



**CEU MATRIX**  
THE INSTITUTE FOR ADDICTION & CRIMINAL JUSTICE STUDIES

# **OVERVIEW OF CO-OCCURRING DISORDERS TREATMENT**

## **4 Continuing Education Credits**

Asynchronous Distance Learning Course

*Content Level: Beginning*

**Course Author: Robert A. Shearer, Ph.D.**

**Last Updated: 2026**

Approved by such credentialing bodies as:

- **National Association of Alcoholism and Drug Abuse Counselors (NAADAC) #94564**
- **National Board of Certified Counselors (NBCC) #6310**

*All approval bodies are listed at [ceumatrix.com/accreditations](http://ceumatrix.com/accreditations)*

For questions or to request accessibility accommodations please email us at: [support@ceumatrix.com](mailto:support@ceumatrix.com)

© 2026 CEU Matrix. All rights reserved.



Welcome to CEU Matrix. We have been committed to supporting the continuing education of behavioral health professionals since 2007. Please reach out with any questions, ideas, or feedback.

---

*Do the best you can until you know better.  
Then when you know better, do better.*

— Maya Angelou

---

## **COPYRIGHT**

---

Original course materials, including the front matter, supplemental research synthesis, post-test, and CEU Matrix-authored content: © Copyright 2026 CEU Matrix. All rights reserved.

This course is based on a SAMHSA Center for Substance Abuse Treatment publication, in the public domain as a work of the United States Government under 17 U.S.C. § 105.

No portion of the CEU Matrix-authored content may be reproduced in any manner without the written permission of the publisher, in accordance with the U.S. Copyright Act of 1976, Title 17 U.S.C.

## **ABOUT THE INSTRUCTOR**

---

Dr. Robert A. Shearer is a retired professor of Criminal Justice, Sam Houston State University. He received his Ph.D. in Counseling and Psychology from Texas A & M University, Commerce. Prior to teaching Criminal Justice, he taught Educational Psychology at Mississippi State University on campus and in the extension program across rural Mississippi during the civil rights era.

He has been teaching, training, consulting and conducting research in the fields of Criminal Justice, human behavior, and addictions for over thirty-six years. He is the author of over sixty professional and refereed articles in Criminal Justice and behavior. He is also the author of *Interviewing: Theories, Techniques, and Practices*, 5th edition published by Prentice Hall. Dr. Shearer has also created over a dozen measurement, research, and assessment instruments in Criminal Justice and addictions.

He has been a psychotherapist in private practice and served as a consultant to dozens of local, state, and national agencies. His interests continue to be substance abuse program assessment and evaluation. He has taught courses in interviewing, human behavior, substance abuse counseling, drugs-crime-social policy, assessment and treatment planning, and educational psychology. He has also taught several university level psychology courses in the Texas Department of Criminal Justice Institutional Division, led group therapy in prison, trained group therapists, and served as an expert witness in various courts of law.

He has been the president of the International Association of Addictions and Offender Counseling and the editor of the *Journal of Addictions and Offender Counseling* as well as a member of many Criminal Justice, criminology, and counseling professional organizations prior to retirement.

# Co-Occurring Disorders: Updated Prevalence, Outcomes, and Treatment Evidence

---

The COCE Overview Papers on which this course is based established the foundational framework for understanding co-occurring mental health and substance use disorders — their definitions, epidemiology, screening and assessment protocols, treatment principles, and models for service integration. Since these papers were published, the co-occurring disorders research base has matured from establishing that integration is necessary to quantifying the outcome disadvantages that individuals with co-occurring disorders face, documenting population-level prevalence with greater precision, identifying what treatment components produce the strongest results, and extending the evidence base to youth populations that the original COCE materials addressed only peripherally.

The treatment outcome disadvantage that individuals with co-occurring disorders experience — a clinical reality this course acknowledges but does not fully quantify — was measured in a 2025 rapid review and meta-analysis that examined 13 primary studies drawn from 35 systematic reviews and meta-analyses spanning 2000 to 2024. The analysis found that individuals with concurrent mental health and substance use disorders faced approximately double the likelihood of negative outcomes compared to those with a single disorder, with a pooled risk ratio of 1.71. Negative outcomes included relapse, emergency department visits, rehospitalization, and death. The analysis found insufficient evidence to examine whether this disadvantage varies by gender, race, or income level (Scott & Gorey, 2025). For the treatment framework this course describes — which emphasizes integrated approaches that address both conditions simultaneously — the Scott and Gorey meta-analysis provides the strongest quantitative justification yet for why integration matters. The 1.71 risk ratio means that treating either condition alone while ignoring the other does not simply leave one problem unaddressed; it actively produces worse outcomes for the condition being treated. Integration is not a clinical ideal — it is a measurable survival factor.

