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

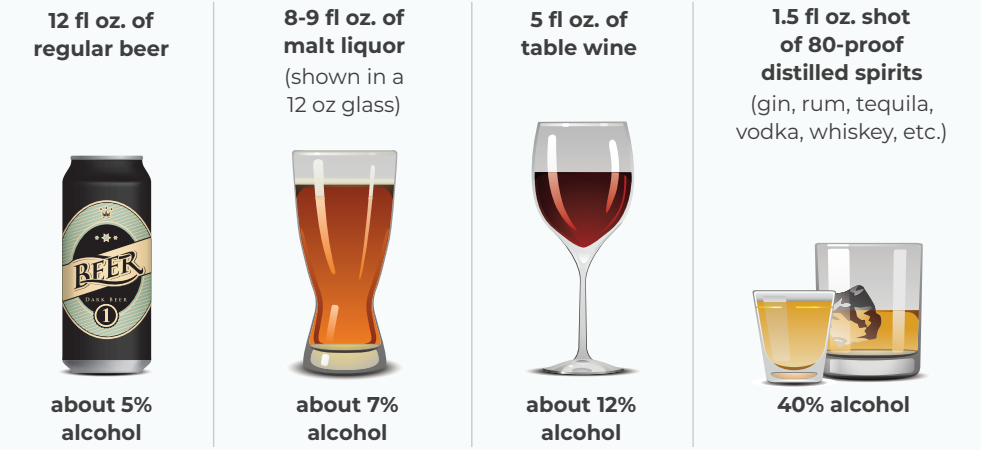
Exhibit 1.1 defines key terms that appear in this TIP.

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:



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 dexmethylphenidate 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 indepth 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.

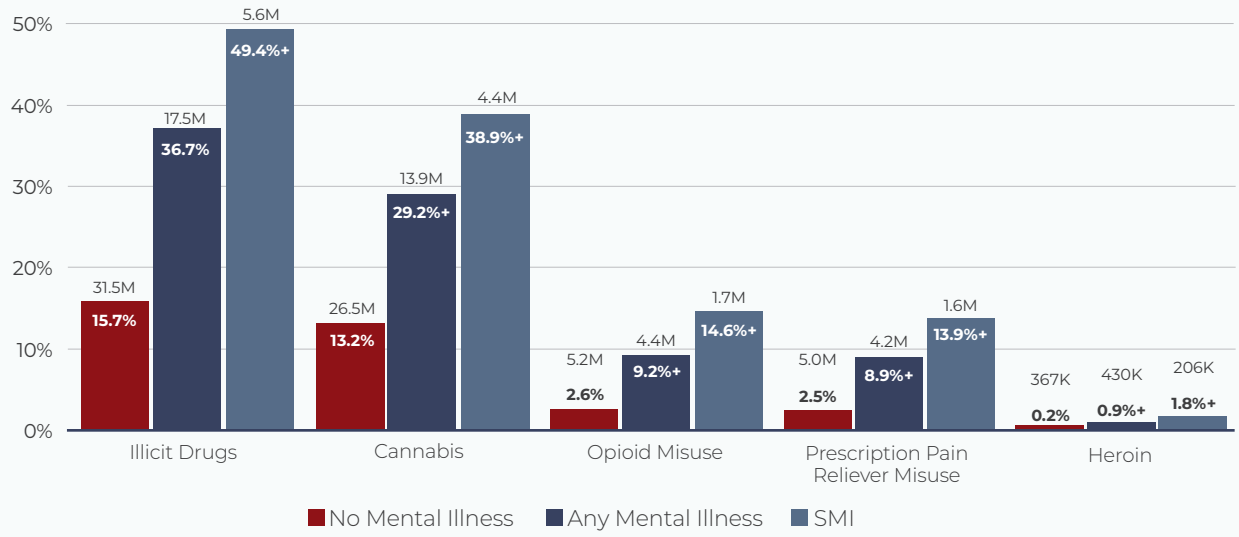
> "Comorbidity is important because it is the rule rather than the exception with mental health disorders."
>
> *Source: Lai, Cleary, Sitharthan, & Hunt, 2015; p. 8*

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) 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:

