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Presents

SUBSTANCE USE DISORDER TREATMENT FOR PEOPLE WITH CO-OCCURRING DISORDERS, MODULE 4

(REVISED 2025)

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Substance Use Disorder Treatment for People With Co-Occurring Disorders, Module 4

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This distance learning course package was developed for CEU Matrix John Tinsley, PhD. It is based on information found in SAMHSA Publication PEP20-02-01-004.

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Dr. John H. Tinsley is a former assistant professor of Medical Physiology at the Texas A&M University System College of Medicine. He received his Ph.D. from Texas A&M University, College Station, Texas; M.S. from the University of North Carolina; and his B.S. from the University of Oklahoma.

He has been teaching, training, consulting and conducting research in the fields of Medical Physiology and Behavioral Biology for over twenty-nine years. Dr. Tinsley has authored over twenty-five professional and refereed articles, including invited reviews. He has been a member of the American Society for Physiology, and work done in 2001 led to an international award from The European Society on Microcirculation. Dr. Tinsley has received research funding from the Veteran's Administration, American Heart Association, and Scott and White Hospital. In addition, he has served on numerous review committees for national grant-funding agencies and scientific journals.

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The CEUMatrix – The Institute for Addiction and Criminal Justice Studies homepage (www.ceumatrix.com) contains many pieces of information and valuable links to a variety of programs, news and research findings, and information about credentialing – both local and national. We update our site on a regular basis to keep you apprised of any changes or developments in the field of addiction counseling and credentialing. Be sure to visit our site regularly, and we do recommend that you bookmark the site for fast and easy return.

Substance Use Disorder Treatment for People with Co-Occurring Disorders, Module 4

In Module 4, readers will learn:

- **COD treatment can be sequential, simultaneous (but in parallel), or concurrent (and integrated).**

- **People with CODs face a multitude of individual, logistic, socioeconomic, cultural, organizational, systemic, and policy-related barriers to accessing and using SUD treatment and mental health services**

- **Integrated care is recommended as a best practice for serving people with CODs**

- **Mutual supports, including from peer recovery support specialists, are critical because they offer clients information and support from others with a lived experience with mental illness, SUDs, or both.**

- **Pharmacotherapy is often a core part of COD treatment, especially for people with depression, bipolar I disorder, anxiety, schizophrenia/psychotic disorders, AUD, or OUD.**

- **This country has a major shortage of mental health and addiction professionals, and the shortage will only continue to grow unless the feld uses strategies to increase the size of the workforce and retain current professionals**

- **Recruitment, hiring, and retention techniques can help programs attract and keep the right candidates while reducing turnover**

- **Burnout is a major component of turnover and is prominent in these felds because of the complex and challenging nature of the client population.**

- **Many professionals working with clients who have CODs feel uncomfortable or inadequately prepared to offer effective COD services, but better training and active clinical supervision can remedy this.**

- **Supervisors and administrators must ensure that counselors are properly trained if good client outcomes are to be achieved.**

Substance Use Disorder Treatment for People With Co-Occurring Disorders

UPDATED 2020

TREATMENT IMPROVEMENT PROTOCOL

TIP 42

SAMHSA
Substance Abuse and Mental Health Services Administration

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Foreword

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

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

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

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Assistant Secretary for Mental Health and Substance Use
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Executive Summary

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

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

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

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

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

Overall Key Messages

People with SUDs are more likely than those without SUDs to have co-occurring mental disorders. **Addiction counselors encounter clients with CODs as a rule, not an exception.** Mental disorders likely to co-occur with addiction include depressive disorders, bipolar I disorder, posttraumatic stress disorder (PTSD), personality disorders (PDs), anxiety disorders, schizophrenia and other psychotic disorders, ADHD, and eating and feeding disorders.

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

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

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

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

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

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

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

Content Overview

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

Chapter 1: Introduction to SUD Treatment for People With CODs

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

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

In Chapter 1, readers will learn about:

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

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

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

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

In Chapter 2, readers will learn that:

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

Chapter 3: Screening and Assessment of CODs

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

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

In Chapter 3, readers will learn that:

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

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

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

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

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

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

In Chapter 4, readers will learn that:

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

Chapter 5: Strategies for Working With People Who Have CODs

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

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

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

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

In Chapter 5, readers will learn that:

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

Chapter 6: CODs Among Special Populations

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

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

In Chapter 6, readers will learn that:

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

mental health service and SUD treatment access barriers and are likelier to have negative treatment outcomes.
- Counselors and other providers should learn how to provide culturally responsive assessments and treatments or other services to meet the unique needs facing clients of diverse racial/ethnic backgrounds who have CODs.

Chapter 7: Treatment Models and Settings for People With CODs

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

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

In Chapter 7, readers will learn that:

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

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

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

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

In Chapter 8, readers will learn that:

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

TIP ORGANIZATION BY KEY TOPIC AREAS OF INTEREST

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

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

TIP Development Participants

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

Consensus Panel

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

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

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

Modified TCs for Clients With CODs

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

WHAT MAKES TCs WORK?

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

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

Treatment Activities/Interventions

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

EXHIBIT 7.2. TC Activities and Components

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

Source: NIDA (2015).

Key Modifications

The MTC alters the traditional TC approach in response to the client's psychiatric and addiction-related symptoms, cognitive impairments, reduced level of functioning, short attention span, and poor urge control. A noteworthy alteration is the change from encounter group to conflict resolution group. Conflict resolution groups have the following features:

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

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

- **Increased flexibility**
- **Decreased intensity**
- **Greater individualization**

More recent adaptations also can include:

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

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

Role of the Family

Many MTC clients come from highly impaired, disrupted family situations. MTC programs offer them a new frame of reference and support group. Some clients do have available intact families or family members who are supportive. For these clients, MTC programs offer various family-centered activities like special family weekend

