Executive Summary

For purposes of this TIP, *co-occurring disorders* refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have co-occurring disorders have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders. A diagnosis of co-occurring disorders (COD) occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder. Many may think of the typical person with COD as having a severe mental disorder combined with a severe substance use disorder, such as schizophrenia combined with alcohol dependence. However, counselors working in addiction agencies are more likely to see persons with severe addiction combined with mild- to moderate-severity mental disorders; an example would be a person with alcohol dependence combined with a depressive disorder or an anxiety disorder. Efforts to provide treatment that will meet the unique needs of people with COD have gained momentum over the past 2 decades in both substance abuse treatment and mental health services settings.

Throughout this TIP, the term "substance abuse" refers to both substance abuse and substance dependence (as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision* [DSM-IV-TR] [American Psychiatric Association 2000]) and encompasses the use of both alcohol and other psychoactive substances. Though unfortunately ambiguous, this term was chosen partly because the lay public, politicians, and many substance abuse treatment professionals commonly use "substance abuse" to describe any excessive use of any addictive substance. Readers should attend to the context in which the term occurs to determine the range of possible meanings; in most cases, however, the term refers to all substance use disorders described by the DSM-IV. It should be noted, however, that although nicotine dependency is recognized as a disorder in DSM-IV, an important difference between tobacco addiction and other addictions is that tobacco's chief effects are medical rather than behavioral, and, as such, it is not treated as substance abuse in this TIP. Nonetheless, because of the high numbers of

the COD population addicted to nicotine as well as the devastating health consequences of tobacco use, nicotine dependency is included as an important cross-cutting issue for people with substance use disorders and mental illness.

Terms for mental disorders may have somewhat different lay and professional definitions. For example, while most people might become depressed or anxious briefly around a life stress, this does not mean that they have a "mental disorder" as is used in this text. Because the DSM-IV is the national standard for definitions of mental disorders, it is used in this TIP. In certain States, however, only certain trained professionals "officially" can diagnose either a mental or substance use disorder.

In the late 1970s, practitioners began to recognize that the presence of substance abuse in combination with mental disorders had profound and troubling implications for treatment outcomes. This growing awareness has culminated in today's emphasis on the need to recognize and address the interrelationship of these disorders through new approaches and appropriate adaptations of traditional treatment. In the decades from the 1970s to the present, substance abuse treatment programs typically reported that 50 to 75 percent of their clients had COD, while corresponding mental-health settings cited proportions of 20 to 50 percent. During the same period of time, a body of knowledge has evolved that clarifies the treatment challenges presented by the combination of substance use and mental disorders and illuminates the likelihood of poorer outcomes for such clients in the absence of targeted treatment efforts.

The treatment and research communities have not been passive in the face of this challenge. Innovative strategies have emerged and been tested, and the treatment population has been defined more precisely. Findings have shown that many substance abuse treatment clients with less serious mental disorders do well with traditional substance abuse treatment methods, while those with more serious mental disorders need intervention modifications and additions to enhance treatment effectiveness and, in most instances, to result in successful treatment outcomes.

The Quadrants of Care, developed by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD), is a useful classification of *service coordination by severity* in the context of substance abuse and mental health settings. The NASADAD–NASMHPD four-quadrant framework provides a structure for fostering consultation, collaboration, and integration among drug abuse and mental health treatment systems and providers to deliver appropriate care to every client with COD. Although the material in this TIP relates to all four quadrants, the TIP is designed primarily to provide guidance for addiction counselors working in quadrant II and III settings. The four categories of COD are

- Quadrant I: Less severe mental disorder/less severe substance disorder
- Quadrant II: More severe mental disorder/less severe substance disorder
- Quadrant III: Less severe mental disorder/more severe substance disorder
- Quadrant IV: More severe mental disorder/more severe substance disorder

The American Society of Addiction Medicine (ASAM) also has developed a client placement system to facilitate effective treatment. The ASAM Patient Placement Criteria (ASAM PPC-2R) describe three types of substance abuse programs for people with COD: addiction only services, dual diagnosis capable, and dual diagnosis enhanced. This TIP employs a related system that classifies both substance abuse and mental health programs as basic, intermediate, and advanced in terms of their progress toward providing more integrated care. Further, counselors or other readers who use this TIP will have beginning, intermediate, or advanced backgrounds and experience in COD, and, therefore, different needs. The TIP is structured to meet the needs of addiction counselors with basic backgrounds as well as

the differing needs of those with intermediate and advanced backgrounds.

The integration of substance abuse treatment and mental health services for persons with COD has become a major treatment initiative. Integrated treatment coordinates substance abuse and mental health interventions to treat the whole person more effectively; the term refers broadly to any mechanism by which treatment interventions for COD are combined within a primary treatment relationship or service setting. As such, integrated treatment reflects the longstanding concern within substance abuse treatment programs for treating the whole person, and recognizes the importance of ensuring that entry into any one system can provide access to all needed systems.

As developed in the substance abuse treatment field, the recovery perspective acknowledges that recovery is a long-term process of internal change in which progress occurs in stages, an understanding critical to treatment planning. In preparing a treatment plan, the clinician should recognize that treatment takes place in different settings (e.g., residential and outpatient) over time, and that much of the recovery process typically occurs outside of, or following, treatment (e.g., through participation in mutual self-help groups). Practitioners often divide treatment into phases, usually including engagement, stabilization, primary treatment, and continuing care (also known as aftercare). Use of these phases enables the clinician (whether within the substance abuse or mental health treatment system) to apply coherent, stepwise approaches in developing and using treatment protocols.

This TIP identifies key elements of programming for COD in substance abuse treatment agencies; the paragraphs that follow provide an outline of these essential elements. While the needs and functioning of substance abuse treatment are accentuated, the elements described have relevance for mental health agencies and other service systems that seek to coordinate mental health and substance abuse services for their clients who need both.

Treatment planning begins with screening and assessment. The *screening process* is designed to identify those clients seeking substance abuse treatment who show signs of mental health problems that warrant further attention. Easy-to-use screening instruments will accomplish this purpose and can be administered by counseling staff with minimal preparation.

A *basic assessment* consists of gathering information that will provide evidence of COD and mental and substance use disorder diagnoses; assess problem areas, disabilities, and strengths; assess readiness for change; and gather data to guide decisions regarding the necessary level of care. Intake information consists of the following categories and items:

- *Background* is described by obtaining data on family; relevant cultural, linguistic, gender, and sexual orientation issues; trauma history; marital status; legal involvement and financial situation; health; education; housing status; strengths and resources; and employment.
- *Substance use* is established by age of first use, primary drugs used, patterns of drug use (including information related to diagnostic criteria for abuse or dependence), and past or current treatment. It is important to identify periods of abstinence of 30 days or longer to isolate the mental health symptoms, treatment, and disability expressed during these abstinent periods.
- *Psychiatric problems* are elaborated by determining both family and client histories of psychiatric problems (including diagnosis, hospitalization, and other treatments), current diagnoses and symptoms, and medications and medication adherence. It is important to identify past periods of mental health stability, determine past successful treatment for mental disorders, and discover the nature of substance use disorder issues arising during these stable periods. Identification of any current treatment providers enables vitally important information sharing and cooperation.
- *Integrated assessment* identifies the interactions among the symptoms of mental disor-

ders and substance use, as well as the interactions of the symptoms of substance use disorders and mental health symptoms. Integrated assessment also considers how all the interactions relate to treatment experiences, especially stages of change, periods of stability, and periods of crisis.

Diagnosis is an important part of the assessment process. The TIP provides a discussion of mental disorders selected from the DSM-IV-TR and the diagnostic criteria for each disorder. Key information about substance abuse and particular mental disorders is distilled, and appropriate counselor actions and approaches are recommended for the substance abuse treatment client who manifests symptoms of one or more of these mental disorders. The consensus panel recognizes that addiction counselors are not expected to diagnose mental disorders. The limited aims of providing this material are to increase substance abuse treatment counselors' familiarity with mental disorder terminology and criteria and to provide advice on how to proceed with clients who demonstrate the symptoms of these disorders.

The use of proper *medication* is an essential program element, helping clients to stabilize and control their symptoms, thereby increasing their receptivity to other treatment. Pharmacological advances over the past few decades have produced more effective psychiatric medications with fewer side effects. With the support of better medication regimens, many people with serious mental disorders who once would have been institutionalized, or who would have been too unstable for substance abuse treatment, have been able to participate in treatment, make progress, and lead more productive lives. To meet the needs of this population, the substance abuse treatment counselor needs better understanding of the signs and symptoms of mental disorders and access to medical support. The counselor's role is first to provide the prescribing physician with an accurate description of the client's behavior and symptoms, which ensures that proper medication is chosen, and then to assist the client in adhering to the medication regimen. The substance abuse counselor and program can, and often do, employ peers or the peer community to help and support individual efforts to follow prescription instructions.