The prevalence dimension of co-occurring disorders — which this course presents primarily through older epidemiological surveys — has been updated by two large-scale studies that confirm the scope of the problem across different populations. A 2025 Australian population survey using data from 2020 to 2022 found that approximately 46% of individuals with either a mental health or substance use disorder met criteria for two or more diagnosable conditions. This prevalence remained relatively stable compared to 2007 data, though young adults aged 16 to 24 showed significantly higher co-occurrence rates in the recent survey period. The authors concluded that "continued effort is needed to develop and implement transdiagnostic interventions" (Sunderland et al., 2025). A separate 2025 study examining prevalence among incarcerated adults in Australia found that dual diagnosis was the most common presentation at 40 to 44% across multiple data sources, exceeding the prevalence of either mental illness alone (7-17%) or substance use disorder alone (15-27%) (Coulter et al., 2025). For the epidemiology section of this course, these findings establish that co-occurring disorders are not the exception — they are the most common clinical presentation in multiple populations. In correctional settings specifically, dual diagnosis is the norm rather than a subgroup requiring special programming, and any treatment system that separates mental health from substance use services is organized around a clinical fiction.

The patient-centered care components that produce the best outcomes for individuals with substance use disorders — including those with co-occurring conditions — were mapped in a 2025 scoping review of 135 peer-reviewed articles published between 1994 and 2024. The review identified six

patient-centered care dimensions: therapeutic alliance (studied in 35.6% of articles), shared decision-making, personalized supports, integrated care for co-occurring conditions, trauma-informed care, and culturally-informed care. Findings indicated largely positive associations between these components and service outcomes, though most studies examined only single dimensions rather than measuring how multiple patient-centered care components interact (Myers et al., 2025). For the overarching principles this course describes — particularly the emphasis on welcoming all clients, meeting them where they are, and providing integrated services — the Myers et al. review confirms that the therapeutic relationship is the most-studied and most consistently supported ingredient in effective treatment. The practical implication for co-occurring disorders treatment is that clinical technique matters less than the therapeutic alliance through which it is delivered, and programs that prioritize evidence-based protocols over relationship quality may be optimizing the wrong variable.

The youth dimension of co-occurring disorders treatment — which the COCE materials address primarily in terms of system-level integration — was examined in a 2025 scoping review of evidence-based interventions for youth aged 10 to 29 with concurrent mental health and substance use disorders. The analysis included 30 peer-reviewed studies, with 63.3% being randomized controlled trials. Mood disorders were the most prevalent co-occurring condition (50%), followed by behavioral disorders (30%). However, the review found "substantial clinical and methodological heterogeneity" among the studies, indicating that the evidence base for youth-specific concurrent disorder treatment remains fragmented despite the growing number of trials (Marshall et al., 2025). For the treatment planning framework this course provides, the youth evidence gap has practical implications. Clinicians treating adolescents and young adults with co-occurring disorders cannot draw on the same depth of integrated treatment evidence available for adults. The mood disorder predominance in youth studies suggests that depression-substance use and anxiety-substance use combinations may warrant different intervention approaches than the serious mental illness-substance use combinations that dominate the adult co-occurring disorders literature.

The question of which client factors predict successful completion of dual diagnosis treatment — essential information for treatment matching that this course discusses at the system level — was examined in a 2025 retrospective cohort study of 181 admissions to a 12-week inpatient dual diagnosis program. The sample was predominantly male (53.6%), with common substances including alcohol (52%), cannabis (40%), and methamphetamine (43%). The analysis found that none of the demographic or clinical factors studied — including mental health severity, age, gender, and substance use pattern — demonstrated any statistically significant effect on the likelihood of program completion (Membrey et al., 2025). For the screening and assessment framework this course presents, the Membrey et al. finding challenges the assumption that clinical assessment can reliably identify which dual diagnosis clients will succeed in intensive treatment. If standard intake variables do not predict completion, then treatment systems that use these variables to determine treatment intensity or placement may be gatekeeping based on factors that have no demonstrated relationship to outcomes. The finding supports a system that offers intensive integrated treatment to all eligible clients rather than rationing access based on prognostic assumptions.

# Definitions and Terms Relating to Co-Occurring Disorders

## OVERVIEW PAPER 1



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
Substance Abuse and Mental Health Services Administration  
Center for Mental Health Services  
Center for Substance Abuse Treatment  
[www.samhsa.gov](http://www.samhsa.gov)

## About COCE and COCE Overview Papers

The Co-Occurring Center for Excellence (COCE), funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a leading national resource for the field of co-occurring mental health and substance use disorders (COD). COCE's mission is threefold: (1) to receive and transmit advances in treatment for all levels of COD severity, (2) to guide enhancements in the infrastructure and clinical capacities of service systems, and (3) to foster the infusion and adoption of evidence- and consensus-based COD treatment and program innovations into clinical practice. COCE consists of national and regional experts including COCE Senior Staff, Senior Fellows, Steering Council, affiliated organizations (see inside back cover), and a network of more than 200 senior consultants, all of whom join service recipients in shaping COCE's mission, guiding principles, and approaches. COCE accomplishes its mission through technical assistance and training, delivered through curriculums and materials online, by telephone, and through in-person consultation.

COCE Overview Papers are concise and easy-to-read introductions to state-of-the-art knowledge in COD. They are anchored in current science, research, and practices. The intended audiences for these overview papers are mental health and substance abuse administrators and policymakers at State and local levels, their counterparts in American Indian tribes, clinical providers, other providers, and agencies and systems through which clients might enter the COD treatment system. For a complete list of available overview papers, see the back cover.

For more information on COCE, including eligibility requirements and processes for receiving training or technical assistance, direct your e-mail to [coce@samhsa.hhs.gov](mailto:coce@samhsa.hhs.gov), call (301) 951-3369, or visit COCE's Web site at [www.coce.samhsa.gov](http://www.coce.samhsa.gov).