EXHIBIT 7.3. TC Modifications for People With CODs

STRUCTURAL MODIFICATIONS	PROCESS MODIFICATIONS	INTERVENTION MODIFICATIONS
There is increased flexibility in program activities.	Sanctions are fewer with greater opportunity for corrective learning experiences.	Orientation and instruction are emphasized in programming/planning.
Meetings and activities are shorter.		Individual counseling is provided more frequently to enable clients to absorb the TC experience.
There is greatly reduced intensity of interpersonal interaction.	Engagement and stabilization receive more time and effort.	Task assignments are individualized.
More explicit affirmation is given for achievements.		Breaks are offered frequently during work tasks.
Greater sensitivity is shown to individual differences.	Progression through the program is paced individually, according to the client's rate of learning.	Individual counseling and instruction are more immediately provided in work-related activities.
Greater responsiveness to the special developmental needs of the individual.		Engagement is emphasized throughout treatment.
More staff guidance is given in the implementation of activities; many activities remain staff assisted for a considerable period of time.	Criteria for moving to the next phase are flexible to allow lower functioning clients to move through the program phase system.	Activities are designed to overlap.
There is greater staff responsibility to act as role models and guides.		Activities proceed at a slower pace.
Smaller units of information are presented gradually and are fully discussed.	Live-out reentry (continuing care) is an essential component of the treatment process.	Individual counseling is used to assist in the effective use of the community.
Greater emphasis is placed on assisting individuals.		The conflict resolution group replaces the encounter group.
Increased emphasis is placed on providing instruction, practice, and assistance.	Clients can return to earlier phases to solidify gains as necessary.	

Source: Sacks & Sacks (2011).

ADVICE TO ADMINISTRATORS: RECOMMENDED TREATMENT AND SERVICES FROM THE MTC MODEL

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

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

visiting, family education and counseling sessions, and, if children are involved, classes focused on prevention. All such activities occur later in treatment to facilitate client reintegration into the family and into mainstream living.

Empirical Evidence

A series of studies has established that:

- MTCs affect a wide range of clinical and functional variables, including substance use, mental disorder symptoms, criminal behavior, employment, and housing (Sacks, McKendrick, Sacks, & Cleland, 2010). For instance, a review of TCs and MTCs (Magor-Blatch, Bhullar, Thomson, & Thorsteinsson, 2014) reported reduced substance use (including increased abstinence and reduced risk of relapse), decreased criminal behavior (including rearrests and reincarcerations), and improved psychological functioning among diverse populations, including people with CODs. However, benefits were more consistent from pre–post treatment than when comparing TCs/MTCs with control groups (e.g., no treatment, other treatment).
- Among people involved in the criminal justice system who have CODs, MTCs can effectively reduce SUD and mental illness symptoms, delay relapse, improve social functioning, reduce criminal activity, and decrease recidivism compared with traditional TCs (Magor-Blatch et al., 2014; Peters et al., 2017). MTCs also appear to reduce reincarceration better than parole supervision (Sacks, Chaple, Sacks, McKendrick, & Cleland, 2012).
- People with CODs and HIV receiving MTC continuing care had a greater decrease in SUD and mental illness symptoms at 6 months than people receiving standard continuing care (Sacks, McKendrick, Vazan, Sacks, & Cleland, 2011). Larger improvements were observed in MTC clients who had higher levels of psychosocial functioning and health at the start of treatment.
- MTCs can meet the various needs of pregnant and parenting women with SUDs—many of whom have co-occurring mental disorders, experiences with homelessness, criminal justice involvement, or a combination thereof. One such program (Bromberg, Backman, Krow, & Frankel, 2010) reduced recidivism, promoted long-term abstinence (about 90 percent of clients remained abstinent for 2 years after program completion), and facilitated drug-free births and healthy infant development.

Outpatient SUD Treatment

Treatment for SUDs occurs most frequently in outpatient settings—a term that encompasses a variety of disparate programs (Cohen, Freeborn, & McManus, 2013; NIDA, 2018b; SAMHSA, 2019a).

RESOURCE ALERT: HOW TO IMPLEMENT TC/MTC PROGRAMMING

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

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

Some offer high-intensity services, like several hours of treatment each week, which can include mental health and other support services as well as individual and group counseling for substance misuse; others provide minimal services, such as only one or two brief sessions to give clients information and refer them elsewhere (NIDA, 2018b). Some agencies offer outpatient programs that provide services several hours per day and several days per week, thus meeting the LOCUS criteria for High Intensity Community Based Services.

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

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

Prevalence

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

CODs are commonly found in clients who enter SUD treatment. In 2018, 50.2 percent of individuals

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

Empirical Evidence of Effectiveness

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

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

Outpatient treatment can also be leveraged as a form of continuing care, such as following discharge from hospitalization or release from jail/prison, to help clients maintain long-term recovery and wellness (Grella & Shi, 2011). Six-month outpatient ACT for men with SMI and SUD (Noel, Woods, Routhier, & Drake, 2016) was effective in sustaining improvements clients experienced during the previous 6 months in residential treatment, including improvements in mental health, substance use, housing, education, employment, family functioning, spirituality, and sleep hygiene. Outpatient mental health services focused on supporting community reintegration following release from jail were associated with 12-month declines in number of arrests and number of days in jail among people with CODs and people with mental disorders only (Alarid & Rubin, 2018).

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

Designing Outpatient Programs for Clients With CODs

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

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

RESOURCE ALERT: OUTPATIENT SUD TREATMENT

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

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

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

Referral and Placement

Careful assessment will help identify those clients who require more secure inpatient treatment settings (e.g., clients who are actively suicidal or homicidal), as well as those who require 24-hour medical monitoring, those who need detoxification, and those with serious SUDs who may require a period of abstinence or reduced use before they can engage actively in all treatment components. Information about the full screening and assessment process, which includes referral, is in Chapter 3.

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

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

Engagement and Retention

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

IMPROVING ENGAGEMENT AND ADHERENCE OF CLIENTS WITH CODS IN OUTPATIENT SETTINGS

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

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

the ACT and ICM models provide techniques that enable clients to access services and foster the development of treatment relationships.