Several other features complete the list of essential components of treatment for COD, including *enhanced staffing* that incorporates professional mental health specialists, psychiatric consultation, or an onsite psychiatrist (for assessment, diagnosis, and medication); *psychoeducational classes* (e.g., mental disorders and substance abuse, relapse prevention) that provide increased awareness about the disorders and their symptoms; onsite *double trouble groups* to discuss the interrelated problems of mental and substance use disorders, which will help to identify triggers for relapse; and participation in community-based *dual recovery mutual self-help groups*, which afford an understanding, supportive environment and a safe forum for discussing medication, mental health, and substance abuse issues.

Treatment providers are advised to view clients with COD and their treatment in the context of their culture, ethnicity, geographic area, socioeconomic status, gender, age, sexual orientation, religion, spirituality, and any physical or cognitive disabilities. The provider especially needs to appreciate the distinctive ways in which a client's culture may view disease or disorder, including COD. Using a model of disease familiar and culturally relevant to the client can help communication and facilitate treatment.

In addition to the essential elements described above, several well-developed and successful strategies from the substance abuse field are being adapted for COD. The TIP presents those strategies (briefly noted in the following paragraphs) found to have promise for effective treatment of clients with COD.

Motivational Interviewing (MI) is a client-centered, directive method for enhancing intrinsic motivation to change (by exploring and resolving ambivalence) that has proven effective in helping clients clarify goals and commit to change. MI has been modified to meet the spe-

cial circumstances of clients with COD, with promising results from initial studies to improve client engagement in treatment.

Contingency Management (CM) maintains that the form or frequency of behavior can be altered through the introduction of a planned and organized system of positive and negative consequences. It should be noted that many counselors and programs employ CM principles informally by rewarding or praising particular behaviors and accomplishments. Similarly, CM principles are applied formally (but not necessarily identified as such) whenever the attainment of a level or privilege is contingent on meeting certain behavioral criteria. Demonstration of the efficacy of CM principles for clients with COD is still needed.

Cognitive–Behavioral Therapy (CBT) is a general therapeutic approach that seeks to modify negative or self-defeating thoughts and behaviors, and is aimed at achieving change in both. CBT uses the client's cognitive distortions as the basis for prescribing activities to promote change. Distortions in thinking are likely to be more severe with people with COD who are, by definition, in need of increased coping skills. CBT has proven useful in developing these coping skills in a variety of clients with COD.

Relapse Prevention (RP) has proven to be a particularly useful substance abuse treatment strategy and it appears adaptable to clients with COD. The goal of RP is to develop the client's ability to recognize cues and to intervene in the relapse process, so lapses occur less frequently and with less severity. RP endeavors to anticipate likely problems, and then helps clients to apply various tactics for avoiding lapses to substance use. Indeed, one form of RP treatment, Relapse Prevention Therapy, has been specifically adapted to provide integrated treatment of COD, with promising results from some initial studies.

Because outpatient treatment programs are widely available and serve the greatest number of clients, it is imperative that these programs use the best available treatment models to reach the greatest possible number of persons with COD. In addition to the essential elements and the strategies described above, two outpatient models from the mental health field have been valuable for outpatient clients with both substance use and serious mental disorders: Assertive Community Treatment (ACT) and Intensive Case Management (ICM).

ACT programs, historically designed for clients with serious mental illness, employ extensive outreach activities, active and continuing engagement with clients, and a high intensity of services. ACT emphasizes multidisciplinary teams and shared decisionmaking. When working with clients who have COD, the goals of the ACT model are to engage them in helping relationships, assist them in meeting basic needs (e.g., housing), stabilize them in the community, and ensure that they receive direct and integrated substance abuse treatment and mental health services. Randomized trials with clients having serious mental and substance use disorders have demonstrated better outcomes on many variables for ACT compared to standard case management programs.

The goals of ICM are to engage individuals in a trusting relationship, assist in meeting their basic needs (e.g., housing), and help them access and use brokered services in the community. The fundamental element of ICM is a low caseload per case manager, which translates into more intensive and consistent services for each client. ICM has proven useful for clients with serious mental illness and co-occurring substance use disorders. (The consensus panel notes that direct translation of ACT and ICM models from the mental health settings in which they were developed to substance abuse settings is not self-evident. These initiatives likely must be modified and evaluated for application in such settings.)

Residential treatment for substance abuse occurs in a variety of settings, including long- (12 months or more) and short-term residential treatment facilities, criminal justice institutions, and halfway houses. In many substance abuse treatment settings, psychological disturbances have been observed in an increasing

proportion of clients over time; as a result, important initiatives have been developed to meet their needs.

The Modified Therapeutic Community (MTC) is a promising residential model from the substance abuse field for those with substance use and serious mental disorders. The MTC adapts the principles and methods of the therapeutic community to the circumstances of the client, making three key alterations: increased flexibility, more individualized treatment, and reduced intensity. The latter point refers especially to the conversion of the traditional encounter group to a conflict resolution group, which is highly structured, guided, of very low emotional intensity, and geared toward achieving self-understanding and behavior change. The MTC retains the central feature of TC treatment; a culture is established in which clients learn through mutual self-help and affiliation with the peer community to foster change in themselves and others. A series of studies has established better outcomes and benefit cost of the MTC model compared to standard services. A need for more verification of the MTC approach remains.

Because acute and primary care settings encounter chronic physical diseases in combination with substance use and mental disorders, treatment models appropriate to medical settings are emerging, two of which are described in the TIP. In these and other settings, it is particularly important that administrators assess organizational readiness for change prior to implementing a plan of integrated care. The considerable differences between the medical and social service cultures should not be minimized or ignored; rather, opportunities should be provided for relationship and team building.

Within the general population of persons with COD, the needs of a number of specific subgroups can best be met through specially adapted or designed programs. These include persons with *specific disorders* (such as bipolar disorder) and *groups with unique requirements* (such as women, the homeless, and clients in the criminal justice system). The two categories often overlap; for example, a number of recovery models are emerging for women with substance use disorders who are survivors of trauma, many of whom have posttraumatic stress disorder. The TIP highlights a number of promising approaches to treatment for particular client groups, while recognizing that further development is needed, both of disorder-specific interventions and of interventions targeted to the needs of specific populations.

Returning to life in the community after residential placement is a major undertaking for clients with COD, and relapse is an ever-present danger. Discharge planning is important to maintain gains achieved through residential or outpatient treatment. Depending on program and community resources, a number of continuing care (aftercare) options may be available for clients with COD who are leaving treatment. These options include mutual self-help groups, relapse prevention groups, continued individual counseling, psychiatric services (especially important for clients who will continue to require medication), and ICM to continue monitoring and support. A carefully developed discharge plan, produced in collaboration with the client, will identify and relate client needs to community resources, ensuring the supports needed to sustain the progress achieved in treatment.

During the past decade, dual recovery mutual self-help approaches have been developed for individuals affected by COD and are becoming an important vehicle for providing continued support in the community. These approaches apply a broad spectrum of personal responsibility and peer support principles, often employing 12-Step methods that provide a planned regimen of change. The clinician can help clients locate a suitable group, find a sponsor (ideally one who also has COD and is at a late stage of recovery), and become comfortable in the role of group member.

Continuity of care refers to coordination of care as clients move across different service systems and is characterized by three features:

consistency among primary treatment activities and ancillary services, *seamless transitions* across levels of care (e.g., from residential to outpatient treatment), and *coordination* of present with past treatment episodes. Because both substance use and mental disorders typically are long-term chronic disorders, continuity of care is critical; the challenge in any system of care is to institute mechanisms to ensure that all individuals with COD experience the benefits of continuity of care.

The consensus panel recognizes that the role of the client (the consumer) with COD in the design of, and advocacy for, improved services should continue to expand. The consensus panel recommends that program design and development activities of agencies serving clients with COD continue to incorporate consumer and advocacy groups. These groups help to further the refinement and responsiveness of the treatment program, thus enhancing clients' self-esteem and investment in their own treatment.

All good treatment depends on a trained staff. The consensus panel underscores the importance of creating a supportive environment for staff and encouraging continued *professional development*, including skills acquisition, values clarification, and competency attainment. An organizational commitment to staff development is necessary to implement programs successfully and to maintain a motivated and effective staff. It is essential to provide consistently high-quality and supportive supervision, favorable tuition reimbursement and release time policies, appropriate pay and health/retirement benefits, helpful personnel policies that bolster staff well-being, and incentives or rewards for work-related achievements. Together, these elements help create the infrastructure needed for quality service.

The consensus panel supports and encourages the development of a unified substance abuse and mental health approach to co-occurring disorders. Recognizing that *system integration* is difficult to achieve and that the need for improved COD services in substance abuse treatment agencies is urgent, the panel recommends that, at this stage, the emphasis be placed on assisting the substance abuse treatment system in the development of *increased internal capability* to treat individuals with COD effectively. A parallel effort should be undertaken in the mental health system, with the two systems continuing to work cooperatively on services to individual clients.

