substance use treatment. *AIDS Patient Care and STDs*, 28(2), 71–81. doi:10.1089/apc.2013.0179
- Drake, R. E., Bond, G. R., Goldman, H. H., Hogan, M. F., & Karakus, M. (2016). Individual placement and support services boost employment for people with serious mental illnesses, but funding is lacking. *Health Affairs (Millwood)*, 35(6), 1098–1105. doi:10.1377/hlthaff.2016.0001
- Drake, R. E., Luciano, A. E., Mueser, K. T., Covell, N. H., Essock, S. M., Xie, H., & McHugo, G. J. (2016). Longitudinal course of clients with co-occurring schizophrenia-spectrum and substance use disorders in urban mental health centers: A 7-year prospective study. *Schizophrenia Bulletin*, 42(1), 202–211. doi:10.1093/schbul/sbv110
- Drymalski, W. M., & Campbell, T. C. (2009). A review of Motivational Interviewing to enhance adherence to antipsychotic medication in patients with schizophrenia: Evidence and recommendations. *Journal of Mental Health*, 18(1), 6–15. doi:10.1080/09638230802052161
- Drymalski, W. M., & Nunley, M. R. (2016). The use of the Addiction Severity Index psychiatric composite scores to predict psychiatric inpatient admissions. *Journal of Addictions Nursing*, 27(3), 190–196. doi:10.1097/jan.0000000000000134
- Drymalski, W. M., & Nunley, M. R. (2018). Sensitivity of the ASAM criteria to psychiatric need. *International Journal of Mental Health and Addiction*, 16(3), 617–629. doi:10.1007/s11469-017-9801-8
- Duijkers, J. C., Vissers, C. T., & Egger, J. I. (2016). Unraveling executive functioning in dual diagnosis. *Frontiers in Psychology*, 7, 979.
- Dundon, W. D., Pettinati, H. M., Lynch, K. G., Xie, H., Varillo, K. M., Makadon, C., & Oslin, D. W. (2008). The therapeutic alliance in medical-based interventions impacts outcome in treating alcohol dependence. *Drug and Alcohol Dependence*, 95(3), 230–236. doi:10.1016/j.drugalcdep.2008.01.010

- Dunne, E. M., Burrell, L. E., 2nd, Diggins, A. D., Whitehead, N. E., & Latimer, W. W. (2015). Increased risk for substance use and health-related problems among homeless veterans. *American Journal of Addictions, 24*(7), 676–680. doi:10.1111/ajad.12289
- Dursa, E. K., Barth, S. K., Schneiderman, A. I., & Bossarte, R. M. (2016). Physical and mental health status of Gulf War and Gulf Era veterans: Results from a large population-based epidemiological study. *Journal of Occupational and Environmental Medicine, 58*(1), 41–46. doi:10.1097/jom.0000000000000627
- Dye, M. H., Roman, P. M., Knudsen, H. K., & Johnson, J. A. (2012). The availability of integrated care in a national sample of therapeutic communities. *Journal of Behavioral Health Services & Research, 39*(1), 17–27. doi:10.1007/s11414-011-9251-1
- Dykstra, R. E., Schumacher, J. A., Mota, N., & Coffey, S. F. (2015). Examining the role of antisocial personality disorder in intimate partner violence among substance use disorder treatment seekers with clinically significant trauma histories. *Violence Against Women, 21*(8), 958–974. doi:10.1177/1077801215589377
- Eby, L. T., Burk, H., & Maher, C. P. (2010). How serious of a problem is staff turnover in substance abuse treatment? A longitudinal study of actual turnover. *Journal of Substance Abuse Treatment, 39*(3), 264–271. doi:10.1016/j.jsat.2010.06.009
- Eby, L. T., Laschober, T. C., & Curtis, S. L. (2014). Substance abuse-specific knowledge transfer or loss? Treatment program turnover versus professional turnover among substance abuse clinicians. *Journal of Addictive Diseases, 33*(3), 243–252. doi:10.1080/10550887.2014.950022
- Edwards, R. (2006). The role and competencies of staff in the treatment of coexisting problems of mental health and substance misuse. In R. G. Hussein (Ed.), *Dual diagnosis nursing* (pp. 285–295). Hoboken, NJ: Blackwell Publishing.
- Egan, T. E., Dawson, A. E., & Wymbs, B. T. (2017). Substance use in undergraduate students with histories of attention-deficit/hyperactivity disorder (ADHD): The role of impulsivity. *Substance Use and Misuse, 52*(10), 1375–1386. doi:10.1080/10826084.2017.1281309
- Ellenhorn, R. (2015). Assertive community treatment: A “living-systems” alternative to hospital and residential care. *Psychiatric Annals, 45*(3), 120–125. doi:10.3928/00485713-20150304-06
- Elmquist, J., Shorey, R. C., Anderson, S., & Stuart, G. L. (2015). Eating disorder symptoms and length of stay in residential treatment for substance use: A brief report. *Journal of Dual Diagnosis, 11*(3–4), 233–237. doi:10.1080/15504263.2015.1104480
- Epstein, A. J., Barry, C. L., Fiellin, D. A., & Busch, S. H. (2015). Consumers’ valuation of primary care-based treatment options for mental and substance use disorders. *Psychiatric Services, 66*(8), 772–774. doi:10.1176/appi.ps.201500077
- Evans, E., Padwa, H., Li, L., Lin, V., & Hser, Y. I. (2015). Heterogeneity of mental health service utilization and high mental health service use among women eight years after initiating substance use disorder treatment. *Journal of Substance Abuse Treatment, 59*, 10–19. doi:10.1016/j.jsat.2015.06.021
- Ewing, G., Austin, L., Diffin, J., & Grande, G. (2015). Developing a person-centred approach to career assessment and support. *British Journal of Community Nursing, 20*(12), 580–584. doi:10.12968/bjcn.2015.20.12.580
- Farren, C. K., Hill, K. P., & Weiss, R. D. (2012). Bipolar disorder and alcohol use disorder: A review. *Current Psychiatry Reports, 14*(6), 659–666. doi:10.1007/s11920-012-0320-9
- Fazel, S., Yoon, I. A., & Hayes, A. J. (2017). Substance use disorders in prisoners: An updated systematic review and meta-regression analysis in recently incarcerated men and women. *Addiction, 112*(10), 1725–1739. doi:10.1111/add.13877
- Fearn, N. E., Vaughn, M. G., Nelson, E. J., Salas-Wright, C. P., DeLisi, M., & Qian, Z. (2016). Trends and correlates of substance use disorders among probationers and parolees in the United States 2002–2014. *Drug and Alcohol Dependence, 167*, 128–139. doi:10.1016/j.drugalcdep.2016.08.003
- Fisher, W. H., Geller, J. L., & Pandiani, J. A. (2009). The changing role of the state psychiatric hospital. *Health Affairs, 28*(3), 676–684. doi:10.1377/hlthaff.28.3.676
- Flanagan, J. C., Korte, K. J., Killeen, T. K., & Back, S. E. (2016). Concurrent treatment of substance use and PTSD. *Current Psychiatry Reports, 18*(8). doi:10.1007/s11920-016-0709-y
- Food and Drug Administration (FDA). (March 2007). Strattera. Patient information. www.accessdata.fda.gov/drugsatfda_docs/label/2007/021411s004s012s013s015s021lbl.pdf
- Food and Drug Administration. (2010). Kapvay. Prescribing information. www.accessdata.fda.gov/drugsatfda_docs/label/2010/022331s001s002lbl.pdf
- Food and Drug Administration. (2013). Intuniv. Prescribing information. www.accessdata.fda.gov/drugsatfda_docs/label/2013/022037s009lbl.pdf
- Food and Drug Administration. (April 28, 2017). Depression: FDA-approved medications may help. Consumer updates. Retrieved from www.fda.gov/forconsumers/consumerupdates/ucm095980.htm



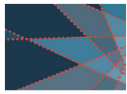
- Food and Drug Administration. (March 5, 2019). *FDA approves new nasal spray medication for treatment-resistant depression; available only at a certified doctor's office or clinic*. Retrieved from www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm632761.htm
- Ford, J. A., & Perna, D. (2015). Prescription drug misuse and suicidal ideation: Findings from the National Survey on Drug Use and Health. *Drug and Alcohol Dependence*, 157, 192–196. doi:10.1016/j.drugalcdep.2015.10.010
- Fouladi, F., Mitchell, J. E., Crosby, R. D., Engel, S. G., Crow, S., Hill, L., . . . Steffen, K. J. (2015). Prevalence of alcohol and other substance use in patients with eating disorders. *European Eating Disorders Review*, 23(6), 531–536. doi:10.1002/erv.2410
- Fountoulakis, K. N., Grunze, H., Vieta, E., Young, A., Yatham, L., Blier, P., . . . Moeller, H. J. (2017). The International College of Neuro-Psychopharmacology (CINP) treatment guidelines for bipolar disorder in adults (CINP-BD-2017), Part 3: The clinical guidelines. *International Journal of Neuropsychopharmacology*, 20(2), 180–195. doi:10.1093/ijnp/pyw109
- Fowler, K. A., Jack, S. P. D., Lyons, B. H., Betz, C. J., & Petrosky, E. (2018). Surveillance for violent deaths—National Violent Death Reporting System, 18 states, 2014. *MMWR Surveillance Summaries*, 67(2), 1–36. doi:10.15585/mmwr.ss6702a1
- Franko, D. L., Keshaviah, A., Eddy, K. T., Krishna, M., Davis, M. C., Keel, P. K., & Herzog, D. B. (2013). A longitudinal investigation of mortality in anorexia nervosa and bulimia nervosa. *American Journal of Psychiatry*, 170(8), 917–925. doi:10.1176/appi.ajp.2013.12070868
- Fries, H. P., & Rosen, M. I. (2011). The efficacy of assertive community treatment to treat substance use. *Journal of the American Psychiatric Nurses Association*, 17(1), 45–50. doi:10.1177/1078390310393509
- Frisman, L. K., Mueser, K. T., Covell, N. H., Lin, H. J., Crocker, A., Drake, R. E., & Essock, S. M. (2009). Use of integrated dual disorder treatment via assertive community treatment versus clinical case management for persons with co-occurring disorders and antisocial personality disorder. *Journal of Nervous and Mental Disease*, 197(11), 822–828. doi:10.1097/NMD.0b013e3181beac52
- Frounfelker, R. L., Wilkniss, S. M., Bond, G. R., Devitt, T. S., & Drake, R. E. (2011). Enrollment in supported employment services for clients with a co-occurring disorder. *Psychiatric Services*, 62(5), 545–547. doi:10.1176/ps.62.5.pss6205_0545
- Fruzzetti, A. E. (October 03, 2017). *Why borderline personality disorder is misdiagnosed*. Retrieved from www.nami.org/Blogs/NAMI-Blog/October-2017/Why-Borderline-Personality-Disorder-is-Misdiagnose
- Fulton, J. J., Calhoun, P. S., Wagner, H. R., Schry, A. R., Hair, L. P., Feeling, N., . . . Beckham, J. C. (2015). The prevalence of posttraumatic stress disorder in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans: A meta-analysis. *Journal of Anxiety Disorders*, 31, 98–107. doi:10.1016/j.janxdis.2015.02.003
- Gadermann, A. M., Alonso, J., Vilagut, G., Zaslavsky, A. M., & Kessler, R. C. (2012). Comorbidity and disease burden in the National Comorbidity Survey Replication (NCS-R). *Depression and Anxiety*, 29(9), 797–806. doi:10.1002/da.21924
- Gainsbury, S. M. (2017). Cultural competence in the treatment of addictions: Theory, practice and evidence. *Clinical Psychology & Psychotherapy*, 24(4), 987–1001. doi:10.1002/cpp.2062
- Galán, C. A., & Humphreys, K. L. (Aug 2, 2017). ADHD and substance use: Current evidence and treatment considerations. *Psychiatric Times*, 34(8), 1–3.
- Garcia, S., Martinez-Cengotitabengoa, M., Lopez-Zurbano, S., Zorrilla, I., Lopez, P., Vieta, E., & Gonzalez-Pinto, A. (2016). Adherence to antipsychotic medication in bipolar disorder and schizophrenic patients: A systematic review. *Journal of Clinical Psychopharmacology*, 36(4), 355–371. doi:10.1097/jcp.0000000000000523
- Garner, B. R., & Hunter, B. D. (2014). Predictors of staff turnover and turnover intentions within addiction treatment settings: Change over time matters. *Substance Abuse*, 8, 63–71. doi:10.4137/SART.S17133
- GBD 2016 Disease and Injury Incidence and Prevalence Collaborators. (2017). Global, regional, and national incidence, prevalence, and years lived with disability for 328 diseases and injuries for 195 countries, 1990–2016: A systematic analysis for the Global Burden of Disease Study 2016. *Lancet*, 390(10100), 1211–1259. doi:10.1016/s0140-6736(17)32154-2
- Gentile, S. (2017). Untreated depression during pregnancy: Short- and long-term effects in offspring. A systematic review. *Neuroscience*, 342, 154–166. doi:10.1016/j.neuroscience.2015.09.001
- Ghafoori, B., Barragan, B., & Palinkas, L. (2014). Mental health service use among trauma-exposed adults: A mixed-methods study. *Journal of Nervous and Mental Disease*, 202(3), 239–246. doi:10.1097/nmd.0000000000000108
- Gibbon, S., Duggan, C., Stoffers, J., Huband, N., Vollm, B. A., Ferriter, M., & Lieb, K. (2010). Psychological interventions for antisocial personality disorder. *Cochrane Database of Systematic Reviews*, 6, CD007668. doi:10.1002/14651858.CD007668.pub2
- Gilmer, T. P., Manning, W. G., & Ettner, S. L. (2009). A cost analysis of San Diego County's REACH program for homeless persons. *Psychiatric Services*, 60(4), 445–450. doi:10.1176/appi.ps.60.4.445

- Gilmore, A. K., Brignone, E., Painter, J. M., Lehavot, K., Fargo, J., Suo, Y., . . . Gundlapalli, A. V. (2016). Military sexual trauma and co-occurring posttraumatic stress disorder, depressive disorders, and substance use disorders among returning Afghanistan and Iraq veterans. *Women's Health Issues, 26*(5), 546–554. doi:10.1016/j.whi.2016.07.001
- Glenn, A. L., Johnson, A. K., & Raine, A. (2013). Antisocial personality disorder: A current review. *Current Psychiatry Reports, 15*(12), 427. doi:10.1007/s11920-013-0427-7
- Gold, A. K., Otto, M. W., Deckersbach, T., Sylvia, L. G., Nierenberg, A. A., & Kinrys, G. (2018). Substance use comorbidity in bipolar disorder: A qualitative review of treatment strategies and outcomes. *American Journal of Addictions, 27*(3), 188–201. doi:10.1111/ajad.12713
- Gold, L. H. (2014). DSM-5 and the assessment of functioning: The World Health Organization disability assessment schedule 2.0 (WHODAS 2.0). *Journal of the American Academy of Psychiatry and the Law, 42*(2), 173–181.
- Goldstein, R. B., Smith, S. M., Chou, S. P., Saha, T. D., Jung, J., Zhang, H., . . . Grant, B. F. (2016). The epidemiology of DSM-5 posttraumatic stress disorder in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions-III. *Social Psychiatry and Psychiatric Epidemiology, 51*(8), 1137–1148. doi:10.1007/s00127-016-1208-5
- Goodman, D. J., Milliken, C. U., Theiler, R. N., Nordstrom, B. R., & Akerman, S. C. (2015). A multidisciplinary approach to the treatment of co-occurring opioid use disorder and posttraumatic stress disorder in pregnancy: A case report. *Journal of Dual Diagnosis, 11*(3–4), 248–257. doi:10.1080/15504263.2015.1104484
- Goodrich, D. E., Kilbourne, A. M., Nord, K. M., & Bauer, M. S. (2013). Mental health collaborative care and its role in primary care settings. *Current Psychiatry Reports, 15*(8), 383. doi:10.1007/s11920-013-0383-2
- Goodwin, R. D., & Stein, D. J. (2013). Anxiety disorders and drug dependence: Evidence on sequence and specificity among adults. *Psychiatry and Clinical Neurosciences, 67*(3), 167–173. doi:10.1111/pcn.12030
- Grant, B. F., Chou, S. P., Goldstein, R. B., Huang, B., Stinson, F. S., Saha, T. D., . . . Ruan, W. J. (2008). Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: Results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry, 69*(4), 533–545. doi:ej07m03916
- Grant, B. F., Goldstein, R. B., Saha, T. D., Chou, S. P., Jung, J., Zhang, H., . . . Hasin, D. S. (2015). Epidemiology of DSM-5 alcohol use disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions III. *JAMA Psychiatry, 72*(8), 757–766. doi:10.1001/jamapsychiatry.2015.0584
- Grant, B. F., Hasin, D. S., Stinson, F. S., Dawson, D. A., Chou, S. P., Ruan, W. J., & Pickering, R. P. (2004). Prevalence, correlates, and disability of personality disorders in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry, 65*(7), 948–958.
- Grant, B. F., Saha, T. D., Ruan, W. J., Goldstein, R. B., Chou, S. P., Jung, J., . . . Hasin, D. S. (2016). Epidemiology of DSM-5 drug use disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions-III. *JAMA Psychiatry, 73*(1), 39–47. doi:10.1001/jamapsychiatry.2015.2132
- Grattan, A., Sullivan, M. D., Saunders, K. W., Campbell, C. I., & Von Korff, M. R. (2012). Depression and prescription opioid misuse among chronic opioid therapy recipients with no history of substance abuse. *Annals of Family Medicine, 10*(4), 304–311. doi:10.1370/afm.1371
- Green, C. A., Yarborough, M. T., Polen, M. R., Janoff, S. L., & Yarborough, B. J. (2015). Dual recovery among people with serious mental illnesses and substance problems: A qualitative analysis. *Journal of Dual Diagnosis, 11*(1), 33–41. doi:10.1080/15504263.2014.975004
- Green, K. L., Brown, G. K., Jager-Hyman, S., Cha, J., Steer, R. A., & Beck, A. T. (2015). The predictive validity of the Beck Depression Inventory suicide item. *Journal of Clinical Psychiatry, 76*(12), 1683–1686. doi:10.4088/JCP.14m09391
- Gregorowski, C., Seedat, S., & Jordaan, G. P. (2013). A clinical approach to the assessment and management of co-morbid eating disorders and substance use disorders. *BMC Psychiatry, 13*, 289. doi:10.1186/1471-244x-13-289
- Grella, C. E. (2008). From generic to gender-responsive treatment: Changes in social policies, treatment services, and outcomes of women in substance abuse treatment. *Journal of Psychoactive Drugs, 40*(Suppl. 5), 327–343.
- Grella, C. E., & Shi, Y. (2011). Stability of outcomes following residential drug treatment for patients with co-occurring disorders. *Journal of Dual Diagnosis, 7*(1–2), 103–112. doi:10.1080/15504263.2011.566067
- Grewal, R. S., & George, T. P. (July 14, 2017). Cannabis-induced psychosis: A review. *Psychiatric Times, 34*(7), 1–5.
- Group, W. A. W. (2002). The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Development, reliability and feasibility. *Addiction, 97*(9), 1183–1194.
- Guerrero, E., & Andrews, C. M. (2011). Cultural competence in outpatient substance abuse treatment: Measurement and relationship to wait time and retention. *Drug and Alcohol Dependence, 119*(1–2), e13–e22. doi:10.1016/j.drugalcdep.2011.05.020
- Guerrero, E. G. (2013). Enhancing access and retention in substance abuse treatment: The role of Medicaid payment acceptance and cultural competence. *Drug and Alcohol Dependence, 132*(3), 555–561. doi:10.1016/j.drugalcdep.2013.04.005



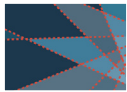
- Guerrero, E. G., Padwa, H., Lengnick-Hall, R., Kong, Y., & Perrigo, J. L. (2015). Leadership and licensure for drug treatment and the implementation of co-occurring disorder treatment in community mental health centers. *Community Mental Health Journal*, 51(5), 554–566. doi:10.1007/s10597-015-9886-0
- Guille, C., Newman, R., Fryml, L. D., Lifton, C. K., & Epperson, C. N. (2013). Management of postpartum depression. *Journal of Midwifery & Women's Health*, 58(6), 643–653. doi:10.1111/jmwh.12104
- Habel, L. A., Cooper, W. O., Sox, C. M., Chan, K. A., Fireman, B. H., Arbogast, P. G., . . . Selby, J. V. (2011). ADHD medications and risk of serious cardiovascular events in young and middle-aged adults. *JAMA*, 306(24), 2673–2683. doi:10.1001/jama.2011.1830
- Hagler, K. J., Rice, S. L., Munoz, R. E., Salvador, J. G., Forcehimes, A. A., & Bogenschutz, M. P. (2015). "It Might Actually Work This Time": Benefits and barriers to adapted 12-step facilitation therapy and mutual-help group attendance from the perspective of dually diagnosed individuals. *Journal of Addictions Nursing*, 26(3), 120–128. doi:10.1097/jan.0000000000000083
- Haller, M., Colvonen, P. J., Davis, B. C., Trim, R. S., Bogner, R., Sevcik, J., & Norman, S. B. (2016). Examining pretreatment differences between veterans in residential versus outpatient treatment for alcohol use disorder and comorbid combat-related PTSD. *Journal of Dual Diagnosis*, 12(3–4), 282–289. doi:10.1080/15504263.2016.1256516
- Haller, M., Norman, S. B., Cummins, K., Trim, R. S., Xu, X., Cui, R., . . . Tate, S. R. (2016). Integrated cognitive behavioral therapy versus cognitive processing therapy for adults with depression, substance use disorder, and trauma. *Journal of Substance Abuse Treatment*, 62, 38–48. doi:10.1016/j.jsat.2015.11.005
- Halloran, L. (2013). Substance abuse in primary care. *Journal for Nurse Practitioners*, 9(7), 475–476.
- Hamdi, N. R., & Iacono, W. G. (2014). Lifetime prevalence and co-morbidity of externalizing disorders and depression in prospective assessment. *Psychological Medicine*, 44(2), 315–324. doi:10.1017/s0033291713000627
- Han, B., Compton, W. M., Blanco, C., & Colpe, L. J. (2017). Prevalence, treatment, and unmet treatment needs of US adults with mental health and substance use disorders. *Health Affairs (Millwood)*, 36(10), 1739–1747.
- Han, B., Olfson, M., & Mojtabai, R. (2017). Depression care among adults with co-occurring major depressive episodes and substance use disorders in the United States. *Journal of Psychiatric Research*, 91, 47–56. doi:10.1016/j.jpsychires.2017.02.026
- Harrison, J., Cousins, L., Spybrook, J., & Curtis, A. (2017). Peers and co-occurring research-supported interventions. *Journal of Evidence-Informed Social Work*, 14(3), 201–215. doi:10.1080/23761407.2017.1316220
- Harrison, M. L., Moore, K. A., Young, S., Flink, D., & Ochshorn, E. (2008). Implementing the comprehensive, continuous, integrated system of care model for individuals with co-occurring disorders: Preliminary findings from a residential facility serving homeless individuals. *Journal of Dual Diagnosis*, 4(3), 238–259.
- Harrold, S. A., Libet, J., Pope, C., Lauerer, J. A., Johnson, E., & Edlund, B. J. (2018). Increasing physical activity for veterans in the Mental Health Intensive Case Management Program: A community-based intervention. *Perspectives in Psychiatric Care*, 54(2), 266–273. doi:10.1111/ppc.12233
- Harrop, E. N., & Marlatt, G. A. (2010). The comorbidity of substance use disorders and eating disorders in women: Prevalence, etiology, and treatment. *Addictive Behaviors*, 35(5), 392–398. doi:10.1016/j.addbeh.2009.12.016
- Hartz, S. M., Pato, C. N., Medeiros, H., Cavazos-Rehg, P., Sobell, J. L., Knowles, J. A., . . . Pato, M. T. (2014). Comorbidity of severe psychotic disorders with measures of substance use. *JAMA Psychiatry*, 71(3), 248–254. doi:10.1001/jamapsychiatry.2013.3726
- Harvard Medical School. (2005). *National Comorbidity Survey (NCS)*. Retrieved from <https://www.hcp.med.harvard.edu/ncs/>
- Hasin, D., Fenton, M. C., Skodol, A., Krueger, R., Keyes, K., Geier, T., . . . Grant, B. (2011). Personality disorders and the 3-year course of alcohol, drug, and nicotine use disorders. *Archives of General Psychiatry*, 68(11), 1158–1167. doi:10.1001/archgenpsychiatry.2011.78
- Hasin, D., & Kilcoyne, B. (2012). Comorbidity of psychiatric and substance use disorders in the United States: Current issues and findings from the NESARC. *Current Opinion in Psychiatry*, 25(3), 165–171. doi:10.1097/YCO.0b013e3283523dcc
- Hasin, D. S., & Grant, B. F. (2015). The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) Waves 1 and 2: Review and summary of findings. *Social Psychiatry and Psychiatric Epidemiology*, 50(11), 1609–1640. doi:10.1007/s00127-015-1088-0
- Hasin, D. S., Kerridge, B. T., Saha, T. D., Huang, B., Pickering, R., Smith, S. M., . . . Grant, B. F. (2016). Prevalence and correlates of DSM-5 cannabis use disorder, 2012–2013: Findings from the National Epidemiologic Survey on Alcohol and Related Conditions-III. *American Journal of Psychiatry*, 173(6), 588–599. doi:10.1176/appi.ajp.2015.15070907
- Hasin, D. S., O'Brien, C. P., Auriacombe, M., Borges, G., Bucholz, K., Budney, A., . . . Grant, B. F. (2013). DSM-5 criteria for substance use disorders: Recommendations and rationale. *American Journal of Psychiatry*, 170(8), 834–851. doi:10.1176/appi.ajp.2013.12060782