Discharge Planning

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

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

Discharge planning for clients with CODs must ensure continuity of services, medication management, and support, without which client stability and recovery are severely compromised. Relapse prevention interventions after outpatient treatment need to be modified so clients can recognize symptoms of SUD or mental disorder relapse on their own, use symptom management techniques (e.g., self-monitoring, reporting to a "buddy," group monitoring), and access

assessment services rapidly, as the return of psychiatric symptoms can often trigger substance use relapse.

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

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

Residential SUD Treatment

Residential treatment for SUDs comes in a variety of forms, including long-term residential treatment facilities, criminal justice-based programs, halfway houses, and short-term residential programs. The long-term residential SUD treatment facility is the primary treatment site and the focus of this section of the TIP. Historically, residential SUD treatment facilities have provided treatment to clients with more serious and active SUDs but with less severe mental disorders. Most providers now agree that the prevalence of people with SMI entering residential SUD treatment facilities has risen.

Prevalence

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

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

Empirical Evidence of Effectiveness

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

Designing Residential Programs for Clients With CODs

To design and develop services for clients with CODs, providers and administrators can undertake a series of interrelated program activities. The specific MTC model that appeared previously in this chapter serves as a frame of reference in the following sections, but it is not a prescriptive model.

Intake

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

1. **Written referral.** Referral information from other programs or services can include the client's psychiatric diagnosis, history, current level of mental functioning, medical status (including results of screening for tuberculosis, HIV, sexually transmitted disease, hepatitis), and assessment of functional level. Referrals also may include a psychosocial history and a physical examination.
2. **Intake interview.** An intake interview is conducted at the program site by a counselor or clinical team. At this time, the referral material is reviewed for accuracy and completeness, and each client is interviewed to determine if the referral is appropriate in terms of the history of mental and substance use problems. The client's residential and treatment history is reviewed to assess the adequacy of past treatment attempts. Furthermore, each client's motivation and readiness for change are assessed, and the client's willingness to accept the current placement as part of the recovery process is evaluated. Screening instruments, such as those described in Chapter 3 and located in Appendix C, can be used in conjunction with this intake interview.
3. **Program review.** Each client should receive a complete description of the program and a tour of the facility to ensure that both are acceptable. This review includes a description of the daily operation of the program in terms of groups, activities, and responsibilities; a tour of the physical site (including sleeping arrangements and communal areas); and an introduction to some of the clients who are already enrolled in the program.
4. **Team meeting.** At the end of the intake interview and program review, the team meets with the client to decide whether to proceed with admission to the program. The client's receptivity to the program is considered, and additional information (e.g., involvement with the justice system, suicide attempts) is obtained as needed. It should be noted that the decision-making process is inclusive; that is, a program accepts referrals as long as the clients meet the eligibility criteria, are not currently a danger to self or others, do not refuse medication, express a readiness and motivation for treatment, and accept the placement and the program as part of their recovery process.

Engagement and Retention

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

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

Discharge Planning

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

- Discharge planning begins upon entry into the program.

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

Given the chronic and cyclical nature of SUDs and mental disorders, continuing care following residential services (such as the provision of lower intensity outpatient treatment postdischarge) can help optimize client stability and functioning. Individuals with SUDs who receive continuing care are retained in treatment and maintain abstinence more so than clients who do not participate in continuing care (McKay, 2009).

Acute Care and Other Medical Settings

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

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

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

RECOMMENDATIONS FOR CONTINUING CARE FOLLOWING DISCHARGE FROM RESIDENTIAL TREATMENT

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

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

HOW COMMON ARE MENTAL DISORDERS AND SUDS IN ACUTE CARE AND OTHER MEDICAL SETTINGS?

- **More than 70 percent of primary care visits are related to psychosocial needs** (National Association of State Mental Health Program Directors, 2012).
  - In a sample of 2,000 adults in primary care clinics in four states, 36 percent met *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013) criteria for an SUD in the last year, including almost 22 percent with a moderate/severe SUD (Wu et al., 2017). About 28 percent endorsed past-year illicit drug or nonmedical medication use.
  - From 2012 to 2014 (Cherry, Albert, & McCaig, 2018), 26 percent of mental health office visits in large metropolitan areas, 44 percent of visits in small-to-medium metropolitan areas, and 54 percent of visits in rural areas were to primary care.
- Of the 1.18 billion ambulatory medical visits that occurred between 2009 and 2011 (Lagisetty, Maust, Heisler, & Bohnert, 2017), **17.6 million involved an SUD diagnosis.**
  - This included 8.6 percent for AUD, 64.2 percent for tobacco use disorder, and 9.6 percent for OUD.
  - Among the people with an SUD, 13.4 percent also had anxiety, 5.7 percent had depression, and 2.3 percent had bipolar disorder.
- Data from the National Hospital Ambulatory Medical Care Survey indicate that **from 2005 to 2011, mental and substance use–related ED visits increased from 27.9 per 1,000 visits to 35.1 per 1,000 visits,** with the greatest increases observed in people ages 25 to 44 (Ayangbayi, Okunade, Karakus, & Nianogo, 2017). Odds of visits were higher in people who were uninsured or on public health insurance, or had been discharged from a hospital in the previous week.
- **Individuals with CODs are more likely than people without CODs to use EDs for mental disorder and SUD-related needs** (Moulin et al., 2018), as are individuals experiencing homelessness (Lam, Arora, & Menchine, 2016).

Prevalence

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

Empirical Evidence of Effectiveness

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

Primary care–based SUD treatment can reduce gaps in service use by offering treatment in a setting that clients prefer. More than 42,000 U.S. adults were screened for SUDs to assess

willingness to enter SUD treatment based on service setting (Barry, Epstein, Fiellin, Fraenkel, & Busch, 2016). Those who screened positive but were not currently enrolled in SUD treatment were randomized to one of three hypothetical treatment setting vignettes: treatment in a specialty drug treatment center (i.e., usual care), primary care, or collaborative care in a primary care setting. About a quarter (24.6 percent) of people with an SUD and 18 percent with AUD who were randomized to specialty care were willing to enter treatment, whereas more people randomized to the primary care setting were willing to enter treatment (37 percent with an SUD; 20 percent with AUD). Similarly, more people randomized to the primary/collaborative care setting were willing to enter treatment than people in the specialty care setting (34 percent with an SUD; almost 21 percent with AUD). Nonspecialty settings like primary care clinics may be desirable for individuals needing SUD treatment because of a perceived lack of stigma attached to medical facilities (compared with, for instance, methadone clinics) and the ability of medical settings to address both SUD treatment and physical healthcare needs in one location (Barry et al., 2016).