Much has been accomplished in the field of COD in the last 10 years, and the knowledge acquired is ready for broader dissemination and application. The importance of the transfer and application of knowledge and technology has likewise become better understood. The consensus panel emphasizes the need for new government initiatives that improve services by promoting innovative technology transfer strategies using material from this TIP and from other resources (e.g., the Substance Abuse and Mental Health Services Administration's [SAMHSA's] *Report to Congress on the Treatment and Prevention of Co-Occurring Substance Abuse and Mental Disorders* and SAMHSA's Center for Mental Health Service's *Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit*) are adapted and shaped to the particular program context and circumstances.

1 Introduction

In This Chapter...

The Evolving Field of Co-Occurring Disorders

Important Developments That Led to This TIP

Organization of This TIP

Overview

Over the past few decades, practitioners and researchers increasingly have recognized the link between substance abuse and mental disorders. Treatment Improvement Protocol (TIP) 9, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse* (Center for Substance Abuse Treatment [CSAT] 1994*a*), answered the treatment field's need for an overview of diagnostic criteria, assessment, psychopharmacology, specific mental disorders, and the need for linkage between the mental health services system and substance abuse treatment system.

Subsequent to TIP 9, research has provided a more in-depth understanding of co-occurring substance use and mental disorders—how common they are, the multiple problems they create, and the impact they have on treatment and treatment outcome. As knowledge of co-occurring disorders (COD) continues to evolve, new challenges arise: How do we treat specific populations such as the homeless and those in our criminal justice system? What is the role of housing? What about those with specific mental disorders such as posttraumatic stress disorder? Where is the best locus for treatment? Can we build an integrated system of care? The main purpose of this TIP is to provide addiction counselors and other practitioners with this state-of-the-art information on the rapidly advancing field of co-occurring substance use and mental disorders.

Following a discussion of the evolving field of co-occurring disorders, this chapter addresses the developments that led to this TIP. It then 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. The organization of the TIP is laid out for the reader, with the components of each chapter and appendix described in an effort to help users of the TIP quickly locate subjects of immediate interest.

The Evolving Field of Co-Occurring Disorders

Today's emphasis on the relationship between substance use and mental disorders dates to the late 1970s, when practitioners increasingly became aware of the implications of these disorders, when occurring together, for treatment outcomes. The association between depression and substance abuse was particularly striking and became the subject of several early studies (e.g., Woody and Blaine 1979). In the 1980s and 1990s, however, both the substance abuse and mental health communities found that a wide range of mental disorders were associated with substance abuse, not just depression (e.g., De Leon 1989; Pepper et al. 1981; Rounsaville et al. 1982*b*; Sciacca 1991). During this period, studies conducted in substance abuse programs typically reported that 50 to 75 percent of clients had *some type of* co-occurring mental disorder (although not usually a severe mental disorder) while studies in mental health settings reported that between 20 and 50 percent of their clients had a co-occurring substance use disorder. (See Sacks et al. 1997*b* for a summary of studies and Compton et al. 2000 for a more recent study.)

The multiple studies reflect the extent to which COD constitutes a clinical concern. At the same time, however, these studies varied in that they (1) were conducted in an array of settings and on a range of sample sizes from 68 to 20,291, (2) used different measures and criteria for determining a disorder, and (3) reported on different time periods (i.e., either lifetime or current, or both). This diversity in reporting can produce differing estimates and suggests a need to address the broad range of survey and analytic strategies used to generate estimates. Further work to clarify the type, severity, and clinical significance of co-occurring disorders can contribute to an improved understanding of the phenomenon and treatment. Nevertheless, it is important that, in spite of those differences, there is a consistency in reporting significant rates of disorder across all studies.

Researchers not only found a link between substance abuse and mental illness, they also found the dramatic impact the complicating presence of substance abuse may have on the course of treatment for mental illness. One study of 121 clients with psychoses found that those with substance abuse problems (36 percent) spent twice as many days in the hospital over the 2 years prior to treatment as clients without substance abuse problems (Crome 1999; Menezes et al. 1996). These clients often have poorer outcomes, such as higher rates of HIV infection, relapse, rehospitalization, depression, and suicide risk (Drake et al. 1998*b*; Office of the Surgeon General 1999).

Researchers also have clearly demonstrated that substance abuse treatment for clients with co-occurring mental illness and substance use disorders can be beneficial—even for clients with serious mental symptoms. For example, the National Treatment Improvement Evaluation Study (NTIES) found marked reductions in suicidality the year following substance abuse treatment compared to the year prior to treatment for both male and female clients and nonabused women. Suicide attempts declined about four fifths for both the 3,037 male clients and the 1,374 female clients studied (Karageorge 2001). Many clients in traditional substance abuse treatment settings who had mild to moderate mental disorders were found to do well with traditional substance abuse treatment methods (Hser et al. 2001; Hubbard et al. 1989; Joe et al. 1995; Simpson et al. 2002; Woody et al. 1991). However, modifications designed to address mental disorders may further enhance treatment effectiveness and can be essential for people with severe mental disorders. This TIP will discuss the modifications and approaches practitioners have found to be helpful. For examples, see the sections on suicide assessment and intervention in chapter 8 and appendix D.

Just as the field of treatment for substance use and mental disorders has evolved to become more precise, so too has the terminology used to describe people with both substance use and mental disorders. The term *co-occurring disorders* replaces the terms *dual disorder* or *dual diagnosis*. These latter terms, though used commonly to refer to the combination of substance use and mental disorders, are confusing in that they also refer to other combinations of disorders (such as mental disorders and mental retardation). Furthermore, the terms suggest that there are only two disorders occurring at the same time, when in fact there may be more. For purposes of this TIP, *co-occurring disorders* refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have co-occurring disorders have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders. A diagnosis of co-occurring disorders occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder. (See chapter 2 for more discussion of terminology used in this TIP.)

New models and strategies are receiving attention and encouraging treatment innovation (Anderson 1997; De Leon 1996; Miller 1994*a*; Minkoff 1989; National Advisory Council [NAC] 1997; Onken et al. 1997; Osher and Drake 1996). Reflecting the increased interest in issues surrounding effective treatment for this population, the American Society of Addiction Medicine (ASAM) added substantial new sections on clients with COD to an update of its patient placement criteria. These sections refine criteria both for placing clients with COD in treatment and for establishing and operating programs to provide services for such clients (ASAM 2001).

In another important development, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) began surveying its members about effective treatment of clients with COD in their States (Gustafson et al. 1999). In addition, NASADAD has joined with the National Association of State Mental Health Program Directors (NASMHPD) (NASMHPD-NASADAD 1999, 2000) and other collaborators in a series of national efforts designed to

- Foster improvement in treatment by emphasizing the importance of knowledge of both mental health and substance abuse treatment when working with clients for whom both issues are relevant.
- Provide a classification of treatment settings to facilitate systematic planning, consultations, collaborations, and integration.
- Reduce the stigma associated with both disorders and increase the acceptance of substance abuse and mental health concerns as a standard part of healthcare information gathering.

> Researchers have clearly demonstrated that substance abuse treatment of clients with co-occurring mental illness and substance use disorders can be beneficial.

These efforts are slowly changing the way that the public, policymakers, and substance abuse counselors view mental illness. Still, stigma attached to mental illness remains. One topic worth mentioning is the public perception that people with mental illness are dangerous and pose a risk of violence. However, studies have shown that the public's fear is greater than the actual risk, and that often, people with mental disorders are not particularly violent; it is when substance abuse is added that violence can ensue. For example, Steadman et al. (1998) found that substance abuse symptoms significantly raised

the rate of violence in both individuals with mental illness and those without mental illness. This research adds support to the importance of treating both mental illness and substance abuse.

In recent years, dissemination of knowledge has been widespread. Numerous books and hundreds of articles have been published, from counseling manuals and instruction (Evans and Sullivan 2001; Pepper and Massaro 1995) to database analysis of linkage among treatment systems and payors (Coffey et al. 2001). Several annual "dual diagnosis" conferences emerged. One of the most long-standing is the annual conference on The Person With Mental Illness and Substance Abuse, hosted by MCP Hahnemann University (now Drexel University), which began in 1988.

In spite of these developments, individuals with substance use and mental disorders commonly appear at facilities that are not prepared to treat them. They may be treated for one disorder without consideration of the other disorder, often "bouncing" from one type of treatment to another as symptoms of one disorder or another become predominant. Sometimes they simply "fall through the cracks" and do not receive needed treatment. This TIP captures the current state-of-the-art treatment strategies to assist counselors and treatment agencies in providing appropriate services to clients with COD.

Important Developments That Led to This TIP

Important developments in a number of areas pointed to the need for a revised TIP on co-occurring disorders. Among the factors that contributed to the need for this document are the availability of significant data on the prevalence of COD, the emergence of new treatment populations with COD (such as people who are homeless, people with HIV/AIDS, and persons in the criminal justice system), and changes in treatment delivery (including an increasing number of programs serving persons with COD). The following section provides a summary of data relevant to each of these key areas.