- Hasin, D. S., Sarvet, A. L., Meyers, J. L., Saha, T. D., Ruan, W. J., Stohl, M., & Grant, B. F. (2018). Epidemiology of Adult DSM-5 major depressive disorder and its specifiers in the United States. *JAMA Psychiatry*, 75(4), 336–346. doi:10.1001/jamapsychiatry.2017.4602
- Haug, N. A., Duffy, M., & McCaul, M. E. (2014). Substance abuse treatment services for pregnant women: Psychosocial and behavioral approaches. *Obstetrics and Gynecology Clinics of North America*, 41(2), 267–296. doi:10.1016/j.ogc.2014.03.001
- Havassy, B. E., & Mericle, A. A. (2013). Recent violence among persons entering short-term residential mental health and substance abuse treatment. *Journal of Dual Diagnosis*, 9(3). doi:10.1080/15504263.2013.804773
- Haviland, M. G., Banta, J. E., Sonne, J. L., & Przekop, P. (2016). Posttraumatic stress disorder-related hospitalizations in the United States (2002–2011): Rates, co-occurring illnesses, suicidal ideation/self-harm, and hospital charges. *Journal of Nervous and Mental Disease*, 204(2), 78–86. doi:10.1097/NMD.0000000000000432
- Hawk, K., & D'Onofrio, G. (2018). Emergency department screening and interventions for substance use disorders. *Addiction Science & Clinical Practice*, 13(1), 18. doi:10.1186/s13722-018-0117-1
- Healey, P., Stager, M. L., Woodmass, K., Dettlaff, A. J., Vergara, A., Janke, R., & Wells, S. J. (2017). Cultural adaptations to augment health and mental health services: A systematic review. *BMC Health Services Research*, 17(1), 8. doi:10.1186/s12913-016-1953-x
- Health Resources and Services Administration (HRSA). (2018). *Behavioral health workforce projections, 2016–2030: Addiction counselors*. Retrieved from <https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/addiction-counselors-2018.pdf>
- Health Resources and Services Administration. (2020, March 1). Shortage areas. Retrieved from <https://data.hrsa.gov/topics/health-workforce/shortage-areas>
- Heffner, J. L., Blom, T. J., & Anthenelli, R. M. (2011). Gender differences in trauma history and symptoms as predictors of relapse to alcohol and drug use. *American Journal of Addictions*, 20(4), 307–311. doi:10.1111/j.1521-0391.2011.00141.x
- Heimberg, R. G., Hofmann, S. G., Liebowitz, M. R., Schneier, F. R., Smits, J. A. J., Stein, M. B., . . . Craske, M. G. (2014). Social anxiety disorder in DSM-5. *Depression and Anxiety*, 31(6), 472–479. doi:10.1002/da.22231
- Hendershot, C. S., Witkiewitz, K., George, W. H., & Marlatt, G. A. (2011). Relapse prevention for addictive behaviors. *Substance Abuse Treatment, Prevention, and Policy*, 6, 17. doi:10.1186/1747-597x-6-17
- Henry, M., Shivji, A., de Sousa, T., and Cohen, R. (2015). *The 2015 Annual Homeless Assessment Report (AHAR) to Congress. Part 1 – Point in time estimates of homelessness*. Retrieved from <https://files.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf>
- Henry, M., Watt, R., Rosenthal, L., & Shivji, A. (2016, November). *The 2016 Annual Homeless Assessment Report (AHAR) to Congress. Part 1: Point-in-time estimates of homelessness*. Retrieved from <https://files.hudexchange.info/resources/documents/2016-AHAR-Part-1.pdf>
- Henry, M., Watt, R., Mahathey, A., Ouellette, J., Sitler, A., & Abt Associates. (2020, January). *The 2019 Annual Homeless Assessment Report (AHAR) to Congress. Part 1: Point-in-time estimates of homelessness*. Retrieved from <https://files.hudexchange.info/resources/documents/2019-AHAR-Part-1.pdf>
- Hermes, E., & Rosenheck, R. (2016). Psychopharmacologic services for homeless veterans: Comparing psychotropic prescription fills among homeless and non-homeless veterans with serious mental illness. *Community Mental Health Journal*, 52(2), 142–147. doi:10.1007/s10597-015-9904-2
- Heslin, K. C., Elixhauser, A., & Steiner, C. A. (2015, June). *Hospitalizations involving mental and substance use disorders among adults, 2012*. HCUP Statistical Brief #191. Agency for Healthcare Research and Quality, Rockville, MD. Retrieved from www.hcup-us.ahrq.gov/reports/statbriefs/sb191-Hospitalization-Mental-Substance-Use-Disorders-2012.pdf
- Hien, D. A., Jiang, H., Campbell, A. N. C., Hu, M.-C., Miele, G. M., Cohen, L. R., . . . Nunes, E. V. (2010). Do treatment improvements in PTSD severity affect substance use outcomes? A secondary analysis from a randomized clinical trial in NIDA's Clinical Trials Network. *American Journal of Psychiatry*, 167(1), 95–101. doi:10.1176/appi.ajp.2009.09091261
- Hjorthoj, C. R., Hjorthoj, A. R., & Nordentoft, M. (2012). Validity of Timeline Follow-Back for self-reported use of cannabis and other illicit substances—Systematic review and meta-analysis. *Addictive Behaviors*, 37(3), 225–233. doi:10.1016/j.addbeh.2011.11.025
- Hogan, M. F., & Grumet, J. G. (2016). Suicide prevention: An emerging priority for health care. *Health Affairs*, 35(6), 1084–1090. doi:10.1377/hlthaff.2015.1672
- Holden, K., McGregor, B., Thandi, P., Fresh, E., Sheats, K., Belton, A., . . . Satcher, D. (2014). Toward culturally centered integrative care for addressing mental health disparities among ethnic minorities. *Psychological Services*, 11(4), 357–368. doi:10.1037/a0038122
- Horsfall, J., Cleary, M., Hunt, G. E., & Walter, G. (2009). Psychosocial treatments for people with co-occurring severe mental illnesses and substance use disorders (dual diagnosis): A review of empirical evidence. *Harvard Review of Psychiatry*, 17(1), 24–34. doi:10.1080/10673220902724599



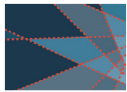
- Hudson, J. I., Hiripi, E., Pope, H. G., Jr., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*, 61(3), 348–358. doi:10.1016/j.biopsych.2006.03.040
- Huggard, P., Law, J., & Newcombe, D. (2017). A systematic review exploring the presence of vicarious trauma, compassion fatigue, and secondary traumatic stress in alcohol and other drug clinicians. *Australasian Journal of Disaster and Trauma Studies*, 21(2), 65–72.
- Hunt, E., Peters, R. H., & Kremling, J. (2015). Behavioral health treatment history among persons in the justice system: Findings from the Arrestee Drug Abuse Monitoring II Program. *Psychiatric Rehabilitation Journal*, 38(1), 7–15. doi:10.1037/prj0000132
- Hunt, G. E., Malhi, G. S., Cleary, M., Lai, H. M. X., & Sitharthan, T. (2016a). Comorbidity of bipolar and substance use disorders in national surveys of general populations, 1990–2015: Systematic review and meta-analysis. *Journal of Affective Disorders*, 206, 321–330. doi:10.1016/j.jad.2016.06.051
- Hunt, G. E., Malhi, G. S., Cleary, M., Lai, H. M. X., & Sitharthan, T. (2016b). Prevalence of comorbid bipolar and substance use disorders in clinical settings, 1990–2015: Systematic review and meta-analysis. *Journal of Affective Disorders*, 206, 331–349. doi:10.1016/j.jad.2016.07.011
- Hunt, G. E., Siegfried, N., Morley, K., Sitharthan, T., & Cleary, M. (2013). Psychosocial interventions for people with both severe mental illness and substance misuse. *Cochrane Database of Systematic Reviews*, 10, CD001088. doi:10.1002/14651858.CD001088.pub3
- Hunt, G. E., Siegfried, N., Morley, K., Sitharthan, T., & Cleary, M. (2014). Psychosocial interventions for people with both severe mental illness and substance misuse. *Schizophrenia Bulletin*, 40(1), 18–20.
- Hunt, T. K., & Forbush, K. T. (2016). Is “drunkorexia” an eating disorder, substance use disorder, or both? *Eating Behaviors*, 22, 40–45. doi:10.1016/j.eatbeh.2016.03.034
- Hunter, S. B., Schwartz, R. P., & Friedmann, P. D. (2016). Introduction to the Special Issue on the Studies on the Implementation of Integrated Models of Alcohol, Tobacco, and/or Drug Use Interventions and Medical Care. *Journal of Substance Abuse Treatment*, 60, 1–5. doi:10.1016/j.jsat.2015.10.001
- Ilgen, M. A., Bohnert, A. S., Ignacio, R. V., McCarthy, J. F., Valenstein, M. M., Kim, H. M., & Blow, F. C. (2010). Psychiatric diagnoses and risk of suicide in veterans. *Archives of General Psychiatry*, 67(11), 1152–1158. doi:10.1001/archgenpsychiatry.2010.129
- Jaffe, D. J. (2017). *What is “serious mental illness” and what is not?* Retrieved from <https://mentalillnesspolicy.org/serious-mental-illness-not/>
- Jahn, D. R., Muralidharan, A., Drapalski, A. L., Brown, C. H., Fang, L. J., & Lucksted, A. (2018). Differences in suicide and death ideation among veterans and nonveterans with serious mental illness. *Psychological Services*, 15(1), 31–39. doi:10.1037/ser0000127
- Johnson, J. A., Lee, A., Vinson, D., & Seale, J. P. (2013). Use of AUDIT-based measures to identify unhealthy alcohol use and alcohol dependence in primary care: A validation study. *Alcoholism: Clinical and Experimental Research*, 37(Suppl. 1), e253–e259. doi:10.1111/j.1530-0277.2012.01898.x
- Jones, C. M., & McCance-Katz, E. F. (2019). Co-occurring substance use and mental disorders among adults with opioid use disorder. *Drug and Alcohol Dependence*, 197, 78–82. doi:10.1016/j.drugalcdep.2018.12.030
- Jones, D., & Arndt, S. (2017, October). *The Iowa Pregnant and Postpartum Women’s Residential Treatment Program: Annual report*. Retrieved from <https://idph.iowa.gov/Portals/1/userfiles/148/PPW%20Year%202%20Eval.pdf>
- Jones, I., Chandra, P. S., Dazzan, P., & Howard, L. M. (2014). Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period. *Lancet*, 384(9956), 1789–1799. doi:10.1016/s0140-6736(14)61278-2
- Jones, I., & Shakespeare, J. (2014). Postnatal depression. *BMJ*, 349, g4500. doi:10.1136/bmj.g4500
- Jones, Q., Johnston, B., Biola, H., Gomez, S., & Crowder, C. (2018). Implementing standardized substance use disorder screening in primary care. *Journal of the American Academy of Physician Assistants*, 31(10), 42–45. doi:10.1097/01.Jaa.0000511792.75301.73
- Joseph, R., Kester, R., O’Brien, C., & Huang, H. (2017). The evolving practice of psychiatry in the era of integrated care. *Psychosomatics*, 58(5), 466–473. doi:10.1016/j.psym.2017.04.003
- Joyce, T. F., & Bailey, B. (2015). Supporting recovery in acute care and emergency settings [PowerPoint slides]. Retrieved from www.samhsa.gov/sites/default/files/programs_campaigns/recovery_to_practice/supporting-recovery-in-acute-care-emergency-settings.pdf
- Kaiser Family Foundation. (2017). *Uninsured rates for the nonelderly by race/ethnicity*. Retrieved from www.kff.org/uninsured/state-indicator/rate-by-raceethnicity/?currentTImeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
- Kaiser Permanente. (2019). Alcohol use in older adults. Retrieved from <https://wa.kaiserpermanente.org/healthAndWellness/index.jhtml?item=%2Fcommon%2FhealthAndWellness%2FhealthyLiving%2Flifestyle%2Falcohol-seniors.html>
- Kanbur, N., & Harrison, A. (2016). Co-occurrence of substance use and eating disorders: An approach to the adolescent patient in the context of family centered care. A literature review. *Substance Use and Misuse*, 51(7), 853–860. doi:10.3109/10826084.2016.1155614

- Kang, H. K., Bullman, T. A., Smolenski, D. J., Skopp, N. A., Gahm, G. A., & Reger, M. A. (2015). Suicide risk among 1.3 million veterans who were on active duty during the Iraq and Afghanistan wars. *Annals of Epidemiology*, 25(2), 96–100. doi:10.1016/j.annepidem.2014.11.020
- Kantor, V., Knefel, M., & Lueger-Schuster, B. (2017). Perceived barriers and facilitators of mental health service utilization in adult trauma survivors: A systematic review. *Clinical Psychology Review*, 52, 52–68. doi:10.1016/j.cpr.2016.12.001
- Katzman, M. A., Bilkey, T. S., Chokka, P. R., Fallu, A., & Klassen, L. J. (2017). Adult ADHD and comorbid disorders: Clinical implications of a dimensional approach. *BMC Psychiatry*, 17(1), 302. doi:10.1186/s12888-017-1463-3
- Keeley, R. D., Brody, D. S., Engel, M., Burke, B. L., Nordstrom, K., Moralez, E., . . . Emsermann, C. (2016). Motivational interviewing improves depression outcome in primary care: A cluster randomized trial. *Journal of Consulting and Clinical Psychology*, 84(11), 993–1007. doi:10.1037/ccp0000124
- Keen, I. L., Whitehead, N. E., Clifford, L., Rose, J., & Latimer, W. (2014). Perceived barriers to treatment in a community-based sample of illicit-drug-using African American men and women. *Journal of Psychoactive Drugs*, 46(5), 444–449. doi:10.1080/02791072.2014.964382
- Kelley, K. J., & Kelley, M. F. (2013). Teaching empathy and other compassion-based communication skills. *Journal for Nurses in Professional Development*, 29(6), 321–324. doi:10.1097/01.nnd.0000436794.24434.90
- Kelly, J. F., Greene, M. C., & Bergman, B. G. (2016). Recovery benefits of the “therapeutic alliance” among 12-step mutual-help organization attendees and their sponsors. *Drug and Alcohol Dependence*, 162, 64–71. doi:10.1016/j.drugalcdep.2016.02.028
- Kelly, T. M., & Daley, D. C. (2013). Integrated treatment of substance use and psychiatric disorders. *Social Work in Public Health*, 28(3–4), 388–406. doi:10.1080/19371918.2013.774673
- Kerfoot, K. E., Rosenheck, R. A., Petrakis, I. L., Swartz, M. S., Keefe, R. S., McEvoy, J. P., & Stroup, T. S. (2011). Substance use and schizophrenia: Adverse correlates in the CATIE study sample. *Schizophrenia Research*, 132(2–3), 177–182. doi:10.1016/j.schres.2011.07.032
- Kerner, B. (2015). Comorbid substance use disorders in schizophrenia: A latent class approach. *Psychiatry Research*, 225(3), 395–401. doi:10.1016/j.psychres.2014.12.006
- Kertesz, S. G., Crouch, K., Milby, J. B., Cusimano, R. E., & Schumacher, J. E. (2009). Housing first for homeless persons with active addiction: Are we overreaching? *Milbank Quarterly*, 87(2), 495–534. doi:10.1111/j.1468-0009.2009.00565.x
- Kessler, R. C. (2005). National Comorbidity Survey. Retrieved from www.hcp.med.harvard.edu/ncs/
- Kessler, R. C., Adler, L., Barkley, R., Biederman, J., Conners, C. K., Demler, O., . . . Zaslavsky, A. M. (2006). The prevalence and correlates of adult ADHD in the United States: Results from the National Comorbidity Survey Replication. *American Journal of Psychiatry*, 163(4), 716–723. doi:10.1176/appi.ajp.163.4.716
- Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S. L., . . . Zaslavsky, A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine*, 32(6), 959–976.
- Kessler, R. C., Barker, P. R., Colpe, L. J., Epstein, J. F., Gfroerer, J. C., Hiripi, E., . . . Zaslavsky, A. M. (2003). Screening for serious mental illness in the general population. *Archives of General Psychiatry*, 60(2), 184–189.
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives Of General Psychiatry*, 62(6), 593–602.
- Kessler, R. C., Green, J. G., Gruber, M. J., Sampson, N. A., Bromet, E., Cuitan, M., . . . Zaslavsky, A. M. (2010). Screening for serious mental illness in the general population with the K6 screening scale: Results from the WHO World Mental Health (WMH) survey initiative. *International Journal of Methods in Psychiatric Research*, 19(Suppl. 1), 4–22. doi:10.1002/mpr.310
- Kessler, R. C., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Wittchen, H. U. (2012). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research*, 21(3), 169–184. doi:10.1002/mpr.1359
- Keyser, D. J., Watkins, K. E., Vilamovska, A. M., & Pincus, H. A. (2008). Focus on alcohol & drug abuse: Improving service delivery for individuals with co-occurring disorders: New perspectives on the quadrant model. *Psychiatric Services*, 59(11), 1251–1253. doi:10.1176/appi.ps.59.11.1251
- Keyser-Marcus, L., Alvanzo, A., Rieckmann, T., Thacker, L., Sepulveda, A., Forcehimes, A., Islam, L. Z., . . . Svikis, D. S. (2015). Trauma, gender, and mental health symptoms in individuals with substance use disorders. *Interpersonal Violence*, 30(1), 3–24. doi:10.1177/0886260514532523
- Khalid, M. M., & Hamilton, R. J. (2020). Beta-blocker toxicity. StatPearls [Internet]. Retrieved from www.ncbi.nlm.nih.gov/books/NBK448097/?report=printable
- Kidd, S. A., Davidson, L., & McKenzie, K. (2017). Common factors in community mental health intervention: A scoping review. *Community Mental Health Journal*, 53(6), 627–637. doi:10.1007/s10597-017-0117-8



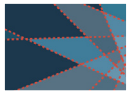
- Kidorf, M., Brooner, R. K., Gandotra, N., Antoine, D., King, V. L., Peirce, J., & Ghazarian, S. (2013). Reinforcing integrated psychiatric service attendance in an opioid-agonist program: A randomized and controlled trial. *Drug and Alcohol Dependence*, 133(1), 30–36.
- Killeen, T. K., Back, S. E., & Brady, K. T. (2015). Implementation of integrated therapies for comorbid post-traumatic stress disorder and substance use disorders in community substance abuse treatment programs. *Drug and Alcohol Review*, 34(3), 234–241. doi:10.1111/dar.12229
- Kills Small, N. J., Simons, J. S., & Stricherz, M. (2007). Assessing criterion validity of the Simple Screening Instrument for Alcohol and Other Drug Abuse (SSI-AOD) in a college population. *Addictive Behaviors*, 32(10), 2425–2431. doi:10.1016/j.addbeh.2007.04.003
- Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M., & Friedman, M. J. (2013). National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria. *Journal of Traumatic Stress*, 26(5), 537–547. doi:10.1002/jts.21848
- Kim, G., DeCoster, J., Bryant, A. N., & Ford, K. L. (2016). Measurement equivalence of the K6 Scale: The effects of race/ethnicity and language. *Assessment*, 23(6), 758–768. doi:10.1177/1073191115599639
- Kimerling, R., Makin-Byrd, K., Louzon, S., Ignacio, R. V., & McCarthy, J. F. (2016). Military sexual trauma and suicide mortality. *American Journal of Preventive Medicine*, 50(6), 684–691. doi:10.1016/j.amepre.2015.10.019
- Klassen, L. J., Bilkey, T. S., Katzman, M. A., & Chokka, P. (2012). Comorbid attention deficit/hyperactivity disorder and substance use disorder: Treatment considerations. *Current Drug Abuse Reviews*, 5(3), 190–198.
- Kline, A., Weiner, M. D., Ciccone, D. S., Interian, A., St. Hill, L., & Losonczy, M. (2014). Increased risk of alcohol dependency in a cohort of National Guard troops with PTSD: A longitudinal study. *Journal of Psychiatric Research*, 50, 18–25. doi:10.1016/j.jpsychires.2013.11.007
- Knight, D. K., Broome, K. M., Edwards, J. R., & Flynn, P. M. (2011). Supervisory turnover in outpatient substance abuse treatment. *Journal of Behavioral Health Services & Research*, 38(1), 80–90. doi:10.1007/s11414-009-9198-7
- Köck, P., & Walter, M. (2018). Personality disorder and substance use disorder—An update. *Mental Health and Prevention*, 12, 82–89. doi:10.1016/j.mhp.2018.10.003
- Kolbasovsky, A. (2009). Reducing 30-day inpatient psychiatric recidivism and associated costs through intensive case management. *Professional Case Management*, 14(2), 96–105. doi:10.1097/NCM.0b013e31819e026a
- Kondo, K., Low, A., Jindai, K., Mendelson, A., Motu'apuaka, M., Mansoor, D., . . . Hartung, D. (2015). *Interventions to improve pharmacological adherence among adults with psychotic spectrum disorders, bipolar disorder, and posttraumatic stress disorder* (Vol. VA ESP Project #05-225). Washington, DC: U.S. Department of Veterans Affairs.
- Konkoly Thege, B., Horwood, L., Slater, L., Tan, M. C., Hodgins, D. C., & Wild, T. C. (2017). Relationship between interpersonal trauma exposure and addictive behaviors: A systematic review. *BMC Psychiatry*, 17(1), 164. doi:10.1186/s12888-017-1323-1
- Krasnova, A., Eaton, W. W., & Samuels, J. F. (2019). Antisocial personality and risks of cause-specific mortality: Results from the Epidemiologic Catchment Area study with 27 years of follow-up. *Social Psychiatry Psychiatric Epidemiology*, 54(5), 617–625. doi: 10.1007/s00127-018-1628-5
- Krawczyk, N., Feder, K. A., Saloner, B., Crum, R. M., Kealhofer, M., & Mojtai, R. (2017). The association of psychiatric comorbidity with treatment completion among clients admitted to substance use treatment programs in a U.S. national sample. *Drug and Alcohol Dependence*, 175, 157–163. doi:10.1016/j.drugalcdep.2017.02.006
- Krebs, P., Norcross, J. C., Nicholson, J. M., & Prochaska, J. O. (2018). Stages of change and psychotherapy outcomes: A review and meta-analysis. *Journal of Clinical Psychology*, 74(11), 1964–1979. doi:10.1002/jclp.22683
- Kuerbis, A. N., Neighbors, C. J., & Morgenstern, J. (2011). Depression's moderation of the effectiveness of intensive case management with substance-dependent women on temporary assistance for needy families: Outpatient substance use disorder treatment utilization and outcomes. *Journal of Studies on Alcohol and Drugs*, 72(2), 297–307.
- Kumar, G. S., & Klein, R. (2013). Effectiveness of case management strategies in reducing emergency department visits in frequent user patient populations: A systematic review. *Journal of Emergency Medicine*, 44(3), 717–729. doi:10.1016/j.jemermed.2012.08.035
- Kumar, N., Stowe, Z. N., Han, X., & Mancino, M. J. (2016). Impact of early childhood trauma on retention and phase advancement in an outpatient buprenorphine treatment program. *American Journal on Addictions*, 25(7), 542–548. doi: 10.1111/ajad.12437.
- Kuo, C., Schonbrun, Y. C., Zlotnick, C., Bates, N., Todorova, R., Kao, J. C., & Johnson, J. (2013). A qualitative study of treatment needs among pregnant and postpartum women with substance use and depression. *Substance Use and Misuse*, 48(14), 1498–1508. doi:10.3109/10826084.2013.800116
- Kupfer, D. J. (2015). Anxiety and DSM-5. *Dialogues in Clinical Neuroscience*, 17(3), 245–246.

- Laakso, L. J. (2012). Motivational interviewing: Addressing ambivalence to improve medication adherence in patients with bipolar disorder. *Issues in Mental Health Nursing*, 33(1), 8–14. doi:10.3109/01612840.2011.618238
- Lagisetty, P. A., Maust, D., Heisler, M., & Bohnert, A. (2017). Physical and mental health comorbidities associated with primary care visits for substance use disorders. *Journal of Addiction Medicine*, 11(2), 161–162. doi:10.1097/adm.0000000000000280
- Lai, H. M., Cleary, M., Sitharthan, T., & Hunt, G. E. (2015). Prevalence of comorbid substance use, anxiety and mood disorders in epidemiological surveys, 1990–2014: A systematic review and meta-analysis. *Drug and Alcohol Dependence*, 154, 1–13. doi:10.1016/j.drugalcdep.2015.05.031
- Lally, J., & MacCabe, J. H. (2015). Antipsychotic medication in schizophrenia: A review. *British Medical Bulletin*, 114(1), 169–179. doi:10.1093/bmb/ldv017
- Lam, C. N., Arora, S., & Menchine, M. (2016). Increased 30-day emergency department revisits among homeless patients with mental health conditions. *Western Journal of Emergency Medicine*, 17(5), 607–612. doi:10.5811/westjem.2016.6.30690
- Lambert, M. J., & Simon, W. (2008). The therapeutic relationship: Central and essential in psychotherapy outcome. In S. F. Hick & T. Bien (Eds.), *Mindfulness and the therapeutic relationship* (pp.19–33). New York, NY: Guilford Press.
- Lambert-Harris, C., Saunders, E. C., McGovern, M. P., & Xie, H. (2013). Organizational capacity to address co-occurring substance use and psychiatric disorders: Assessing variation by level of care. *Journal of Addiction Medicine*, 7(1), 25–32. doi:10.1097/ADM.0b013e318276e7a4
- Lamberti, J. S., Weisman, R. L., Cerulli, C., Williams, G. C., Jacobowitz, D. B., Mueser, K. T., . . . Caine, E. D. (2017). A randomized controlled trial of the Rochester Forensic Assertive Community Treatment Model. *Psychiatric Services*, 68(10), 1016–1024. doi:10.1176/appi.ps.201600329
- Landess, J., & Holoyda, B. (2017). Mental health courts and forensic assertive community treatment teams as correctional diversion programs. *Behavioral Sciences and the Law*, 35(5–6), 501–511. doi:10.1002/bsl.2307
- Lanier, D., & Ko, S. (2008). *Screening in primary care settings for illicit drug use: Assessment of screening instruments—A supplemental evidence update for the U.S. Preventive Services Task Force*. Evidence Synthesis No. 58, Part 2. AHRQ Publication No. 08-05108-EF-2. Rockville, MD: Agency for Healthcare Research and Quality.
- Laschober, T. C., & Eby, L. T. (2013). Substance use disorder counselors' job performance and turnover after 1 year: Linear or curvilinear relationship? *Administration and Policy in Mental Health and Mental Health Services Research*, 40(4), 300–310.
- Lawson, K. M., Back, S. E., Hartwell, K. J., Moran-Santa Maria, M., & Brady, K. T. (2013). A comparison of trauma profiles among individuals with prescription opioid, nicotine, or cocaine dependence. *American Journal of Addictions*, 22(2), 127–131. doi:10.1111/j.1521-0391.2013.00319.x
- Lee King, P. A., Duan, L., & Amaro, H. (2015). Clinical needs of in-treatment pregnant women with co-occurring disorders: Implications for primary care. *Maternal and Child Health Journal*, 19(1), 180–187. doi:10.1007/s10995-014-1508-x
- Lee, M. T., Acevedo, A., Garnick, D. W., Horgan, C. M., Panas, L., Ritter, G. A., & Campbell, K. M. (2018). Impact of agency receipt of incentives and reminders on engagement and continuity of care for clients with co-occurring disorders. *Psychiatric Services*, 69(7), 804–811. doi:10.1176/appi.ps.201700465
- Lee, M. T., Horgan, C. M., Garnick, D. W., Acevedo, A., Panas, L., Ritter, G. A., . . . Reynolds, M. (2014). A performance measure for continuity of care after detoxification: Relationship with outcomes. *Journal of Substance Abuse Treatment*, 47(2), 130–139.
- Lee, N. K., Cameron, J., & Jenner, L. (2015). A systematic review of interventions for co-occurring substance use and borderline personality disorders. *Drug and Alcohol Review*, 34(6), 663–672. doi:10.1111/dar.12267
- Lee, S. S., Humphreys, K. L., Flory, K., Liu, R., & Glass, K. (2011). Prospective association of childhood attention-deficit/hyperactivity disorder (ADHD) and substance use and abuse/dependence: A meta-analytic review. *Clinical Psychology Review*, 31(3), 328–341. doi:10.1016/j.cpr.2011.01.006
- LePage, J. P., Lewis, A. A., Crawford, A. M., Parish, J. A., Ottomanelli, L., Washington, E. L., & Cipher, D. J. (2016). Incorporating individualized placement and support principles into vocational rehabilitation for formerly incarcerated veterans. *Psychiatric Services*, 67(7), 735–742. doi:10.1176/appi.ps.201500058
- Lijffijt, M., Hu, K., & Swann, A. C. (2014). Stress modulates illness-course of substance use disorders: A translational review. *Frontiers in Psychiatry*, 5, 83. doi:10.3389/fpsy.2014.00083.
- Lindsey, W. T., Stewart, D., & Childress, D. (2012). Drug interactions between common illicit drugs and prescription therapies. *American Journal of Drug and Alcohol Abuse*, 38(4), 334–343. doi:10.3109/00952990.2011.643997
- Lo, C. C., Cheng, T. C., & de la Rosa, I. A. (2015). Depression and substance use: A temporal-ordered model. *Substance Use & Misuse*, 50(10), 1274–1283.
- Lockwood, P. L. (2016). The anatomy of empathy: Vicarious experience and disorders of social cognition. *Behavioural Brain Research*, 311, 255–266. doi:10.1016/j.bbr.2016.05.048