Designing Acute Medical and Primary Care Programs for Clients With CODs

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

The discussion that follows highlights the essential features of providing treatment to clients with CODs in acute care and other medical settings.

Screening and Assessment in Acute and Other Medical Settings

Clients entering acute care or other medical facilities generally are not seeking SUD treatment. Often, providers (primary care and mental health) are not familiar with SUDs. Their lack of expertise can lead

THE INTEGRATION OF CARE FOR MENTAL HEALTH, SUBSTANCE ABUSE AND OTHER BEHAVIORAL HEALTH CONDITIONS INTO PRIMARY CARE: AMERICAN COLLEGE OF PHYSICIANS (ACP) POSITION PAPER

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

Source: Crowley & Kirschner (2015).

to unrealistic expectations or frustrations, which may be directed inappropriately toward the client.

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

Although addiction screening can and should be offered in both nonurgent and urgent medical care settings, approaches may need to be implemented differently for each. O'Grady, Kapoor, and colleagues (2019) describe use of a screening, brief intervention, and referral for treatment (often referred to as SBIRT) program for people with or at risk for addiction that was implemented at EDs and primary care clinics. Compared with people screened as high risk for substance misuse in the primary care clinics, those screened as high risk in the EDs were significantly more likely to also have unstable housing, be unemployed, have self-reported "extreme" stress, have "serious" depression or anxiety, and have poor current health. They also reported higher addiction screening scores and more frequent substance use than people in the primary care clinics. Prescreening in the EDs was less likely to be completed than in primary care because clients were more likely to be in acute states, actively intoxicated, or have altered mental status. Further, more than one-third of people who prescreened positive for substance misuse did not receive full screening and intervention. This finding is consistent with results from two longitudinal surveys of 1,500 ED physicians that found only 15 percent to 20 percent of clients were screened for substance misuse and only 19 percent to 26 percent of ED physicians reported using a formal addiction screening tool (Broderick Kaplan, Martini, & Caruso, 2015).

These data are worrisome, given feedback from the American College of Emergency Physicians (2017) that ED professionals are, "positioned and qualified to mitigate the consequences of alcohol misuse through screening programs, brief intervention, and referral to treatment" and that EDs should maintain "wide availability of resources necessary to address the needs of patients with alcohol-related problems and those at-risk for them." ED staff may therefore require additional training to better recognize and respond to clients with addiction, particularly those with severe disorders. Formal procedures may also be needed to foster successful referral and implementation of brief interventions (e.g., education, harm reduction).

Interventions

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

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

limits to confidentiality at intake and their consent documented.

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

Historically, providers in acute care settings have not been concerned with treating SUDs beyond detoxification, stabilization, and referral. However, as the uptake of brief interventions increases and as the healthcare field's awareness grows about the importance of detecting and treating SUDs and mental disorders, treatment options are expanding beyond just stabilization and referral. In EDs, case managers help triage "high users" (who often include people with SUDs, mental disorders, or both [Minassian, Vilke, & Wilson, 2013; Moulin et

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

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

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

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

Administrative Questions

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

Capacity/Resource Questions

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

Financing Questions

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

Clinical Supports Questions

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

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

RESOURCE ALERT: HOW TO INTEGRATE PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES FOR PEOPLE WITH SMI

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

al., 2018; Smith, Stocks, & Santora, 2015]) to appropriate levels of care (e.g., admission, outpatient referral) (Turner & Stanton, 2015). Aspects of case management interventions—which are typically delivered not solely by case managers but collaboratively with other ED team members like nurses, physicians, and social workers—that can reduce ED visits, and in some cases reduce ED costs (Kumar & Klein, 2013) include:

- Educating clients about and linking them to community resources to address symptoms/problems.
- Offering referral to mental health services and SUD treatment.
- Assisting clients with transportation needs.
- Assisting clients with financial benefits/public assistance.
- Performing crisis intervention.
- Helping clients acquire stable housing.
- Working with clients to create an ED treatment plan or other individualized care plan.
- Following up with clients after discharge, including when providing referrals to specialty care.

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

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

Pharmacotherapy

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

Medication for Mental Illness

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

A person may have a history of taking different medications in the past or may report a change in his or her medications while working with a counselor. People need different medications depending on how their illness is expressing itself (e.g., which symptoms are most severe or most disabling). Medications used to treat the first episode of a mental illness may be different from those used later in disease course. Age may affect medication selection and dosage; aging affects metabolism and the bioavailability of some drugs. Sometimes a medication becomes less effective over time and will have to be changed or another medication added. There may also be periods when no medication is used at all.

Medication Management

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

KNOWING WHEN TO REFER FOR MEDICATION MANAGEMENT

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

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

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

- A physician.
- A psychiatrist.
- An advanced practice registered nurse (especially a psychiatric/mental health specialty nurse).

Considerations for the SUD Treatment Provider

A patient who appears sedated, agitated, or intoxicated may be experiencing a medication side effect or other medical illness. Medications that work in the brain are considered "psychotropic," meaning they affect a person's mental state. Drugs of misuse are psychotropic, too. **The benefits, side**

effects, and drug interactions of medications for mental illness can affect clients similarly to, or look like some of the effects of, illicit substances. This may be triggering for the client or those around him or her or lead to misuse of prescribed medication. Illicit substances and prescribed medications may interact with one another, potentially reducing the beneficial effects of the prescribed medication (Lindsey, Stewart, & Childress, 2012).

Medication for Depression

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

Several classes of medications have been approved for treating depression (FDA, 2017), including selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), and monoamine oxidase inhibitors (MAOIs). Each works in different ways but ultimately treats depression by changing the balance of chemicals (neurotransmitters) in the brain that regulate mood, such as serotonin, norepinephrine, and dopamine. Sometimes medication not specifically approved for depression, such as mood stabilizers or anti-psychotics, will be added to the antidepressant to address specific symptoms (FDA, 2017).