## Acknowledgments

COCE Overview Papers are produced by The CDM Group, Inc. (CDM) under Co-Occurring Center for Excellence (COCE) Contract Number 270-2003-00004, Task Order Number 270-2003-00004-0001 with the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). Jorielle R. Brown, Ph.D., Center for Substance Abuse Treatment (CSAT), serves as COCE's Task Order Officer, and Lawrence Rickards, Ph.D., Center for Mental Health Services (CMHS), serves as the Alternate Task Order Officer. George Kanuck, COCE's Task Order Officer with CSAT from September 2003 through November 2005, provided the initial Federal guidance and support for these products.

COCE Overview Papers follow a rigorous development process, including peer review. They incorporate contributions from COCE Senior Staff, Senior Fellows, consultants, and the CDM production team. Senior Staff members Michael D. Klitzner, Ph.D., Fred C. Osher, M.D., and Rose M. Urban, LCSW, J.D., co-lead the content and development process. Senior Staff members Stanley Sacks, Ph.D., and Fred C. Osher, M.D., made major writing contributions. Other major contributions were made by Project Director Jill Hensley, M.A., and Senior Fellows Kenneth Minkoff, M.D., David Mee-Lee, M.S., M.D., and Joan E. Zweben, Ph.D. Editorial support was provided by CDM staff members Janet Humphrey, J. Max Gilbert, Michelle Myers, and Darlene Colbert.

## Disclaimer

The contents of this overview paper do not necessarily reflect the views or policies of CSAT, CMHS, SAMHSA, or DHHS. The guidelines in this paper should not be considered substitutes for individualized client care and treatment decisions.

## Electronic Access and Copies of Publication

Copies may be obtained free of charge from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 462-7600; TDD (for hearing

impaired), (800) 487-4889, or electronically through the following Internet World Wide Web sites: [www.nacadi.samhsa.gov](http://www.nacadi.samhsa.gov) or [www.coce.samhsa.gov](http://www.coce.samhsa.gov).

## Public Domain Notice

All materials appearing in COCE Overview Papers, except those taken directly from copyrighted sources, are in the public domain and may be reproduced or copied without permission from SAMHSA/CSAT/CMHS or the authors.

## Recommended Citation

Center for Substance Abuse Treatment. *Definitions and Terms Relating to Co-Occurring Disorders*. COCE Overview Paper 1. DHHS Publication No. (SMA) 06-4163 Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2006.

## Originating Offices

Co-Occurring and Homeless Activities Branch, Division of State and Community Assistance, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

Homeless Programs Branch, Division of Service and Systems Improvement, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

## Publication History

COCE Overview Papers are revised as the need arises. For a summary of all changes made in each version, go to COCE's Web site at: [coce.samhsa.gov/cod\\_resources/papers.htm](http://coce.samhsa.gov/cod_resources/papers.htm). Printed copies of this paper may not be as current as the versions posted on the Web site.

DHHS Publication No. (SMA) 06-4163  
Printed 2006.

Date posted on the Web site: 4/21/06

## SUMMARY

This paper provides definitions of terms associated with substance-related disorders, mental disorders, co-occurring disorders, and programs. The purpose for which a definition is used and the context in which it is used will affect its meaning, dimensions, and precision. Thus, context and purpose should be made explicit in any policy, initiative, financing mechanism, or system in which a definition is used.

## INTRODUCTION

It is essential to employ a common language in order to develop consensus on how to address the needs of persons with co-occurring disorders (COD). Over time, numerous terms have been used to describe co-occurring disorders and their treatment. To avoid confusion in terminology and provide a starting point for dialogue among service providers, administrators, financing agencies, and policymakers, this overview paper compiles definitions consistent with state-of-the-art science and treatment practices relating to COD.

## TERMS ASSOCIATED WITH SUBSTANCE-RELATED DISORDERS

### Substance Abuse, Substance Dependence, and Substance-Induced Disorders

The standard use of these terms derives from the DSM-IV-TR, within which substance-related disorders are divided into substance use disorders and substance-induced disorders. Substance use disorders are further divided into substance abuse and substance dependence.

There are 11 categories of substance use disorders (e.g., disorders related to alcohol, cannabis, cocaine, opioids, nicotine) (see Table 1), which are separated by criteria into abuse and dependence. The term “substance abuse” has come to be used informally to refer to both abuse and dependence. By and large, the terms “substance dependence” and “addiction” have come to mean the same thing, though debate exists about the interchangeable use of these terms. Finally, the system of care for substance-related disorders is usually referred to as the substance abuse treatment system.

Substance-induced disorders are important to consider in a discussion of COD. Although they actually represent the direct result of substance use, their presentation can be clinically identical to other mental disorders. Therefore, individuals with substance-induced disorders must be included in COD planning and service delivery.

**Substance abuse**, as defined in the DSM-IV-TR, is a “maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances” (American Psychiatric Association [APA], 2000,

p. 198). Individuals who abuse substances may experience harmful consequences such as

- Repeated failure to fulfill roles for which they are responsible
- Use in situations that are physically hazardous
- Legal difficulties
- Social and interpersonal problems

**Table 1: Classes of Substance Use Disorders**

- ▶ Alcohol
- ▶ Amphetamine or similarly acting sympathomimetics
- ▶ Caffeine
- ▶ Cannabis
- ▶ Cocaine
- ▶ Hallucinogens
- ▶ Inhalants
- ▶ Nicotine
- ▶ Opioids
- ▶ Phencyclidine (PCP) or similarly acting arylcyclohexylamines
- ▶ Sedatives, hypnotics, or anxiolytics

Source: APA, 2000, p. 191.