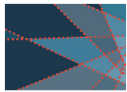
- Lotito, M., & Cook, E. (2015). A review of suicide risk assessment instruments and approaches. *Mental Health Clinician, 5*(5), 216–223.
- Lu, W., Yanos, P. T., Silverstein, S. M., Mueser, K. T., Rosenberg, S. D., Gottlieb, J. D., . . . Giacobbe, G. (2013). Public mental health clients with severe mental illness and probable posttraumatic stress disorder: Trauma exposure and correlates of symptom severity. *Journal of Traumatic Stress, 26*(2), 266–273. doi:10.1002/jts.21791
- Lucas, C., & Martin, J. (2013). Smoking and drug interactions. *Australian Prescriber, 36*, 102–104.
- Luciano, A., Belstock, J., Malmberg, P., McHugo, G. J., Drake, R. E., Xie, H., . . . Covell, N. H. (2014). Predictors of incarceration among urban adults with co-occurring severe mental illness and a substance use disorder. *Psychiatric Services, 65*(11), 1325–1331. doi:10.1176/appi.ps.201300408
- Luciano, A., Bryan, E. L., Carpenter-Song, E. A., Woods, M., Armstrong, K., & Drake, R. E. (2014). Long-term sobriety strategies for men with co-occurring disorders. *Journal of Dual Diagnosis, 10*(4), 212–219. doi:10.1080/15504263.2014.961884
- Luciano, A., & Carpenter-Song, E. A. (2014). A qualitative study of career exploration among young adult men with psychosis and co-occurring substance use disorder. *Journal of Dual Diagnosis, 10*(4), 220–225. doi:10.1080/15504263
- Lugoboni, F., Levin, F. R., Pieri, M. C., Manfredini, M., Zamboni, L., Somaini, L., . . . Gruppo InterSert Collaborazione, S. (2017). Co-occurring attention deficit hyperactivity disorder symptoms in adults affected by heroin dependence: Patients characteristics and treatment needs. *Psychiatry Research, 250*, 210–216. doi:10.1016/j.psychres.2017.01.052
- Luo, S. X., & Levin, F. R. (2017). Towards precision addiction treatment: New findings in co-morbid substance use and attention-deficit hyperactivity disorders. *Current Psychiatry Reports, 19*(3), 14. doi:10.1007/s11920-017-0769-7
- Lusk, S. L., Koch, L. C., & Paul, T. M. (2016). Recovery-oriented vocational rehabilitation services for individuals with co-occurring psychiatric disabilities and substance use disorders. *Rehabilitation Research, Policy, and Education, 30*(3), 243–258.
- Lutterman, T., Shaw, R., Fisher, W., & Manderscheid, R. (2017, August). Trend in psychiatric inpatient capacity, United States and each state, 1970 to 2014. Retrieved from www.nri-inc.org/media/1319/tac-paper-10-psychiatric-inpatient-capacity-final-09-05-2017.pdf
- Lydecker, K. P., Tate, S. R., Cummins, K. M., McQuaid, J., Granholm, E., & Brown, S. A. (2010). Clinical outcomes of an integrated treatment for depression and substance use disorders. *Psychology of Addictive Behaviors, 24*(3), 453–465. doi:10.1037/a0019943
- Ma, M., Coles, A. S., & George, T. P. (2018, September 27). Understanding and treating co-occurring bipolar disorder and substance use disorders. *Psychiatric Times*. Retrieved from www.psychiatrictimes.com/bipolar-disorder/understanding-and-treating-co-occurring-bipolar-disorder-and-substance-use-disorders
- Macy, R. J., Renz, C., & Pelino, E. (2013). Partner violence and substance abuse are intertwined: Women's perceptions of violence-substance connections. *Violence Against Women, 19*(7), 881–902. doi:10.1177/1077801213498208
- Magidson, J. F., Liu, S.-M., Lejuez, C. W., & Blanco, C. (2012). Comparison of the course of substance use disorders among individuals with and without generalized anxiety disorder in a nationally representative sample. *Journal of Psychiatric Research, 46*(5), 659–666. doi:10.1016/j.jpsychires.2012.02.011
- Magor-Blatch, L., Bhullar, N., Thomson, B., & Thorsteinsson, E. (2014). A systematic review of studies examining effectiveness of therapeutic communities. *Therapeutic Communities, 35*(4), 168–184. doi:10.1108/TC-07-2013-0024
- Maisto, S. A., Roos, C. R., O'Sickey, A. J., Kirouac, M., Connors, G. J., Tonigan, J. S., & Witkiewitz, K. (2015). The indirect effect of the therapeutic alliance and alcohol abstinence self-efficacy on alcohol use and alcohol-related problems in Project MATCH. *Alcoholism: Clinical and Experimental Research, 39*(3), 504–513. doi:10.1111/acer.12649
- Malivert, M., Fatséas, M., Denis, C., Langlois, E., & Auriacombe, M. (2012). Effectiveness of therapeutic communities: A systematic review. *European Addiction Research, 18*(1), 1–11. doi:10.1159/000331007
- Malte, C. A., Cox, K., & Saxon, A. J. (2017). Providing intensive addiction/housing case management to homeless veterans enrolled in addictions treatment: A randomized controlled trial. *Psychology of Addictive Behaviors, 31*(3), 231–241. doi:10.1037/adb0000273
- Mandavia, A., Robinson, G. G., Bradley, B., Ressler, K. J., & Powers, A. (2016). Exposure to childhood abuse and later substance use: Indirect effects of emotion dysregulation and exposure to trauma. *Journal of Traumatic Stress, 29*(5), 422–429. doi:10.1002/jts.22131
- Mangrum, L. F. (2009). Client and service characteristics associated with addiction treatment completion of clients with co-occurring disorders. *Addictive Behaviors, 34*(10), 898–904. doi:10.1016/j.addbeh.2009.03.006
- Mansfield, A. J., Greenbaum, M. A., Schaper, K. M., Banducci, A. N., & Rosen, C. S. (2017). PTSD care among veterans with and without co-occurring substance use disorders. *Psychiatric Services, 68*(6), 632–635. doi:10.1176/appi.ps.201600128

- Manuel, J. I., Covell, N. H., Jackson, C. T., & Essock, S. M. (2011). Does assertive community treatment increase medication adherence for people with co-occurring psychotic and substance use disorders? *Journal of the American Psychiatric Nurses Association*, 17(1), 51–56. doi:10.1177/1078390310395586
- Markota, M., Rummans, T. A., Bostwick, J. M., & Lapid, M. I. (2016). Benzodiazepine use in older adults: Dangers, management, and alternative therapies. *Mayo Clinic Proceedings*, 91(11), 1632–1639. doi:10.1016/j.mayocp.2016.07.024
- Marlatt, G. A. (1985). Relapse prevention: Theoretical rationale and overview of the model. In G. A. Marlatt & J. R. Gordon (Eds.), *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors* (1st ed., pp. 3–70). New York: Guilford Press.
- Marlatt, G. A., & Gordon, J. R. (Eds.). (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: Guilford Press.
- Marmar, C. R., Schlenger, W., Henn-Haase, C., Qian, M., Purchia, E., Li, M., . . . Kulka, R. A. (2015). Course of posttraumatic stress disorder 40 years after the Vietnam War: Findings from the National Vietnam Veterans Longitudinal Study. *JAMA Psychiatry*, 72(9), 875–881. doi:10.1001/jamapsychiatry.2015.0803
- Marmorstein, N. R. (2012). Anxiety disorders and substance use disorders: Different associations by anxiety disorder. *Journal of Anxiety Disorders*, 26(1), 88–94. doi:10.1016/j.janxdis.2011.09.005
- Marotta, P. L. (2017). Childhood adversities and substance misuse among the incarcerated: Implications for treatment and practice in correctional settings. *Substance Use and Misuse*, 52(6), 717–733. doi:10.1080/10826084.2016.1261899
- Marquant, T., Sabbe, B., Van Nuffel, M., & Goethals, K. (2016). Forensic assertive community treatment: A review of the literature. *Community Mental Health Journal*, 52(8), 873–881.
- Marshall, T., Goldberg, R. W., Braude, L., Dougherty, R. H., Daniels, A. S., Ghose, S. S., . . . Delphin-Rittmon, M. E. (2014). Supported employment: Assessing the evidence. *Psychiatric Services*, 65(1), 16–23. doi:10.1176/appi.ps.2013.00262
- Martinez-Raga, J., Szerman, N., Knecht, C., & de Alvaro, R. (2013). Attention deficit hyperactivity disorder and dual disorders. Educational needs for an underdiagnosed condition. *International Journal of Adolescent Medicine and Health*, 25(3), 231–243. doi:10.1515/ijamh-2013-0057
- Martínez-Vispo, C., Martínez, López-Durán, A., Fernández del Río, E., & Becoña, E. (2018). Effects of behavioural activation on substance use and depression: A systematic review. *Substance Abuse: Treatment, Prevention, and Policy*, 13(1), 36. doi:10.1186/s13011-018-0173-2
- Martino, S., Carroll, K. M., Nich, C., & Rounsaville, B. J. (2006). A randomized controlled pilot study of motivational interviewing for patients with psychotic and drug use disorders. *Addiction*, 101(10), 1479–1492. doi:10.1111/j.1360-0443.2006.01554.x
- Martins, S. S., & Gorelick, D. A. (2011). Conditional substance abuse and dependence by diagnosis of mood or anxiety disorder or schizophrenia in the U.S. population. *Drug and Alcohol Dependence*, 119(1–2), 28–36. doi:10.1016/j.drugalcdep.2011.05.010
- Mason, R., & Du Mont, J. (2015). Advancing our knowledge of the complexity and management of intimate partner violence and co-occurring mental health and substance abuse problems in women. *F1000 Prime Reports*, 7, 65. doi:10.12703/P7-65
- Masson, C. L., Shopshire, M. S., Sen, S., Hoffman, K. A., Hengl, N. S., Bartolome, J., . . . Iguchi, M. Y. (2013). Possible barriers to enrollment in substance abuse treatment among a diverse sample of Asian Americans and Pacific Islanders: Opinions of treatment clients. *Journal of Substance Abuse Treatment*, 44(3), 309–315. doi:10.1016/j.jsat.2012.08.005
- Matusow, H., Guarino, H., Rosenblum, A., Vogel, H., Uttaro, T., Khabir, S., . . . Magura, S. (2013). Consumers' experiences in dual focus mutual aid for co-occurring substance use and mental health disorders. *Substance Abuse: Research and Treatment*, 7, 39–47. doi:10.4137/SART.S11006
- Maura, J., & Weisman de Mamani, A. (2017). Mental health disparities, treatment engagement, and attrition among racial/ethnic minorities with severe mental illness: A review. *Journal of Clinical Psychology in Medical Settings*, 24(3–4), 187–210. doi:10.1007/s10880-017-9510-2
- Mauritz, M. W., Goossens, P. J., Draijer, N., & van Achterberg, T. (2013). Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness. *European Journal of Psychotraumatology*, 4. Published online. doi:10.3402/ejpt.v4i0.19985
- McCabe, S. E., West, B. T., Jutkiewicz, E. M., & Boyd, C. J. (2017). Multiple DSM-5 substance use disorders: A national study of US adults. *Human Psychopharmacology*, 32(5). doi:10.1002/hup.2625
- McCallum, S., Mikocka-Walus, A., Turnbull, D., & Andrews, J. M. (2015). Continuity of care in dual diagnosis treatment: Definitions, applications, and implications. *Journal of Dual Diagnosis*, 11(3–4), 217–232. doi:10.1080/15504263.2015.1104930
- McCance-Katz, E. F. (2019). *The National Survey on Drug Use and Health: 2018*. Slide Presentation. Retrieved from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Assistant-Secretary-nsduh2018_presentation.pdf



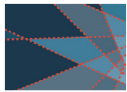
- McCarty, D., Braude, L., Lyman, D. R., Dougherty, R. H., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Substance abuse intensive outpatient programs: Assessing the evidence. *Psychiatric Services*, 65(6), 718–726.
- McCauley, J. L., Killeen, T., Gros, D. F., Brady, K. T., & Back, S. E. (2012). Posttraumatic stress disorder and co-occurring substance use disorders: Advances in assessment and treatment. *Clinical Psychology: Science and Practice*, 19(3), 283–304. doi:10.1111/cpsp.12006
- McCloskey, M. S., & Ammerman, B. A. (2018). Suicidal behavior and aggression-related disorders. *Current Opinion in Psychology*, 22, 54–58. doi:10.1016/j.copsyc.2017.08.010
- McConaughy, E. A., Prochaska, J., & Velicer, W. F. (1983). Stages of change in psychotherapy: Measurement and sample profiles. *Psychotherapy: Theory, Research, and Practice*, 20(3), 368–375.
- McDermid, J., Sareen, J., El-Gabalawy, R., Pagura, J., Spiwak, R., & Enns, M. W. (2015). Co-morbidity of bipolar disorder and borderline personality disorder: Findings from the National Epidemiologic Survey on Alcohol and Related Conditions. *Comprehensive Psychiatry*, 58, 18–28. doi:10.1016/j.comppsy.2015.01.004
- McDermott, K. W., Elixhauser, A., & Sun, R. (2017, June). *Trends in hospital inpatient stays in the United States, 2005–2014*. HCUP Statistical Brief #225. Agency for Healthcare Research and Quality, Rockville, MD. Retrieved from www.hcup-us.ahrq.gov/reports/statbriefs/sb225-Inpatient-US-Stays-Trends.pdf
- McDonald, D., & Arlinghaus, S. L. (2014). The role of intensive case management services in reentry: The northern Kentucky female offender reentry project. *Women and Criminal Justice*, 24(3), 229–251. doi:10.1080/08974454.2014.909759
- McDonell, M. G., Kerbrat, A. H., Comtois, K. A., Russo, J., Lowe, J. M., & Ries, R. K. (2012). Validation of the co-occurring disorder quadrant model. *Journal of Psychoactive Drugs*, 44(3), 266–273. doi:10.1080/02791072.2012.705065
- McDonell, M. G., Srebnik, D., Angelo, F., McPherson, S., Lowe, J. M., Sugar, A., . . . Ries, R. K. (2013). Randomized controlled trial of contingency management for stimulant use in community mental health patients with serious mental illness. *American Journal of Psychiatry*, 170(1), 94–101. doi:10.1176/appi.ajp.2012.11121831
- McGovern, M. P., Clark, R. E., & Samnaliev, M. (2007). Co-occurring psychiatric and substance use disorders: A multistate feasibility study of the quadrant model. *Psychiatric Services*, 58(7), 949–954. doi:10.1176/ps.2007.58.7.949
- McGovern, M. P., Lambert-Harris, C., Alterman, A. I., Xie, H., & Meier, A. (2011). A randomized controlled trial comparing integrated cognitive behavioral therapy versus individual addiction counseling for co-occurring substance use and posttraumatic stress disorders. *Journal of Dual Diagnosis*, 7(4), 207–227.
- McGovern, M. P., Lambert-Harris, C., Gotham, H. J., Claus, R. E., & Xie, H. (2014). Dual diagnosis capability in mental health and addiction treatment services: An assessment of programs across multiple state systems. *Administration and Policy in Mental Health*, 41(2), 205–214. doi:10.1007/s10488-012-0449-1
- McGovern, M. P., Lambert-Harris, C., Xie, H., Meier, A., McLeman, B., & Saunders, E. (2015). A randomized controlled trial of treatments for co-occurring substance use disorders and post-traumatic stress disorder. *Addiction*, 110(7), 1194–1204. doi:10.1111/add.12943
- McGovern, M. P., Saunders, E. C., & Kim, E. (2013). Substance abuse treatment implementation research. *Journal of Substance Abuse Treatment*, 44(1), 1–3. doi:10.1016/j.jsat.2012.09.006
- McGrath, J., Saha, S., Welham, J., El Saadi, O., MacCauley, C., & Chant, D. (2004). A systematic review of the incidence of schizophrenia: The distribution of rates and the influence of sex, urbanicity, migrant status and methodology. *BMC Medicine*, 2, 13. doi:10.1186/1741-7015-2-13
- McHugh, R. K. (2015). Treatment of co-occurring anxiety disorders and substance use disorders. *Harvard Review of Psychiatry*, 23(2), 99–111. doi:10.1097/HRP.0000000000000058
- McHugh, R. K., Gratz, K. L., & Tull, M. T. (2017). The role of anxiety sensitivity in reactivity to trauma cues in treatment-seeking adults with substance use disorders. *Comprehensive Psychiatry*, 78, 107–114. doi:10.1016/j.comppsy.2017.07.011
- McHugh, R. K., Votaw, V. R., Sugarman, D. E., & Greenfield, S. F. (2018). Sex and gender differences in substance use disorders. *Clinical Psychology Review*, 12–23. doi:10.1016/j.cpr.2017.10.012
- McHugo, G. J., Drake, R. E., Burton, H. L., & Ackerson, T. H. (1995). A scale for assessing the stage of substance abuse treatment in persons with severe mental illness. *Journal of Nervous and Mental Disease*, 183(12), 762–767.
- McHugo, G. J., Drake, R. E., Xie, H., & Bond, G. R. (2012). A 10-year study of steady employment and non-vocational outcomes among people with serious mental illness and co-occurring substance use disorders. *Schizophrenia Research*, 138(2–3), 233–239. doi:10.1016/j.schres.2012.04.007
- McKay J. R. (2009). Continuing care research: What we have learned and where we are going. *Journal of Substance Abuse Treatment*, 36(2), 131–145.
- McKay, J. R., Knepper, C., Deneke, E., O'Reilly, C., & DuPont, R. L. (2016). An initial evaluation of a comprehensive continuing care intervention for clients with substance use disorders: My first year of recovery (MyFYR). *Journal of Substance Abuse Treatment*, 67, 50–54. doi:10.1016/j.jsat.2016.04.003

- McKee, S. A., Harris, G. T., & Cormier, C. A. (2013). Implementing residential integrated treatment for co-occurring disorders. *Journal of Dual Diagnosis*, 9(3), 249–259.
- McKenzie, K., & Chang, Y. P. (2015). The effect of nurse-led motivational interviewing on medication adherence in patients with bipolar disorder. *Perspectives in Psychiatric Care*, 51(1), 36–44. doi:10.1111/ppc.12060
- McKeown, R. E., Holbrook, J. R., Danielson, M. L., Cuffe, S. P., Wolraich, M. L., & Visser, S. N. (2015). The impact of case definition on attention-deficit/hyperactivity disorder prevalence estimates in community-based samples of school-aged children. *Journal of the American Academy of Child Adolescent Psychiatry*, 54(1), 53–61. doi:10.1016/j.jaac.2014.10.014
- McKetin, R., Voce, A., Burns, R., Ali, R., Lubman, D. I., Baker, A. L., & Castle, D. J. (2018). Latent psychotic symptom profiles amongst people who use methamphetamine: What do they tell us about existing diagnostic categories? *Frontiers in Psychiatry*, 9, 578. doi:10.3389/fpsy.2018.00578
- McKinney, J. M., Hirsch, J. K., & Britton, P. C. (2017). PTSD symptoms and suicide risk in veterans: Serial indirect effects via depression and anger. *Journal of Affective Disorders*, 214, 100–107. doi:10.1016/j.jad.2017.03.008
- McLellan, A. T., Kushner, H., Metzger, D., Peters, R., Smith, I., Grissom, G., . . . Argeriou, M. (1992). The fifth edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment*, 9(3), 199–213.
- Mdege, N. D., & Lang, J. (2011). Screening instruments for detecting illicit drug use/abuse that could be useful in general hospital wards: A systematic review. *Addictive Behaviors*, 36(12), 1111–1119. doi:10.1016/j.addbeh.2011.07.007
- Mee-Lee, D., Shulman, G. D., Fishman, M. J., Gastfriend, D. R., & Miller, M. M. (Eds.). (2013). *The ASAM criteria: Treatment for addictive, substance-related, and co-occurring conditions* (3rd ed.). Carson City, NV: The Change Companies.
- Meier, A., McGovern, M. P., Lambert-Harris, C., McLeman, B., Franklin, A., Saunders, E. C., & Xie, H. (2015). Adherence and competence in two manual-guided therapies for co-occurring substance use and posttraumatic stress disorders: Clinician factors and patient outcomes. *American Journal of Drug and Alcohol Abuse*, 41(6), 527–534. doi:10.3109/00952990.2015.1062894
- Meier, P. S., & Barrowclough, C. (2009). Mental health problems: Are they or are they not a risk factor for dropout from drug treatment? A systematic review of the evidence. *Drugs: Education, Prevention and Policy*, 16(1), 7–38. doi:10.1080/09687630701741030
- Melemis, S. M. (2015). Relapse prevention and the five rules of recovery. *Yale Journal of Biology and Medicine*, 88(3), 325–332.
- Mentalhelp.Net. (2019a). *Mental Health, Dual-Diagnosis, & Behavioral Addictions*. Retrieved from www.mentalhelp.net/articles/behavioral-addictions-mental-health-dual-diagnosis/
- MentalHelp.Net. (2019b). *Schizophrenia*. Retrieved from www.mentalhelp.net/articles/schizophrenia/
- Mericle, A. A., Ta Park, V. M., Holck, P., & Arria, A. M. (2012). Prevalence, patterns, and correlates of co-occurring substance use and mental disorders in the United States: Variations by race/ethnicity. *Comprehensive Psychiatry*, 53(6), 657–665. doi:10.1016/j.comppsy.2011.10.002
- Merrick, M. T., Ports, K. A., Ford, D. C., Afifi, T. O., Gershoff, E. T., & Grogan-Kaylor, A. (2017). Unpacking the impact of adverse childhood experiences on adult mental health. *Child Abuse and Neglect*, 69, 10–19. doi:10.1016/j.chiabu.2017.03.016
- Meyer, R. E., Salzman, C., Youngstrom, E. A., Clayton, P. J., Goodwin, F. K., Mann, J. J., . . . Sheehan, D. V. (2010). Suicidality and risk of suicide—Definition, drug safety concerns, and a necessary target for drug development: A consensus statement. *Journal of Clinical Psychiatry*, 71(8), e1–e21. doi:10.4088/JCP.10cs06070blu
- Miller, J. M., & Khey, D. N. (2016). An implementation and process evaluation of the Louisiana 22nd judicial district's behavioral health court. *American Journal of Criminal Justice*, 41(1). doi:10.1007/s12103-015-9326-2
- Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York: Guilford Press.
- Miller, W. R., & Tonigan, J. S. (1996). Assessing drinkers' motivation for change: The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). *Psychology of Addictive Behaviors*, 10(2), 81–89. doi:10.1037/0893-164X.10.2.81
- Minassian, A., Vilke, G. M., & Wilson, M. P. (2013). Frequent emergency department visits are more prevalent in psychiatric, alcohol abuse, and dual diagnosis conditions than in chronic viral illnesses such as hepatitis and human immunodeficiency virus. *Journal of Emergency Medicine*, 45(4), 520–525. doi:10.1016/j.jemermed.2013.05.007
- Minkoff, K. (1989). An integrated treatment model for dual diagnosis of psychosis and addiction. *Hospital and Community Psychiatry*, 40(10), 1031–1036.
- Minnich, A., Erford, B. T., Bardhoshi, G., & Atalay, Z. (2018). Systematic review of the Michigan Alcoholism Screening Test. *Journal of Counseling and Development*, 96(3), 335–344. doi:10.1002/jcad.12207
- Mitchell, F. M. (2015). Racial and ethnic health disparities in an era of health care reform. *Health and Social Work*, 40(3), e66–e74. doi:10.1093/hsw/hlv038



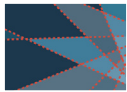
- Mitchell, M. S., Leon, C. L. K., Byrne, T. H., Lin, W. C., & Bharel, M. (2017). Cost of health care utilization among homeless frequent emergency department users. *Psychological Services, 14*(2), 193–202. doi:10.1037/ser0000113
- Mohamed, S. (2013). Dual diagnosis among intensive case management participants in the Veterans Health Administration: Correlates and outcomes. *Journal of Dual Diagnosis, 9*(4), 311–321. doi:10.1080/15504263.2013.835162
- Molina, B. S. G., Howard, A. L., Swanson, J. M., Stehli, A., Mitchell, J. T., Kennedy, T. M., ... Hoza, B. (2018). Substance use through adolescence into early adulthood after childhood-diagnosed ADHD: Findings from the MTA longitudinal study. *Journal of Child Psychology and Psychiatry, 59*(6), 692–702. doi:10.1111/jcpp.12855
- Monica, C., Nikkel, R. E., & Drake, R. E. (2010). Dual Diagnosis Anonymous of Oregon. *Psychiatric Services, 61*, 738–740.
- Moore, K. A., Young, M. S., Barrett, B., & Ochshorn, E. (2009). A 12-month follow-up evaluation of integrated treatment for homeless individuals with co-occurring disorders. *Journal of Social Service Research, 35*(4), 322–335. doi:10.1080/01488370903110829
- Morgan, O., Kuramoto, F., Emmet, W., Stange, J. L., & Nobunaga, E. (2014). The impact of the Affordable Care Act on behavioral health care for individuals from racial and ethnic communities. *Journal of Social Work in Disability and Rehabilitation, 13*(1–2), 139–161. doi:10.1080/1536710X.2013.870518
- Morgenstern, J., Neighbors, C. J., Kuerbis, A., Riordan, A., Blanchard, K. A., McVeigh, K. H., . . . McCrady, B. (2009). Improving 24-month abstinence and employment outcomes for substance-dependent women receiving temporary assistance for needy families with intensive case management. *American Journal of Public Health, 99*(2), 328–333. doi:10.2105/ajph.2007.133553
- Morisano, D., Babor, T. F., & Robaina, K. A. (2014). Co-occurrence of substance use disorders with other psychiatric disorders: Implications for treatment services. *Nordic Studies on Alcohol and Drugs, 31*(1), 5–25.
- Morrens, M., Dewilde, B., Sabbe, B., Dom, G., De Cuyper, R., & Moggi, F. (2011). Treatment outcomes of an integrated residential programme for patients with schizophrenia and substance use disorder. *European Addiction Research, 17*(3), 154–163. doi:10.1159/000324480
- Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health, 39*(5), 341–352. doi:10.1007/s10488-011-0352-1
- Morse, G. A., York, M. M., Dell, N., Blanco, J., & Birchmier, C. (2017). Improving outcomes for homeless people with alcohol disorders: A multi-program community-based approach. *Journal of Mental Health, 1*–8. doi:10.1080/09638237.2017.1340617
- Morse, S., & Bride, B. E. (2017). Decrease in healthcare utilization and costs for opioid users following residential integrated treatment for co-occurring disorders. *Healthcare (Basel), 5*(3), 54. doi:10.3390/healthcare5030054
- Morse, S. A., Watson, C., MacMaster, S. A., & Bride, B. E. (2015). Differences between older and younger adults in residential treatment for co-occurring disorders. *Journal of Dual Diagnosis, 11*(1), 75–82. doi:10.1080/15504263.2014.993263
- Moulin, A., Evans, E. J., Xing, G., & Melnikow, J. (2018). Substance use, homelessness, mental illness and Medicaid coverage: A set-up for high emergency department utilization. *Western Journal of Emergency Medicine, 19*(6), 902–906. doi:10.5811/westjem.2018.9.38954
- Mueser, K. T., Campbell, K., & Drake, R. E. (2011). The effectiveness of supported employment in people with dual disorders. *Journal of Dual Diagnosis, 7*(1–2), 90–102.
- Mueser, K. T., & Gingerich, S. (2013). Treatment of co-occurring psychotic and substance use disorders. *Social Work in Public Health, 28*(3–4), 424–439. doi:10.1080/19371918.2013.774676
- Muhuri, P. K., & Gfroerer, J. C. (2009). Substance use among women: Associations with pregnancy, parenting, and race/ethnicity. *Maternal and Child Health Journal, 13*(3), 376–385. doi:10.1007/s10995-008-0375-8
- Mundon, C. R., Anderson, M. L., & Najavits, L. M. (2015). Attitudes toward substance abuse clients: An empirical study of clinical psychology trainees. *Journal of Psychoactive Drugs, 47*(4), 293–300. doi:10.1080/02791072.2015.1076090
- Munn-Chernoff, M. A., & Baker, J. H. (2016). A primer on the genetics of comorbid eating disorders and substance use disorders. *European Eating Disorders Review, 24*(2), 91–100. doi:10.1002/erv.2424
- Munn-Chernoff, M. A., Grant, J. D., Agrawal, A., Sartor, C. E., Werner, K. B., Bucholz, K. K., . . . Duncan, A. E. (2015). Genetic overlap between alcohol use disorder and bulimic behaviors in European American and African American women. *Drug and Alcohol Dependence, 153*, 335–340. doi:10.1016/j.drugalcdep.2015.05.043
- Nam, E., Matejkowski, J., & Lee, S. (2017). Racial/ethnic differences in contemporaneous use of mental health and substance use treatment among individuals experiencing both mental illness and substance use disorders. *Psychiatric Quarterly, 88*(1), 185–198. doi:10.1007/s11126-016-9444-0