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

Side Effects

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

Medication for Anxiety Disorders

Anxiety disorders are best treated with combined psychotherapy and medication (Benich, Bragg, & Freedy, 2016). Medication can help relieve distressing symptoms. Antidepressants and benzodiazepines are the most common classes

EXHIBIT 7.6. Side Effects of Antidepressants

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

A NOTE ABOUT SEROTONIN SYNDROME

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

Mild serotonin syndrome can look like opioid withdrawal. More serious serotonin syndrome can look like intoxication with a stimulant or hallucinogen or withdrawal from a benzodiazepine. Fever, dangerously high blood pressure, and seizure can lead to organ failure and death if the syndrome is not recognized and treated. Counselors should remain vigilant for and seek medical evaluation for possible serotonin syndrome when clients with CODs present with unexpected withdrawal or intoxication symptoms.

of FDA-approved medication for anxiety. Antidepressants in the SSRI and SNRI classes are considered first-line therapy. Benzodiazepines should generally be used only for short periods, taken per a schedule rather than as needed (Benich et al., 2016). **Taking benzodiazepines with opioids markedly increases the risk of overdose** (NIDA, Revised March 2018).

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

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

Medication for PTSD

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

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

Medication for Bipolar Disorder

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

Mood Stabilizers

Medication to prevent severe mood fluctuations can be effective at treating mania, particularly the first-line medication lithium (Fountoulakis et al., 2017). Mood stabilizers treat and prevent mania by decreasing abnormal activity in the brain. People taking lithium need to see a physician regularly for monitoring of blood levels and kidney and thyroid functioning. Side effects that may improve with time are nausea, diarrhea, dizziness, muscle weakness, fatigue, and feeling "dazed."

Other symptoms are likely to continue, such as fine tremor, frequent urination, and thirst. Lithium can cause skin disorders like acne, psoriasis, and rashes. Serious side effects include irregular heart rhythm and serotonin syndrome. Anesthesia and antidepressants are associated with serotonin syndrome when taken with lithium. Elevated blood levels of lithium can cause uncontrollable shaking, clumsiness, ringing in the ears, slurred speech, and blurred vision. **Salt, caffeine, alcohol, other medications, and dosing mistakes can cause lithium toxicity, which can be a medical emergency.**

Antiseizure Medication

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

Antipsychotic Medication

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

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

Medication for Schizophrenia and Other Psychotic Disorders

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

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

Side Effects

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

muscle spasms, tremors, and restlessness. They may also cause a condition of abnormal muscle movements called **tardive dyskinesia,** which can persist even when the medication is discontinued. Some antipsychotics cause electrocardiogram abnormalities, such as QT prolongation, a condition in which the heart takes longer to recharge between beats. **An individual can overdose on antipsychotics, especially if they are combined with alcohol or other sedating drugs.**

Medication for Attention Deficit Hyperactivity Disorder

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

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

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

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

Medication for PDs

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

Medication for Feeding and Eating Disorders

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

Medication for SUDs

Because SUDs are brain-based diseases, pharmacologic research has explored the development of agents that can effectively target disruptions in neurotransmitters and

neuromodulators that occur as a part of addiction. These medications often help reduce withdrawal symptoms or craving, which in turn can make abstinence easier to achieve and sustain. In general, pharmacotherapy for SUDs is considered supportive rather than curative and is typically combined with psychotherapy, behavioral counseling, psychoeducation, mutual support, other recovery services, or a combination of these.

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

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

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

Medication for AUD

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

Medication for OUD

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

RESOURCE ALERT: LEARNING MORE ABOUT PHARMACOTHERAPY AND CODs

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

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

Conclusion

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

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

KEY MESSAGES

- Mental health and addiction labor force problems directly affect treatment access, quality, and cost. Without addressing gaps in personnel and training, the behavioral health field will struggle to meet the needs of the growing numbers of people living with co-occurring disorders (CODs).
- Although current workforce challenges may seem daunting, substance use disorder (SUD) treatment supervisors and administrators can help confront and overcome these difficulties by creating, implementing, and sustaining professional development and training opportunities within their organizations. This in turn will help support the uptake and utilization of best practices.
- Recruitment and retention priorities are urgently needed because of the challenging nature of the addiction and mental health service professions, which leads to high rates of staff burnout and turnover.
- Professional education and accreditation, combined with mentoring and supervision, can help increase adoption of core and advanced clinical competencies, increase providers' comfort with working with people who have CODs, reduce stigma surrounding the profession/field, and provide structured career development.

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

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

This chapter is divided into two main sections:

- The first half addresses recruitment, hiring, and retention in the behavioral health workforce. Finding, getting, and keeping the right employees is critical to ensuring the long-term sustainability, viability, and effectiveness of the field. Toward that end, the chapter contains links to practical, web-based resources for programs and administrators, including toolkits and manuals.
- The second half of this chapter focuses on ensuring the competency and professional development of program staff. This section includes detailed discussions about the role of training, supervision, and credentialing, all of which are necessary components of preparing the field to deliver evidence-based care and fostering increased service provision.

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

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

Recruitment, Hiring, and Retention

As of March 2020, the Health Resources and Services Administration (HRSA) has identified approximately 5,537 mental health professional shortage areas in the United States, requiring 6,387 mental health practitioners to fill the shortage (HRSA, 2020). **The behavioral health workforce is fraught with profession gaps and similar challenges that serve as barriers to treatment access for people with mental disorders and SUDs.** For instance (Olfson, 2016; Weil, 2015):

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

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

- Lack of support for COD services, such as low allocation of resources, discontinuing consultations with outside COD experts, discontinuing onsite drug testing of clients, and not implementing integrated care procedures even when already developed by staff
- Lack of COD training opportunities
- An inability to bill for CODs (e.g., certain organizations would only permit billing for mental health services and not SUD treatment)
- Lack of local addiction services, which make coordinating care, referring clients to specialty services, and linking clients to needed resources more difficult. Even when these services are present, available slots are limited and wait-times are often long.
- Large caseloads and limited time to work with clients
- Difficulty initiating and maintaining contact with outside SUD treatment providers, especially with providers in residential treatment settings
- Fragmented, nonintegrated care that results in different providers using different (and sometimes opposing) treatment approaches with the same client. This is particularly problematic when clients on pharmacotherapy attend mutual-support groups or treatment programs that strongly discourage psychotropic medication.

left by psychiatry and psychology (particularly in treating clients with SMI), but this will require additional training in behavioral health assessment, diagnosis, and treatment and better compensation.