The Availability of Prevalence and Other Data

Prevalence and other data on COD have established the scope and impact of the problem, and the need for appropriate treatment and services. Four key findings are borne out by prevalence and other available data, each of which is important in understanding the challenges of providing effective treatment to this population.

(1) COD are common in the general adult population, though many individuals with COD go untreated.

National surveys suggest COD are common in the adult population. For example, the National Survey on Drug Use and Health (NSDUH) reports that in 2002, 4 million adults met the criteria for both serious mental illness (SMI) and substance dependence and abuse. NSDUH information is based on a sample of 67,500 American civilians aged 12 or older in noninstitutionalized settings (Office of Applied Studies [OAS] 2003*b*). The NSDUH defined SMI as having at some time during the past year a diagnosable mental, behavioral, or emotional disorder that met the criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV) (American Psychiatric Association 1994) and resulted in functional impairment that substantially interfered with or limited one or more major life activities. The NSDUH classification scheme was not diagnosis specific, but function specific. Results from the survey are highlighted below.

- SMI is highly correlated with substance dependence or abuse. Among adults with SMI in 2002, 23.2 percent were dependent on or abused alcohol or illicit drugs, while the rate among adults without SMI was only 8.2 percent. Among adults with substance depen-

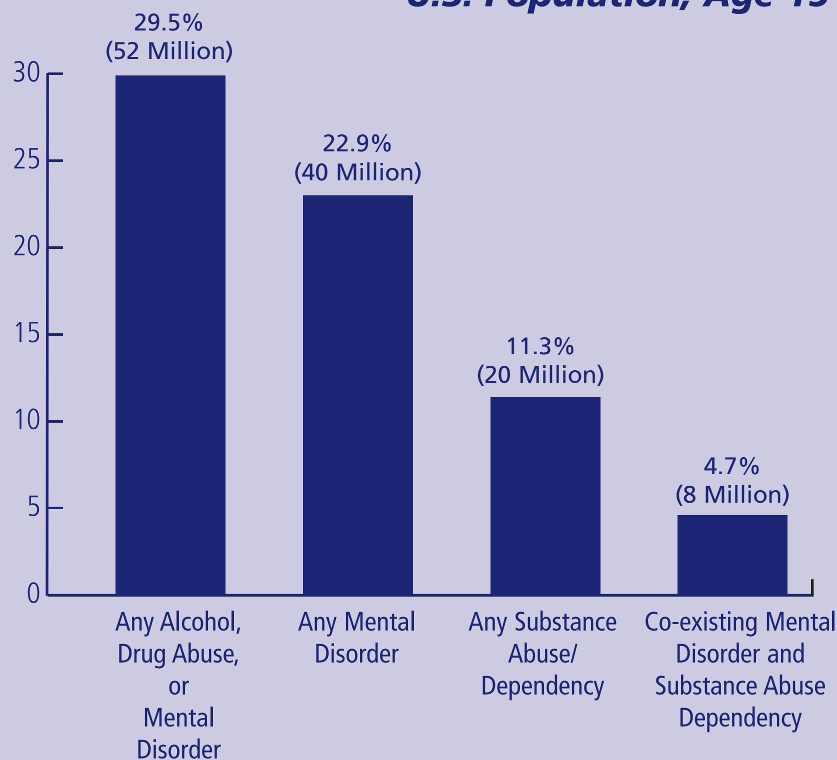
dence or abuse, 20.4 percent had SMI; the rate of SMI was 7 percent among adults who were not dependent on or abusing a substance.

- Among adults who used an illicit drug in the past year, 17.1 percent had SMI in that year, while the rate was 6.9 percent among adults who did not use an illicit drug. Conversely, among adults with SMI, 28.9 percent used an illicit drug in the past year while the rate was 12.7 percent among those without SMI (OAS 2003*b*).
- SMI was correlated with binge alcohol use (defined as drinking five or more drinks on the same occasion on at least one day in the past 30 days). Among adults with SMI, 28.8 percent were binge drinkers, while 23.9 percent of adults with no SMI were binge drinkers.

Earlier, the National Comorbidity Study (NCS) reported 1991 information on mental disorders and substance abuse or dependence in a sample of 8,098 American civilians aged 15 to 54 in noninstitutionalized settings. Figure 1-1 shows estimates from the NCS of the comparative number of any alcohol, drug abuse, or mental disorder (52 million), any mental disorder (40 million), any substance abuse/dependence disorder (20 million), and both mental disorder and substance abuse/dependence (8 million) in the past year.

In a series of articles derived from the NCS, Kessler and colleagues give a range of estimates related to both the lifetime and 12-month prevalence of COD (Kessler et al. 1994, 1996*a*, *b*, 1997). They estimate that 10 million Americans of all ages and in both institutional and noninstitutional settings have COD in any given year. Kessler et al.

Figure 1-1
Persons With Alcohol, Drug Abuse, or Mental Disorder in the Past Year (See Endnote[1])
U.S. Population, Age 15 to 54, 1991



Source: Kessler et al. 1994. Table 2 and unpublished data from the survey.

also estimate the lifetime prevalence of COD (not shown in Figure 1-1, which relates only the prevalence in the past 12 months) (1996*a*, p. 25) as follows: "…51 percent of those with a lifetime addictive disorder also had a lifetime mental disorder, compared to 38 percent in the ECA." (The ECA—Epidemiologic Catchment Area study—predated the NCS study; this National Institute of Mental Health study of 20,291 people was representative of the total U.S. community and institutional populations [Regier et al. 1990]).

Comparative figures for individuals with COD whose addictive disorders involve alcohol versus drugs are also available. Fifty-three percent of the respondents with lifetime *alcohol* abuse or dependence also had one or more lifetime mental disorders. For respondents with lifetime *illicit drug* abuse/dependence, 59 percent also had a lifetime mental disorder, and 71 percent of those with lifetime illicit drug abuse/ dependence had alcohol abuse or dependence over their lifetime (Office of the Inspector General 1995).

Research suggests that the likelihood of seeking treatment is strongly increased in the presence of at least one co-occurring condition.

A recent first report from the National Comorbidity Survey Replication, conducted between February 2001 and December 2002 (Kessler and Walters 2002), provides more precise information on rates of specific disorders. For example, rates of major depressive disorder were reported at 6.6 percent in the general population in the last year, or an estimated number between 13.1 and 14.2 million people (Kessler et al. 2003*b*). Additional data from a new and expanded NCS survey are now available (e.g., Breslau et al. 2004*a*, *b*; Kessler 2003; Kessler et al. 2003*a*).

Research suggests that the likelihood of seeking treatment is strongly increased in the presence of at least one co-occurring condition. The National Longitudinal Alcohol Epidemiologic Study (NLAES)—a nationwide household survey of 42,862 respondents aged 18 or older conducted by the National Institute on Alcohol Abuse and Alcoholism—reveals that a large increase in treatment for an alcohol disorder and a drug disorder occurs when there is a co-occurring "major depressive disorder" (Grant 1997). NCS data suggest that people with more than two disorders are more likely to receive treatment than those with "only" two. People with three or more diagnosable conditions were the most likely to be severely impaired and to require hospitalization (NAC 1997).

While people with co-occurring disorders are more likely to seek treatment, research consistently shows a gap between the number of people who are identified in a survey as having a disorder and the number of people receiving any type of treatment. Even of those with three or more disorders, a troubling 60 percent never received any treatment (Kessler et al. 1994; NAC 1997). Based on NLAES data, Grant (1997, p. 13) notes that one of the most interesting results of the survey is the "sheer number of respondents with alcohol and drug use disorders missing from the treated population. Only 9.9 percent and 8.8 percent of the respondents classified with past-year alcohol and drug use disorders, respectively, sought treatment."

(2) *Some evidence supports an increased prevalence of people with COD and of more programs for people with COD.*

NASADAD conducts voluntary surveys of State Alcohol and Drug Abuse Agencies and produces the State Alcohol and Drug Abuse Profile (SADAP) reports. In 1996, NASADAD asked the States to describe any special programs in their States for clients with COD

and to provide any available fiscal year (FY) 1995 statistics on the number of "dually diagnosed" clients treated (Gustafson et al. 1997). Forty-one States plus Palau, Puerto Rico, and the U.S. Virgin Islands responded. About 3 years later, 31 States responded to a request for detailed statistics on the number of persons admitted in FYs 1996 and 1997 to programs for treatment of COD (Gustafson et al. 1999). In general, examination of SADAP State profiles for information related to COD suggests about a 10 percent increase since the NASADAD survey in both the number of people with COD entering treatment and in the number of programs in many States over that 3-year period (Gustafson et al. 1999).

The 2002 National Survey of Substance Abuse Treatment Services (N-SSATS) indicated that about 49 percent of 13,720 facilities nationwide reporting substance abuse services offered programs or groups for those with COD (OAS 2003*a*). However, only 38 percent of the 8,292 responding facilities that focused primarily on substance abuse offered such COD programming. Sixty-three percent of the 1,126 responding mental health services that offered substance abuse services offered COD programs or groups. About 70 percent of the 3,440 facilities that have a mix of mental health and substance abuse treatment services offer COD programs or groups.