- Nanni, V., Uher, R., & Danese, A. (2012). Childhood maltreatment predicts unfavorable course of illness and treatment outcome in depression: A meta-analysis. *American Journal of Psychiatry*, 169(2), 141–151.
- National Academies of Sciences, Engineering, and Medicine. (2016). Part 3: Instruments available for measuring specific mental illness diagnoses with functional impairment. In *Measuring specific mental illness diagnoses with functional impairment: Workshop summary*. Washington, DC: National Academies Press.
- National Association of State Mental Health Program Directors (NASMHPD). (June 2012). *Fact sheet on accelerating integration of primary care, behavioral health and prevention: The SBHA role*. Retrieved from www.nasmhpd.org/sites/default/files/Behavioral%20Health%20Primary_Fact%20Sheet%20Accelerating%20Integration%20of%20Primary%20Care.pdf
- National Association of State Mental Health Program Directors, & National Association of State Alcohol and Drug Abuse Directors (NASADAD). (March 1999). *National dialogue on co-occurring mental health and substance abuse disorders*. Retrieved from <http://nasadad.org/2015/03/national-dialogue-on-co-occurring-mental-health-and-substance-abuse-disorders/>
- National Institute of Mental Health (NIMH). (n.d.). Ask Suicide-Screening Questions (ASQ) Toolkit. Retrieved from <https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml>
- National Institute of Mental Health. (2016, February). *Schizophrenia*. Retrieved from www.nimh.nih.gov/health/topics/schizophrenia/index.shtml
- National Institute of Mental Health. (2016, October). *Mental health medications: Overview*. Retrieved from www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml
- National Institute of Mental Health. (2017, November). *Attention-deficit/hyperactivity disorder (ADHD)*. Retrieved from www.nimh.nih.gov/health/statistics/attention-deficit-hyperactivity-disorder-adhd.shtml - part 154905
- National Institute of Mental Health. (2019). *Suicide*. Retrieved from www.nimh.nih.gov/health/statistics/suicide.shtml
- National Institute on Alcohol Abuse and Alcoholism. (n.d.). *Drinking levels defined*. Retrieved from <https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking>
- National Institute on Drug Abuse. (2012a). Adoption of NIDA's evidence-based treatments in real world settings—A National Advisory Council on Drug Abuse Workgroup report. Retrieved from www.drugabuse.gov/sites/default/files/files/evidence-based_treatments_in_real_world_settings_workgroup_report.pdf
- National Institute on Drug Abuse. (2012b). *Resource guide: Screening for drug use in general medical settings*. Retrieved from www.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen
- National Institute on Drug Abuse. (2015, July). *How are therapeutic communities adapting to the current environment?* Retrieved from www.drugabuse.gov/publications/research-reports/therapeutic-communities/how-are-therapeutic-communities-adapting-to-current-environment
- National Institute on Drug Abuse. (2018a). *Common comorbidities with substance use disorders*. Retrieved from <https://d14rmgtwzf5a.cloudfront.net/sites/default/files/1155-common-comorbidities-with-substance-use-disorders.pdf>
- National Institute on Drug Abuse. (2018b). *Principles of drug addiction treatment: A research-based guide* (3rd ed.). Rockville, MD: National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services.
- National Institute on Drug Abuse. (2018c). *Treatment and recovery*. In *Drugs, brains, and behavior: The science of addiction* (pp. 22–25). Bethesda, MD: National Institute on Drug Abuse.
- National Institute on Drug Abuse. (2018d, July). *Sex and gender differences in substance use disorder treatment*. Retrieved from www.drugabuse.gov/publications/research-reports/substance-use-in-women/sex-gender-differences-in-substance-use-disorder-treatment
- National Institute on Drug Abuse. (Revised March 2018). *Benzodiazepines and opioids*. Retrieved from www.drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids
- Neumiller, S., Bennett-Clark, F., Young, M. S., Dates, B., Broner, N., Leddy, J., . . . De Jong, F. (2009). Implementing assertive community treatment in diverse settings for people who are homeless with co-occurring mental and addictive disorders: A series of case studies. *Journal of Dual Diagnosis*, 5(3–4), 239–263. doi:10.1080/15504260903175973
- Newell, J. M., Nelson-Gardell, D., & MacNeil, G. (2016). Clinician responses to client traumas: A chronological review of constructs and terminology. *Trauma, Violence, & Abuse*, 17(3), 306–13. doi: 10.1177/1524838015584365
- Newton-Howes, G., & Foulds, J. (2018). Personality disorder and treatment outcome in alcohol use disorder. *Current Opinion in Psychiatry*, 31(1), 50–56. doi:10.1097/YCO.0000000000000375
- Nicosia, N., Macdonald, J. M., & Arkes, J. (2013). Disparities in criminal court referrals to drug treatment and prison for minority men. *American Journal of Public Health*, 103(6), e77–e84. doi:10.2105/ajph.2013.301222



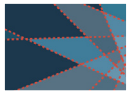
- Noel, V., Woods, M., Routhier, J., & Drake, R. (2016). Planning treatment and assessing recovery in participants with dual diagnosis: Preliminary evaluation of a new clinical tool. *Journal of Dual Diagnosis*, 12(1), 55–62. doi:10.1080/15504263.2016.1146555
- Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The long-term health consequences of child physical abuse, emotional abuse, and neglect: A systematic review and meta-analysis. *PLoS Medicine*, 9(11), e1001349. doi:10.1371/journal.pmed.1001349
- Nowotny, K. M. (2015). Race/ethnic disparities in the utilization of treatment for drug dependent inmates in U.S. state correctional facilities. *Addictive Behaviors*, 40, 148–153. doi:10.1016/j.addbeh.2014.09.005
- O'Connell, M., Kaspro, W., & Rosenheck, R. A. (2010). National dissemination of supported housing in the VA: Model adherence versus model modification. *Psychiatric Rehabilitation Journal*, 33(4), 308–319. doi:10.2975/33.4.2010.308.319
- O'Connell, M. J., Flanagan, E. H., Delphin-Rittmon, M. E., & Davidson, L. (2017). Enhancing outcomes for persons with co-occurring disorders through skills training and peer recovery support. *Journal of Mental Health*, 1–6. doi:10.1080/09638237.2017.1294733
- O'Connor, R., & Pirkis, J. (2016). *The international handbook of suicide prevention* (2nd ed.). Chichester, UK: Wiley Blackwell.
- O'Grady, M. A., Kapoor, S., Kwon, N., Morley, J., Auerbach, M., Neighbors, C. J., . . . Morgenstern, J. (2019). Substance use screening and brief intervention: Evaluation of patient and implementation differences between primary care and emergency department settings. *Journal of Evaluation in Clinical Practice* 25(3), 441–447. doi:10.1111/jep.13060
- O'Grady, M. A., Neighbors, C. J., Lincourt, P., Burke, C., & Maldonado, A. (2019). Development and testing of an addiction treatment level of care determination tool. *Journal of Behavioral Health Services & Research*, 46, 487–496. doi:10.1007/s11414-018-9623-x
- O'Hara, M. W., & Engeldinger, J. (2018). Treatment of postpartum depression: Recommendations for the clinician. *Clinical Obstetrics and Gynecology*, 61(3), 604–614. doi:10.1097/grf.0000000000000353
- O'Hara, M. W., & McCabe, J. E. (2013). Postpartum depression: Current status and future directions. *Annual Review of Clinical Psychology*, 9, 379–407. doi:10.1146/annurev-clinpsy-050212-185612
- Office of Disease Prevention and Health Promotion. (2019). *Topics & objectives A–Z. Healthy People 2020*. Retrieved from www.healthypeople.gov/2020/topics-objectives
- Office of Minority Health. (October 2018). *The national CLAS standards*. Retrieved from <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53>
- Oldham, J. M. (March 2005). *Guideline watch: Practice guideline for the treatment of patients with borderline personality disorder*. Arlington, VA: American Psychiatric Association. Retrieved from https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bpd-watch.pdf
- Olson, M. (2016). Building the mental health workforce capacity needed to treat adults with serious mental illnesses. *Health Affairs*, 35(6), 983–990. doi:10.1377/hlthaff.2015.1619
- Oquendo, M. A., Currier, D., Liu, S. M., Hasin, D. S., Grant, B. F., & Blanco, C. (2010). Increased risk for suicidal behavior in comorbid bipolar disorder and alcohol use disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). *Journal of Clinical Psychiatry*, 71(7), 902–909. doi:10.4088/JCP.09m05198gry
- Oser, C. B., Biebel, E. P., Pullen, E., & Harp, K. L. (2013). Causes, consequences, and prevention of burnout among substance abuse treatment counselors: A rural versus urban comparison. *Journal of Psychoactive Drugs*, 45(1), 17–27. doi:10.1080/02791072.2013.763558
- Osman, A., Bagge, C. L., Gutierrez, P. M., Konick, L. C., Kopper, B. A., & Barrios, F. X. (2001). The Suicidal Behaviors Questionnaire-Revised (SBQ-R): Validation with clinical and nonclinical samples. *Assessment*, 8(4), 443–454. doi:10.1177/107319110100800409
- Paddock, S. M., Hunter, S. B., & Leininger, T. J. (2014). Does group cognitive-behavioral therapy module type moderate depression symptom changes in substance abuse treatment clients? *Journal of Substance Abuse Treatment*, 47(1), 78–85. doi:10.1016/j.jsat.2014.02.005
- Padgett, D. K., Stanhope, V., Henwood, B. F., & Stefancic, A. (2011). Substance use outcomes among homeless clients with serious mental illness: Comparing Housing First with Treatment First programs. *Community Mental Health Journal*, 47(2), 227–232. doi:10.1007/s10597-009-9283-7
- Padwa, H., Guerrero, E. G., Braslow, J. T., & Fenwick, K. M. (2015). Barriers to serving clients with co-occurring disorders in a transformed mental health system. *Psychiatric Services*, 66(5), 547–550. doi:10.1176/appi.ps.201400190
- Padwa, H., Larkins, S., Crevecoeur-MacPhail, D. A., & Grella, C. E. (2013). Dual diagnosis capability in mental health and substance use disorder treatment programs. *Journal of Dual Diagnosis*, 9(2), 179–186. doi:10.1080/15504263.2013.778441
- Palmer, R. H., Nugent, N. R., Brick, L. A., Bidwell, C. L., McGeary, J. E., Keller, M. C., & Knopik, V. S. (2016). Evidence of shared genome-wide additive genetic effects on interpersonal trauma exposure and generalized vulnerability to drug dependence in a population of substance users. *Journal of Traumatic Stress*, 29(3), 197–204. doi:10.1002/jts.22103

- Paquette, K., & Pannella Winn, L. A. (2016). The role of recovery housing: Prioritizing choice in homeless services. *Journal of Dual Diagnosis*, 12(2), 153–162. doi:10.1080/15504263.2016.1175262
- Paris, J. (2014). After DSM-5: Where does personality disorder research go from here? *Harvard Review of Psychiatry*, 22(4), 216–221. doi:10.1097/HRP.0000000000000041
- Park, T. W., Cheng, D. M., Samet, J. H., Winter, M. R., & Saitz, R. (2015). Chronic care management for substance dependence in primary care among patients with co-occurring disorders. *Psychiatric Services*, 66(1), 72–79. doi:10.1176/appi.ps.201300414
- Parks, J., & Radke, A. Q. (Eds.) (July 2014). *The vital role of state psychiatric hospitals*. Retrieved from <https://www.nasmhpd.org/sites/default/files/The%20Vital%20Role%20of%20State%20Psychiatric%20HospitalsTechnical%20Report%20July%202014.pdf>
- Pasche, S. (2012). Exploring the comorbidity of anxiety and substance use disorders. *Current Psychiatry Reports*, 14(3), 176–181. doi:10.1007/s11920-012-0264-0
- Patel, K. R., Cherian, J., Gohil, K., & Atkinson, D. (2014). Schizophrenia: Overview and treatment options. *Pharmacy & Therapeutics*, 39(9), 638–645.
- Pathways to Housing DC. (2017). *Program updates*. Retrieved from <https://pathwaystohousingdc.org/wp-content/uploads/financials/Annual%20Highlights%202016-2017.pdf>
- Pathways to Housing PA. (2018). *Reclaiming lives. Triennial Report 2018*. Retrieved from <https://pathwaystohousingpa.org/sites/pathwaystohousingpa.org/files/PTH%20Triennial%2011.1.18.pdf>
- Peachey, J. E., & Lei, H. (1988). Assessment of opioid dependence with naloxone. *British Journal of Addiction*, 83(2), 193–201.
- Pearce, S., & Autrique, M. (2010). On the need for randomised trials of therapeutic community approaches. *Therapeutic Communities*, 31(4), 338–355.
- Pearce, S., & Pickard, H. (2013). How therapeutic communities work: Specific factors related to positive outcome. *International Journal of Social Psychiatry*, 59(7), 636–645. doi:10.1177/0020764012450992
- Pearson, C., Montgomery, A. E., & Locke, G. (2009). Housing stability among homeless individuals with serious mental illness participating in Housing First programs. *Journal of Community Psychology*, 37(3), 404–417. doi:10.1002/jcop.20303
- Penn, P. E., Brooke, D., Brooks, A. J., Gallagher, S. M., & Barnard, A. D. (2016). Co-occurring conditions clients and counselors compare 12-step and smart recovery mutual help. *Journal of Groups in Addiction and Recovery*, 11(2), 76–92. doi:10.1080/1556035X.2015.1104643
- Perry, A. E., Neilson, M., Martyn-St. James, M., Glanville, J. M., McCool, R., Duffy, S., . . . Hewitt, C. (2015). Interventions for drug-using offenders with co-occurring mental illness. *Cochrane Database of Systematic Reviews*, 1, CD010901. doi:10.1002/14651858.cd010901
- Peters, R. H., Young, M. S., Rojas, E. C., & Gorey, C. M. (2017). Evidence-based treatment and supervision practices for co-occurring mental and substance use disorders in the criminal justice system. *American Journal of Drug and Alcohol Abuse*, 43(4), 475–488. doi:10.1080/00952990.2017.1303838
- Petrakis, I. L., & Simpson, T. L. (2017). Posttraumatic stress disorder and alcohol use disorder: A critical review of pharmacologic treatments. *Alcoholism: Clinical and Experimental Research*, 41(2), 226–237. doi:10.1111/acer.13297
- Petrakis, M., Robinson, R., Myers, K., Kroes, S., & O'Connor, S. (2018). Dual diagnosis competencies: A systematic review of staff training literature. *Addictive Behaviors Reports*, 7, 53–57. doi:10.1016/j.abrep.2018.01.003
- Pew Research Center. (2018, January 12). *Blacks and Hispanics are overrepresented in U.S. prisons*. Retrieved from <http://www.pewresearch.org/fact-tank/2018/01/12/shrinking-gap-between-number-of-blacks-and-whites-in-prison/ft-18-01-10-prisonracegaps-2/>
- Pierre, J. M. (2018). Real world challenges in managing dual diagnosis patients. *Current Psychiatry*, 17(9), 24–30.
- Pietrzak, R. H., Goldstein, R. B., Southwick, S. M., & Grant, B. F. (2011). Prevalence and Axis I comorbidity of full and partial posttraumatic stress disorder in the United States: Results from Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Anxiety Disorders*, 25(3), 456–465. doi:10.1016/j.janxdis.2010.11.010
- Pinedo, M., Zembre, S., & Rogers, S. (2018). Understanding barriers to specialty substance abuse treatment among Latinos. *Journal of Substance Abuse Treatment*, 94, 1–8. doi:10.1016/j.jsat.2018.08.004
- Plakun, E. M. (2018). Clinical and insurance perspectives on intermediate levels of care in psychiatry. *Journal of Psychiatric Practice*, 24(2), 111–116. doi:10.1097/prs.0000000000000291
- Polcin, D. L. (2016). Co-occurring substance abuse and mental health problems among homeless persons: Suggestions for research and practice. *Journal of Social Distress and the Homeless*, 26(1), 1–10. doi:10.1179/1573658X15Y.0000000004
- Polcin, D. L., Galloway, G. P., Bond, J., Korch, R., & Greenfield, T. K. (2010). How do residents of recovery houses experience confrontation between entry and 12-month follow-up? *Journal of Psychoactive Drugs*, 42(1), 49–62. doi:10.1080/02791072.2010.10399785



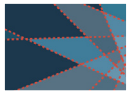
- Polcin, D. L., Mulia, N., & Laura, J. M. A. (2012). Substance users' perspectives on helpful and unhelpful confrontation: Implications for recovery. *Journal of Psychoactive Drugs*, 44(2), 144–152. doi:10.1080/02791072.2012.684626
- Pompili, M., Serafini, G., Innamorati, M., Dominici, G., Ferracuti, S., Kotzalidis, G. D., . . . Lester, D. (2010). Suicidal behavior and alcohol abuse. *International Journal of Environmental Research and Public Health*, 7(4), 1392–1431. doi:10.3390/ijerph7041392
- Pompili, M., Sher, L., Serafini, G., Forte, A., Innamorati, M., Dominici, G., . . . Girardi, P. (2013). Posttraumatic stress disorder and suicide risk among veterans: A literature review. *Journal of Nervous and Mental Disease*, 201(9), 802–812. doi:10.1097/NMD.0b013e3182a21458
- Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., . . . Mann, J. J. (2011). The Columbia-Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry*, 168(12), 1266–1277. doi:10.1176/appi.ajp.2011.10111704
- Post, L. M., Feeny, N. C., Zoellner, L. A., & Connell, A. M. (2016). Post-traumatic stress disorder and depression co-occurrence: Structural relations among disorder constructs and trait and symptom dimensions. *Psychology and Psychotherapy*, 89(4), 418–434. doi:10.1111/papt.12087
- Powell, D. J., & Brodsky, A. (2004). *Clinical supervision in alcohol and drug abuse counseling: Principles, models, methods* (Revised ed.). San Francisco: Jossey-Bass.
- Priester, M. A., Browne, T., Iachini, A., Clone, S., DeHart, D., & Seay, K. D. (2016). Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: An integrative literature review. *Journal of Substance Abuse Treatment*, 61, 47–59. doi:10.1016/j.jsat.2015.09.006
- Pringle, J., Grasso, K., & Lederer, L. (2017). Integrating the integrated: Merging Integrated Dual Diagnosis Treatment (IDDT) with Housing First. *Community Mental Health Journal*, 53(6), 672–678. doi:10.1007/s10597-017-0107-x
- Pringsheim, T., & Gardner, D. M. (2014). Dispensed prescriptions for quetiapine and other second-generation antipsychotics in Canada from 2005 to 2012: A descriptive study. *CMAJ Open*, 2(4), e225–e232. doi:10.9778/cmajo.20140009
- Prins, A., Bovin, M. J., Kimerling, R., Kaloupek, D. G., Marx, B. P., Pless Kaiser, A., & Schnurr, P. P. (2015). *Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)* [Measurement instrument]. Retrieved from www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf
- Prins, A., Bovin, M. J., Smolenski, D. J., Marx, B. P., Kimerling, R., Jenkins-Guarnieri, M. A., . . . Tiet, Q. Q. (2016). The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5): Development and evaluation within a veteran primary care sample. *Journal of General Internal Medicine*, 31(10), 1206–1211. doi:10.1007/s11606-016-3703-5
- Prins, S. J. (2014). Prevalence of mental illnesses in US state prisons: A systematic review. *Psychiatric Services*, 65(7), 862–872. doi:10.1176/appi.ps.201300166
- Prochaska, J. J., Sung, H. Y., Max, W., Shi, Y., & Ong, M. (2012). Validity study of the K6 scale as a measure of moderate mental distress based on mental health treatment need and utilization. *International Journal of Methods in Psychiatric Research*, 21(2), 88–97. doi:10.1002/mpr.1349
- Prochaska, J. O., & DiClemente, C. C. (1992). Stages of change in the modification of problem behaviors. *Progress in Behavior Modification*, 28, 183–218.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47(9), 1102–1114.
- Proctor, S. L., & Herschman, P. L. (2014). The continuing care model of substance use treatment: What works, and when is “enough,” “enough?” *Psychiatry Journal*, 692423. doi:10.1155/2014/692423
- Puntis, S., Rugkåsa, J., Forrest, A., Mitchell, A., & Burns, T. (2015). Associations between continuity of care and patient outcomes in mental health care: A systematic review. *Psychiatric Services*, 66(4), 354–363.
- Quinn, K., Boone, L., Scheidell, J. D., Mateu-Gelabert, P., McGorray, S. P., Beharie, N., . . . Khan, M. R. (2016). The relationships of childhood trauma and adulthood prescription pain reliever misuse and injection drug use. *Drug and Alcohol Dependence*, 169, 190–198. doi:10.1016/j.drugalcdep.2016.09.021
- Raza, G. T., DeMarce, J. M., Lash, S. J., & Parker, J. D. (2014). Paranoid personality disorder in the United States: The role of race, illicit drug use, and income. *Journal of Ethnic Substance Abuse*, 13(3), 247–257. doi:10.1080/15332640.2013.850463
- Regnart, J., Truter, I., & Meyer, A. (2017). Critical exploration of co-occurring attention-deficit/hyperactivity disorder, mood disorder and substance use disorder. *Expert Review of Pharmacoeconomics & Outcomes Research*, 17(3), 275–282. doi:10.1080/14737167.2017.1351878
- Reif, S., Braude, L., Lyman, D. R., Dougherty, R. H., Daniels, A. S., Ghose, S. S., . . . Delphin-Rittmon, M. E. (2014). Peer recovery support for individuals with substance use disorders: Assessing the evidence. *Psychiatric Services*, 65(7), 853–861. doi:10.1176/appi.ps.201400047

- Reif, S., George, P., Braude, L., Dougherty, R. H., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Residential treatment for individuals with substance use disorders: assessing the evidence. *Psychiatric Services*, 65(3), 301–312. doi:10.1176/appi.ps.201300242
- Reingle Gonzalez, J. M., & Connell, N. M. (2014). Mental health of prisoners: Identifying barriers to mental health treatment and medication continuity. *American Journal of Public Health*, 104(12), 2328–2333. doi:10.2105/AJPH.2014.302043
- Ries, R. K. (1993). The dually diagnosed patient with psychotic symptoms. *Journal of Addictive Diseases*, 12(3), 103–122. doi:10.1300/J069v12n03_09
- Riper, H., Andersson, G., Hunter, S. B., de Wit, J., Berking, M., & Cuijpers, P. (2014). Treatment of comorbid alcohol use disorders and depression with cognitive-behavioural therapy and motivational interviewing: A meta-analysis. *Addiction*, 109(3), 394–406. doi:10.1111/add.12441
- Ritschel, L. A., Lim, N. E., & Stewart, L. M. (2015). Transdiagnostic applications of DBT for adolescents and adults. *American Journal of Psychotherapy*, 69(2), 111–128. doi:10.1176/appi.psychotherapy.2015.69.2.111
- Ritter, S., & Platt, L. M. (2016). What's new in treating inpatients with personality disorders?: Dialectical behavior therapy and old-fashioned, good communication. *Journal of Psychosocial Nursing and Mental Health Services*, 54(1), 38–45. doi:10.3928/02793695-20151216-03
- Roberts, N. P., Roberts, P. A., Jones, N., & Bisson, J. I. (2016). Psychological therapies for post-traumatic stress disorder and comorbid substance use disorder. *Cochrane Database of Systematic Reviews*, 4, CD010204. doi:10.1002/14651858.CD010204.pub2
- Rog, D. J., Marshall, T., Dougherty, R. H., George, P., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Permanent supportive housing: Assessing the evidence. *Psychiatric Services*, 65(3), 287–294. doi:10.1176/appi.ps.201300261
- Rojas, E. C., & Peters, R. H. (2015). Evidence-based practices for co-occurring disorders in offenders. *Addiction Research & Theory*, 24(3), 223–235.
- Romano, M., & Peters, L. (2015). Evaluating the mechanisms of change in motivational interviewing in the treatment of mental health problems: A review and meta-analysis. *Clinical Psychology Review*, 38, 1–12. doi:10.1016/j.cpr.2015.02.008
- Root, T. L., Pinheiro, A. P., Thornton, L., Strober, M., Fernandez-Aranda, F., Brandt, H., . . . Bulik, C. M. (2010). Substance use disorders in women with anorexia nervosa. *International Journal of Eating Disorders*, 43(1), 14–21. doi:10.1002/eat.20670
- Rosenblum, A., Matusow, H., Fong, C., Vogel, H., Uttaro, T., Moore, T. L., & Magura, S. (2014). Efficacy of dual focus mutual aid for persons with mental illness and substance misuse. *Drug and Alcohol Dependence*, 135, 78–87. doi:10.1016/j.drugalcdep.2013.11.012
- Rosenthal, R. J. (1992). Pathological gambling. *Psychiatric Annals*, 22(2), 72–78. doi:10.3928/0048-5713-19920201-09
- Ross, L. E., & Dennis, C. L. (2009). The prevalence of postpartum depression among women with substance use, an abuse history, or chronic illness: A systematic review. *Journal of Women's Health*, 18(4), 475–486. doi:10.1089/jwh.2008.0953
- Roush, S., Monica, C., Carpenter-Song, E., & Drake, R. E. (2015). First-person perspectives on Dual Diagnosis Anonymous (DDA): A qualitative study. *Journal of Dual Diagnosis*, 11(2), 136–141. doi:10.1080/15504263.2015.1025215
- Rowe, J. (2012). Great expectations: A systematic review of the literature on the role of family carers in severe mental illness, and their relationships and engagement with professionals. *Journal of Psychiatric and Mental Health Nursing*, 19(1), 70–82. doi:10.1111/j.1365-2850.2011.01756.x
- Rubinsky, A. D., Ellerbe, L. S., Gupta, S., Phelps, T. E., Bowe, T., Burden, J. L., & Harris, A. H. S. (2017). Outpatient continuing care after residential substance use disorder treatment in the US Veterans Health Administration: Facilitators and challenges. *Substance Abuse*, 39(3), 322–330. doi:10.1080/08897077.2017.1391923
- Ruglass, L. M., Lopez-Castro, T., Papini, S., Killeen, T., Back, S. E., & Hien, D. A. (2017). Concurrent treatment with prolonged exposure for co-occurring full or subthreshold posttraumatic stress disorder and substance use disorders: A randomized clinical trial. *Psychotherapy and Psychosomatics*, 86(3), 150–161. doi:10.1159/000462977
- Ruglass, L. M., Miele, G. M., Hien, D. A., Campbell, A. N., Hu, M. C., Caldeira, N., . . . Nunes, E. V. (2012). Helping alliance, retention, and treatment outcomes: A secondary analysis from the NIDA Clinical Trials Network Women and Trauma Study. *Substance Use & Misuse*, 47(6), 695–707. doi:10.3109/10826084.2012.659789
- Ruiz, M. A., Douglas, K. S., Edens, J. F., Nikolova, N. L., & Lilienfeld, S. O. (2012). Co-occurring mental health and substance use problems in offenders: Implications for risk assessment. *Psychological Assessment*, 24(1), 77–87. doi:10.1037/a0024623
- Ruiz, M. A., Peters, R. H., Sanchez, G. M., & Bates, J. P. (2009). Psychometric properties of the Mental Health Screening Form III within a metropolitan jail. *Criminal Justice and Behavior*, 36(6), 607–619. doi:10.1177/0093854809334013
- Ruscio, A. M., Hallion, L. S., Lim, C. C. W., Aguilar-Gaxiola, S., Al-Hamzawi, A., Alonso, J., . . . Scott, K. M. (2017). Cross-sectional comparison of the epidemiology of DSM-5 Generalized Anxiety Disorder across the globe. *JAMA Psychiatry*, 74(5), 465–475. doi:10.1001/jamapsychiatry.2017.0056