Recruitment and Retention

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

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

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

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

- **Step 1. Gather organizational baseline information.** Before programs can effectively recruit and hire the right personnel, they first need to assess the landscape: What are the current retention rates for healthcare providers? What previously used recruitment and hiring strategies have proved effective and ineffective for the field? What can be learned about job satisfaction from exit interviews?
- **Step 2. Decide on a priority recruitment and retention focus (job position).** Programs should gather and analyze data to identify their most pressing hiring needs and challenges. This should result in programs selecting the most urgent priority position to fill.
- **Step 3. Analyze the selected job position.** Once a priority position is selected from Step 2, programs need to identify the benefits and challenges of the position to develop a clear and accurate position description.
- **Step 4. Write an accurate job description.** The position description needs to be articulate, direct, and thorough to attract the best fitting, most qualified candidates possible.
- **Step 5. Identify the strategy and intervention.** Programs can choose from among several options the best recruitment or retention strategy that fits their needs and that they feel will be most effective at helping them overcome their specific challenges.
- **Step 6. Develop an action plan.** At this step, the strategy and intervention are implemented. In preparation, programs should develop and assign specific tasks; appoint managers to oversee the process; define outcomes for their intervention; determine steps for monitoring, communicating about, and assessing the intervention's effectiveness; and finalize the implementation plan.

Source: SAMHSA (n.d.).

RESOURCE ALERT: RECRUITMENT AND RETENTION RESOURCES FOR THE BEHAVIORAL HEALTH WORKFORCE

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

Reducing Staff Turnover

Behavioral health service provider turnover and burnout can strain organizational infrastructure, prevent clients from receiving much-needed services, and weaken the field as a whole. The Department of Labor's Bureau of Labor Statistics estimates a national turnover rate across all professions of around 3.7 percent (Bureau of Labor Statistics, February 11, 2020). By comparison, **turnover in the behavioral health field is quite high.** Among addiction counselors and supervisors, average annual turnover has been estimated to range between 23 percent and 33 percent (Eby, Burk, & Maher, 2010; Knight, Broome, Edwards, & Flynn, 2011; Laschober & Eby, 2013) and between approximately 17 percent and 26 percent among mental health therapists and supervisors (Beidas et al., 2016; Bukach, Ejaz, Dawson, & Gitter, 2017). In both sectors, turnover is usually voluntary—an additional cause for concern. Reasons for behavioral health service providers to leave their jobs voluntarily include burnout (driven by factors like high workload and not having a clear understanding of job roles and duties), low levels of support from supervisors and coworkers, and job dissatisfaction (related to high workload and poor supervisory relationships) (Garner & Hunter, 2014; Yanchus, Periard, & Osatuke, 2017; Young, 2015). (Also see the section "Avoiding Burnout.")

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

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

Turnover in the addiction field is linked to attitudinal and organizational predictors, including lower job satisfaction, lower job involvement, less support from supervisors or coworkers, and poor role manageability (Garner & Hunter, 2014). These factors are largely modifiable and are

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

To decrease staff turnover, whenever possible, programs should:

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

important targets for monitoring and implementing programmatic changes to help providers feel satisfied, supported, and competent on the job (Yanchus et al., 2017). Exhibit 8.2 offers methods for reducing staff turnover.

Avoiding Burnout

A logical approach to reducing turnover is to prevent the occurrence of burnout. Burnout has been reported in as much as 67 percent of professionals in the mental health field (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Reasons mirror those for turnover, including, but not limited to, demanding workloads and not feeling rewarded by one's work (Young, 2015). Often, mental health service and SUD treatment providers are expected to manage growing and more complex caseloads. "Compassion fatigue" may occur when the pressures of work erode a counselor's spirit and outlook and begin to interfere with the counselor's personal life; see also Treatment Improvement Protocol (TIP) 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (Center for Substance Abuse Treatment [CSAT], 2000c, p. 64). Assisting clients who have CODs is difficult and emotionally taxing; the danger of burnout is considerable. Program administrators must maintain awareness of the problem of burnout and the benefits of reducing turnover. Program administrators must demonstrate interest in staff well-being to sustain morale and team cohesion.

To lessen burnout among counselors working with a demanding caseload that includes clients with CODs, behavioral health service organizations should (Atkinson, Rodman, Thuras, Shiroma, &

RESOURCE ALERT: DEALING WITH STRESS IN BEHAVIORAL HEALTH SERVICE SETTINGS

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

Lime, 2017; Oser, Biebel, Pullen, & Harp, 2013; Morse et al., 2012):

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

Competency and Professional Development

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

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

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

- About 43 percent met or exceeded criteria for COD-capable programming.
- About half had mission statements, organizational certification and licensure, service coordination, and financial incentives focused on treating either mental illness or SUDs but not both.
- 24 of 30 programs could only bill for mental health services or SUD treatment but not both.
- 18 programs routinely used clinical interview assessment techniques adapted to CODs, but only 6 of those programs had formal standardized screening tools for CODs. Only five programs had formal procedures in place to conduct comprehensive assessments of clients who screen positive for CODs.
- Most programs lacked stagewise treatments specifically for CODs, including a lack of psychoeducation about and recovery support for both mental disorders and SUDs.
- 18 programs had onsite prescribers.
- 23 programs used supervision and consultation to address mental conditions and substance use. However, most programs did not have licensed or otherwise competently trained staff to provide COD services other than pharmacotherapy management.
- Over 80 percent of the sites offered direct staff training in basic competencies (e.g., prevalence, signs and symptoms, assessment procedures), but only about 57 percent of programs had staff with at least some advanced competency training in treating CODs.