Still it must be kept in mind that of all the approximately 1.36 million clients in treatment for substance use disorders in 2002, about 68 percent were treated in facilities whose primary focus was substance abuse services and 23 percent were treated in facilities whose focus was a mix of both mental health and substance abuse services. Only 4 percent of these individuals were in facilities whose primary focus was the provision of mental health services.

(3) Rates of mental disorders increase as the number of substance use disorders increases, further complicating treatment.

In their analysis of data from a series of studies supported by the National Institute on Drug Abuse, the Drug Abuse Treatment Outcome Study (DATOS), Flynn et al. (1996) demonstrate that the likelihood of mental disorders rises with the increasing number of substance dependencies. Participating clients were assessed according to DSM-III-R criteria (*Diagnostic and Statistical Manual for Mental Disorders,* 3d edition revised) for lifetime antisocial personality, major depression, generalized anxiety disorder, and/or any combination of these disorders.

DATOS was a national study of clients entering more than 90 substance abuse treatment programs in 11 metropolitan areas, mainly during 1992 (Flynn et al. 1997). Of the initial intake sample of 10,010 clients, 7,402 completed an intake and a clinical assessment interview and met DSM-III-R criteria for dependence on alcohol, cocaine, and/or heroin. Figure 1-2 (p. 8) shows a general trend of increase in the rates of DSM-III-R lifetime antisocial personality disorder, major depression, and generalized anxiety disorder as the number of substance dependencies involving alcohol, heroin, and cocaine increases (except for the relationship between alcohol dependence only and major depression and generalized anxiety). Since the use of multiple drugs is common in those with substance use disorders, treatment is further complicated for these people by the greater incidence of mental disorders that accompanies multiple drug use.

(4) Compared to people with mental or substance use disorders alone, people with COD are more likely to be hospitalized. Some evidence suggests that the rate of hospitalization for people with COD is increasing.

According to Coffey and colleagues, the rate of hospitalization for clients with both a mental and a substance use disorder was more than 20 times the rate for substance-abuse–only clients and five times the rate for mental-

Figure 1-2

Rates of Antisocial Personality, Depression, and Anxiety Disorder by Drug Dependency (%). Taken From the Drug Abuse Treatment Outcome Study (DATOS)

Drug dependency	Antisocial personality	Major depression	Generalized anxiety
Alcohol only	34.7	17.8	5.5
Heroin only	27	7	2
Heroin and alcohol	46.3	13.2	3.2
Cocaine only	30.4	8.4	2.7
Cocaine and alcohol	47	13.6	4.7
Cocaine and heroin	44	10.8	2.2
Cocaine, heroin, and alcohol	59.8	17.1	6.3
Overall	39.3	11.7	3.7

Source: Flynn et al. 1996; data are from the NIDA-supported DATOS study.

disorder–only clients (Coffey et al. 2001). This estimate is based on an analysis of the CSAT/Center for Mental Health Services (CMHS) Integrated Data Base Project, in which a team studied information from the mental health, substance abuse, and Medicaid agencies in Delaware, Oklahoma, and Washington. Using a broad coding for health policy research to study discharges between 1990–1995 from community hospitals nationwide, Duffy (2004, p. 45) estimated that clients classified as having both a substance-related disorder and a mental disorder significantly "…increased from 9.4 to 17.22 per 10,000 population …" with the 35–45 year age group increasing the most among the 7 age groups studied from childhood to 65 or older.

Treatment Innovation for Other Populations With COD

Further treatment innovation has been required to meet the needs and associated problems of other treatment populations with high rates of COD such as people who are homeless, those in the criminal justice system, persons living with HIV/AIDS and other infectious diseases (e.g., hepatitis), and those with trauma and posttraumatic stress disorder (PTSD).

Homeless populations

Data on the increasing rates of co-occurring mental and sub stance use disorders in homeless populations are now available (North et al. 2004). North and colleagues estimate that rates of co-occurring Axis I and substance use disorders among females who are homeless increased from 14.3 percent in 1990 to 36.7

percent in 2000 and that rates among men who are homeless increased from 23.2 percent in 1990 to 32.2 percent in 2000.

North and colleagues also compared data collected in their 2000 study with estimates from ECA data collected in the early 1980s. They found that alcohol and drug use for both males and females rose considerably over the 2 decades. In 2000, 84 percent of the men who were homeless and 58 percent of the women who were homeless had a substance use disorder (North et al. 2004). The article reports an increase in bipolar disorder from 1990 to 2000 and an increase in major depression from 1980 to 2000. (Major depression accounted for the majority of all Axis I non-substance disorders.) The authors also noted that non-Axis I antisocial personality disorder (APD) appeared to change little from 1980 to 2000, with 10 to 20 percent of women who were homeless and 20 to 25 percent of men who were homeless receiving APD diagnoses in both time periods (North et al. 2004).

The increased prevalence of COD among people who are homeless and the need to provide services to this growing population has led to treatment innovations and research on service delivery. One of the main challenges is how to engage this group in treatment. CMHS's Access to Community Care and Effective Services and Supports initiative, which supported programs in nine States over a 5-year period, indicated the effectiveness of integrated systems, including the value of street outreach (Lam and Rosenheck 1999; Rosenheck et al. 1998). Both systems integration and comprehensive services, such as Assertive Community Treatment (ACT) and Intensive Case Management (ICM), were seen as essential and effective (Integrating Systems of Care 1999; Winarski and Dubus 1994). (See chapter 6 for a discussion of these approaches.)

Offenders

The Bureau of Justice Statistics estimates that "at midyear 1998, an estimated 283,800 mentally ill offenders were incarcerated in the Nation's prisons and jails" (Ditton 1999, p. 1). Surveys by the Bureau found that "16 percent of State prison inmates, 7 percent of Federal inmates, and 16 percent of those in local jails reported either a mental condition or an overnight stay in a mental hospital" (Ditton 1999). In addition, an estimated 547,800 probationers—16 percent—said they had had a mental condition or stayed overnight in a mental hospital at some point in their lifetime (Ditton 1999).

The Office of National Drug Control Policy (ONDCP) emphasized that "the fastest and most cost-effective way to reduce the demand for illicit drugs is to treat chronic, hard core drug users" (ONDCP 1995, p. 53). These "hard core users" are in need of COD services. The NTIES study reported that, when given the choice to rate their desire for certain services as "not important," "somewhat important," or "very important," 37 percent of a population that was predominantly criminal-justice–involved rated mental health services as "very important" (Karageorge 2000).

The substance abuse treatment and mental health services communities have been called on to provide, or assist in providing, treatment to these individuals. This requires the integration of substance abuse treatment and mental health services and the combination of these approaches with those that address criminal thinking and behavior, while attending to both public health and public safety concerns.

HIV/AIDS and infectious diseases

The association between psychological dysfunction and a tendency to engage in high-risk behaviors (Joe et al. 1991; Simpson et al. 1993) suggests that it is important to integrate HIV/AIDS prevention and treatment with

substance abuse treatment and mental health services for the COD population. Advances in the treatment of HIV/AIDS (such as antiretroviral combination therapy, including protease inhibitors) and the improved outcomes resulting from such therapies potentially will extend the survival of those with HIV/AIDS and co-occurring disorders. This will extend their requirement for continued mental health and substance abuse services. For persons with COD who also have HIV/AIDS or other infectious diseases (e.g., hepatitis C), primary medical care should be integrated with COD treatment. To be successful, this treatment should include an emphasis on treatment adherence (see chapter 7 for one such model).

Trauma and PTSD

Many persons with substance use disorders have experienced trauma, often as a result of abuse. A significant number of them have the recognized mental disorder known as PTSD. Recent studies have demonstrated strong connections between trauma and addictions, including the possibility that childhood abuse plays a part in the development of substance use disorders (Anderson et al. 2002; Brady et al. 2000; Chilcoat and Breslau 1998*b*; Jacobsen et al. 2001). Although substance abuse treatment clinicians have counseled these clients for years, new treatment strategies for PTSD and trauma have expanded treatment options (see chapter 8 and appendix D). The forthcoming TIP *Substance Abuse Treatment and Trauma* will explore these issues in depth (CSAT in development *d*).