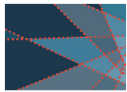
- Sacks, S., Chaple, M., Sacks, J. Y., McKendrick, K., & Cleland, C. M. (2012). Randomized trial of a reentry modified therapeutic community for offenders with co-occurring disorders: Crime outcomes. *Journal of Substance Abuse Treatment*, 42(3), 247–259. doi:10.1016/j.jsat.2011.07.011
- Sacks, S., Chaple, M., Sirikantraporn, J., Sacks, J. Y., Knickman, J., & Martinez, J. (2013). Improving the capability to provide integrated mental health and substance abuse services in a state system of outpatient care. *Journal of Substance Abuse Treatment*, 44(5), 488–493. doi:10.1016/j.jsat.2012.11.001
- Sacks, S., McKendrick, K., Sacks, J. Y., & Cleland, C. M. (2010). Modified therapeutic community for co-occurring disorders: Single investigator meta analysis. *Substance Abuse*, 31(3), 146–161. doi:10.1080/08897077.2010.495662
- Sacks, S., McKendrick, K., Vazan, P., Sacks, J. Y., & Cleland, C. M. (2011). Modified therapeutic community aftercare for clients triply diagnosed with HIV/AIDS and co-occurring mental and substance use disorders. *AIDS Care*, 23(12), 1676–1686. doi:10.1080/09540121.2011.582075
- Sacks, S., & Sacks, J. Y. (2011, February 10). *Modified therapeutic community and specialized housing programs for justice-involved individuals with co-occurring mental and substance use disorders illnesses*. A presentation at the JMHCP National Training and Technical Assistance Event: Achieving and Communicating Public Health and Safety Outcomes for our Communities. Baltimore, MD.
- Saha, S., Chant, D., Welham, J., & McGrath, J. (2005). A systematic review of the prevalence of schizophrenia. *PLoS Medicine*, 2(5). doi:10.1371/journal.pmed.0020141
- Saloner, B., & Le Cook, B. (2013). Blacks and Hispanics are less likely than whites to complete addiction treatment, largely due to socioeconomic factors. *Health Affairs*, 32(1), 135–145. doi:10.1377/hlthaff.2011.0983
- Samet, S., Fenton, M. C., Nunes, E., Greenstein, E., Aharonovich, E., & Hasin, D. (2013). Effects of independent and substance-induced major depressive disorder on remission and relapse of alcohol, cocaine and heroin dependence. *Addiction*, 108(1), 115–123. doi:10.1111/j.1360-0443.2012.04010.x
- Samuels, E. A., Bernstein, S. L., Marshall, B. D. L., Krieger, M., Baird, J., & Mello, M. J. (2018). Peer navigation and take-home naloxone for opioid overdose emergency department patients: Preliminary patient outcomes. *Journal of Substance Abuse Treatment*, 94, 29–34. doi:10.1016/j.jsat.2018.07.013
- Sanchez, K., Ybarra, R., Chapa, T., & Martinez, O. N. (2016). Eliminating behavioral health disparities and improving outcomes for racial and ethnic minority populations. *Psychiatric Services*, 67(1), 13–15. doi:10.1176/appi.ps.201400581
- Sanchez-Moreno, J., Martinez-Aran, A., & Vieta, E. (2017). Treatment of functional impairment in patients with bipolar disorder. *Current Psychiatry Reports*, 19(1), 3. doi:10.1007/s11920-017-0752-3
- Sansone, R. A., & Sansone, L. A. (2011a). Gender patterns in borderline personality disorder. *Innovations in Clinical Neuroscience*, 8(5), 16–20.
- Sansone, R. A., & Sansone, L. A. (2011b). Substance use disorders and borderline personality. *Innovations in Clinical Neuroscience*, 8(9), 10–13.
- Sansone, R. A., & Sansone, L. A. (2015). Borderline personality in the medical setting. *Primary Care Companion for CNS Disorders*, 17(3). doi:10.4088/PCC.14r01743
- Sarkar, J., & Duggan, C. (2010). Diagnosis and classification of personality disorder: Difficulties, their resolution and implications for practice. *Advances in Psychiatric Treatment*, 16(5), 388–396. doi:10.1192/apt.16.6.476a
- Sarvet, A. L., Wall, M. M., Keyes, K. M., Olfson, M., Cerdá, M., & Hasin, D. S. (2018). Self-medication of mood and anxiety disorders with marijuana: Higher in states with medical marijuana laws. *Drug and Alcohol Dependence*, 186, 10–15. doi:10.1016/j.drugalcdep.2018.01.009
- Savic, M., Best, D., Manning, V., & Lubman, D. I. (2017). Strategies to facilitate integrated care for people with alcohol and other drug problems: A systematic review. *Substance Abuse: Treatment, Prevention, and Policy*, 12(1). doi:10.1186/s13011-017-0104-7
- Schaffer, A., Isometsa, E. T., Tondo, L., H. Moreno, D., Turecki, G., Reis, C., . . . Yatham, L. N. (2015). International Society for Bipolar Disorders Task Force on Suicide: Meta-analyses and meta-regression of correlates of suicide attempts and suicide deaths in bipolar disorder. *Bipolar Disorders*, 17(1), 1–16. doi:10.1111/bdi.12271
- Schaumberg, K., Welch, E., Breithaupt, L., Hubel, C., Baker, J. H., Munn-Chernoff, M. A., . . . Bulik, C. M. (2017). The science behind the Academy for Eating Disorders' nine truths about eating disorders. *European Eating Disorders Review*, 25(6), 432–450. doi:10.1002/erv.2553
- Schneier, F. R., Foose, T. E., Hasin, D. S., Heimberg, R. G., Liu, S. M., Grant, B. F., & Blanco, C. (2010). Social anxiety disorder and alcohol use disorder co-morbidity in the National Epidemiologic Survey on Alcohol and Related Conditions. *Psychological Medicine*, 40(6), 977–988. doi:10.1017/S0033291709991231
- Schoenthaler, S. J., Blum, K., Fried, L., Oscar-Berman, M., Giordano, J., Modestino, E. J., & Badgaiyan, R. (2017). The effects of residential dual diagnosis treatment on alcohol abuse. *Journal of Systems and Integrative Neuroscience*, 3(4). doi:10.15761/jsin.1000169
- Schulte, S. J., Meier, P. S., & Stirling, J. (2011). Dual diagnosis clients' treatment satisfaction – A systematic review. *BMC Psychiatry*, 11, 64.

- Schulz, P. E., & Arora, G. (2015). Depression. *Behavioral Neurology and Neuropsychiatry*, 21(3), 756–771. doi:10.1212/01.CON.0000466664.35650.b4
- Schumm, J. A., & Gore, W. L. (2016). Simultaneous treatment of co-occurring posttraumatic stress disorder and substance use disorder. *Current Treatment Options in Psychiatry*, 3(1), 28–36. doi:10.1007/s40501-016-0071-z
- Scott, E. L., & Hulvershorn, L. (2011, September 7). Anxiety disorders with comorbid substance abuse. *Psychiatric Times*, 28(9), 1–2.
- Seal, K. H., Cohen, G., Waldrop, A., Cohen, B. E., Maguen, S., & Ren, L. (2011). Substance use disorders in Iraq and Afghanistan veterans in VA healthcare, 2001–2010: Implications for screening, diagnosis and treatment. *Drug and Alcohol Dependence*, 116(1–3), 93–101. doi:10.1016/j.drugalcdep.2010.11.027
- Selzer, M. L. (1971). The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *American Journal of Psychiatry*, 127(12), 1653–1658. doi:10.1176/ajp.127.12.1653
- Shapiro, B., Coffa, D., & McCance-Katz, E. F. (2013). A primary care approach to substance misuse. *American Family Physician*, 88(2), 113–121.
- Shattock, L., Berry, K., Degnan, A., & Edge, D. (2018). Therapeutic alliance in psychological therapy for people with schizophrenia and related psychoses: A systematic review. *Clinical Psychology & Psychotherapy*, 25(1), e60–e85. doi:10.1002/cpp.2135
- Sheehan, D. V., Harnett-Sheehan, K., & Raj, B. A. (1996). The measurement of disability. *International Clinical Psychopharmacology*, 11(Suppl. 3), 89–95.
- Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., . . . Dunbar, G. C. (1998). The Mini-International Neuropsychiatric Interview (M.I.N.I.): The development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry*, 59(Suppl. 20), 22–33; quiz 34–57.
- Sheehan, L., Nieweglowski, K., & Corrigan, P. (2016). The stigma of personality disorders. *Current Psychiatry Reports*, 18(1), 1–7. doi:10.1007/s11920-015-0654-1
- Shenoy, A., & Appel, J. M. (2017). Safeguarding confidentiality in electronic health records. *Cambridge Quarterly of Healthcare Ethics*, 26(2), 337–341. doi:10.1017/s0963180116000931
- Sher, L., Siever, L. J., Goodman, M., McNamara, M., Hazlett, E. A., Koenigsberg, H. W., & New, A. S. (2015). Gender differences in the clinical characteristics and psychiatric comorbidity in patients with antisocial personality disorder. *Psychiatry Research*, 229(3), 685–689. doi:10.1016/j.psychres.2015.08.022
- Sherman, L. J., Lynch, S. E., Greeno, C. G., & Hoeffel, E. M. (2017, July 11). *Behavioral health workforce: Quality assurance practices in substance abuse treatment facilities*. SAMHSA CBHSQ report. Retrieved from www.samhsa.gov/data/sites/default/files/report_3059/ShortReport-3059.html
- Shinn, G., & Brose, M. (2017). *Building partnerships and collaboration between housing providers and behavioral health practitioners*. Mental Health Association Oklahoma. Retrieved from www.samhsa.gov/sites/default/files/programs_campaigns/recovery_to_practice/homelessness-3-building-partnerships.pdf
- Shionogi Pharma Inc. (2010). KAPVAY (clonidine hydrochloride) extended-release tablets, oral Initial U.S. approval: 1974. Prescribing information. Retrieved from www.accessdata.fda.gov/drugsatfda_docs/label/2010/022331s001s002lbl.pdf
- Shire US Inc. (Revised February 2013). INTUNIV® (guanfacine) extended-release tablets, for oral use. Initial U.S. approval: 1986 Retrieved from www.accessdata.fda.gov/drugsatfda_docs/label/2013/022037s009lbl.pdf
- Simon, R. I., Hales, R. E., & American Psychiatric Publishing. (2012). *The American Psychiatric Publishing textbook of suicide assessment and management* (2nd ed.). Washington, DC: American Psychiatric Publishing.
- Simon, V., Czobor, P., Balint, S., Meszaros, A., & Bitter, I. (2009). Prevalence and correlates of adult attention-deficit hyperactivity disorder: Meta-analysis. *British Journal of Psychiatry*, 194(3), 204–211. doi:10.1192/bjp.bp.107.048827
- Simpson, T. L., Lehavot, K., & Petrakis, I. L. (2017). No wrong doors: Findings from a critical review of behavioral randomized clinical trials for individuals with co-occurring alcohol/drug problems and posttraumatic stress disorder. *Alcoholism: Clinical and Experimental Research*, 41(4), 681–702. doi:10.1111/acer.13325
- Simpson, T. L., Stappenbeck, C. A., Luterek, J. A., Lehavot, K., & Kaysen, D. L. (2014). Drinking motives moderate daily relationships between PTSD symptoms and alcohol use. *Journal of Abnormal Psychology*, 123(1), 237–247. doi:10.1037/a0035193
- Sinha, A., Lewis, O., Kumar, R., Yeruva, S. L. H., & Curry, B. H. (2016). Adult ADHD medications and their cardiovascular implications. *Case Reports in Cardiology*, 2016, 2343691. doi: 10.1155/2016/2343691
- Skinner, H. A. (1982). The Drug Abuse Screening Test. *Addictive Behaviors*, 7(4), 363–371. doi:10.1016/0306-4603(82)90005-3
- Smelson, D., Farquhar, I., Fisher, W., Pressman, K., Pinals, D. A., Samek, B., . . . Sawh, L. (2018). Integrating a co-occurring disorders intervention in drug courts: An open pilot trial. *Community Mental Health Journal*, 55(2), 222–231. doi:10.1007/s10597-018-0255-7



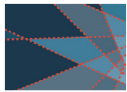
- Smelson, D. A., Zaykowski, H., Guevermont, N., Siegfriedt, J., Sawh, L., Modzelewski, D., ... Kane, V. (2016). Integrating permanent supportive housing and co-occurring disorders treatment for individuals who are homeless. *Journal of Dual Diagnosis*, 12(2), 193–201. doi:10.1080/15504263.2016.1174010
- Smink, F. R. E., van Hoeken, D., & Hoek, H. W. (2013). *Epidemiology, course, and outcome of eating disorders*. *Current Opinion in Psychiatry*, 26(6), 543–548. doi:10.1097/YCO.0b013e328365a24f
- Smith, D. E. (2012). Editor's note: The medicalization of therapeutic communities in the era of health care reform. *Journal of Psychoactive Drugs*, 44(2), 93–95. doi:10.1080/02791072.2012.684608
- Smith, J. D., Mittal, D., Chekuri, L., Han, X., & Sullivan, G. (2017). A comparison of provider attitudes toward serious mental illness across different health care disciplines. *Stigma and Health*, 2(4), 327–337.
- Smith, J. P., & Book, S. W. (2008). Anxiety and substance use disorders: A review. *Psychiatric Times*, 25(10), 19–23.
- Smith, J. P., & Randall, C. L. (2012). Anxiety and alcohol use disorders: Comorbidity and treatment considerations. *Alcohol Research*, 34(4), 414–431.
- Smith, M. W., Stocks, C., & Santora, P. B. (2015). Hospital readmission rates and emergency department visits for mental health and substance abuse conditions. *Community Mental Health Journal*, 51(2), 190–197. doi:10.1007/s10597-014-9784-x
- Smith, R. J., Jennings, J. L., & Cimino, A. (2010). Forensic continuum of care with Assertive Community Treatment (ACT) for persons recovering from co-occurring disabilities: Long-term outcomes. *Psychiatric Rehabilitation Journal*, 33(3), 207–218.
- Smith, S. M., Goldstein, R. B., & Grant, B. F. (2016). The association between post-traumatic stress disorder and lifetime DSM-5 psychiatric disorders among veterans: Data from the National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III). *Journal of Psychiatric Research*, 82, 16–22. doi:10.1016/j.jpsychires.2016.06.022
- Sohal, H., Eldridge, S., & Feder, G. (2007). The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: A diagnostic accuracy study in general practice. *BMC Family Practice*, 8, 49. doi:10.1186/1471-2296-8-49
- Sohn, H. (2017). Racial and ethnic disparities in health insurance coverage: Dynamics of gaining and losing coverage over the life-course. *Population Research and Policy Review*, 36(2), 181–201. doi:10.1007/s11113-016-9416-y
- Solari, C. D., Morris, S., Shivji, A., & Souza, T. D. (2016, October). *The 2015 Annual Homeless Assessment Report (AHAR) to Congress. Part 1 - PIT estimates of homelessness in the U.S.* Retrieved from <https://files.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf>
- Sowers, W. (2016). *Level of Care Utilization System for psychiatric and addiction services (LOCUS), Adult version 20*. Task Force on Level of Care Determinations of the American Association of Community Psychiatrists (AACP). Dallas, TX: AACP. Retrieved from <https://drive.google.com/file/d/0B89glzXJnn4cV1dESWI2eFEzc3M/view>
- Spinelli, M. A., Ponath, C., Tieu, L., Hurstak, E. E., Guzman, D., & Kushel, M. (2017). Factors associated with substance use in older homeless adults: Results from the HOPE HOME study. *Substance Abuse*, 38(1), 88–94. doi:10.1080/08897077.2016.1264534
- Stahler, G. J., Mennis, J., & DuCette, J. P. (2016). Residential and outpatient treatment completion for substance use disorders in the U.S.: Moderation analysis by demographics and drug of choice. *Addictive Behaviors*, 58, 129–135. doi:10.1016/j.addbeh.2016.02.030
- Stefancic, A., Henwood, B. F., Melton, H., Shin, S. M., Lawrence-Gomez, R., & Tsemberis, S. (2013). Implementing housing first in rural areas: Pathways Vermont. *American Journal of Public Health*, 103(Suppl. 2), S206–S209. doi:10.2105/ajph.2013.301606
- Stein, L. I., & Test, M. A. (1980). Alternative to mental hospital treatment: I. Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry*, 37(4), 392–397.
- Sterling, S., Chi, F., & Hinman, A. (2011). Integrating care for people with co-occurring alcohol and other drug, medical, and mental health conditions. *Alcohol Research & Health*, 33(4), 338–349.
- Stice, E., Marti, C. N., & Rohde, P. (2013). Prevalence, incidence, impairment, and course of the proposed DSM-5 eating disorder diagnoses in an 8-year prospective community study of young women. *Journal of Abnormal Psychology*, 122(2), 445–457. doi:10.1037/a0030679
- Stinson, J. D., Quinn, M. A., & Levenson, J. S. (2016). The impact of trauma on the onset of mental health symptoms, aggression, and criminal behavior in an inpatient psychiatric sample. *Child Abuse and Neglect*, 61, 13–22. doi:10.1016/j.chiabu.2016.09.005
- Stirman, S. W., Gutner, C. A., Langdon, K., & Graham, J. R. (2016). Bridging the gap between research and practice in mental health service settings: An overview of developments in implementation theory and research. *Behavior Therapy*, 47(6), 920–936. doi:10.1016/j.beth.2015.12.001

- Stone, D. M., Simon, T. R., Fowler, K. A., Kegler, S. R., Yuan, K., Holland, K. M., . . . Crosby, A. E. (2018). Vital signs: Trends in state suicide rates — United States, 1999–2016 and circumstances contributing to suicide — 27 states, 2015. *Morbidity and Mortality Weekly Report*, 67(22), 617–624. doi:10.15585/mmwr.mm6722a1
- Stone, E. M., Chen, L. N., Daumit, G. L., Linden, S., & McGinty, E. E. (2019). General medical clinicians' attitudes toward people with serious mental illness: A scoping review. *Journal of Behavioral Health Services & Research*, 18. doi:10.1007/s11414-019-09652-w
- Stringfellow, E. J., Kim, T. W., Gordon, A. J., Pollio, D. E., Grucza, R. A., Austin, E. L., . . . Kertesz, S. G. (2016). Substance use among persons with homeless experience in primary care. *Substance Abuse*, 37(4), 534–541. doi:10.1080/08897077.2016.1145616
- Strom, J. B., Kramer, D. B., Wang, Y., Shen, C., Wasfy, J. H., Landon, B. E., . . . Yeh, R. W. (2017). Short-term rehospitalization across the spectrum of age and insurance types in the United States. *PLoS ONE*, 12(7), e0180767. doi:10.1371/journal.pone.0180767
- Subodh, B. N., Sharma, N., & Shah, R. (2018). Psychosocial interventions in patients with dual diagnosis. *Indian Journal of Psychiatry*, 60(Suppl. 4), S494–S500. doi:10.4103/psychiatry.IndianJPsychiatry_18_18
- Substance Abuse and Mental Health Services Administration. (n.d.) Recruitment and Retention Toolkit.
- Substance Abuse and Mental Health Services Administration. (2000). *Integrating substance abuse treatment and vocational services*. Treatment Improvement Protocol (TIP) Series, No. 38. HHS Publication No. (SMA) 12-4216. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2008). Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT. Retrieved from <https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/sma08-4344>
- Substance Abuse and Mental Health Services Administration. (2009a). *Integrated treatment for co-occurring disorders: training frontline staff*. DHHS Pub. No. SMA-08-4366. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- Substance Abuse and Mental Health Services Administration. (2009b). *SAFE-T – Suicide assessment five-step evaluation and triage*. Pocket card. Retrieved from <https://store.samhsa.gov/system/files/sma09-4432.pdf>
- Substance Abuse and Mental Health Services Administration. (2009c). *Substance abuse treatment: Addressing the specific needs of women*. Revised 2013. Treatment Improvement Protocol (TIP) Series 51 (HHS Publication No. (SMA)13-4426). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2011a). Clients with substance use and eating disorders. *Advisory*, 10(1), 1–11. Retrieved from <https://store.samhsa.gov/product/clients-with-substance-use-and-eating-disorders/SMA10-4617>
- Substance Abuse and Mental Health Services Administration. (2011b). *Dual diagnosis capability in mental health treatment toolkit version 4.0*. (HHS Publication No. SMA-XX-XXXX). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2012). SAMHSA's working definition of recovery. Retrieved from <https://store.samhsa.gov/system/files/pep12-recdef.pdf>
- Substance Abuse and Mental Health Services Administration. (2013). *Behavioral health services for people who are homeless*. (HHS Publication No. (SMA) 13-4734). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2014a). *Improving cultural competence*. Treatment Improvement Protocol (TIP) Series No. 59 (HHS Publication No. (SMA) 14-4849). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2014b). *Trauma-informed care in behavioral health services*. Treatment Improvement Protocol (TIP) Series 57. (HHS Publication No. (SMA) 14-4816.). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration (2014c). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
- Substance Abuse and Mental Health Services Administration. (2015a). Adults with attention deficit hyperactivity disorder and substance use disorders. *Advisory* 14(3). Retrieved from <https://store.samhsa.gov/product/Advisory-Adults-With-Attention-Deficit-Hyperactivity-Disorder-and-Substance-Use-Disorders/SMA15-4925>
- Substance Abuse and Mental Health Services Administration. (2015b). *Screening and assessment of co-occurring disorders in the justice system*. (HHS Publication No. (SMA)-15-4930). Rockville, MD: Substance Abuse and Mental Health Services Administration.



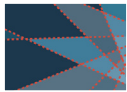
- Substance Abuse and Mental Health Services Administration. (2015c, March). *Women in the mirror: Addressing co-occurring mental health issues and trauma in women with substance use disorders*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/women_children_families/women-in-mirror.pdf
- Substance Abuse and Mental Health Services Administration. (2016). An introduction to bipolar disorder and co-occurring substance use disorders. *Advisory*, 15(2). Retrieved from <https://store.samhsa.gov/system/files/sma16-4960.pdf>
- Substance Abuse and Mental Health Services Administration. (2017). *Suicide prevention*. Retrieved from <https://www.samhsa.gov/suicide-prevention>
- Substance Abuse and Mental Health Services Administration. (2018a). *Behavioral health services for American Indians and Alaska Natives*. Treatment Improvement Protocol (TIP) Series 61 (HHS Publication No. (SMA) 18-5070). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2018b). *Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health* (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2018c). *Medications for opioid use disorder*. Treatment Improvement Protocol (TIP) Series 63 (HHS Publication No. (SMA) 18-5063FULLDOC). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2018d). *National Mental Health Services Survey (N-MHSS): 2017. Data on mental health treatment facilities*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2018e). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2017. Data on substance abuse treatment facilities*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2019a). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2018. Data on substance abuse treatment facilities*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2019b). *National Mental Health Services Survey (N-MHSS): 2018. Data on mental health treatment facilities*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration. (2019c). *Enhancing motivation for change in substance use disorder treatment*. Treatment Improvement Protocol (TIP) Series 35. (SAMHSA Publication No. PEP19-02-01-003). Rockville, MD: Center for Substance Abuse Treatment.
- Substance Abuse and Mental Health Services Administration. (2019d). *Mental health annual report: 2017. Use of mental health services: National client level data*. Rockville, MD: Center for Behavioral Health Statistics and Quality.
- Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2017). *Treatment Episode Data Set (TEDS): 2005–2015. National admissions to substance abuse treatment services*. BHSIS Series S-91, HHS Publication No. (SMA) 17-5037. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2019). *Treatment Episode Data Set (TEDS): 2017. Admissions to and discharges from publicly-funded substance use treatment*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Sullivan, J. T., Sykora, K., Schneiderman, J., Naranjo, C. A., & Sellers, E. M. (1989). Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). *British Journal of Addiction*, 84(11), 1353–1357.
- Sun, A. P. (2012). Helping homeless individuals with co-occurring disorders: The four components. *Social Work*, 57(1), 23–37.
- Sung, Y. K., La Flair, L. N., Mojtabai, R., Lee, L. C., Spivak, S., & Crum, R. M. (2016). The association of alcohol use disorders with suicidal ideation and suicide attempts in a population-based sample with mood symptoms. *Archives of Suicide Research*, 20(2), 219–232. doi:10.1080/13811118.2015.1004489
- Swann, A. C. (2010). The strong relationship between bipolar and substance-use disorder. *Annals of the New York Academy of Sciences*, 1187, 276–293. doi:10.1111/j.1749-6632.2009.05146.x
- Swopes, R. M., Davis, J. L., & Scholl, J. A. (2017). Treating substance abuse and trauma symptoms in incarcerated women: An effectiveness study. *Journal of Interpersonal Violence*, 32(7), 1143–1165. doi:10.1177/0886260515587668

- Szaflarski, M., Bauldry, S., Cubbins, L. A., & Meganathan, K. (2017). Nativity, race-ethnicity, and dual diagnosis among US adults. *Research in the Sociology of Health Care*, 35, 171–191.
- Tang, Z., Claus, R. E., Orwin, R. G., Kissin, W. B., & Arieira, C. (2012). Measurement of gender-sensitive treatment for women in mixed-gender substance abuse treatment programs. *Drug and Alcohol Dependence*, 123(1–3), 160–166. doi:10.1016/j.drugalcdep.2011.11.003
- Taylor, O. D. (2010). Barriers to treatment for women with substance use disorders. *Journal of Human Behavior in the Social Environment*, 20(3), 393–409. doi:10.1080/10911351003673310
- Teeters, J. B., Lancaster, C. L., Brown, D. G., & Back, S. E. (2017). Substance use disorders in military veterans: Prevalence and treatment challenges. *Substance Abuse and Rehabilitation*, 8, 69–77. doi:10.2147/sar.S116720
- Test, M. A. (1992). Training in community living. In R. P. Lieberman (Ed.), *Handbook of psychiatric rehabilitation* (pp. 153–170). New York, NY: MacMillan Publishing.
- Thiel, N., Hertenstein, E., Nissen, C., Herbst, N., Külz, A. K., & Voderholzer, U. (2013). The effect of personality disorders on treatment outcomes in patients with obsessive-compulsive disorders. *Journal of Personality Disorders*, 27(6), 697–715. doi:10.1521/pedi_2013_27_104
- Thomson, M., & Sharma, V. (2017). Therapeutics of postpartum depression. *Expert Review of Neurotherapeutics*, 17(5), 495–507. doi:10.1080/14737175.2017.1265888
- Thronson, L. R., & Pagalilauan, G. L. (2014). Psychopharmacology. *Medical Clinics of North America*, 98(5), 927–958. doi:10.1016/j.mcna.2014.06.001
- Thurber, S., Wilson, A., Realmuto, G., & Specker, S. (2018). The relationship between the INTERMED patient complexity instrument and Level of Care Utilisation System (LOCUS). *International Journal of Psychiatry in Clinical Practice*, 22(1), 80–82. doi:10.1080/13651501.2017.1353635
- Tiet, Q. Q., & Schutte, K. K. (2012). Treatment setting and outcomes of patients with co-occurring disorders. *Journal of Groups in Addiction & Recovery*, 7(1), 53–76. doi:10.1080/1556035X.2012.632330
- Timko, C., Sutkowi, A., & Moos, R. (2010). Patients with dual diagnoses or substance use disorders only: 12-step group participation and 1-year outcomes. *Substance Use & Misuse*, 45(4), 613–627. doi:10.3109/10826080903452421
- Tolliver, B. K., & Anton, R. F. (2015). Assessment and treatment of mood disorders in the context of substance abuse. *Dialogues in Clinical Neuroscience*, 17(2), 181–190.
- Tonigan, J. S., Pearson, M. R., Magill, M., & Hagler, K. J. (2018). AA attendance and abstinence for dually diagnosed patients: A meta-analytic review. *Addiction*, 113(11), 1970–1981. doi:10.1111/add.14268
- Trivedi, R. B., Post, E. P., Sun, H., Pomerantz, A., Saxon, A. J., Piette, J. D., . . . Nelson, K. (2015). Prevalence, comorbidity, and prognosis of mental health among US veterans. *American Journal of Public Health*, 105(12), 2564–2569. doi:10.2105/ajph.2015.302836
- Trudeau, K. J., Burtner, J., Villapiano, A. J., Jones, M., Butler, S. F., & Joshi, K. (2018). Burden of schizophrenia or psychosis-related symptoms in adults undergoing substance abuse evaluation. *Journal of Nervous and Mental Disease*, 206(7), 528–536. doi:10.1097/NMD.0000000000000835
- Trull, T. J., Freeman, L. K., Vebares, T. J., Choate, A. M., Helle, A. C., & Wyckoff, A. M. (2018). Borderline personality disorder and substance use disorders: An updated review. *Borderline Personality Disorder and Emotion Dysregulation*, 5, 15. doi:10.1186/s40479-018-0093-9
- Trull, T. J., Jahng, S., Tomko, R. L., Wood, P. K., & Sher, K. J. (2010). Revised NESARC personality disorder diagnoses: Gender, prevalence, and comorbidity with substance dependence disorders. *Journal of Personality Disorders*, 24(4), 412–426. doi:10.1521/pedi.2010.24.4.412
- Tsai, J. (2018). Lifetime and 1-year prevalence of homelessness in the US population: Results from the National Epidemiologic Survey on Alcohol and Related Conditions-III. *Journal of Public Health (Oxford, England)*, 40(1), 65–74. doi:10.1093/pubmed/idx034
- Tsai, J., & Cao, X. (2019). Association between suicide attempts and homelessness in a population-based sample of US veterans and non-veterans. *Journal of Epidemiology and Community Health*, 73(4), 346–352. doi:10.1136/jech-2018-211065
- Tsai, J., Kaspro, W. J., & Rosenheck, R. A. (2014). Alcohol and drug use disorders among homeless veterans: Prevalence and association with supported housing outcomes. *Addictive Behaviors*, 39(2), 455–460. doi:10.1016/j.addbeh.2013.02.002
- Tsai, J., Lee, C. Y. S., Byrne, T., Pietrzak, R. H., & Southwick, S. M. (2017). Changes in public attitudes and perceptions about homelessness between 1990 and 2016. *American Journal of Community Psychology*, 60(3–4), 599–606. doi:10.1002/ajcp.12198
- Tsai, J., & Rosenheck, R. A. (2012). Outcomes of a group intensive peer-support model of case management for supported housing. *Psychiatric Services*, 63(12), 1186–1194.
- Tsemberis, S., & Eisenberg, R. F. (2000). Pathways to housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. *Psychiatric Services*, 51(4), 487–493. doi:10.1176/appi.ps.51.4.487