The consensus panel underscores the importance of an investment in creating a supportive environment for staff that encourages professional development to include skill acquisition, values clarification, training, and competency attainment equal to an investment in new COD program development. An organizational commitment to both is necessary for successful implementation of programs. Examples of staff support may include standards of practice related to consistent

high-quality supervision, favorable tuition reimbursement and release-time policies, helpful personnel policies related to bolstering staff wellness practices, and incentives or rewards for work-related achievement. Together these elements help create an environment in which high-quality service can thrive.

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

Attitudes and Values

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

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

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

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

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

How To Improve Providers' Attitudes Toward Clients With CODs

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

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

Provider Competencies

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

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

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

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

Basic Competencies

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

Intermediate Competencies

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

RESOURCE ALERT: OREGON HEALTH AUTHORITY'S COMPETENCY CHECKLISTS FOR COD PROVIDERS

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

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

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

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

EXHIBIT 8.5. Six Intermediate Competencies for Treating People With CODs

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

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

Advanced Competencies

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

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

- Understand the transtheoretical model and how client motivation and readiness to change affect behavior.
- Learn to enhance motivation via motivational interviewing and motivational enhancement therapy skills.
- Be aware of the relapse prevention model and integrating relapse prevention skills into treatments.
- Use criteria from *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association [APA], 2013) to assess substance-related and other mental disorders.
- Understand the effects of level of functioning and degree of disability related to both substance-related and mental disorders, separately and combined.
- Apply knowledge of psychotropic medications, their actions, medical risks, side effects, and possible interactions with other substances.
- Use integrated models of assessment, intervention, and recovery for people having both substance-related and mental disorders, as opposed to sequential treatment efforts that resist integration.
- Collaboratively develop and implement an integrated treatment plan based on thorough assessment that addresses both/all disorders and establishes sequenced goals based on urgent needs, considering the stage of recovery, stage of change, and level of engagement.
- Involve the person, family members, and other supports and service providers (including peer supports and those in the natural support system) in establishing, monitoring, and refining the current treatment plan.
- Help clients expand their social networks and systems of support.

Supervision

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

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

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

Continuing Professional Development

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

RESOURCE ALERT: COMPETENCIES AND TRAINING FOR SUD TREATMENT SUPERVISORS

- Family Health International 360's Training Curriculum on Drug Addiction Counseling Trainer Manual. Chapter 9: Clinical Supervision and Support (www.fhi360.org/sites/default/files/media/documents/Training%20Curriculum%20on%20Drug%20Addiction%20Counseling%20-%20Chapter%209.pdf)
- SAMHSA's TAP 21-A: Competencies for Substance Abuse Treatment Clinical Supervisors (https://store.samhsa.gov/system/files/sma12-4243.pdf)
- SAMHSA's Recruitment and Retention Toolkit chapter on Supervision Intervention Strategies (http://toolkit.ahpnet.com/Supervision-Intervention-Strategies.aspx)

and determine what they need to continue their professional development.

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

Education and Training

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

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

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

> The scope of practice that addiction counselors must follow legally and under which they can be reimbursed varies from state to state (University of Michigan Behavioral Health Workforce Research Center, 2018). In some states, practice privileges are broad, and in others they are quite restrictive. For instance, certain states mandate that addiction counselors can only conduct assessments and provide treatments for SUDs, limiting their ability to serve clients with CODs. Certification requirements and authorized services also are inconsistent. The lack of standardized training, credentialing, and practices makes it difficult for the behavioral health field as a whole to effectively respond to gaps in COD treatment access and provision.

Discipline-Specific Education

Staff education and training are fundamental to all SUD treatment programs. Few university-based programs offer a formal curriculum on CODs, despite some improvement during the past decade. Many professional organizations are promoting the development of competencies and practice standards for intervening with substance use problems, including the American Psychiatric Association, American Psychological Association, American Society of Addiction Medicine, National Association of Social Workers, and American Counseling Association. They are also specifically encouraging faculty members to enhance their knowledge in this area so they can better prepare their students to meet the needs of clients with CODs. **The consensus panel encourages all such organizations to identify standards and competencies for their membership related to CODs and to encourage the development of training for specific disciplines.**

Because the consequences of both addiction and mental disorders can present with physical or psychiatric manifestations, medical students, internal medicine and general practice residents, and general psychiatry residents all need to be educated in the problems of CODs. Too few hours of medical education are devoted to the problems

MEETING THE GROWING DEMAND FOR ADDICTION COUNSELORS IN THE FUTURE: FARING WELL OR FALLING SHORT?

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

of addiction and mental disorders. Medication can play a critical role in the treatment of CODs, so having adequately trained physicians who can manage medication therapies for clients with CODs is important.

Continuing Education and Training

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

Continuing education is useful because it can respond rapidly to the needs of a workforce that has diverse educational backgrounds and experience. To have practical utility, competency training must address the day-to-day concerns that counselors face in working with clients who have CODs. The educational context must be rich with information, culturally sensitive, designed for adult students, and must include examples and role models. Ideally, the instructors have extensive experience as practitioners in the field.

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

Continuing education is essential for effective provision of services to people with CODs, but it is not sufficient in and of itself. Counselors must have ongoing support, supervision, and opportunity to practice new skills if they are to truly integrate COD content into their practice.

Cross-Training

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

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

EXHIBIT 8.7. Certification for Health Professions

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

National Training Resources

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

COD/Addiction Certification in Health Disciplines

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

Conclusion

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

Appendix A: Substance Use Disorder Treatment for People with Co-Occurring Disorders, Module 4

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions.

> Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions using the answer sheet found at the end of this appendix. Then, return to your browser and go to the Student Center located at:
>
> http://www.ceumatrix.com/studentcenter
>
> Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Take Exam' and you will be presented with the electronic exam.
>
> To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater you will have access to the Certificate of Completion. This is the final step in the process, and you may save and/or print your Certificate of Completion.
>
> If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

If you have any difficulty with this process, or need assistance, please e-mail us at ceumatrix@ceumatrix.com and ask for help.