Changes in Treatment Delivery

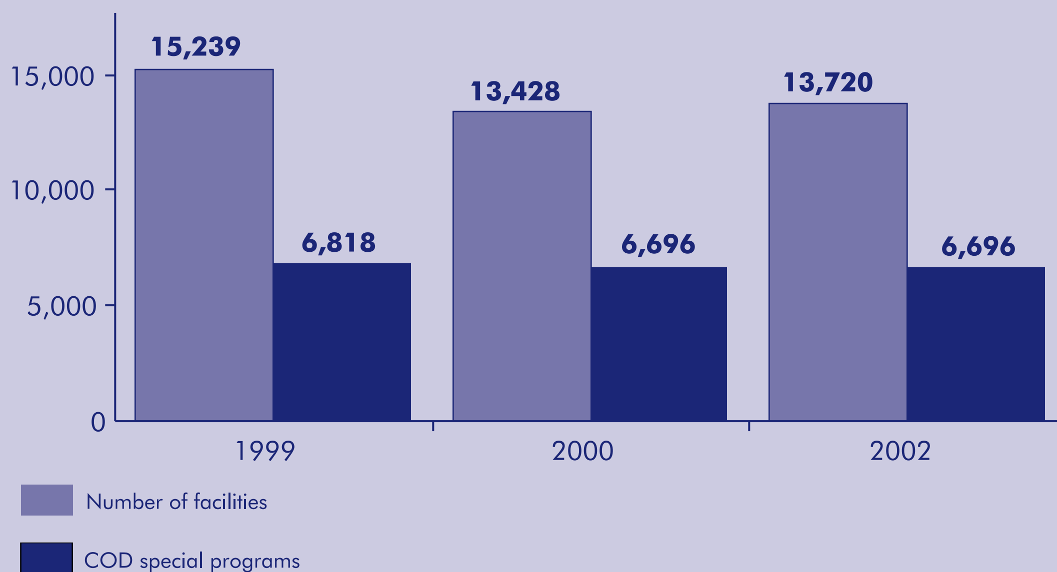
The substance abuse treatment field has recognized the importance of COD programming. In 1995, only 37 percent of the substance use disorder treatment programs reporting data to the Substance Abuse and Mental Health Services Administration (SAMHSA) offered COD programming. By 1997, this percentage had increased to almost half (data not shown).

According to 2002 N-SSATS data, the number of programs for COD peaked in 1999, followed by a slight decline in 2000 that remained constant in 2002. This tracked the number of substance use disorder treatment providers, which also peaked in 1999. In 1999, there were 15,239 substance abuse treatment programs reporting to SAMHSA; in 2000, there were 13,428; in 2002, there were 13,720 (OAS 2003*a*). Figure 1-3 shows that the number of programs for people with COD decreased slightly from 1999 to 2000, from 6,818 to 6,696, but remained constant in 2002 at 6,696 (OAS 2003*a*). However, the ratio between the total number of substance abuse treatment programs and those offering COD programming has been relatively stable since 1997, increasing slightly from 44.7 percent in 1999 to 49.9 percent in 2000, and then remaining roughly constant at 48.8 percent in 2002.

An important consideration for the public mental health and substance abuse delivery systems is the recognition that not all people with emotional problems are candidates for care within the public mental health system. Because many States prioritize the funding of mental health slots by providing access to those who meet the criteria for the most severe and persistent mental illnesses, it is important for treatment providers to recognize the criteria that their State jurisdiction uses to provide care. For example, a treatment program may be aware that a person has psychological symptoms signifying stress, a diagnosable mental disorder, a serious mental disorder, a severe and persistent mental disorder, or, finally, a severe and persistent mental disorder with disability. From the point of view of the behavioral healthcare delivery system, these distinctions are important. In a State that restricts the use of its Federal community mental health services dollars to those with severe and persistent mental illness, a person not meeting the criteria for that condition may not be eligible for mental health services.

Figure 1-3

Substance Abuse Treatment Facilities Offering Special Programs for Clients With COD: 1999–2002[1]



[1]Survey reference dates were October 1 for 1999 and 2000 and March 29, 2002. See appendix C of source for changes in the survey base, methods, and instruments that affect analysis of trends over time.

Source: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, UFDS Survey, 1996–1999; National Survey of Substance Abuse Treatment Services (N-SSATS), 2000 and 2002. http://wwwdasis.samhsa.gov/dasis2/nssats/nssats_2002_q.pdf

If a client/consumer has a primary substance abuse problem and a "non-eligible" mental disorder—that is, a disorder that cannot by regulation or law be treated in a public mental health program—then all providers should be aware of this. The difference between ideal care and available care is critical to the utility of this TIP. Furthermore, during periods of financial difficulty, the prospect of additional resources being created to address complex problems is not likely. Thus, an integrated care framework is preferred in this TIP. An integrated framework recognizes that quality evidence-based individualized care can be provided within a behavioral health delivery system using existing resources and partnerships.

Advances in Treatment

Advances in the treatment of COD, such as improved assessments, psychological interventions, psychiatric medications, and new models and methods, have greatly increased available options for the counselor and the client.

"No wrong door" policy

The publication of *Changing the Conversation* (CSAT 2000*a*) signaled several fundamental advances in the field. Of particular importance is the principle of "no wrong door." This principle has served to alert treatment providers that the healthcare delivery system, and each provider within it, has a responsibility to address the range of client

needs wherever and whenever a client presents for care. When clients appear at a facility that is not qualified to provide some type of needed service, those clients should carefully be guided to appropriate, cooperating facilities, with followup by staff to ensure that clients receive proper care. The evolution of the *Changing the Conversation* paradigm signals a recognition that recovery is applicable to all people in need of substance abuse services: to the client with psychiatric problems in the substance abuse treatment delivery system, the client with substance abuse problems in the traditional mental health services delivery system, or the client with co-occurring behavior problems in a traditional physical health delivery system. Every "door" in the healthcare delivery system should be the "right" door.

Treatment approaches are emerging with demonstrated effectiveness in achieving positive outcomes for clients with COD.

Mutual self-help for people with COD

Based on the Alcoholics Anonymous model, the mutual self-help movement has grown to encompass a wide variety of addictions. Narcotics Anonymous and Cocaine Anonymous are two of the largest mutual self-help organizations for chemical addiction; Recoveries Anonymous and Schizophrenics Anonymous are the best known for mental illness. Though these typically are referred to as "self-help" groups, this TIP adopts the term "mutual self-help" because it is more descriptive of the way most participants see these groups—as a means of both helping themselves and supporting each other in achieving specific personal goals.

Mutual self-help programs, which include but are not limited to 12-Step groups, apply a broad spectrum of personal responsibility and peer support principles, usually including 12-Step methods that prescribe a planned regimen of change. In recent years, mutual self-help groups that have been adapted to clients with COD have become increasingly available. A more extensive discussion of these dual recovery mutual self-help programs can be found in chapter 7.

Integrated care as a priority for people with severe and persistent mental illness

For those with severe and persistent mental illness, integrated treatment, as originally articulated by Minkoff (1989), emphasized the correspondence between the treatment models for mental illness and addiction in a residential setting. The model stressed a parallel view of recovery, concomitant treatment of mental illness and substance abuse, application of treatment stages, and the use of strategies from both the mental health and substance abuse treatment fields. During the last decade, integrated treatment has continued to evolve, and several models have been described (Drake and Mueser 1996*b*; Lehman and Dixon 1995; Minkoff and Drake 1991; Solomon et al. 1993).

For the purposes of this TIP, *integrated treatment* refers more broadly to any mechanism by which treatment interventions for COD are combined within the context of a primary treatment relationship or service setting. Integrated treatment is a means of coordinating substance abuse and mental health interventions to treat the whole person more effectively. In a review of mental health center-based research for clients with serious and persistent mental illness, Drake and colleagues (1998*b*) concluded that comprehensive, integrated treatment, "especially when delivered for 18 months or longer, resulted in significant reductions of substance abuse and, in some cases, in substantial rates of remission, as well as reductions in hospital use and/or improvements in other outcomes" (p.

601). Several studies based in substance abuse treatment centers addressing a range of COD have demonstrated better treatment retention and outcome when mental health services were integrated onsite (Charney et al. 2001; McLellan et al. 1993; Saxon and Calsyn 1995; Weisner et al. 2001).

An integrated care framework supports the provision of some assessment and treatment wherever the client enters the treatment system, ensures that arrangements to facilitate consultations are in place to respond to client issues for which a provider does not have inhouse expertise, and encourages all counselors and programs to develop increased competency in treating individuals with COD. Several States have received Community Action Grants from SAMHSA to develop comprehensive continuous integrated systems of care. It is especially important that appropriate substance abuse and mental health services for clients with COD be designed specifically for the substance abuse treatment system—a system that addresses a wide range of COD, not mainly those with severe and persistent mental illness. This subject is explored in chapter 3, and some approaches to integrated treatment in substance abuse treatment settings are examined in chapter 3 and chapter 6.

Development of effective approaches, models, and strategies

Treatment approaches are emerging with demonstrated effectiveness in achieving positive outcomes for clients with COD. These include a variety of promising treatment approaches that provide comprehensive integrated treatment. Successful strategies with important implications for clients with COD also include interventions based on addiction work in contingency management, cognitive–behavioral therapy, relapse prevention, and motivational interviewing. These strategies are discussed in chapter 5. In fact, it is now possible to identify "guiding principles" and "fundamental elements" for COD treatment in COD settings that are common to a variety of approaches. These are discussed at length in chapter 3 and chapter 6, respectively. Specific program models that have proven effective for the COD population with serious mental illness include ACT and the Modified Therapeutic Community. ICM also has proven useful in treating clients with COD. See chapter 6 for a discussion of these models.