**Substance dependence** is “a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems” (APA, 2000, p. 192). This maladaptive pattern of substance use includes all the features of abuse and additionally such features as

- Increased tolerance for the drug, resulting in the need for ever-greater amounts of the substance to achieve the intended effect
- An obsession with securing the drug and with its use
- Persistence in using the drug in the face of serious physical or psychological problems

**Substance-induced disorders** include substance intoxication, substance withdrawal, and groups of symptoms that are “in excess of those usually associated with the intoxication or withdrawal that is characteristic of the particular substance and are sufficiently severe to warrant independent clinical attention” (APA, 2000, p. 210). Substance-induced disorders **present as** a wide variety of symptoms that are

characteristic of other mental disorders such as delirium, dementia, amnesia, psychosis, mood disturbance, anxiety, sleep disorders, and sexual dysfunction.

To meet diagnostic criteria, there must be evidence of substance intoxication or withdrawal, maladaptive behavior, and a temporal relationship between the symptoms and the substance use must be established. Clients will seek care for substance-induced disorders, such as cocaine-induced psychosis, and COD systems must be able to address these conditions.

## TERMS ASSOCIATED WITH MENTAL DISORDERS

The standard use of terms for non–substance–related mental disorders also derives from the DSM-IV-TR. These terms are used throughout the medical, social service, and behavioral health fields. The major relevant disorders for COD include schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, and personality disorders (see Table 2). While several disorders listed in the DSM-IV-TR may (and frequently do) co-exist with COD, they are excluded from the definition of co-occurring disorders because other service sectors have traditionally been responsible for caring for persons with these disorders (e.g., developmentally disabled) or the qualities of the disorder are not typically responsive to behavioral health interventions (e.g., dementia). In these instances, the costs of providing care typically come from sources outside the behavioral health system. For example, the elderly person with Alzheimer’s dementia and alcohol abuse will typically have service authorized by medical care organizations, while the adolescent with developmental disability and cannabis abuse will have services financed through State disability monies.

**Table 2: Major Relevant Categories of Mental Disorders for COD**

- ▶ Schizophrenia and other psychotic disorders
- ▶ Mood disorders
- ▶ Anxiety disorders
- ▶ Somatoform disorders
- ▶ Factitious disorders
- ▶ Dissociative disorders
- ▶ Sexual and gender identity disorders
- ▶ Eating disorders
- ▶ Sleep disorders
- ▶ Impulse-control disorders
- ▶ Adjustment disorders
- ▶ Personality disorders
- ▶ Disorders usually first diagnosed in infancy, childhood, or adolescence

Source: APA, 2000.

## Distinctions Between Mental Disorders and Serious Mental Illnesses

Normal, and even exaggerated, responses to stressful experiences should not be confused with a diagnosable mental disorder. Only when intense emotions, thoughts, and/or behaviors occur over extended periods of time and result in impairment in functioning are they considered mental disorders. Nonetheless, clients with substance use disorders will seek services for severe or acute symptoms that do not meet diagnostic criteria for a mental disorder. Like persons with substance-induced disorders, these individuals must be included in COD planning and service delivery because their symptoms require screening, assessment, and treatment planning. Mental disorders are characterized by:

- The nature and severity of symptoms
- The duration of symptoms
- The extent to which symptoms interfere with one’s ability to carry out daily routines, succeed at work or school, and form and keep meaningful interpersonal relationships

The Alcohol, Drug Abuse and Mental Health Administration Reorganization Act of 1992 (Public Law 102-321) required SAMHSA to develop definitions of serious emotional disturbance for children and adolescents and serious mental illness for adults. These definitions are used to establish Block Grant target populations and prevalence estimates for States but also have an application in the design and delivery of services for persons with COD. Despite efforts at standardization, each State has its own definition of these terms and its own definition of its “priority populations.” These definitions have implications for access to public mental health services.

Children with a **serious emotional disturbance** (SED) are defined as “persons from birth up to age 18, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the [DSM-IV], that resulted in functional impairment which substantially interferes with or limits the child’s role or functioning in family, school, or community activities” (CSAT, 1998, p. 266). Such roles or functioning include achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills.

Adults with a **serious mental illness** (SMI) are defined by SAMHSA as “persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the [DSM-IV], resulting in functional impairment which substantially interferes with or limits one or more major life activities” (CSAT, 1998, p. 265). Such activities can include:

- Basic daily living skills (e.g., eating, maintaining personal hygiene)

- Instrumental living skills (e.g., managing money, negotiating transportation, taking medication as prescribed)
- Functioning in social, family, and vocational or educational contexts

Two features of these definitions should be considered:

- Persons with SMI and SED include people with any mental disorder listed in the DSM-IV (or the equivalent *International Classification of Diseases, Tenth Revision*) with the exception of substance-related disorders, developmental disorders, dementias, and mental disorders due to a general medical condition, which are excluded unless they co-occur with another diagnosable SMI or SED.
- Adults or children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have SMI or SED.