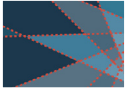
- Tsemberis, S. J. (2010). *Housing First: The Pathways model to end homelessness for people with mental health and substance use disorders*. Center City, Minnesota: Hazelden Publishing.
- Tsemberis, S. J., Moran, L., Shinn, M., Asmussen, S. M., & Shern, D. L. (2003). Consumer preference programs for individuals who are homeless and have psychiatric disabilities: A drop-in center and a supported housing program. *American Journal of Community Psychology*, 32(3–4), 305–317.
- Turner, S. B., & Stanton, M. P. (2015). Psychiatric case management in the emergency department. *Professional Case Management*, 20(5), 217–227; quiz 228–219. doi:10.1097/ncm.0000000000000106
- Tyrer, P., Sharfstein, S., O'Reilly, R., Allison, S., & Bastiampillai, T. (2017). Psychiatric hospital beds: An Orwellian crisis. *Lancet*, 389(10067), 363. doi:10.1016/s0140-6736(17)30149-6
- U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012, September). *2012 National Strategy for Suicide Prevention: Goals and objectives for action*. Washington, DC: HHS.
- U.S. Department of Health and Human Services, Office of the Surgeon General. (2016, November). *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS.
- U.S. Department of Housing and Urban Development. (2018). 2018 Continuum of Care Homeless Populations and Subpopulations Report - All states, territories, Puerto Rico, and DC. Washington, DC: Author. Retrieved May 29, 2018, from https://files.hudexchange.info/reports/published/CoC_PopSub_NatTerrDC_2018.pdf
- U.S. Interagency Council on Homelessness. (2014, June). *Implementing Housing First in Permanent Supportive Housing*. Fact Sheet from USICH with assistance from the Substance Abuse and Mental Health Services Administration. Retrieved from www.usich.gov/resources/uploads/asset_library/Implementing_Housing_First_in_Permanent_Supportive_Housing.pdf
- U.S. Preventive Services Task Force (USPTSF). (2013). Archived: *Intimate partner violence and abuse of elderly and vulnerable adults: Screening*. Retrieved from www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening
- Udo, T., & Grilo, C. M. (2018). Prevalence and correlates of DSM-5-defined eating disorders in a nationally representative sample of U.S. adults. *Biological Psychiatry*, 84(5), 345–354. doi:10.1016/j.biopsych.2018.03.014
- Ullman, S. E., Relyea, M., Peter-Hagene, L., & Vasquez, A. L. (2013). Trauma histories, substance use coping, PTSD, and problem substance use among sexual assault victims. *Addictive Behaviors*, 38(6), 2219–2223. doi:10.1016/j.addbeh.2013.01.027
- University of Michigan Behavioral Health Workforce Research Center. (2018). *Scopes of practice and reimbursement patterns of addiction counselors, community health workers, and peer recovery specialists in the behavioral health workforce*. Ann Arbor, MI: University of Michigan School of Public Health.
- Upshur, C. C., Jenkins, D., Weinreb, L., Gelberg, L., & Orvek, E. A. (2017). Prevalence and predictors of substance use disorders among homeless women seeking primary care: An 11 site survey. *American Journal of Addictions*, 26(7), 680–688. doi:10.1111/ajad.12582
- Üstün, T. B., & World Health Organization. (2010). *Measuring health and disability: Manual for WHO Disability Assessment Schedule WHODAS 2.0*. Geneva: World Health Organization.
- Vallejo, Z., & Amaro, H. (2009). Adaptation of mindfulness-based stress reduction program for addiction relapse prevention. *The Humanistic Psychologist*, 37(2), 192–206. doi:10.1080/08873260902892287
- van de Glind, G., Van Emmerik-van Oortmerssen, K., Carpentier, P. J., Levin, F. R., Koeter, M. W. J., Barta, C., . . . van den Brink, W. (2013). The International ADHD in Substance Use Disorders Prevalence (IASP) study: Background, methods and study population. *International Journal of Methods in Psychiatric Research*, 22(3), 232–244.
- Vanderplasschen, W., Colpaert, K., Autrique, M., Rapp, R. C., Pearce, S., Broekaert, E., & Vandevelde, S. (2013). Therapeutic communities for addictions: A review of their effectiveness from a recovery-oriented perspective. *Scientific World Journal*, 13, 427817. doi:10.1155/2013/427817
- Vanderwaal, F. M. (2015). Impact of motivational interviewing on medication adherence in schizophrenia. *Issues in Mental Health Nursing*, 36(11), 900–904. doi:10.3109/01612840.2015.1058445
- van Emmerik-van Oortmerssen, K., van de Glind, G., van den Brink, W., Smit, F., Crunelle, C. L., Swets, M., & Schoevers, R. A. (2012). Prevalence of attention-deficit hyperactivity disorder in substance use disorder patients: A meta-analysis and meta-regression analysis. *Drug and Alcohol Dependence*, 122(1–2), 11–19. doi:10.1016/j.drugalcdep.2011.12.007
- Vega, W. A., Canino, G., Cao, Z., & Alegria, M. (2009). Prevalence and correlates of dual diagnoses in U.S. Latinos. *Drug and Alcohol Dependence*, 100(1–2), 32–38. doi:10.1016/j.drugalcdep.2008.08.018

- Verges, A., Jackson, K. M., Bucholz, K. K., Trull, T. J., Lane, S. P., & Sher, K. J. (2014). Personality disorders and the persistence of substance use disorders: A reanalysis of published NESARC findings. *Journal of Abnormal Psychology, 123*(4), 809–820. doi:10.1037/abn0000011
- Vest, B. M., Hoopsick, R. A., Homish, D. L., Daws, R. C., & Homish, G. G. (2018). Childhood trauma, combat trauma, and substance use in National Guard and reserve soldiers. *Substance Abuse, 39*(4), 452–460. doi:10.1080/08897077.2018.1443315
- Veterans Administration/Department of Defense (VA/DoD). (2015). *VA/DoD clinical practice guideline for the management of substance use disorders*. Version 3.0. Retrieved from www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGRevised22216.pdf
- Veterans Administration/Department of Defense. (2017). *VA/DoD clinical practice guideline for the management of posttraumatic stress disorder and acute stress disorder*. Version 3.0. Retrieved from www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal012418.pdf
- Vigod, S. N., Wilson, C. A., & Howard, L. M. (2016). Depression in pregnancy. *BMJ (Online), 352*. doi:10.1136/bmj.i1547
- Volkert, J., Gablonski, T.-C., & Rabung, S. (2018). Prevalence of personality disorders in the general adult population in Western countries: Systematic review and meta-analysis. *British Journal of Psychiatry, 213*(6), 709–715. doi:10.1192/bjp.2018.202
- Volpi-Abadie, J., Kaye, A. M., & Kaye, A. D. (2013). Serotonin syndrome. *Ochsner Journal, 13*(4), 533–540.
- Vorspan, F., Mehtelli, W., Dupuy, G., Bloch, V., & Lépine, J. P. (2015). Anxiety and substance use disorders: Co-occurrence and clinical issues. *Current Psychiatry Reports, 17*(2). doi:10.1007/s11920-014-0544-y
- Vrana, C., Killeen, T., Brant, V., Mastrogiovanni, J., & Baker, N. L. (2017). Rationale, design, and implementation of a clinical trial of a mindfulness-based relapse prevention protocol for the treatment of women with comorbid post traumatic stress disorder and substance use disorder. *Contemporary Clinical Trials, 61*, 108–114. doi:10.1016/j.cct.2017.07.024
- Vujanovic, A. A., Bonn-Miller, M. O., & Petry, N. M. (2016). Co-occurring posttraumatic stress and substance use: Emerging research on correlates, mechanisms, and treatments—Introduction to the special issue. *Psychology of Addictive Behaviors, 30*(7), 713–719. doi:10.1037/adb0000222
- Vujanovic, A. A., Meyer, T. D., Heads, A. M., Stotts, A. L., Villarreal, Y. R., & Schmitz, J. M. (2017). Cognitive-behavioral therapies for depression and substance use disorders: An overview of traditional, third-wave, and transdiagnostic approaches. *American Journal of Drug and Alcohol Abuse, 43*(4), 402–415. doi:10.1080/00952990.2016.1199697
- Vujanovic, A. A., Smith, L. J., Green, C. E., Lane, S. D., & Schmitz, J. M. (2018). Development of a novel, integrated cognitive-behavioral therapy for co-occurring posttraumatic stress and substance use disorders: A pilot randomized clinical trial. *Contemporary Clinical Trials, 65*, 123–129. doi:10.1016/j.cct.2017.12.013
- Wakeman, S. E., Rigotti, N. A., Chang, Y., Herman, G. E., Erwin, A., Regan, S., & Metlay, J. P. (2019). Effect of integrating substance use disorder treatment into primary care on inpatient and emergency department utilization. *Journal of General Internal Medicine, 34*(6), 871–877. doi:10.1007/s11606-018-4807-x
- Walley, A. Y., Palmisano, J., Sorensen-Alawad, A., Chaisson, C., Raj, A., Samet, J. H., & Drainoni, M. L. (2015). Engagement and substance dependence in a primary care-based addiction treatment program for people infected with HIV and people at high-risk for HIV infection. *Journal of Substance Abuse Treatment, 59*, 59–66. doi:10.1016/j.jsat.2015.07.007
- Walsh, F. P. & Tickle, A. C. (2013). Working towards recovery: The role of employment in recovery from serious mental health problems: A qualitative meta-synthesis. *International Journal of Psychosocial Rehabilitation, 17*(2) 35–49.
- Walsh, K., McLaughlin, K. A., Hamilton, A., & Keyes, K. M. (2017). Trauma exposure, incident psychiatric disorders, and disorder transitions in a longitudinal population representative sample. *Journal of Psychiatric Research, 92*, 212–218. doi:10.1016/j.jpsychires.2017.05.001
- Walter, K. H., Levine, J. A., Highfill-McRoy, R. M., Navarro, M., & Thomsen, C. J. (2018). Prevalence of posttraumatic stress disorder and psychological comorbidities among U.S. active duty service members, 2006–2013. *Journal of Traumatic Stress, 31*(6), 837–844. doi:10.1002/jts.22337
- Walton, M. T., & Hall, M. T. (2016). The effects of employment interventions on addiction treatment outcomes: A review of the literature. *Journal of Social Work Practice in the Addictions, 16*(4), 358–384.
- Watkins, K. E., Hunter, S., Hepner, K., Paddock, S., Zhou, A., & de la Cruz, E. (2012). Group cognitive-behavioral therapy for clients with major depression in residential substance abuse treatment. *Psychiatric Services, 63*(6), 608–611. doi:10.1176/appi.ps.201100201
- Watkins, L. E., Sippel, L. M., Pietrzak, R. H., Hoff, R., & Harpaz-Rotem, I. (2017). Co-occurring aggression and suicide attempt among veterans entering residential treatment for PTSD: The role of PTSD symptom clusters and alcohol misuse. *Journal of Psychiatric Research, 87*, 8–14. doi:10.1016/j.jpsychires.2016.12.009
- Watson, D. P., Orwat, J., Wagner, D. E., Shuman, V., & Tolliver, R. (2013). The Housing First Model (HFM) fidelity index: Designing and testing a tool for measuring integrity of housing programs that serve active substance users. *Substance Abuse Treatment, Prevention, and Policy, 8*, 16. doi:10.1186/1747-597x-8-16

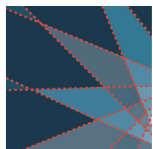


- Waye, K. M., Goyer, J., Dettor, D., Mahoney, L., Samuels, E. A., Yedinak, J. L., & Marshall, B. D. L. (2019). Implementing peer recovery services for overdose prevention in Rhode Island: An examination of two outreach-based approaches. *Addictive Behaviors, 89*, 85–91. doi:10.1016/j.addbeh.2018.09.027
- Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). *The PTSD Checklist for DSM-5 (PCL-5) – Standard*. Retrieved October 15, 2019, from www.ptsd.va.gov/professional/assessment/documents/PCL5_Standard_form.PDF
- Weaver, N., Coffey, M., & Hewitt, J. (2017). Concepts, models and measurement of continuity of care in mental health services: A systematic appraisal of the literature. *Journal of Psychiatric and Mental Health Nursing, 24*(6), 431–450. doi:10.1111/jpm.12387
- Weil, T. P. (2015). Insufficient dollars and qualified personnel to meet United States mental health needs. *Journal of Nervous and Mental Disease, 203*(4), 233–240.
- Weinstein, Z. M., Wakeman, S. E., & Nolan, S. (2018). Inpatient addiction consult service: Expertise for hospitalized patients with complex addiction problems. *Medical Clinics of North America, 102*(4), 587–601. doi:10.1016/j.mcna.2018.03.001
- Weiss, R. D., & Connery, H. S. (2001). *Integrated group therapy for bipolar disorder and substance abuse*. New York, NY: Guilford Press.
- Werner, F. M., & Covenas, R. (2017). Long-term administration of antipsychotic drugs in schizophrenia and influence of substance and drug abuse on the disease outcome. *Current Drug Abuse Reviews, 10*(1), 19–24. doi:10.2174/1874473710666171020104524
- Westmoreland, P., Krantz, M. J., & Mehler, P. S. (2016). Medical complications of anorexia nervosa and bulimia. *American Journal of Medicine, 129*(1), 30–37. doi:10.1016/j.amjmed.2015.06.031
- White, A. R. (2011). Characteristics of three consumer cohorts in vocational rehabilitation: A comparison of consumers with dual-diagnosis, psychiatric, or substance use related disorders. *Journal of Applied Rehabilitation Counseling, 42*(1), 15–24.
- White, L. M., McGrew, J. H., Salyers, M. P., & Firmin, R. L. (2014). Assertive community treatment for parents with serious mental illnesses: A comparison of “parent-sensitive” assertive community treatment teams versus other teams. *Psychiatric Rehabilitation Journal, 37*(3), 251–260. doi:10.1037/prj0000050
- WHO ASSIST Working Group. (2002). The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Development, reliability and feasibility. *Addiction, 97*(9), 1183–1194.
- Wile, M., & Goodwin, K. (2018, February). *The costs and consequences of disparities in behavioral health care*. National Conference of State Legislatures. Retrieved from <http://www.ncsl.org/research/health/the-costs-and-consequences-of-disparities-in-behavioral-health-care.aspx>
- Wilens, T., Zulauf, C., Martelon, M., Morrison, N. R., Simon, A., Carrellas, N. W., . . . Anselmo, R. (2016). Nonmedical stimulant use in college students: Association with attention-deficit/hyperactivity disorder and other disorders. *Journal of Clinical Psychiatry, 77*(7), 940–947. doi:10.4088/JCP.14m09559
- Wilens, T. E., Adler, L. A., Tanaka, Y., Xiao, F., D’Souza, D. N., Gutkin, S. W., & Upadhyaya, H. P. (2011). Correlates of alcohol use in adults with ADHD and comorbid alcohol use disorders: Exploratory analysis of a placebo-controlled trial of atomoxetine. *Current Medical Research and Opinion, 27*(12), 2309–2320. doi:10.1185/03007995.2011.628648
- Wilens, T. E., & Morrison, N. R. (2011). The intersection of attention-deficit/hyperactivity disorder and substance abuse. *Current Opinion in Psychiatry, 24*(4), 280–285. doi:10.1097/YCO.0b013e328345c956
- Wilkerson, A. H., Hackman, C. L., Rush, S. E., Usdan, S. L., & Smith, C. S. (2017). “Drunkorexia”: Understanding eating and physical activity behaviors of weight conscious drinkers in a sample of college students. *Journal of American College Health, 65*(7), 492–501. doi:10.1080/07448481.2017.1344848
- Willison, C. (2017). Shelter from the storm: Roles, responsibilities, and challenges in United States housing policy governance. *Health Policy, 121*, 1113–1123.
- Wise, E. A. (2010). Evidence-based effectiveness of a private practice intensive outpatient program with dual diagnosis patients. *Journal of Dual Diagnosis, 6*(1), 25–45. doi:10.1080/15504260903498862
- Wisner, K. L., Sit, D. K. Y., McShea, M. C., Rizzo, D. M., Zoretich, R. A., Hughes, C. L., . . . Hanusa, B. H. (2013). Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA Psychiatry, 70*, 490–498.
- Wittchen, H. U. (2010). Screening for serious mental illness: Methodological studies of the K6 screening scale. *International Journal of Methods in Psychiatric Research, 19*(Suppl. 1), 1–3. doi:10.1002/mpr.316
- Wittchen, H. U., Gloster, A. T., Beesdo-Baum, K., Fava, G. A., & Craske, M. G. (2010). Agoraphobia: A review of the diagnostic classificatory position and criteria. *Depression and Anxiety, 27*(2), 113–133. doi:10.1002/da.20646
- Wolff, N., Frueh, B., Shi, J., Gerardi, D., Fabrikant, N., & Schumann, B. (2011). Trauma exposure and mental health characteristics of incarcerated females self-referred to specialty PTSD treatment. *Psychiatric Services, 62*, 954–958.

- Wolff, N., Huening, J., Shi, J., & Frueh, B. C. (2014). Trauma exposure and posttraumatic stress disorder among incarcerated men. *Journal of Urban Health, 91*(4), 707–719. doi:10.1007/s11524-014-9871-x
- Wood, S. R. (2013). Dual severe mental and substance use disorders as predictors of federal inmate assaults. *Prison Journal, 93*(1), 34–56. doi:10.1177/0032885512467312
- Woodhead, E. L., Cowden Hindash, A., & Timko, C. (2013). Dual diagnosis, mutual-help use, and outcomes: A naturalistic follow-up. *Journal of Dual Diagnosis, 9*(2), 158–164. doi:10.1080/15504263.2013.777986
- World Health Organization. (WHO). (n.d.). Constitution. Retrieved from www.who.int/about/who-we-are/constitution
- World Health Organization. (2019). *Premature death among people with severe mental disorders*. Information Sheet. Retrieved from www.who.int/mental_health/management/info_sheet.pdf
- Worley, M. J., Tate, S. R., & Brown, S. A. (2012). Mediation relations between 12-Step attendance, depression and substance use in patients with comorbid substance dependence and major depression. *Addiction, 107*(11), 1974–1983. doi:10.1111/j.1360-0443.2012.03943.x
- Worley, M. J., Trim, R. S., Tate, S. R., Hall, J. E., & Brown, S. A. (2010). Service utilization during and after outpatient treatment for comorbid substance use disorder and depression. *Journal of Substance Abuse Treatment, 39*(2), 124–131. doi:10.1016/j.jsat.2010.05.009
- Wu, L. T., McNeely, J., Subramaniam, G. A., Brady, K. T., Sharma, G., VanVeldhuisen, P., . . . Schwartz, R. P. (2017). DSM-5 substance use disorders among adult primary care patients: Results from a multisite study. *Drug and Alcohol Dependence, 179*, 42–46. doi:10.1016/j.drugalcdep.2017.05.048
- Xie, H., Drake, R. E., McHugo, G. J., Xie, L., & Mohandas, A. (2010). The 10-year course of remission, abstinence, and recovery in dual diagnosis. *Journal of Substance Abuse Treatment, 39*(2), 132–140. doi:10.1016/j.jsat.2010.05.011
- Yager, J., Devlin, M. J., Halmi, K. A., Herzog, D. B., Mitchell, J. E., Powers, P., & Zerbe, K. J. (June 2006). *Practice guideline for the treatment of patients with eating disorders* (3rd ed.). Retrieved from https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders.pdf
- Yager, J., & Feinstein, R. E. (2017). General psychiatric management for suicidal patients, with remarks on chronicity: Contending with the angel of death. *Journal of Nervous and Mental Disease, 205*(6), 419–426. doi:10.1097/nmd.0000000000000701
- Yanchus, N. J., Periard, D., & Osatuke, K. (2017). Further examination of predictors of turnover intention among mental health professionals. *Journal of Psychiatric and Mental Health Nursing, 24*(1), 41–56. doi:10.1111/jpm.12354
- Young, M. S., Barrett, B., Engelhardt, M. A., & Moore, K. A. (2014). Six-month outcomes of an integrated assertive community treatment team serving adults with complex behavioral health and housing needs. *Community Mental Health Journal, 50*(4), 474–479. doi:10.1007/s10597-013-9692-5
- Young, S. (2015). Understanding substance abuse counselor turnover due to burnout: A theoretical perspective. *Journal of Human Behavior in the Social Environment, 25*(6), 675–686. doi:10.1080/10911359.2015.1013658
- Young, S., & Sedgwick, O. (2015). Attention deficit hyperactivity disorder and substance misuse: An evaluation of causal hypotheses and treatment considerations. *Expert Review of Neurotherapeutics, 15*(9), 1005–1014. doi:10.1586/14737175.2015.1059756
- Yu, R., Geddes, J. R., & Fazel, S. (2012). Personality disorders, violence, and antisocial behavior: A systematic review and meta-regression analysis. *Journal of Personality Disorders, 26*(5), 775–792. doi:10.1521/pedi.2012.26.5.775
- Yudko, E., Lozhkina, O., & Fouts, A. (2007). A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *Journal of Substance Abuse Treatment, 32*(2), 189–198. doi:10.1016/j.jsat.2006.08.002
- Yuodelis-Flores, C., & Ries, R. K. (2015). Addiction and suicide: A review. *American Journal on Addictions, 24*(2), 98–104. doi:10.1111/ajad.12185
- Zetterqvist, M. (2015). The DSM-5 diagnosis of nonsuicidal self-injury disorder: A review of the empirical literature. *Child and Adolescent Psychiatry and Mental Health, 9*, 31. doi:10.1186/s13034-015-0062-7
- Zgierska, A., Amaza, I. P., Brown, R. L., Mundt, M., & Fleming, M. F. (2014). Unhealthy drug use: How to screen, when to intervene. *Journal of Family Practice, 63*(9), 524–530.
- Zhu, H., & Wu, L. T. (2018). National trends and characteristics of inpatient detoxification for drug use disorders in the United States. *BMC Public Health, 18*(1), 1073. doi:10.1186/s12889-018-5982-8
- Zilm, D. H., & Sellers, E. M. (1978). The quantitative assessment of physical dependence on opiates. *Drug and Alcohol Dependence, 3*(6), 419–428.
- Zubkoff, L., Shiner, B., & Watts, B. V. (2016). Staff perceptions of substance use disorder treatment in VA primary care-mental health integrated clinics. *Journal of Substance Abuse Treatment, 70*, 44–49. doi:10.1016/j.jsat.2016.07.011
- Zugai, J. S., Stein-Parbury, J., & Roche, M. (2015). Therapeutic alliance in mental health nursing: An evolutionary concept analysis. *Issues in Mental Health Nursing, 36*(4), 249–257. doi:10.3109/01612840.2014.969795



- Zukkoor, S. (2015). *The safety of stimulant medication use in cardiovascular and arrhythmia patients*. Retrieved from <https://www.acc.org/latest-in-cardiology/articles/2015/04/28/10/06/the-safety-of-stimulant-medication-use-in-cardiovascular-and-arrhythmia-patients>
- Zulauf, C. A., Sprich, S. E., Safren, S. A., & Wilens, T. E. (2014). The complicated relationship between attention deficit/hyperactivity disorder and substance use disorders. *Current Psychiatry Reports*, 16(3), 436. doi:10.1007/s11920-013-0436-6
- Zur, J., & Mojtabai, R. (2013). Medicaid expansion initiative in Massachusetts: Enrollment among substance-abusing homeless adults. *American Journal of Public Health*, 103(11), 2007–2013. doi:10.2105/ajph.2013.301283
- Zweben, J. E., & Ashbrook, S. (2012). Mutual-help groups for people with co-occurring disorders. *Journal of Groups in Addiction and Recovery*, 7(2–4), 202–222. doi:10.1080/1556035X.2012.705700



Appendix B—Resources

Training for Providers and Administrators

Sources of Training in Substance Use Disorders

Addiction-Counselors.com (www.addiction-counselors.com/): A website to help professionals and trainees find state-by-state information about substance use disorder (SUD) counseling requirements.

Addictions Nursing Certification Board and the Center for Nursing Education and Testing, Inc. Offers certification in addiction nursing.

- Certified Addictions Registered Nurse: www.cnetnurse.com/carn-exam
- Certified Addictions Registered Nurse-Advanced Practice: www.theabpm.org/become-certified/subspecialties/addiction-medicine/

Addiction Technology Transfer Center (ATTC) Network (<https://attcnetwork.org/centers/global-attc/products-resources-catalog>): Find local ATTC. Course offerings vary.

- Curricula, lectures, videos, and printed training materials available through ATTCs: <https://attcnetwork.org/centers/global-attc/products-resources-catalog>
- Directory of ATTC trainers: <https://attcnetwork.org/trainers>

Addictions Training Institute (<https://addictionstraininginstitute.com/certifications-in-florida/>): Florida-based organization offering national certification in addiction counseling. Maintains a listing of drug and alcohol counseling certificates offered by state.

American Academy of Addiction Psychiatry (www.aaap.org/clinicians/): Offers professional education and trainee resources for psychiatrists.

American Board of Preventive Medicine Addiction Medicine Certification (www.theabpm.org/become-certified/subspecialties/addiction-medicine/): Offers physicians subspecialty certification in addiction medicine.