Pharmacological advances

Pharmacological advances over the past decade have produced antipsychotic, antidepressant, anticonvulsant, and other medications with greater effectiveness and fewer side effects (see appendix F for a listing of medications). With the support available from better medication regimens, many people who once would have been too unstable for substance abuse treatment, or institutionalized with a poor prognosis, have been able to lead more functional lives. To meet the needs of this population, the substance abuse treatment counselor needs both greater understanding of the signs and symptoms of mental illness and greater capacity for consultation with trained mental healthcare providers. As substance abuse treatment counselors learn more about mental illness, they are better able to partner with mental health counselors to design effective treatment for both types of disorders. Such partnerships benefit mental health agencies as well, helping them enhance their ability to treat clients with substance abuse issues.

Increasingly, substance abuse treatment counselors and programs have come to appreciate the importance of providing medication to control symptoms as an essential part of treatment. The counselor has an important role in describing client behavior and symptoms to ensure that proper medication is prescribed when needed. The peer community also is a powerful tool that can be employed to support and monitor medication adherence. Support from mutual self-help groups can include learning about the effects of med-

ication and learning to accept medication as part of recovery. Monitoring involves clients learning from and reflecting on their own and others' reactions, thoughts, and feelings about the ways medications affect them, both positively as symptoms are alleviated, and negatively as unwanted side effects may occur.

Some Recent Developments

Since the consensus panel for this TIP was convened, there have been several important developments in the field of co-occurring disorders. Following is a description of the most recent developments in the field.

National Registry of Effective Programs and Practices

To help its practice and policymaking constituents learn more about evidence-based programs, SAMHSA's Center for Substance Abuse Prevention created the National Registry of Effective Programs and Practices (NREPP), a resource to review and identify effective programs derived primarily from existing scientific literature, effective programs assessed by other rating processes, SAMHSA, and solicitations to the field. When co-occurring disorder treatment programs are submitted for NREPP consideration, teams of scientists review the programs based on four criteria: (1) co-occurring disorders programs, (2) psychopharmacological programs, (3) workplace programs, and (4) general substance abuse prevention and treatment programs. Evaluation is based on methodological quality (a program's overall rigor and substantive contribution) and appropriateness (dissemination capability, cultural sensitivity, and consumer involvement to inform a total rating that describes a program's readiness for adoption and replication). Programs that demonstrate a commitment to complete assessment and comprehensive services receive priority. For programs that target persons with serious mental disorders, priority is given to approaches that integrate substance abuse treatment and mental health services. Targeted techniques and strategies are also eligible for NREPP review. For more detailed information about NREPP, see http://nrepp.samhsa.gov/.

Co-Occurring Disorders State Incentive Grants

The Co-Occurring Disorders State Incentive Grants (COSIG) (funded through SAMHSA's CSAT and CMHS) provide funding to the States to develop or enhance their infrastructure to increase their capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with COD. COSIG uses the definition of co-occurring disorders from this TIP (see the beginning of this chapter). It supports infrastructure development and services across the continuum of COD, from least severe to most severe, but the emphasis is on people with less severe mental disorders and more severe substance use disorders, and on people with more severe mental disorders and less severe substance use disorders (i.e., quadrants II and III—see chapter 2 for a description of the four quadrants). COSIG is appropriate for States at any level of infrastructure development. COSIG also provides an opportunity to evaluate the feasibility, validity, and reliability of the proposed co-occurring performance measures for the future Performance Partnership Grants. Some States and communities throughout the country already have initiated system-level changes and developed innovative programs that overcome barriers to providing services for individuals of all ages who have COD. The COSIG program reflects the experience of States to date. For more information, see http://www.samhsa.gov.

Co-Occurring Center for Excellence

As a result of the pressing need to disseminate and support the adoption of evidence- and consensus-based practices in the field of

COD, SAMHSA established the Co-Occurring Center for Excellence (COCE) in 2003. COCE provides SAMHSA and the field with key resources needed to disseminate knowledge and increase adoption of evidence-based practices in the systems and programs that serve people with COD. The COCE mission is to

- *Transmit* advances in substance abuse and mental health treatment that address all levels of mental disorder severity and that can be adapted to the unique needs of each client.
- *Guide* enhancements in the infrastructure and clinical capacities of the substance abuse and mental health service systems.
- *Foster* the infusion and adoption of evidence-based treatment and program innovation into clinical practice.

To guide its work, COCE has developed a framework that locates the key topics in COD along three dimensions: services and service systems, infrastructure, and special populations. Services and service systems include providers and the services they offer; the nature and structure of the organizations and systems in which services are delivered; and the interrelationships among various providers, organizations, and systems. Infrastructure includes the wide variety of national, State, and local policies, programs, and resources that support, facilitate, catalyze, and otherwise contribute to the work of service providers and service systems. Special populations identifies groups who may require special services, settings, or accommodations to reap the full benefit of COD-related services. At this time, the core products and services of the COCE are envisioned as technical assistance and training, a Web site (http://www.samhsa.gov/co-occurring), meetings and conferences, and future COCE products and services.

Report to Congress on the Prevention and Treatment of Co-Occurring Substance Use Disorders and Mental Disorders

In response to a Congressional mandate, in December 2002 the Department of Health and Human Services provided Congress with a comprehensive report on treatment and prevention of co-occurring substance abuse and mental disorders. The report emphasizes that people with co-occurring disorders can and do recover with appropriate treatment and support services. It also finds there are many longstanding systemic barriers to appropriate treatment and support services for people with co-occurring disorders, including separate administrative structures, eligibility criteria, and funding streams, as well as limited resources for both mental health services and substance abuse treatment. The report identifies the need for various Federal and State agencies, providers, researchers, recovering persons, families, and others to work together to create a system in which both disorders are addressed as primary and treated as such. It also outlines a 5-year blueprint for action to improve the opportunity for recovery by increasing the availability of quality prevention, diagnosis, and treatment services for people with co-occurring disorders. To access the full report, see http://www.samhsa.gov/reports/congress2002/index.html.

As substance abuse treatment counselors learn more about mental illness, they can better partner with mental health counselors to design effective treatment for both disorders.

Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit

Known simply as the "tool kit," and developed by the Psychiatric Research Center at New Hampshire-Dartmouth under the leadership of Robert E. Drake, M.D., Ph.D., this resource package specifically targets clients with COD who have SMI and who are seeking care through mental health services available in their community. The six evidence-based practices described in the tool kit are collaborative psychopharmacology, ACT, family psychoeducation, supported employment, illness management and recovery, and integrated dual disorders treatment (substance use and mental illness). Using materials germane to a variety of audiences (i.e., consumers, family members/caregivers, mental health program leaders, public mental health authorities, and practitioners/clinical supervisors), the tool kit articulates a flexible basic plan that allows materials to be used to implement best practices to their maximum effect. The tool kit is being produced under a contract with SAMHSA's CMHS and through a grant from The Robert Wood Johnson Foundation (CMHS in development).

The TIP is structured to meet the needs of the addiction counselor with a basic background as well as the differing needs of those with intermediate and advanced backgrounds.

Organization of This TIP

Scope

The TIP attempts to summarize for the clinician the state-of-the-art in the treatment of COD in the substance abuse and mental health fields. It contains chapters on terminology, assessment, and treatment strategies and models, as well as recommendations for treatment, research, and policy planning.

The primary concern of this TIP is co-occurring substance use (abuse and dependence) and mental disorders, even though it is recognized that this same vulnerable population also is subject to many other physical and social ills. The TIP includes important work on nicotine dependence, a somewhat large and separate body of work that admittedly does need further integration into the general field of COD. Nicotine dependency is treated here as an important cross-cutting issue. Finally, although the TIP does address several specific populations (i.e., homeless, criminal justice, and women), it does this briefly and does not describe programs specifically for adolescents or for such specialized populations as new Asian and Hispanic/Latino immigrants. At the same time, the authors fully recognize, and the TIP states, that all COD treatment must be culturally relevant.

Audience

The primary audience for this TIP is substance abuse treatment clinicians and counselors, many, but not all, of whom possess certification in substance abuse counseling or related professional licensing. Some may have credentials in the treatment of mental disorders or in criminal justice services. The TIP is structured to meet the needs of the addiction counselor with a basic background as well as the differing needs of those with intermediate and advanced backgrounds. Another equally important audience for the TIP is mental health staff. Secondary audiences include educators, researchers, primary care providers, criminal

justice staff, and other healthcare and social service personnel who work with people with COD.

Approach

The TIP uses three criteria for inclusion of a particular strategy, technique, or model: (1) definitive research (i.e., evidence-based treatments), (2) well-articulated approaches with empirical support, and (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 is a document that reflects the current state of clinical wisdom in the treatment of clients with COD.