## TERMS ASSOCIATED WITH CO-OCCURRING DISORDERS

### Co-Occurring Disorders

The term **co-occurring disorders** (COD) refers to co-occurring substance-related and mental disorders. Clients said to have COD have one or more substance-related disorders as well as one or more mental disorders. The definition of a person with COD (individual-level definition) must be distinguished from a person who requires COD services (service definition).

At the *individual level*, COD exist “when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from [a single disorder]” (CSAT, 2005, p. 3).

Some clients’ mental health and substance abuse problems may not, at a given point in time, fully meet the criteria for diagnoses in DSM-IV-TR categories. While conceptually ideal, diagnostic certainty cannot be the sole basis for system planning and program implementation. For these purposes, COCE encourages the use of a *service definition* of COD. A service definition reflects clinical realities and constraints and/or programmatically meaningful descriptions of “at-risk” populations targeted for prevention and early intervention.

A service definition of COD includes:

- Individuals who are “prediagnosis” in that an established diagnosis in one domain is matched with signs or symptoms of an evolving disorder in the other.
- Individuals who are “postdiagnosis” in that either one or both of their substance-related or mental disorders may have resolved for a substantial period of time.
- Individuals with a “unitary disorder and acute signs and/or symptoms of a co-occurring condition” who present for

services. Suicidal ideation in the context of a diagnosed substance use disorder is an excellent example of a mental health symptom that creates a severity problem, but by itself does not necessarily meet criteria for a formal DSM-IV-TR diagnosis. Substance-related suicidal ideation can produce catastrophic consequences. Consequently, some individuals may exhibit symptoms that suggest the existence of COD, but could be transitory (e.g., substance-induced mood disorders). While the intoxicated person in the emergency room with a diagnosis of a serious mental illness will not necessarily meet abuse or dependence criteria, he or she will still require COD assessment and treatment services.

For system planning and program design purposes, COCE recommends inclusion of the prediagnostic, postdiagnostic, and unitary disorder with acute signs and/or symptoms of a co-occurring condition in a service definition of COD.

Careful assessment to take all present and past signs and symptoms into account is necessary to distinguish among these three COD service subpopulations. Depending on the severity of their symptoms, these individuals may require the same full range of services needed by those who meet the individual criterion for COD (both conditions established independently).

Every initiative must clarify the purpose of defining COD. For a *system* to be responsive to the range of acute and long-term needs of persons with COD, the COD service definition is appropriate. At the *program* level, a narrower subgroup of persons with COD might be proposed that is consistent with the program’s license and staff expertise and credentials. Program definitions may also reflect fiscal realities concerning the COD subpopulations for whom payors are willing to fund services (see nicotine discussion below). Some *research hypotheses* may be better tested using the individual COD definition that excludes the pre- and postdiagnosis subpopulations, or specific diagnostic groups may be targeted.

**Every initiative must clarify the purpose of defining COD. For a system to be responsive to the range of acute and long-term needs of persons with COD, the COD service definition is appropriate.**

The inclusion or exclusion of specific addictive substances in COD definitions has considerable implications for service systems and program planning. Nicotine dependence is a disease of high prevalence, with extraordinarily high rates of morbidity and mortality, and frequently co-occurs with other addictive and mental disorders (Grant et al., 2004). While posing less severe health risks, caffeine dependence is likewise highly prevalent as a co-occurring disorder. These

addictive disorders are included within the individual and service definitions of COD, yet most programs will not target caffeine dependence for treatment, and most payors will not reimburse programs for caffeine interventions. Nicotine dependence will be a critical component of comprehensive assessment and treatment planning for all COD. However, COD service initiatives may choose not to include it as part of their COD service definition unless it co-occurs with an additional substance-related disorder.

Similar issues arise with the DSM-IV category of “impulse-control disorders not elsewhere classified.” This category includes kleptomania, pyromania, and pathological gambling. These disorders share features with substance-related disorders, and some similar intervention strategies have been used to treat them. The person with schizophrenia who routinely spends most of his discretionary income on lottery tickets would benefit from COD interventions. As such, impulse-control disorders should be screened for and assessed, and can be paired with mental disorders to meet COD criteria.

Caffeine dependence, nicotine dependence, and pathological gambling highlight the need to recognize two practical continua. The first is a continuum in the assignment of a COD diagnosis. Whether an individual has crossed the diagnostic threshold for COD ultimately is governed by clinical judgment and determined by multiple factors in addition to diagnoses. These include level of disability, effectiveness of available interventions, financing for interventions, and community and consumer values. Thus, for example, most persons with a mental disorder and caffeine addiction might not reasonably be diagnosed with COD. However, excessive caffeine use that triggers panic attacks in an individual with agoraphobia may qualify as a COD requiring integrated services.

The second continuum refers to eligibility criteria for specific programs or interventions. For example, public health goals would be well served by treating nicotine dependence in all persons with schizophrenia. However, providers may have a difficult time getting reimbursed for such treatment and may choose not to offer it.

Any COD definition should be consistent with the ultimate goal of alleviating the considerable pain and suffering associated with COD. Definitions that exclude vulnerable individuals from effective care should be reconsidered.