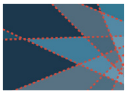
American Osteopathic Academy of Addiction Medicine (www.aoaam.org/Essentials-and-Advanced): Offers physicians basic and advanced courses for in addiction medicine.

Hazelden Betty Ford Foundation (www.hazeldenbettyford.org/education): Hazelden offers training opportunities at many levels and locations, including graduate degree and certification programs, medical and professional education programs, and addiction psychology training (a clinical practicum, doctoral internships, and postdoctoral psychology residency training).

International Certification & Reciprocity Consortium (IC&RC) (<https://internationalcredentialing.org/>): IC&RC is the largest credentialing body in addiction prevention, treatment, and recovery. They offer six credential in addiction counseling, prevention, supervision, and peer recovery. The Advanced Alcohol & Drug Counselor certificate provides credentialing for co-occurring disorder (CODs) services: <https://internationalcredentialing.org/creds/aadc>.

NAADAC, the Association for Addiction Professionals (www.naadac.org/): Oversees the National Certification Commission for Addiction Professionals, through which NAADAC is a leading provider of national credentialing in addiction counseling.

- National Certified Addiction Counselor, Level I: www.naadac.org/ncac-i
- National Certified Addiction Counselor, Level II: www.naadac.org/ncac-ii
- International and State Certification Boards: www.naadac.org/state-international-certification-boards



National Association of Social Workers' (NASW) Certified Clinical Alcohol, Tobacco & Other Drugs Social Worker (www.socialworkers.org/Careers/Credentials-Certifications/Apply-for-NASW-Social-Work-Credentials/Certified-Clinical-Alcohol-Tobacco-Other-Drugs-Social-Worker): Offers social workers certification in addiction services.

Society of Addiction Psychology (Division 50 of the American Psychological Association) (<https://addictionpsychology.org/education-training/certification>): Offers psychologists credentialing in addiction care.

Rutgers Center of Alcohol & Substance Use Studies (<https://alcoholstudies.rutgers.edu/>): Offers professional development opportunities for addiction counselors and professionals in related fields, including the criminal justice system. Their programs are accredited by multiple state and national organizations, including the National Board for Certified Counselors, NAADAC, and NASW.

SAMHSA

- Technical Assistance Publication (TAP) 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*: <https://store.samhsa.gov/system/files/sma12-4171.pdf>
- TAP 21-A: *Competencies for Substance Abuse Treatment Clinical Supervisors* <https://store.samhsa.gov/system/files/sma12-4243.pdf>

Sources of Training in Mental Health

American Counseling Association (ACA) (www.counseling.org/continuing-education/overview): Home study courses, learning institutes, and onsite training.

American Psychological Association (www.apa.org/education/ce): Home study and other approved courses, including some COD-specific offerings (see Continuing Education programs under the topic "addiction").

American Psychiatric Association (APA) (<https://education.psychiatry.org/>): The organization's Learning Center provides online courses and Continuing Education programs, including some in CODs (search the catalog of courses at <https://education.psychiatry.org/Users/ProductList.aspx>).

SAMHSA: Offers online mental health training in numerous areas:

- Disaster Technical Assistance Training: www.samhsa.gov/dtac/education-training
- Mental Health First Aid Training: www.samhsa.gov/homelessness-programs-resources/hpr-resources/mental-health-first-aid-training

Sources of Training in CODs

Addiction Technology Transfer Center (ATTC) Network (<https://attcnetwork.org/centers/global-attc/products-resources-catalog>): Find local ATTC. Course offerings vary.

- Curricula, lectures, videos, and printed training materials available through ATTCs: <https://attcnetwork.org/centers/global-attc/products-resources-catalog>
- Directory of ATTC trainers: <https://attcnetwork.org/trainers>

Adler Graduate School (<https://alfredadler.edu/programs/certificate/certificate-in-COD>): A nonprofit educational institute based in Minnesota that offers online training toward a Certificate in Co-Occurring Substance Use and Mental Health Disorders.

Breining Institute's Certified Co-Occurring Disorders Specialist (www.breining.edu/index.php/professional-certification/certified-co-occurring-disorders-specialist-ccds/): This higher education institution is specifically for addiction professionals and offers numerous courses and certifications, including in CODs.

IC&RC (<https://internationalcredentialing.org/>): IR&RC is the largest credentialing body in addiction prevention, treatment, and recovery. They offer six credential in addiction counseling, prevention, supervision, and peer recovery. The Advanced Alcohol & Drug Counselor certificate provides credentialing for COD services: <https://internationalcredentialing.org/creds/aadc>.

NAADAC, the Association for Addiction Professionals (www.naadac.org/): Oversees the National Certification Commission for Addiction Professionals, through which NAADAC is a leading

provider of national credentialing in addiction counseling. They offer two credentials in CODs:

- Master Addiction Counselor With Co-Occurring Disorders Component: www.naadac.org/mac
- The Oregon Health Authority: Provides a directory of resources on CODs to assist counselors, administrators, and programs with implementation and training.
- Checklists for counselor competencies: www.oregon.gov/oha/HSD/AMH/Pages/Co-occurring.aspx
- Basic Competencies: www.oregon.gov/oha/HSD/AMH/CoOccurring%20Resources/Basic%20Competencies%20Checklist.pdf
- Intermediate Competencies: www.oregon.gov/oha/HSD/AMH/CoOccurring%20Resources/Intermediate%20Competencies%20CheckList.pdf
- Advanced Competencies: www.oregon.gov/oha/HSD/AMH/CoOccurring%20Resources/Advanced%20Competencies%20Checklist.pdf

Other Resources for Counselors, Providers, and Programs

Publications

National Institute on Alcohol Abuse and Alcoholism (NIAAA; www.niaaa.nih.gov/publications): Offers resources, including fact sheets, educator resources, videos, and professional education materials.

National Institute on Drug Abuse (NIDA; www.drugabuse.gov/publications): NIDA publishes a wide variety of treatment-related materials.

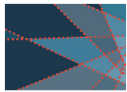
- Comorbidity: Substance Use Disorders and Other Mental Illness: www.drugabuse.gov/publications/drugfacts/comorbidity-substance-use-disorders-other-mental-illnesses
- Common Comorbidities With Substance Use Disorders: www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/introduction

- Criminal Justice Drug Abuse Treatment Studies Series archive of publications and research: www.icpsr.umich.edu/icpsrweb/NAHDAP/series/244/studies
- Other NIDA justice system-related research initiatives: www.drugabuse.gov/researchers/research-resources/criminal-justice-drug-abuse-treatment-studies-cj-dats

National Institute of Mental Health (NIMH; www.nimh.nih.gov/health/publications/index.shtml): NIMH provides manuals and research reports, including texts on disorders and conditions that commonly co-occur with SUDs, such as depression, anxiety, posttraumatic stress disorder (PTSD), schizophrenia, trauma, and suicide risk.

SAMHSA (<https://store.samhsa.gov/professional-research-topics>): Offers numerous publications on a range of evidence-based topics in prevention, treatment, workforce development, and more.

- TAP 21-A, *Competencies for Substance Abuse Treatment Clinical Supervisors*: <https://store.samhsa.gov/system/files/sma12-4243.pdf>
- TIP 27, *Comprehensive Case Management for Substance Abuse Treatment*: <https://store.samhsa.gov/system/files/sma15-4215.pdf>
- TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse*: <https://store.samhsa.gov/system/files/sma12-3952.pdf>
- TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment*: <https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003>
- TIP 38, *Integrating Substance Abuse Treatment and Vocational Services*: <https://store.samhsa.gov/system/files/sma12-4216.pdf>
- TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System*: <https://store.samhsa.gov/system/files/sma13-4056.pdf>
- TIP 45, *Detoxification and Substance Abuse Treatment*: <https://store.samhsa.gov/system/files/sma15-4131.pdf>
- TIP 46, *Substance Abuse: Administrative Issues in Outpatient Treatment*: <https://store.samhsa.gov/system/files/toc.pdf>



- TIP 47, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment*: <https://store.samhsa.gov/system/files/sma13-4182.pdf>
- TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery*: <https://www.ncbi.nlm.nih.gov/books/NBK64057/>
- TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*: <https://store.samhsa.gov/product/TIP-50-Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/SMA15-4381>
- TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women*: <https://store.samhsa.gov/system/files/sma15-4426.pdf>
- TIP 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor*: <https://store.samhsa.gov/system/files/sma14-4435.pdf>
- TIP 55, *Behavioral Health Services for People Who Are Homeless*: <https://store.samhsa.gov/product/TIP-55-Behavioral-Health-Services-for-People-Who-Are-Homeless/SMA15-4734>
- TIP 57, *Trauma-Informed Care in Behavioral Health Services*: <https://store.samhsa.gov/system/files/sma14-4816.pdf>
- TIP 59, *Improving Cultural Competence*: <https://store.samhsa.gov/system/files/sma14-4849.pdf>
- TIP 63, *Medications for Opioid Use Disorder*: <https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder>
- SAMHSA's *Concept of Trauma and Guidance for a Trauma-Informed Approach*: <https://store.samhsa.gov/system/files/sma14-4884.pdf>
- *Screening and Assessment of Co-occurring Disorders in the Justice System*: <https://store.samhsa.gov/system/files/sma15-4930.pdf>

Treatment Locators

Addiction Recovery Guide's Treatment Locators (www.addictionrecoveryguide.org/treatment/treatment_locators): A listing of treatment locators, including methadone providers.

Department of Veterans Affairs Veterans Affairs Substance Use Disorder Program Locator (www.va.gov/directory/guide/SUD.asp): This website provides an interactive treatment locator for Veterans Affairs SUD treatment programs.

Faces & Voices of Recovery Guide to Mutual Aid Support Resources (<http://facesandvoicesofrecovery.org/resources/mutual-aid-resources/>): Offers a comprehensive listing of 12-Step and non-12-Step recovery support groups throughout the United States and online.

Foundations Recovery Network Finding Treatment for Drug Addiction (www.dualdiagnosis.org/addiction-treatment/): Includes a listing of resources to find treatment for CODs.

National Alliance of Advocates for Buprenorphine Treatment (www.treatmentmatch.org/TM_index.php): Offers a free, 24/7, anonymous treatment matching service for patients and providers.

SAMHSA

- SAMHSA's Behavioral Health Treatment Services Locator is a confidential and anonymous source of information for patients and providers about treatment facilities in the United States or U.S. Territories for SUDs and mental disorders (<https://findtreatment.gov/>).
- Finding Quality Treatment for Substance Use Disorders indicates how and where to locate addiction treatment facilities and providers (<https://store.samhsa.gov/system/files/pep18-treatment-loc.pdf>).

General Resources

Confidentiality

Health and Human Services' Mental Health Information Privacy FAQs: (www.hhs.gov/hipaa/for-professionals/faq/mental-health/index.html):

A listing of mental health-related privacy and confidentiality questions by topic areas (e.g., disclosures for coordinated care, group therapy, disclosures to law enforcement).

National Conference of State Legislatures' Mental Health Professionals Duty to Warn (www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx): A searchable database of duty to warn laws for mental health professionals by state.

SAMHSA

- Directory of Single State Agencies for Substance Abuse Services: <https://www.samhsa.gov/sites/default/files/single-state-agencies-directory-08232019.pdf>
- SAMHSA's Laws and Regulations (<https://www.samhsa.gov/about-us/who-we-are/laws-regulations>)

Supervision

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): This training manual offers basic guidance for addiction counseling supervision, including case conferencing and helping supervisees avoid burnout.

SAMHSA

- **Supervision Intervention Strategies** (<http://toolkit.ahpnet.com/Supervision-Intervention-Strategies.aspx>): This section of SAMHSA's Recruitment and Retention Toolkit provides indepth information about effective supervision, including communication and motivation strategies, conflict negotiation, and performance appraisal.

- TIP 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor* (<https://store.samhsa.gov/system/files/sma14-4435.pdf>): This TIP provides guidance on teaching, coaching, consulting, and mentoring functions of clinical supervisors in addiction treatment.

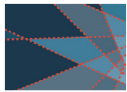
Workforce Recruitment and Retention

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/network-coordinating-office/product/national-workforce-report-national-qualitative-report>): This nationwide survey summarizes findings on recruitment and retention challenges facing the addiction recovery labor force.

Behavioral Health Education Center of Nebraska's Retention Toolkit (www.naadac.org/assets/2416/samhsa-naadac_workforce_bhec_n_retention_toolkit2.pdf): This toolkit was developed to help behavioral health employers improve retention. Although developed out of Nebraska, the toolkit offers suggestions and resources that can be used by any behavioral health service organization.

SAMHSA

- 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
- Recruitment and Retention Toolkit: <http://toolkit.ahpnet.com/Home.aspx>
- Dealing With Stress in the Workplace: Frustration, Stress, and Compassion Fatigue/ Burnout: <http://toolkit.ahpnet.com/Dealing-with-Stress-in-the-Workplace.aspx>
- Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit (version 4.0): www.centerforebp.case.edu/client-files/pdf/ddcat-toolkit.pdf



Criminal Justice System

NIDA

- Criminal Justice Drug Abuse Treatment Studies Series archive of publications and research: www.icpsr.umich.edu/icpsrweb/NAHDAP/series/244/studies
- Other NIDA justice system-related research initiatives: www.drugabuse.gov/researchers/research-resources/criminal-justice-drug-abuse-treatment-studies-cj-dats

SAMHSA

- GAINS Center for Behavioral Health and Justice Transformation: www.samhsa.gov/gains-center
- TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System*: <https://store.samhsa.gov/system/files/sma13-4056.pdf>
- Screening and Assessment of Co-occurring Disorders in the Justice System: <https://store.samhsa.gov/system/files/sma15-4930.pdf>

Homelessness

Housing First

- The National Alliance to End Homelessness's toolkit for adopting a Housing First approach: <https://endhomelessness.org/wp-content/uploads/2009/08/adopting-a-housing-first-approach.pdf>
- United States Interagency Council on Homelessness's Implementing Housing First in Permanent Supportive Housing fact sheet: [www.usich.gov/resources/uploads/asset_library/Implementing Housing First in Permanent Supportive Housing.pdf](http://www.usich.gov/resources/uploads/asset_library/Implementing_Housing_First_in_Permanent_Supportive_Housing.pdf)

Pathways to Housing

- Resources: <https://pathwaystohousingpa.org/housing-first-university/HFU-resources#>
- 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>):

This toolkit describes key aspects of supportive housing for people with mental disorders.

Military Populations

American Counseling Association (ACA)

- Suicide Among Veterans and the Implications for Counselors: www.counseling.org/docs/default-source/vistas/suicide-among-veterans-and-the-implications-for-counselors.pdf?sfvrsn=3803a659_11
- Comparison of Civilian Trauma and Combat Trauma: <https://pdfs.semanticscholar.org/9742/967aac-815ca02c4f599b36be996d0b10d3d9.pdf>
- Counseling Addicted Veterans: What to Know and How to Help: <https://pdfs.semanticscholar.org/9742/967aac-815ca02c4f599b36be996d0b10d3d9.pdf>

Community Anti-Drug Coalitions of America's Strategies for Addressing Substance Abuse in Veteran Populations (www.cadca.org/sites/default/files/mckesson_toolkit_1.pdf): This toolkit was created to help programs implement addiction prevention strategies targeting veterans in their communities.

Department of Veterans Affairs national Center for PTSD (www.ptsd.va.gov/):

- Practice Recommendations for Treatment of Veterans with Comorbid Substance Use Disorder and Posttraumatic Stress Disorder: www.mentalhealth.va.gov/providers/sud/docs/SUD_PTSD_Practice_Recommendations.pdf
- Veteran Outreach Toolkit: Preventing Veteran Suicide is Everyone's Business: www.va.gov/ve/docs/outreachToolkitPreventingVeteranSuicideIsEveryonesBusiness.pdf
- National Strategy for Preventing Veteran Suicide 2018–2028: www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf

SAMHSA's Addressing the Substance Use Disorder Service Needs of Returning Veterans and Their Families (www.samhsa.gov/sites/default/files/veterans_report.pdf): This report summarizes findings from case studies in nine states that implemented addiction prevention and treatment services for returning veterans and their families.

Women

The Iowa Pregnant and Postpartum Women's Residential Treatment Program (<https://idph.iowa.gov/substance-abuse/programs/ppw>): Offers provider resources for treating pregnant and postpartum women with addiction, including an intake form, follow-up strategies, a client satisfaction survey, and documentation requirements.

SAMHSA

- 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>

Integrated Care

Case Western Reserve's Center for Evidence-Based Practices. *Integrated Dual Disorder Treatment Clinical Guide* (www.centerforebp.case.edu/client-files/pdf/iddtclinicalguide.pdf): This manual offer guidance on developing an Integrated Dual Disorder Treatment (IDDT) program.

Milbank Memorial Fund's *Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness* (SMI) (www.milbank.org/wp-content/uploads/2016/04/Integrating-Primary-Care-Report.pdf): This report offers guidance on key implementation techniques to help programs treating clients with SMI learn how to integrate their services into primary care settings.

SAMHSA's Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices KIT (<https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4366>): This toolkit reviews the principles of integrated care for CODs and includes video and written materials.

Assertive Community Treatment (ACT)

Case Western Reserve's Center for Evidence-Based Practices. *Integrated Dual Disorder Treatment Clinical Guide* (www.centerforebp.case.edu/client-files/pdf/iddtclinicalguide.pdf): This manual offers guidance on developing an IDDT program.

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): This toolkit is designed to support programs launching ACT services and covers such areas as staff requirements, critical services, treatment intensity, and program capacity.

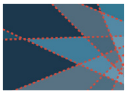
SAMHSA's ACT for Co-Occurring Disorders Evidence-Based Practices KIT (<https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/sma08-4344>): This toolkit reviews the principles of assertive community outreach for clients with CODs and includes video and written materials.

University of Washington Program for ACT (<https://depts.washington.edu/ebpa/projects/pact>): Program resources offered here are wide ranging and include addiction and mental disorder assessment scales, sample staff and client schedules, a case study, a transition assessment tool, and other relevant client measures (e.g., stage of change, recovery beliefs, violence risk).

Therapeutic Communities

Arkansas Department of Human Services Therapeutic Communities Certification Manual (https://humanservices.arkansas.gov/images/uploads/dpsqa/DBHS_Therapeutic_Communities_Certification_-_FINAL.pdf): Summarizes the standards and certification requirements for therapeutic communities (TCs) under the Arkansas Department of Human Services, Division of Behavioral Health Services.

Missouri Department of Corrections and Maryville Treatment Center Therapeutic Community Program Handbook (www.law.umich.edu/special/policyclearinghouse/Documents/MO%20-%20Maryville%20Treatment%20Center%20Therapeutic%20Community%20Program%20Handbook.pdf): Describes therapeutic community (TC) structure, roles, procedures, and guidelines.



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): Offers guidance on adapting the TC model to people with CODs who are involved in the criminal justice system.

NIDA Research Report, *Therapeutic Communities* (https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/therapeuticcomm_rrs_0723.pdf): This research report describes the purpose of TCs, evidence of their effectiveness, fundamental components, and adaptations to special populations, including people experiencing homelessness, women, and people in the criminal justice system.

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): This slide deck offers material on the use of TCs in criminal justice settings, including relapse prevention, use and misuse of therapeutic tools, and staff roles and functions.

Suicide Prevention

ACA

- Suicide Prevention Tip Sheet: www.counseling.org/docs/default-source/Communications-/suicide-prevention-final.pdf?sfvrsn=2
- Counselor Training in Suicide Assessment, Prevention, and Management: www.counseling.org/docs/default-source/vistas/article_65d15528f16116603abcacff0000bee5e7.pdf?sfvrsn=4f43482c_6
- Developing Clinical Skills in Suicide Assessment, Prevention, and Treatment: www.counseling.org/publications/frontmatter/72861-fm.pdf

APA's Practice Guidelines (2016) Recommendations Regarding Assessment of Suicide As Part of the Initial Psychiatric Assessment (<https://stopasuicide.org/assets/docs/APAPracticeGuidelines.pdf>): A checklist of items to assess in determining suicide risk and history during an initial psychiatric assessment.

International Association for Suicide Prevention's Guidelines for Suicide Prevention (www.iasp.info/suicide_guidelines.php): A summary of prevention and risk-reduction strategies for behavioral health service providers.

National Suicide Prevention Lifeline (<https://suicidepreventionlifeline.org/> or 1-800-273-8255): Funded by SAMHSA, this national network of local crisis centers offer free and confidential support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week. Professional initiatives to promote public knowledge of suicide prevention are also provided: <https://suicidepreventionlifeline.org/professional-initiatives/>

SAMHSA

- Suicide Prevention Resource Center: www.sprc.org/
- Suicide Assessment Five-Step Evaluation and Triage for Mental Health Professionals: <https://store.samhsa.gov/system/files/sma09-4432.pdf>
- TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*: <https://store.samhsa.gov/product/TIP-50-Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/SMA15-4381>
- Video companion to TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*: www.youtube.com/watch?v=1n2QZlhezuc&feature=youtu.be

Trauma

SAMHSA's TIP 57, *Trauma-Informed Care in Behavioral Health Services* (<https://store.samhsa.gov/system/files/sma14-4816.pdf>): Includes guidance for working with behavioral health clients with trauma and for implementing trauma-informed programming.

Veterans Affairs National Center for PTSD (www.ptsd.va.gov/): The National Center for PTSD is one of the world's largest repositories of PTSD-related education and resources, designed to improve patient care, increase provider knowledge, and help clients and families better understand this condition. Many of the Center's publications, tools,

and resources are aimed at military personnel (e.g., deployment measures) but many are useful for and applicable to civilian populations as well.

Veterans Affairs/Department of Defense Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder (www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal012418.pdf):

Evidence-based guidelines for treating trauma and extreme stress in military populations, including treatment recommendations and algorithms.

Medication Management

SAMHSA

- TIP 63, *Medications for Opioid Use Disorder* (<https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder>): A compendium of the latest evidence in support of Food and Drug Administration (FDA)-approved pharmacotherapy for opioid use disorder (OUD).
- *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide* (<https://store.samhsa.gov/system/files/sma15-4907.pdf>): Offers a succinct summary of medications for AUD, including how to discuss them with clients, integrating medication into treatment, and medications for people with CODs.

APA's Practice Guideline for the Pharmacological Treatment of Patients With Alcohol Use Disorder (<https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9781615371969>): Clinical practice guideline to inform the use of medication for AUD.

National Library of Medicine's Drug Information Portal (<https://druginfo.nlm.nih.gov/drugportal/>): A searchable database organized by medication name and category.

FDA's Medication Guides Database (www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=medguide.page): A searchable index of FDA-approved medications.

NIMH's Mental Health Medications (www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml): A brief summary of psychotropic medication, their uses, and their side effects.

University of Washington's Commonly Prescribed Psychotropic Medications (<https://aims.uw.edu/resource-library/commonly-prescribed-psychotropic-medications>): A printable factsheet of common antidepressant, antianxiety, antipsychotic, and mood stabilizing medication.

Client and Family Resources

Organizations

Hazelden Betty Ford Foundation (www.hazeldenbettyford.org/recovery/families-friends): Includes support and tools for clients, families, and friends.

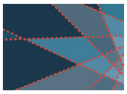
Learn to Cope (www.learn2cope.org/): A secular mutual-support group that offers education, resources, and peer support for families of people with SUDs (although primarily focused on OUD). They also maintain an online forum, but groups are only available in a few states.

Legal Action Center (www.lac.org): Offers information about the rights of people with criminal records, HIV/AIDS, and SUDs.

Mental Health America (www.mentalhealthamerica.net/): A nonprofit community-based organization that aims to improve public knowledge of mental disorders and enhance prevention and treatment strategies. It includes over 200 affiliates in 41 states, 6,500 affiliate staff, and over 10,000 volunteers.

National Alliance on Mental Illness (NAMI; www.nami.org): The largest grassroots educational, peer support, and mental health advocacy organization in the United States. Founded in 1979 by a group of family members of people with mental disorders, NAMI has developed into an association of hundreds of local affiliates, state organizations, and volunteers.

National Empowerment Center (<https://power2u.org/>): The Center has an extensive resource listing including a directory of consumer-run organizations, peer support, and webinars.



National Suicide Prevention Lifeline (<https://suicidepreventionlifeline.org/> or 1-800-273-8255): Funded by SAMHSA, this national network of local crisis centers offer free and confidential support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week.

Parents of Addicted Loved Ones (<https://palgroup.org/>): A secular support group for parents who have a child with an SUD. They only have meetings in some states but also host telephone meetings.

Mutual-Support Programs

Alcoholics Anonymous (AA; www.aa.org): Offers group meetings for people who have problems relating to drinking and wish to stop. AA sponsors offer members personal support from experienced individuals.

Al-Anon Family Groups (www.al-anon.org): Group meetings in which friends and families of people with substance use problems share experiences and learn to apply Al-Anon principles to their situations. Sponsorship helps members get personal support from more experienced individuals in the program.

Cocaine Anonymous (<https://ca.org/>): A mutual-support program for people with cocaine use disorder. Cocaine Anonymous follows the 12-Step tradition and offers meetings worldwide.

Dual Disorders Anonymous ([847] 781-1553): A mutual-support program with 48 groups in several states (more than half in Illinois). This program is modeled after AA.

Dual Diagnosis Anonymous of Oregon (www.ddaoforegon.com/): This mutual-support program uses AA's 12 Step plus five more focused on CODs. The organization has chapters in several states and in Canada.

Dual Recovery Anonymous (www.draonline.org/): This mutual-support program follows 12-Step principles to support people in recovery from addiction and emotional/mental illness. It focuses on preventing relapse and actively improving quality of members' lives via a mutual-support community.

Dual Diagnosis Recovery Network (www.dualdiagnosis.org/resource/ddrn/): Part of Foundations Recovery Network, the Dual Diagnosis Recovery Network is an advocacy group for people with CODs. They offer information on mutual-support programs, outreach, and education.

Emotions Anonymous (<http://emotionsanonymous.org/>): A 12-Step fellowship based on AA for people with any emotional difficulties (not only clinical mental disorders). Groups are located in more than 30 countries, with more than 600 active groups, including Skype and phone meetings.

Faces and Voices of Recovery (<http://facesandvoicesofrecovery.org/>): Offers recovery stories, news and events information, publications, and webinars.

Heroin Anonymous (www.heroinanonymous.org): A nonprofit fellowship of individuals in recovery from heroin addiction and committed to helping each other stay sober. This organization holds local support meetings, a directory of which can be found on their website.

Narcotics Anonymous (NA; www.na.org/): A global, community-based organization with a multilingual, multicultural membership that supports recovery from addiction through a 12-Step program, including regular attendance at group meetings. The group offers an ongoing support network for maintaining a drug-free lifestyle. NA does not focus on any particular addictive substance.

Nar-Anon Family Groups (www.nar-anon.org/): Group meetings in which friends and family of people with drug use problems can share their experiences and learn to apply the 12-Steps Nar-Anon program to their lives. Nar-Anon offers individualized support from experienced members acting as sponsors.

National Mental Health Consumers' Self-Help Clearinghouse (www.mhselfhelp.org/): The organization has developed and offers a resource kit providing the names and contacts for resources and information on substance addictions, co-occurring disorders, services, and mutual help support.

Pills Anonymous (www.pillsanonymous.org): A 12-Step mutual-support fellowship that holds regular meetings in which individuals in recovery from addiction to medication can share their experiences, build their strengths, and offer hope for recovery to one another.

Recoveries Anonymous (www.r-a.org/): A 12-Step mutual fellowship that welcomes people with a broad range of problems, from addictions, to mental disorders, to “problem behaviors” (e.g., compulsive spending, risk-taking, suicidal behaviors).

Schizophrenia Alliance (<https://sardaa.org/schizophrenia-alliance/sa-group-locations/>): Operating under the auspices of the Schizophrenia and Related Disorders Alliance of America, this 12-Step mutual-support program offers information and fellowship for people with schizophrenia or other psychotic disorders, including bipolar disorder. They hold meetings among 150 groups throughout 31 states.