The TIP keeps two questions in the forefront:

1. What does the clinician need to know?
2. How can the information be conveyed in a manner that makes it readily accessible?

Guidance for the Reader

This TIP is both a resource document and a guide on COD that contains both up-to-date knowledge and instructive material. It includes selected literature reviews, synopses of many COD treatment approaches, and some empirical information. The scope of the work in this field generated a complex and extensive document 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"—provides the TIP's most direct and accessible guidance for the counselor. Readers with basic backgrounds, such as addiction counselors or other practitioners, can study the Advice to the Counselor boxes first for the most immediate practical guidance. In particular, the Advice to the Counselor boxes provide a distillation of what the counselor needs to know and what steps to take, which can be followed by a more detailed reading of the relevant material in the section or chapter.

The chair and co-chair of the TIP consensus panel plan to continue working with providers and treatment agencies, and encouraging others to do likewise, to translate the concepts and methods of the TIP into other useable tools specifically shaped to the needs and resources of each agency and situation. It is the hope of the consensus panel that the reader will come away with increased knowledge, encouragement, and resources for the important work of treating persons with COD.

Organization

The TIP is organized into 9 chapters and 14 appendices. Subject areas addressed in each of the remaining chapters and appendices are as follows:

Chapter 2. Definitions, terms, and classification systems for co-occurring disorders

This chapter reviews terminology and classifications related to substance use, clients, treatment, programs, and systems for clients with COD. Key terms used in the TIP and in the field are defined to help the reader understand the framework and language used in this TIP and how this language relates to other terminology and classifications that are familiar to the reader. The main classification systems currently in use in the field are presented.

Chapter 3. Keys to successful programming

The chapter begins with a review of some guiding principles in treatment of clients with COD, and key challenges to establishing services in substance abuse treatment settings are highlighted. This section also presents a system for

classifying substance abuse treatment programs to determine an appropriate level of services and care. The chapter describes some service delivery issues including access, assessment, integrated treatment, comprehensive services, and continuity of care. Finally, critical issues in workforce development are discussed, including values, competencies, education, and training.

Chapter 4. Assessment

This chapter reviews the key principles of assessment, selected assessment instruments, and the assessment process. The chapter also addresses the specific relationship of assessment to treatment planning.

Chapter 5. Strategies for working with clients with co-occurring disorders

This chapter presents guidelines for developing a successful therapeutic relationship with individuals who have COD. It describes specific techniques for counselors that appear to be the most successful in treating clients with COD and introduces guidelines that are important for the successful use of all these strategies.

Chapter 6. Traditional settings and models

The chapter begins by addressing essential programming for clients with COD that can readily be offered in most substance abuse treatment settings. Overarching considerations in effective treatment for this population, regardless of setting, are reviewed. Practices are highlighted that have proven effective for the treatment of persons with COD in outpatient and residential settings. The chapter also highlights several distinctive models.

Chapter 7. Special settings and specific populations

This chapter addresses issues related to providing treatment to clients with COD in acute care and other medical settings, as well as the need to sustain these programs. Because of the critical role mutual self-help groups play in recovery, several dual recovery mutual self-help groups that address the specific concerns of clients with COD are described. Resources available through advocacy groups are highlighted. Finally, the chapter discusses the need to address the particular needs of people with COD within three key populations: homeless persons, criminal justice populations, and women.

Chapter 8. A brief overview of specific mental disorders and cross-cutting issues

With the permission of American Psychiatric Publishing, Inc. (APPI), the consensus panel has taken the opportunity to present to the substance abuse treatment audience basic information contained in the *Diagnostic and Statistical Manual for Mental Disorders, 4th edition, Text Revised* (DSM-IV-TR). The chapter updates material that was presented on the major disorders covered in TIP 9 (i.e., personality disorders, mood disorders, anxiety disorders, and psychotic disorders) and adds other mental disorders with particular relevance to COD that were not covered in TIP 9 (i.e., attention deficit/hyperactivity disorder, PTSD, eating disorders, and pathological gambling). Suicidality and nicotine dependency are presented as cross-cutting issues. The consensus panel is pleased that APPI has allowed this liberal use of its materials to help foster the co-occurring disorders field and positive interchange between the substance abuse treatment and mental health services fields.

The chapter contains key information about substance abuse and the particular mental disorder, highlighting advice to the counselor to help in working with clients with those disorders. A relevant case history accompanies each disorder in this chapter. This chapter is meant to function as a "quick reference" to help the substance abuse treatment counselor understand the mental disorder diagnosis and

its implications for treatment planning. Appendix D contains a more extensive discussion of the same disorders.

Chapter 9. Substance-induced disorders

This chapter provides information on mental disorder symptoms caused by the use of substances. It outlines the toxic effect of substances and provides an overview of substance-induced symptoms that can mimic mental disorders.

Appendices

Appendix A. Bibliography

Appendix A contains the references cited in this TIP and other resources used for background purposes but not specifically cited.

Appendix B. Acronyms

Appendix B contains a key to all the acronyms used in this TIP.

Appendix C. Glossary of terms

This appendix contains the definitions of terms used in this TIP, with the exception of terminology related to specific mental disorders discussed in chapter 8 and appendix D. For these specialized terms, the reader is advised to consult a medical dictionary.

Appendix D. Specific mental disorders: Additional guidance for the counselor

Clients with COD entering treatment often have several disorders, each of which is associated with a growing body of knowledge and range of treatment options. This appendix is meant to serve substance abuse treatment counselors and programs as a resource and training document that provides more extensive information on individual mental disorders than could be included in chapter 8. Although most readers will not read the entire appendix at one time, this mental disorder-oriented section is included so that a counselor who is working with a new client with one or more of these disorders can have detailed information readily available.

Appendix E. Emerging models

In this appendix, the reader can find descriptions of several recent models of care for persons with COD that were (or are being) evaluated under initiatives funded by SAMHSA's CSAT. Though selective and based primarily on available information from recent SAMHSA initiatives, it is hoped that these models will suggest ways in which readers working with a variety of client types and symptom severities in different settings can improve their capacities to assess and treat these clients.

Appendix F. Common medications for disorders

Because medication is such an important adjunct to treatment, this appendix offers a brief review of key issues in pharmacologic management. A table of common medications for various disorders follows this discussion, with comments on the effects of these medications and their implications for addiction counselors and treatment. This material is taken from the Pharmacological Management section of TIP 9 (CSAT 1994*a*, pp. 91–94), followed by the complete text of *Psychotherapeutic Medications 2004: What Every Counselor Should Know* (Mid-America Addiction Technology Transfer Center 2004).

Appendix G. Screening and assessment instruments

A list of selected screening and assessment tools referenced in chapter 4, along with key information on the use of each instrument, appears in this appendix. As a full review of these instruments was beyond the scope of this TIP, readers are urged to review the literature to determine their reliability, validity, and utility, and to gain an understanding of their applicability to specific situations.

Appendix H. Sample screening instruments

This appendix offers two screening instruments available for unrestricted use:

- The Mental Health Screening Form-III
- The Simple Screening Instrument for Substance Abuse

Appendix I. Selected resources of training

Here the reader finds some of the most readily available and well-used sources of training in substance abuse treatment, mental health services, and co-occurring disorders.

Appendix J. Dual recovery mutual self-help programs and other resources for consumers and providers

This appendix provides a brief description and contact information for several mutual self-help groups discussed in the TIP.

Appendix K. Confidentiality

This appendix provides a brief description of the Federal Alcohol and Drug Confidentiality Law and Regulations (42 C.F.R. Part 2) and the Health Insurance Portability and Accountability Act of 1996.

[1]"These estimates are from the National Comorbidity Survey. The survey was based on interviews administered to a probability sample of the noninstitutionalized U.S. civilian population. The NCS sample consisted of 8,098 respondents, age 15 to 54 years. This survey was conducted from September 1990 to February 1992. DSM-III-R criteria were used as the basis for assessing disorders in the general population. A random sample of initial nonrespondents was contacted further and received a financial incentive to participate. A nonresponse weight was used to adjust for the higher rates of [alcohol, drugs, or mental (ADM) disorders] found in the sample of initial nonresponders. The Composite International Diagnostic Interview was modified to eliminate rare diagnoses in the age group studied and to add probes to improve understanding and motivation. The 'substance abuse/dependence' category includes drugs and alcohol. 'Any ADM disorder' includes the following: affective, anxiety, substance abuse/dependence, nonaffective psychosis, and antisocial personality disorders. 'Affective disorders' include major depressive episode, manic episode, and dysthymia. Anxiety disorders include panic disorder, agoraphobia, social phobia, simple phobia, and generalized anxiety disorder. Antisocial personality was assessed only on a lifetime basis. Nonaffective psychoses include schizophrenias, delusional disorder, and atypical psychoses. Substance abuse/dependence includes both abuse of and dependence on alcohol and other drugs" (SAMHSA 1998, p. 7).