### Terms for the Course of Co-Occurring Disorders

- **Remission** refers to the absence of distress or impairment due to a substance use or mental disorder. An individual in remission no longer meets DSM-IV criteria for the previously diagnosed disorder but may well benefit from relapse prevention services.

- **Recovery** consists of “gaining information, increasing self-awareness, developing skills for sober living, and following a program of change” (Lowinson et al., 1992, p. 533). As defined in the President’s New Freedom Commission on Mental Health (NFCMH), recovery is “the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms” (NFCMH, 2003, p. 5). When people with COD are in recovery, it is implied that they are abstinent from the substance causing impairment, are able to function despite symptoms of mental illness, and participate in life activities that are meaningful and fulfilling to them.
- **Relapse** is the return to active substance use in a person with a diagnosed substance use disorder or the return of disabling psychiatric symptoms after a period of remission related to a nonaddictive mental disorder. Relapse is both an anticipated event in the course of recovery and a process in which warning signs appear prior to an individual’s actual recurrence of impairment.

### Quadrants of Care and the Integration Continuum

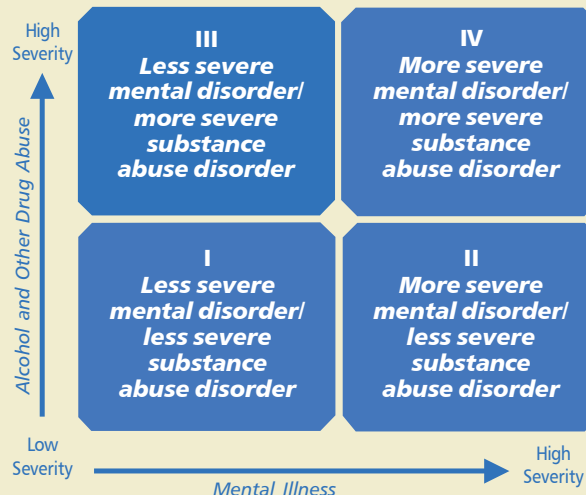
The *National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders* was cosponsored and facilitated by the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Meeting participants created a conceptual framework that classifies clients into four quadrants of care based on relative symptom severity, not diagnosis. The four quadrants are:

- I. Low addiction/low mental illness severity
- II. Low addiction/high mental illness
- III. High addiction/low mental illness
- IV. High addiction/high mental illness (IV) (NASMHPD and NASADAD, 1998) (see Figure 1, page 5).

This model provides a framework for understanding the range of co-occurring conditions and the level of coordination that service systems need to address them. Someone with acute mental illness symptoms and a substance use disorder can be assigned to Quadrant IV for a brief time, then drop back to a less severe quadrant. Although the four-quadrant model is not yet validated, COCE materials and technical assistance will use it to guide discussion and further conceptual development.

The four-quadrant model also provides a structure for moving beyond minimal coordination to fostering consultation, collaboration, and integration among systems and providers in order to deliver appropriate care to every client with COD. Coordination, consultation, collaboration, and integration are not discrete points. Rather, they reside upon a continuum. It is important to note that coordination, consultation, collabo-

**Figure 1: Co-Occurring Disorders by Severity**



Source: NASMHPD and NASADAD, 1998.

*The four-quadrant model provides a structure for moving beyond minimal coordination to fostering consultation, collaboration, and integration among systems and providers in order to deliver appropriate care to every client with COD.*

ration, and integration refer to organizational and provider behavior, and not to service systems structure or the location in which services are provided. The application of these approaches will be discussed in more detail in the COCE Paper titled “Services Integration for Persons With Co-Occurring Disorders.”

- **Minimal coordination** exists if a service provider either (1) is aware of a co-occurring condition or treatment but has no contact with other providers or (2) has referred a person with a co-occurring condition to another provider with little or no followup.
- **Consultation** is a relatively informal process for treating persons with COD, involving two or more service providers and requires the transmission of medical or clinical information or occasional exchange of information about the person’s status and progress. The threshold for “consultation” relative to “minimal coordination” is the occurrence of any interaction between providers after the initial referral, including active steps by the referring party to ensure that the referred person enters the recommended treatment service.
- **Collaboration** is a more formal process of sharing responsibility for treating a person with COD, involving regular and planned communication, sharing of progress reports, or entry into a memorandum of agreement. In a

collaborative relationship, different disorders are treated by different providers yet the roles and responsibilities of the providers are clear. The threshold for “collaboration” relative to “consultation” is the existence of formal agreements and/or expectations for continuing contact between providers.

- **Integration** requires the participation of providers trained in both substance abuse and mental health services to develop a single treatment plan addressing both sets of conditions and the continuing formal interaction and cooperation of these providers in the ongoing reassessment and treatment of the client. The threshold for “integration” relative to “collaboration” is the shared responsibility for the development and implementation of a treatment plan that addresses the COD. Although integrated services may be provided within a single program in a single location, this is not a requirement for an integrated system. Integration might be provided by a single individual, if he or she is qualified to provide services that are intended to address both conditions. Different levels and types of integration are possible, and there is no one way to achieve integrated treatment. Further, not all agencies have the same capacity or resources for achieving treatment integration. Recognizing an organization’s capabilities and providing for both substance and mental health services within those capabilities can enhance treatment effectiveness.