Secular Organizations for Sobriety (www.sossobriety.org/): A nonprofit, nonreligious network of autonomous, nonprofessional local groups that help people achieve and maintain abstinence from alcohol and drug addiction.

Self-Management and Recovery Training (SMART Recovery); www.smartrecovery.org/: SMART Recovery a self-empowering addiction recovery support group that teaches science-based tools for addiction recovery and grants access to an international recovery community of mutual-support groups.

Women for Sobriety (<https://womenforsobriety.org/>): An abstinence-based mutual-support program that helps women find individual paths to recovery by acknowledging their unique needs in recovery. It is not affiliated with other recovery organizations. It offers tools to help women in recovery develop coping skills focused on emotional growth, spiritual growth, self-esteem, and a healthy lifestyle.

Publications and Other Resources

American Society of Addiction Medicine (www.asam.org/resources/patient-resources): Includes a treatment locator, listing of client and family support group, and a treatment guideline about opioid addiction.

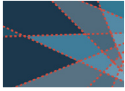
Foundations Recovery Network Articles and Publications (www.dualdiagnosis.org/resource/): Offers material on COD treatment, gender-specific concerns, family functions, mutual support, advocacy, and success stories.

National Institute on Alcohol Abuse and Alcoholism (www.rethinkingdrinking.niaaa.nih.gov/help-links/): Provides links to patient and family education, help lines, and other recovery resources

NIDA (www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/patient-materials): Patient materials include online tools, booklets, and fact sheets about substance misuse, prevention, and treatment.

SAMHSA (<https://store.samhsa.gov/>): Provides patient and family educational tools about SUD and co-occurring mental illness.

- *No Longer Alone. A Story About Alcohol, Drugs, Depression, and Trauma*: <https://store.samhsa.gov/system/files/sma13-4781eng.pdf>
- *People Recover. An Educational Comic Book on Co-Occurring Disorders*: <https://store.samhsa.gov/product/people-recover/sma13-4712>
- *Should You Talk to Someone About a Drug, Alcohol, or Mental Health Problem?* (<https://store.samhsa.gov/product/Should-You-Talk-to-Someone-About-a-Drug-Alcohol-or-Mental-Health-Problem-/sma15-4585>). This publication is available in English, Cambodian, Chinese, Russian, and Vietnamese.
- *Steve’s Path to a Better Life: Alcohol and Depression*: <https://store.samhsa.gov/system/files/sma16-5013.pdf>



Online Boards and Chat Rooms

12-Step forums: Some AA meetings are available online, each with their own view of medication.

- The AA online intergroup directory lists numerous online AA meetings: www.aa-intergroup.org/

Bipolar World Online (<https://bipolarworld.org/>):

This online community includes support chat, an online forum, online journals, and articles about bipolar disorder.

Facebook forums and groups: A handful of COD and addiction recovery organizations maintain a presence on Facebook because of the ease of creating online mutual-support and chat groups.

- Dual Diagnosis Co-Occurring Mental Illness and Substance Disorders Treatment Programs: www.facebook.com/FirstDualDiagnosisTreatmentandPrograms1984/
- Recovery Group for Dual Diagnosis: www.facebook.com/events/139669280229645/
- Secular Organizations for Sobriety: www.facebook.com/groups/251215211975/

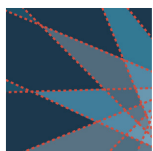
LifeRing Secular Recovery Dual Diagnosis Recovery Online Support Groups (<https://www.lifering.org/post/lifering-offers-dual-diagnosis-recovery-support-group-online>).

Mental Health America Online Support Groups (<https://www.inspire.com/groups/mental-health-america/>).

SMART Recovery Online Forum (www.smartrecovery.org/community/forum.php).

Mobile Apps

Foundations Recovery Network (www.dualdiagnosis.org/apps-for-addiction-recovery-and-mental-health/): maintains a listing of COD, SUD, and mental illness-related mobile apps.



Appendix C—Provider Forms, Measures, and Tools

Biopsychosocial Intake Forms

A sample assessment form is included in a PDF that is linked to the Providers Clinical Support System (PCSS) website. Go to <https://30qkon2g8eif8wrj03zeh041-wpengine.netdna-ssl.com/wp-content/uploads/2017/09/Intake-Assessment-3.pdf> and see pages 23–32 of the PDF.

Suicide and Safety Screening and Assessment Tools

Columbia-Suicide Severity Rating Scale (<http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english>): Numerous versions of this screener are available for different populations, including adults, adolescents, and people with cognitive difficulties. Versions are also available for certain settings, including general care settings, military settings, schools, and military settings. Furthermore, this screener can be downloaded in both English and Spanish.

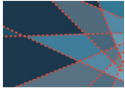
HUMILIATION, AFRAID, RAPE, AND KICK

- **H:** Humiliation—Within the last year, have you been humiliated or emotionally abused in other ways by your partner or your ex-partner?
- **A:** Afraid—Within the last year, have you been afraid of your partner or ex-partner?
- **R:** Rape—Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?
- **K:** Kick—Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?

Source: Sohal, Eldridge, & Feder (2007). Adapted from material distributed under the terms of the Creative Commons Attribution License (<https://creativecommons.org/licenses/by/2.0/>).

Mental Disorder Screening and Assessment Tools

Addiction Severity Index: This is a semistructured interview that takes approximately an hour to administer. Information on administration and scoring can be found at <https://pubs.niaaa.nih.gov/publications/assessingalcohol/InstrumentPDFs/04ASI.pdf>. The interview is available for free online, including here: (http://adai.washington.edu/instruments/pdf/addiction_severity_index_baseline_followup_4.pdf).



MENTAL HEALTH SCREENING FORM-III

Please circle “yes” or “no” for each question.

1. Have you <i>ever</i> talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?	Yes	No
2. Have you <i>ever</i> felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?	Yes	No
3. Have you <i>ever</i> been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?	Yes	No
4. Have you <i>ever</i> been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?	Yes	No
5. Have you <i>ever</i> heard voices no one else could hear or seen objects or things which others could not see?	Yes	No
6. (a) Have you <i>ever</i> been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself?	Yes	No
(b) Did you <i>ever</i> attempt to kill yourself?	Yes	No
7. Have you <i>ever</i> had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed?	Yes	No
8. Have you <i>ever</i> experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?	Yes	No
9. Have you <i>ever</i> given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property?	Yes	No
10. Have you <i>ever</i> felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior?	Yes	No
11. Have you <i>ever</i> experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?	Yes	No
12. Was there <i>ever</i> a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate binge eating, taking enemas, or forcing yourself to throw up?	Yes	No
13. Have you <i>ever</i> had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly nonstop, when you moved quickly from one activity to another, when you needed little sleep, and when you believed you could do almost anything?	Yes	No
14. Have you <i>ever</i> had spells or attacks when you suddenly felt anxious, frightened, or uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, or you felt dizzy or unsteady, as if you would faint?	Yes	No

Continued on next page

Continued

15. Have you <i>ever</i> had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate.	Yes No
16. Have you <i>ever</i> lost considerable sums of money through gambling or had problems at work, in school, or with your family and friends as a result of your gambling?	Yes No
17. Have you <i>ever</i> been told by teachers, guidance counselors, or others that you have a special learning problem?	Yes No

Instructions and scoring information are available online. (https://idph.iowa.gov/Portals/1/Files/SubstanceAbuse/jackson_mentalhealth_screeningtool.pdf).

Source: Carroll & McGinley (2000). Reprinted with permission.

Substance Use/Misuse Screening and Assessment Tools

National Institute on Drug Abuse (NIDA)-Modified Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) (www.drugabuse.gov/nmassist/): NIDA developed

an abbreviated version of the World Health Organization's (WHO) ASSIST tool called the NIDA-Modified ASSIST that can be completed online.

PCSS – Clinical Tools: <https://pcssnow.org/resources/clinical-tools>

ALCOHOL USE DISORDERS IDENTIFICATION TEST

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

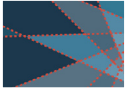
For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or “pure” alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:



QUESTIONS	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	

Continued on next page



Continued

2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
Total						

Source: Babor et al. (2001).

THE ALCOHOL USE DISORDERS IDENTIFICATION TEST CONCISE

How often do you have a drink containing alcohol?

☐ Never	☐ 2-3 times a week
☐ Monthly or less	☐ 4 or more times a week
☐ 2-4 times a month	

How many standard drinks containing alcohol do you have on a typical day?

☐ 1 or 2	☐ 7 to 9
☐ 3 to 4	☐ 10 or more
☐ 5 to 6	

How often do you have six or more drinks on one occasion?

☐ Daily or almost daily	☐ Less than monthly
☐ Weekly	☐ Never
☐ Monthly	

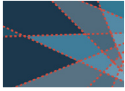
The AUDIT-C tool, along with scoring instructions and further information, is available online at <https://www.queri.research.va.gov/tools/alcohol-misuse/alcohol-faqs.cfm#3>.

Source: Bush, Kivlahan, McDonell, Fihn, & Bradley (1998). Reprinted from material in the public domain.

MICHIGAN ALCOHOLISM SCREENING TEST

	Yes	No	Points
0. Do you enjoy drinking now and then?	☐	☐	
1. * Do you feel you are a normal drinker? ("normal" - drink as much or less than most people)	☐	☐	(2)
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	☐	☐	(2)
3. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?	☐	☐	(1)
4. * Can you stop drinking without a struggle after one or two drinks?	☐	☐	(2)
5. Do you ever feel guilty about your drinking?	☐	☐	(1)
6. * Do friends or relatives think you are a normal drinker?	☐	☐	(2)
7. * Are you able to stop drinking when you want to?	☐	☐	(2)
8. Have you ever attended a meeting of Alcoholics Anonymous (AA)?	☐	☐	(5)
9. Have you gotten into physical fights when drinking?	☐	☐	(1)

Continued on next page

*Continued*

10. Has your drinking ever created problems between you and your wife, husband, a parent, or other relative?	☐	☐	(2)
11. Has your wife, husband (or other family members) ever gone to anyone for help about your drinking?	☐	☐	(2)
12. Have you ever lost friends because of your drinking?	☐	☐	(2)
13. Have you ever gotten into trouble at work or school because of drinking?	☐	☐	(2)
14. Have you ever lost a job because of drinking?	☐	☐	(2)
15. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?	☐	☐	(2)
16. Do you drink before noon fairly often?	☐	☐	(1)
17. Have you ever been told you have liver trouble? Cirrhosis?	☐	☐	(2)
18. ** After heavy drinking have you ever had Delirium Tremens (D.T.s) or severe shaking, or heard voices, or seen things that are really not there?	☐	☐	(2)
19. Have you ever gone to anyone for help about your drinking?	☐	☐	(5)
20. Have you ever been in a hospital because of drinking?	☐	☐	(5)
21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?	☐	☐	(2)
22. Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where drinking was part of the problem?	☐	☐	(2)
23. *** Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (if YES, How many times?__)	☐	☐	(2)
24. *** Have you ever been arrested, or taken into custody even for a few hours, because of other drunk behavior? (if YES, How many times?__)	☐	☐	(2)

* Alcoholic response is negative

** 5 points for Delirium Tremens

*** 2 points for each arrest

SCORING

Add up the points for every question you answered with YES, for Q23 and Q24 multiply the number of times by points

0 - 3 No apparent problem

4 Early or middle problem drinker

5 or more Problem drinker (Alcoholic)

This instrument is available online at www.ncbi.nlm.nih.gov/books/NBK64829.

Source: Adapted from Selzer (1971).

SIMPLE SCREENING INSTRUMENT FOR SUBSTANCE ABUSE

During the past 6 months:

1. Have you used alcohol or other drugs? (such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants)	Yes	No
2. Have you felt that you use too much alcohol or other drugs?	Yes	No
3. Have you tried to cut down or quit drinking or using drugs?	Yes	No
4. Have you gone to anyone for help because of your drinking or drug use? (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program)	Yes	No
5. Have you had any of the following? Put a check mark next to any problems you have experienced.		
☐ Blackouts or other periods of memory loss?		
☐ Injury to your head after drinking or using drugs?		
☐ Convulsions or delirium tremens (DTs)?		
☐ Hepatitis or other liver problems?		
☐ Felt sick, shaky, or depressed when you stopped drinking or using drugs?		
☐ Felt “coke bugs” or a crawling feeling under the skin after you stopped using drugs?		
☐ Injury after drinking or using?		
☐ Used needles to shoot drugs?		

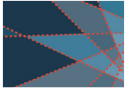
Circle “yes” if at least one of the eight items above is checked

6. Has your drinking or other drug use caused problems between you and your family or friends?	Yes	No
7. Has your drinking or other drug use caused problems at school or at work?	Yes	No
8. Have you been arrested or had other legal problems? (such as bouncing bad checks, driving while intoxicated, theft, or drug possession)	Yes	No
9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs?	Yes	No
10. Do you need to drink or use drugs more and more to get the effect you want?	Yes	No
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?	Yes	No
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?	Yes	No
13. Do you feel bad or guilty about your drinking or drug use?	Yes	No

The next questions are about lifetime experiences.

14. Have you ever had a drinking or other drug problem?	Yes	No
15. Have any of your family members ever had a drinking or drug problem?	Yes	No
16. Do you feel that you have a drinking or drug problem now?	Yes	No

Source: Center for Substance Abuse Treatment (CSAT; 1994). Reprinted from material in the public domain.



Substance Withdrawal Screening Tools

CLINICAL INSTITUTE NARCOTIC ASSESSMENT SCALE FOR WITHDRAWAL SYMPTOMS

Parameters Based on Questions and Observation	Findings	Points
1. Abdominal changes: Do you have any pains in your abdomen? Crampy abdominal pain, diarrhea, active bowel sounds.	No abdominal complaints, normal bowel sound. Reports waves of crampy abdominal pain.	0 1 2
2. Changes in temperature: Do you feel hot or cold? Clammy to touch. Uncontrolled shivering.	None reported. Reports feeling cold, hands cold and clammy to touch. Uncontrolled shivering.	0 1 2
3. Nausea and vomiting: Do you feel sick in your stomach? Have you vomited?	No nausea or vomiting. Mild nausea; no retching or vomiting. Intermittent nausea with dry heaves. Constant nausea; frequent dry heaves and/or vomiting.	0 2 4 6
4. Muscle aches: Do you have any muscle cramps?	No muscle aching reported, arm and neck muscles soft at rest. Mild muscle pains. Reports severe muscle pains, muscles in legs, arms or neck in constant state of contraction.	0 1 3
Parameters Based on Observation Alone	Findings	Points
5. Goose flesh	None visible. Occasional goose flesh but not elicited by touch; not permanent. Prominent goose flesh in waves and elicited by touch. Constant goose flesh over face and arms.	0 1 2 3
6. Nasal congestion	No nasal congestion or sniffing. Frequent sniffing. Constant sniffing, watery discharge.	0 1 2
7. Restlessness	Normal activity. Somewhat more than normal activity; moves legs up and down; shifts position occasionally. Moderately fidgety and restless; shifting position frequently. Gross movement most of the time or constantly thrashes about.	0 1 2 3

Continued on next page

Continued

8. Tremor	None. Not visible but can be felt fingertip to fingertip. Moderate with patient's arm extended. Severe even if arms not extended.	0 1 2 3
9. Lacrimation	None. Eyes watering; tears at corners of eyes. Profuse tearing from eyes over face.	0 1 2
10. Sweating	No sweat visible. Barely perceptible sweating; palms moist. Beads of sweat obvious on forehead. Drenching sweats over face and chest.	0 1 2 3
11. Yawning	None. Frequent yawning. Constant uncontrolled yawning.	0 1 2
TOTAL SCORE	Sum of points for all 11 parameters	

Minimum score = 0, Maximum score = 31. The higher the score, the more severe the withdrawal syndrome. Percent of maximal withdrawal symptoms = total score/31 x 100%.

Source: Peachey & Lei (1988). Adapted with permission of John Wiley and Sons Inc.; permission conveyed through Copyright Clearance Center, Inc.

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE, REVISED

Patient: _____ Date: _____ Time: _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute: _____ Blood pressure: _____

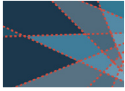
NAUSEA AND VOMITING – Ask “Do you feel sick to your stomach? Have you vomited?” Observation.

- 0 no nausea and no vomiting
- 1 mild nausea with no vomiting
- 2
- 3
- 4 intermittent nausea with dry heaves
- 5
- 6
- 7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES – Ask “Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?” Observation.

- 0 none
- 1 very mild itching, pins and needles, burning or numbness
- 2 mild itching, pins and needles, burning or numbness
- 3 moderate itching, pins and needles, burning or numbness
- 4 moderately severe hallucinations
- 5 severe hallucinations
- 6 extremely severe hallucinations
- 7 continuous hallucinations

Continued on next page



Continued

TREMOR – Arms extended and fingers spread apart. Observation.

- 0** no tremor
- 1** not visible, but can be felt fingertip to fingertip
- 2**
- 3**
- 4** moderate, with patient's arms extended
- 5**
- 6**
- 7** severe, even with arms not extended

PAROXYSMAL SWEATS – Observation.

- 0** no sweat visible
- 1** barely perceptible sweating, palms moist
- 2**
- 3**
- 4** beads of sweat obvious on forehead
- 5**
- 6**
- 7** drenching sweats

ANXIETY – Ask "Do you feel nervous?" Observation.

- 0** no anxiety, at ease
- 1** mild anxious
- 3**
- 4** moderately anxious, or guarded, so anxiety is inferred
- 5**
- 6**
- 7** equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

AUDITORY DISTURBANCES – Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.

- 0** not present
- 1** very mild harshness or ability to frighten
- 2** mild harshness or ability to frighten
- 3** moderate harshness or ability to frighten
- 4** moderately severe hallucinations
- 5** severe hallucinations
- 6** extremely severe hallucinations
- 7** continuous hallucinations

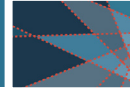
VISUAL DISTURBANCES – Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.

- 0** not present
- 1** very mild sensitivity
- 2** mild sensitivity
- 3** moderate sensitivity
- 4** moderately severe hallucinations
- 5** severe hallucinations
- 6** extremely severe hallucinations
- 7** continuous hallucinations

HEADACHE, FULLNESS IN HEAD – Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

- 0** not present
- 1** very mild
- 2** mild
- 3** moderate
- 4** moderately severe
- 5** severe
- 6** very severe
- 7** extremely severe

Continued on next page



Continued

AGITATION – Observation.

- 0** normal activity
- 1** somewhat more than normal activity
- 2**
- 3**
- 4** moderately fidgety and restless
- 5**
- 6**
- 7** paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM – Ask “What day is this? Where are you? Who am I?”

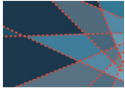
- 0** oriented and can do serial additions
- 1** cannot do serial additions or is uncertain about date
- 2** disoriented for date by no more than 2 calendar days
- 3** disoriented for date by more than 2 calendar days
- 4** disoriented for place/or person

Total **CIWA-Ar Score** _____

Rater’s initials _____

Maximum Possible Score 67

Source: Sullivan, Sykora, Schneiderman, Naranjo, & Sellers (1989).



Trauma Screening and Assessment Tools

PRIMARY CARE PTSD SCREEN FOR DSM-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- A serious accident or fire
- A physical or sexual assault or abuse
- An earthquake or flood
- A war
- Seeing someone be killed or seriously injured
- Having a loved one die through homicide or suicide

Have you ever experienced this kind of event?

YES

NO

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

In the past month, have you...

1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?

YES

NO

2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

YES

NO

3. Been constantly on guard, watchful, or easily startled?

YES

NO

4. Felt numb or detached from people, activities, or your surroundings?

YES

NO

5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

YES

NO

Information about administration and scoring is available online (www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf).

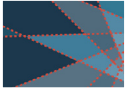
Source: Prins et al. (2015). Reprinted from material in the public domain.

PTSD CHECKLIST FOR DSM-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1 Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2 Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3 Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4 Feeling very upset when someone reminded you of the stressful experience?	0	1	2	3	4
5 Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6 Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7 Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8 Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9 Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10 Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11 Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12 Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13 Feeling distant or cut off from other people?	0	1	2	3	4
14 Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15 Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4

Continued on next page



Continued

16	Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17	Being "superalert" or watchful or on guard?	0	1	2	3	4
18	Feeling jumpy or easily startled?	0	1	2	3	4
19	Having difficulty concentrating?	0	1	2	3	4
20	Trouble falling or staying asleep?	0	1	2	3	4

Information about administration and scoring is available online (www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp).

Source: Weathers et al. (2013). Reprinted from material in the public domain.

Levels of Care Tool

Level of Care Utilization System for Psychiatric and Addiction Services

(LOCUS; <https://drive.google.com/file/d/0B89glzXJnn4cV1dESWI2eFEzc3M/view>): The LOCUS Adult Version 20 is a lengthy measure that assesses many areas of symptoms and functioning to determine level of care.

Functioning and Disability Tools

WHO's Disability Assessment Schedule 2.0

(WHODAS 2.0; www.who.int/classifications/icf/whodasii/en/): Various versions are available in the following locations:

- WHODAS 2.0 36-item version, self-administered: www.who.int/classifications/icf/WHODAS2.0_36itemsSELF.pdf
- WHODAS 2.0 36-item, interviewer-administered: www.who.int/classifications/icf/WHODAS2.0_36itemsINTERVIEW.pdf

- WHODAS 2.0 12-item, self-administered: www.who.int/classifications/icf/WHODAS2.0_12itemsSELF.pdf?ua=1
- WHODAS 2.0 12-item, interviewer-administered: www.who.int/classifications/icf/WHODAS2.0_12itemsINTERVIEW.pdf

Stage of Change Tools

The Stages of Change Readiness and Treatment Eagerness Scale (<https://casaa.unm.edu/inst/socratesv8.pdf>): This scale is available in two formats: one for alcohol use and one for drug use.

The University of Rhode Island Change Assessment Scale (<https://habitslab.umbc.edu/urica/>): Multiple short- and long-form versions of this measure are available, including for alcohol use, drug use, and initiating psychotherapy.

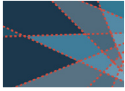
SAMPLE TREATMENT PLAN FOR CASE EXAMPLE GEORGE T. (CHAPTER 3)

Problem	Intervention	Goal
Cocaine use disorder • Work problem primary reason for referral • Family and work support • Resists 12-Step • Mental symptoms trigger use • Action phase	Outpatient treatment • EAP monitoring • Family meetings • Work support group • Teach skills to manage symptoms without using • 12-Step meetings	Abstinence • Negative urinalysis results • Daily recovery plans
Rule out AUD • No clear problem • May trigger cocaine use • Precontemplation phase	• Outpatient motivational enhancement; thorough evaluation of role of alcohol in patient's life, including family education	• Move into contemplation phase of readiness to change • Willing to consider the risk of use or possible abuse
Bipolar disorder • Long history • On lithium • Some mood symptoms • Maintenance phase	• Medication management • Help take medication while in recovery programs • Bipolar Support Alliance meetings • Advocate/collaborate with prescribing health professional • Identify mood symptoms as triggers	• Maintain stable mood • Able to manage fluctuating mood symptoms that do occur without using cocaine or other substances to regulate his bipolar disorder

CONSIDERATIONS IN TREATMENT MATCHING

Variable	Key Data
Acute safety needs Determines need for immediate acute stabilization to establish safety prior to routine assessment	• Immediate risk of harm to self or others • Immediate risk of physical harm or abuse from others (Mee-Lee et al., 2013) • Inability to provide for basic self-care • Medically dangerous intoxication or withdrawal • Potentially lethal medical condition • Acute severe mental symptoms (e.g., mania, psychosis) leading to inability to function or communicate effectively
Quadrant assignment Guides the choice of the most appropriate setting for treatment	• Serious, persistent mental illness (SPMI) vs. non-SPMI • Severely acute or disabling mental symptoms vs. mild to moderate severity symptoms • High (e.g., active SUD) vs. low (e.g., hazardous substance use) severity SUD • Substance dependence in full vs. partial remission (Mee-Lee et al., 2013; American Psychiatric Association, 2013)

Continued on next page



Continued

Variable	Key Data
Level of care Determines client's program assignment	• Dimensions of assessment for each disorder using criteria from the LOCUS
Diagnosis Determines the recommended treatment intervention	• Specific diagnosis of each mental disorder and SUD, including distinction between and SUD and substance-induced symptoms • Information about past and present successful and unsuccessful treatment efforts for each diagnosis • Identification of trauma-related disorders and culture-bound syndromes, in addition to other mental disorders and substance-related problems
Disability Determines case management needs and whether a standard intervention is sufficient—at capable or intermediate level—or whether a more advanced “enhanced” level intervention is essential	• Cognitive deficits, functional deficits, and skill deficits that interfere with ability to function independently or follow treatment recommendations and that may require varying types and amounts of case management or support • Specific functional deficits that may interfere with ability to participate in SUD treatment in a particular program setting and may therefore require a co-occurring-enhanced setting rather than a co-occurring-capable one • Specific deficits in learning or using basic recovery skills that require modified or simplified learning strategies
Strengths and skills Determines areas of prior success around which to organize future treatment interventions and areas of skill building to manage either disorder	• Areas of particular capacity or motivation in relation to general life functioning (e.g., capacity to socialize, work, or obtain housing) • Ability to manage treatment participation for any disorder (e.g., familiarity and comfort with 12-Step programs, commitment to medication adherence)
Availability and continuity of recovery support Determines whether to establish continuing relationships and existing relationship availability to provide contingencies to promote learning	• Presence or absence of continuing treatment relationships, particularly mental disorder treatment relationships, beyond the single episode of care • Presence or absence of an existing and ongoing supportive family, peer support, or therapeutic community; quality and safety of recovery environment (Mee-Lee et al., 2013)

Continued on next page

Continued

Variable	Key Data
Cultural context Determines most culturally appropriate treatment interventions and settings	• Areas of cultural identification and support in relation to each of the following • Ethnic or linguistic culture identification (e.g., attachment to traditional American-Indian cultural healing practices) • Cultures that have evolved around treatment of mental disorders and SUDs (e.g., identification with 12-Step recovery culture; commitment to mental health empowerment movement) • Gender and gender identity • Sexual orientation • Rural vs. urban
Problem domains Determines problems to be solved specifically, and opportunities for contingencies to promote treatment participation	• Is there impairment, need, or (conversely) strength in any of the following areas • Financial • Legal • Employment • Housing • Social/family • Medical, parenting/child protective, abuse/victimization/victimizer
Phase of recovery/stage of change (for each problem) Determines appropriate phase-specific or stage-specific treatment intervention and outcomes	• Requirement for acute stabilization of symptoms, engagement, or motivational enhancement • Active treatment to achieve prolonged stabilization • Relapse prevention/maintenance • Rehabilitation, recovery, and growth • In the motivational enhancement sequence, precontemplation, contemplation, preparation, action, maintenance, or relapse (Prochaska & DiClemente, 1992) • Engagement, stabilization/persuasion, active treatment, or continuing care/relapse prevention (Mueser & Gingerich, 2013; SAMHSA, 2009a)

Additional Screening Tools for Common Mental Disorders

Depression. Patient Health Questionnaire (PHQ-9): <https://www.hiv.uw.edu/page/mental-health-screening/phq-9>

Anxiety. General Anxiety Disorder 7-item (GAD-7) Scale: <https://www.hiv.uw.edu/page/mental-health-screening/gad-7>

This page intentionally left blank.

SAMHSA Knowledge Application Program Resources

TIPs may be ordered or downloaded for free from SAMHSA's Publications Ordering webpage at <https://store.samhsa.gov>. Or, please call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

SAMHSA Publication No. PEP20-02-01-004
Published 2020

Substance Abuse and Mental Health Services Administration
SAMHSA's mission is to reduce the impact of substance abuse
and mental illness on America's communities.

1-877-SAMHSA-7 (1-877-726-4727) | 1-800-486-4889 (TDD)
www.samhsa.gov

SAMHSA
Substance Abuse and Mental Health
Services Administration