Answer the following questions by selecting the most appropriate response.

Quiz

1. What is a significant barrier to effective SUD treatment for individuals with co-occurring disorders (CODs)?
   A. Cognitive barriers
   B. Increased access to treatment
   C. Higher motivation levels
   D. Simplified treatment plans

2. Which of the following is a characteristic of the modifications made for people with CODs in treatment programs?
   A. Increased sanctions for non-compliance
   B. Shorter meetings and activities
   C. Less frequent individual counseling
   D. Higher intensity of interpersonal interaction

3. What is the primary goal of the modifications in treatment programs for clients with CODs?
   A. To reduce treatment costs
   B. To enhance community engagement
   C. To foster change through mutual support
   D. To limit individual counseling sessions

4. What percentage of clients remained abstinent for 2 years after completing the program mentioned in the document?
   A. 90 percent
   B. 80 percent
   C. 70 percent
   D. 95 percent

5. What is one of the four categories of interventions designed to produce change in treatment programs?
   A. Social isolation
   B. Financial management
   C. Crisis intervention
   D. Community enhancement

6. What is a significant factor that affects treatment retention rates among individuals with co-occurring disorders (CODs)?
   A. Positive family relationships
   B. High levels of substance use
   C. Increased time spent in high-risk places
   D. Low motivation for treatment

7. According to the document, what is one of the recommended strategies to enhance client engagement in treatment programs?
A. Limiting client access to support services
B. Implementing behavioral continuing care contracts
C. Reducing the number of treatment sessions
D. Focusing solely on medication management

8. What type of support is suggested to help clients with CODs maintain their treatment gains after discharge?
A. Increased recreational activities
B. Access to community health and social services
C. More time in residential treatment
D. Reduced family involvement

9. What is one of the barriers to integrated care that the ACP recommends addressing?
A. Increasing payment barriers
B. Reducing access to behavioral health services
C. Limiting research on integrated care
D. Strengthening nondiscrimination laws

10. What is a documented outcome for clients in residential settings compared to those in outpatient settings?
A. Higher rates of substance use
B. Lower completion rates of treatment
C. Three times more likely to complete treatment
D. Increased homelessness rates

11. What is the first new antidepressant approved by the FDA since Prozac in 1988?
A. Esketamine
B. Sertraline
C. Fluoxetine
D. Bupropion

12. What is a significant challenge in integrated care settings regarding client information?
A. Strict confidentiality with no sharing
B. Limited access to client records
C. Greater sharing of confidential client information
D. No need for client consent

13. What is one of the key factors that can affect the effectiveness of medication for mental illness?
A. The duration of treatment
B. The age of the client

C. The type of therapy used
D. Drug interactions with illicit substances

14. What is the focus of treatment in integrated care settings compared to traditional settings?
A. More concrete and skills-oriented
B. Less emphasis on client involvement
C. Focus solely on medication
D. No collaboration with other providers

15. What is a common side effect of antidepressants that may last longer than initial side effects?
A. Insomnia
B. Nausea
C. Weight gain
D. Diarrhea

16. What is a potential side effect of antipsychotic medications that can persist even after discontinuation?
A. Serotonin syndrome
B. Tardive dyskinesia
C. QT prolongation
D. Electrocardiogram abnormalities

17. Which class of medications is primarily used to treat schizophrenia and other psychotic disorders?
A. Antidepressants
B. Antipsychotics
C. Mood stabilizers
D. Stimulants

18. What condition is characterized by dangerously high blood pressure and seizures if not treated?
A. Serotonin syndrome
B. Bipolar disorder
C. Substance use disorder
D. Attention deficit hyperactivity disorder

19. What is the primary purpose of pharmacotherapy for substance use disorders (SUDs)?
A. To cure the disorder
B. To manage anxiety symptoms
C. To provide behavioral therapy
D. To reduce withdrawal symptoms and cravings

20. What is a common treatment approach for bipolar disorder?

A. Only medication
B. Only psychotherapy
C. Medication combined with psychotherapy
D. No treatment is necessary

21. What percentage of programs could only bill for either mental health services or SUD treatment but not both?
A. 30%
B. 50%
C. 80%
D. 24%

22. What is one of the essential attitudes and values for working with clients who have CODs?
A. Compassion and empathy
B. Strict adherence to protocols
C. Focus on medication management
D. Avoidance of emotional support

23. According to the document, what is a significant barrier to treatment access for people with mental disorders and SUDs?
A. Inadequate community resources
B. Lack of funding
C. Limited training opportunities
D. High turnover rates

24. What is the estimated number of mental health practitioners needed to fill the shortage in the United States as of March 2020?
A. 5,000
B. 6,387
C. 10,000
D. 4,500

25. What is one of the recommended strategies to create a collegial environment for staff?
A. Encourage competition among coworkers
B. Increase workloads
C. Promote support between coworkers
D. Limit communication

26. What is the primary focus of the consensus panel regarding counselors working with clients who have CODs?
A. To limit their training to SUDs
B. To acquire competencies specific to CODs
C. To focus on administrative tasks
D. To avoid cross-training with mental health

27. What is one of the recommended methods for enhancing the effectiveness of SUD treatment counselors?
A. Providing advanced pharmacotherapy training
B. Limiting training to basic competencies
C. Reducing the number of clients seen
D. Offering workshops and online courses

28. According to the document, what should be included in the integrated treatment plan for clients with CODs?
A. Only addressing substance use disorders
B. Focusing solely on mental health issues
C. Involving family members and support systems
D. Implementing sequential treatment efforts

29. What is a significant barrier to effective treatment for clients with CODs mentioned in the document?
A. Lack of understanding of CODs
B. Excessive funding for treatment programs
C. Overqualified staff members
D. High client satisfaction rates

30. What is emphasized as a crucial aspect of supervision for developing COD competencies?
A. Supervision without feedback mechanisms
B. Minimal supervision to encourage independence
C. Supervision focused only on SUD treatment
D. Supervision by professionals with licensure

Name: _____

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