### Integrated Screening, Assessment, and Interventions

- **Integrated screening** is the determination of the likelihood that a person has a co-occurring substance use or mental disorder. The purpose is not to establish the presence or specific type of such a disorder but to establish the need for an in-depth assessment. Integrated screening is a formal process that typically is brief and occurs soon after the client presents for services.
- **Integrated assessment** consists of gathering information and engaging in a process with the client that enables the provider to establish the presence or absence of co-occurring disorders, determine the client’s readiness for change, identify client strengths or problem areas that may affect the processes of treatment and recovery, and engage the client in the development of an appropriate treatment relationship. The purpose of an assessment is to establish (or rule out) the existence of a clinical disorder or service need and to work with the client to develop a treatment and service plan.
- **Integrated interventions** are specific treatment strategies or therapeutic techniques in which interventions for all COD diagnoses or symptoms (if one is using a broad definition of COD) are combined in a single contact or in a series of contacts over time. These can be acute interventions to establish safety, as well as ongoing efforts to foster recovery.

## TERMS ASSOCIATED WITH PROGRAMS

A **program** is a formally organized array of services and interventions provided in a coherent manner at a specific level (or levels) of care in order to address the needs of particular target populations. Each program has its own staff competencies, policies, and procedures. Programs may be operated directly by public funders (e.g., States and counties) or by privately funded agencies. A single agency may operate many different programs. Some agencies operate only mental health programs; some operate only substance abuse treatment programs, and some do both.

### Program Types

The American Society of Addiction Medicine Patient Placement Criteria, Second Edition, Revised (ASAM PPC-2R) describes three types of programs for people with COD. These definitions should be used within mental health as well as addiction programs.

- **Addiction- or mental-health-only services** refers to programs that “either by choice or for lack of resources [staff or financial], cannot accommodate patients” who have co-occurring disorders that require “ongoing treatment, however stable the illness and however well-functioning the patient” (ASAM, 2001, p. 10).
- **Dual diagnosis capable** (DDC) programs are those that “address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning” (ASAM, 2001, p. 362). Even where such programs are geared primarily toward treating substance use or mental health disorders, program staff are “able to address the interaction between mental and substance-related disorders and their effect on the patient’s readiness to change—as well as relapse and recovery environment issues—through individual and group program content” (ASAM, 2001, p. 362).
- **Dual diagnosis enhanced** (DDE) programs have a higher level of integration of substance abuse and mental health treatment services. These programs are able to provide unified substance abuse and mental health treatment to clients who are, compared to those treatable

*Given the high prevalence of COD within all behavioral service settings, it is reasonable to expect programs to move toward dual diagnosis capable.*

in DDC programs, “more symptomatic and/or functionally impaired as a result of their co-occurring mental disorder” (ASAM, 2001, p. 10). Enhanced-level services “place their primary focus on the integration of services for mental and substance-related disorders in their staffing, services and program content” (ASAM, 2001, p. 362). The Integrated Dual Disorders Toolkit describes a particular type of dual diagnosis enhanced program for adults with SMI (CMHS, 2003).

These program types can be established at any level of care. Given the high prevalence of COD within all behavioral service settings, it is reasonable to expect programs to move toward dual diagnosis capable. While standards for DDC and DDE program licensure or certification have not been established at the national level, States are beginning to develop some core standards.

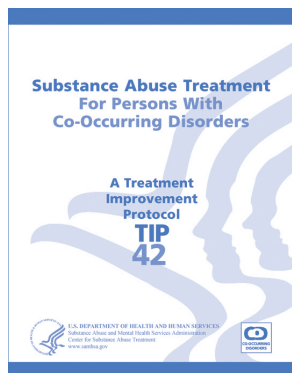
## CONCLUSION

The substance abuse and mental health fields have made considerable progress in addressing the needs of persons with co-occurring substance-related and mental disorders. To the extent that they can share a common language to improve clarity of communication, clinical and programmatic advances will continue. This COCE Overview Paper is an effort to ground these fields in such a common language, to provide a conceptual framework for developing definitions, and to support integrated substance abuse and mental health approaches to persons with COD. Definitions, informed by research and translated by clinical, economic, and political forces, must change over time. As such, this overview paper will be routinely updated to reflect COCE’s effort to bring consensus to the terms we use.

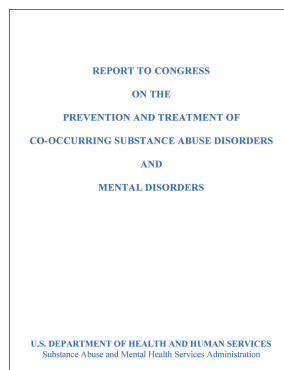
## RECOMMENDED REFERENCES

The definitions in this paper draw heavily on the work of SAMHSA consensus panels and consultants and are derived primarily from a select number of recent or forthcoming publications. It is our hope and expectation that readers of this overview paper will use these references to contextualize terms for their unique circumstances.

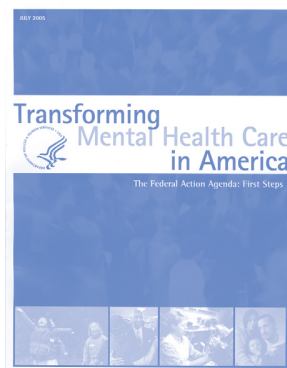
It is not the intent of this paper to provide a comprehensive inventory of language relating to COD, but rather to define the most common terms currently in use. A more complete catalog of COD-related terminology can be found in the glossary (Appendix C) of the TIP *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005).