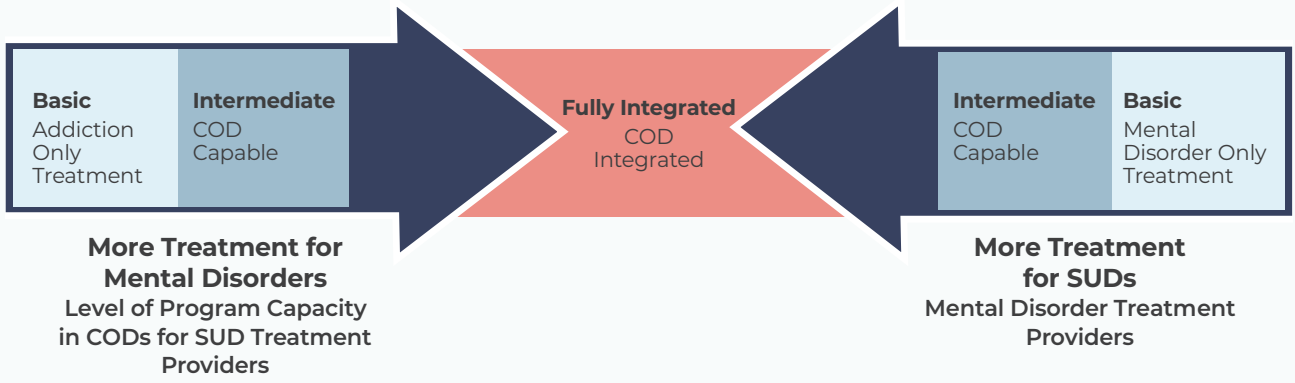
1. A structure that offers unrestricted, **integrated, collaborative services** to clients with CODs
2. **A culture that is welcoming to clients with CODs** and readily offers education about CODs
3. Use of **routine screening, assessment, and diagnosis** (or referral to diagnosis, if needed) for clients 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.

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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 confidentiality[1] 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 suidical ideation over the past twelve months.
- Item 3 assesses the threat of suicide attempt.
- Item 4 evaluates self-reported likelihood of suidical 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	
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	Total Points

ITEM 2: ASSESSES THE *FREQUENCY* OF SUICIDAL *IDEATION* OVER THE PAST 12 MONTHS			
Selected Response:	Never	1 point	
	Rarely (1 time)	2 points	
	Sometimes (2 times)	3 points	
	Often (3-4 times)	4 points	
	Very often (5 or more times)	5 points	Total 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

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 *ever* talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?	Yes	No
2.	Have you *ever* 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 *ever* been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?	Yes	No
4.	Have you *ever* been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?	Yes	No
5.	Have you *ever* heard voices no one else could hear or seen objects or things which others could not see?	Yes	No
6.	(a) Have you *ever* 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? (b) Did you *ever* attempt to kill yourself?	Yes Yes	No No
7.	Have you *ever* 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 *ever* 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 *ever* 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 *ever* 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 *ever* experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?	Yes	No
12.	Was there *ever* 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 *ever* 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 *ever* 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 scaleddown 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, Rynearson-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.

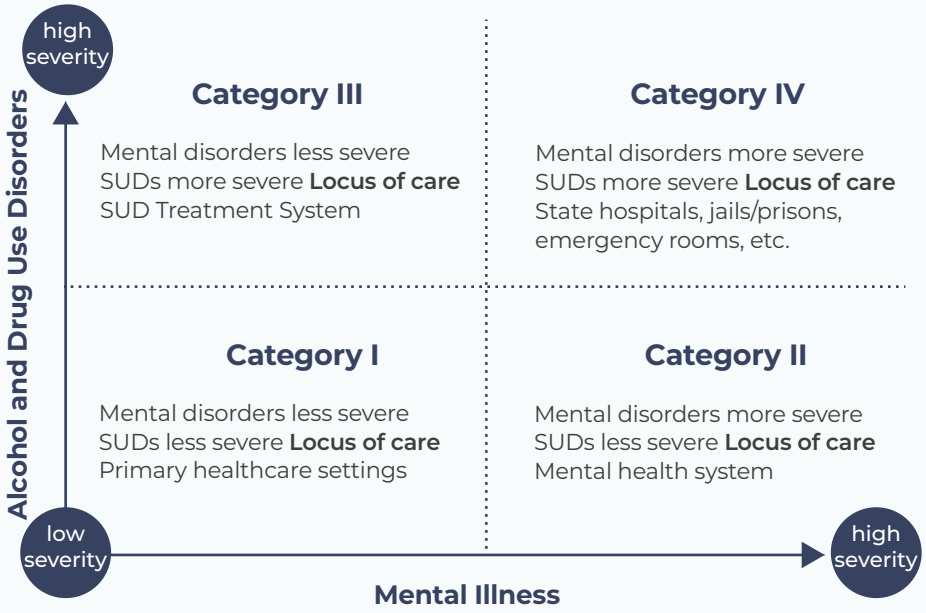
Assessment Step 4: Determine Quadrant and Locus of Responsibility

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 (McDonell 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). Indepth 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 (McConnaughy, 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

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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)

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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.