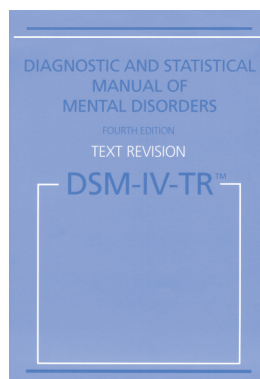
*Substance Abuse Treatment for Persons With Co-Occurring Disorders*, a publication in the Treatment Improvement Protocol (TIP) series of the Center for Substance Abuse Treatment (CSAT).  
**DHHS Publication No. (SMA) 05-3992.**



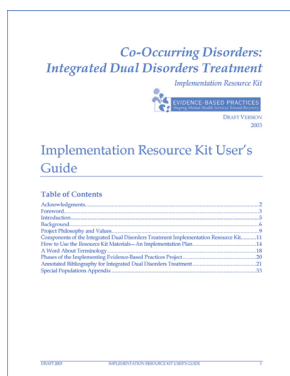
*Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*, released in December 2002. <http://alt.samhsa.gov/reports/congress2002/CoOccurringRpt.pdf>



*Transforming Mental Health Care in America: The Federal Action Agenda: First Steps*, released in July 2005, SAMHSA's recommendations for beginning to transform the mental health care system.  
**DHHS Publication No. (SMA) 05-4060.**



*The Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (American Psychiatric Association, 2000), used throughout the medical and mental health fields to define psychiatric and substance use disorders and provides clinicians with a common language for communicating about these disorders. Periodically updated.



*Co-Occurring Disorders: Integrated Dual Disorders Toolkit*, a project of the Center for Mental Health Services (CMHS), SAMHSA, DHHS, and The Robert Wood Johnson Foundation. Draft version, 2003. Revised version in development. <http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/>

## CITATIONS

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders*, Text Revision (4th ed.). Washington, DC: American Psychiatric Association.

American Society of Addiction Medicine. (2001). *Patient placement criteria for the treatment of substance-related disorders: ASAM PPC-2R* (2nd Rev. ed.) Chevy Chase, MD: American Society of Addiction Medicine.

Center for Mental Health Services. (1998). *Co-occurring psychiatric and substance disorders in managed care systems: Standards of care, practice guidelines, workforce competencies, and training curricula*. (Report of the Center for Mental Health Services Managed Care Initiative: Clinical Standards and Workforce Competencies Project. Co-Occurring Mental and Substance Disorders Panel.) Retrieved December 29, 2004, from <http://www.uphs.upenn.edu/cmhpsr/PDF/cooccurringfinal.pdf>

Center for Mental Health Services. (2003, draft version). *Co-occurring disorders: Integrated dual disorders treatment implementation resource kit*. Retrieved February 9, 2005, from <http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/>

Center for Substance Abuse Treatment. (1998). *Contracting for managed substance abuse and mental health services: A guide for public purchasers*. Technical Assistance Publication Series No. 22. DHHS Publication No. (SMA) 98-3173. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2005). *Substance abuse treatment for persons with co-occurring disorders*. Treatment Improvement Protocol (TIP) Series, No. 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Grant, B. F., Hasin, D. S., Chou, P., Stinson, F. S., & Dawson, D. A. (2004). Nicotine dependence and psychiatric disorders in the United States. *Archives of General Psychiatry*, 61, 1107–1115.

Lowinson, J. H., Ruiz, P., Millman, R. B., & Langrod, J. G. (1992). *Substance abuse: A comprehensive textbook*. Baltimore, MD: Williams and Wilkins.

Minkoff, K. (2001). Best practices: Developing standards of care for individuals with co-occurring psychiatric and substance use disorders. *Psychiatric Services*, 52, 597–599.

National Association of State Mental Health Program Directors & National Association of State Alcohol and Drug Abuse Directors. (1998). *National dialogue on co-occurring mental health and substance abuse disorders*. Washington, DC: National Association of State Alcohol and Drug Abuse Directors. Retrieved December 29, 2004, from [http://www.nasadad.org/Departments/Research/ConsensusFramework/national\\_dialogue\\_on.htm](http://www.nasadad.org/Departments/Research/ConsensusFramework/national_dialogue_on.htm)

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report*. DHHS Publication No. (SMA) 03-3832. Rockville, MD.

Substance Abuse and Mental Health Services Administration. (2002). *Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved November 29, 2004, from <http://alt.samhsa.gov/reports/congress2002/CoOccurringRpt.pdf>

Substance Abuse and Mental Health Services Administration. (2005). *Transforming mental health care in America. Federal action agenda: First steps*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

## COCE Senior Staff Members

### *The CDM Group, Inc.*

Rose M. Urban, LCSW, J.D., Executive Project Director  
Jill G. Hensley, M.A., Project Director  
Anthony J. Ernst, Ph.D.  
Fred C. Osher, M.D.  
Michael D. Klitzner, Ph.D.  
Sheldon R. Weinberg, Ph.D.  
Debbie Tate, M.S.W., LCSW

### *National Development & Research Institutes, Inc.*

Stanley Sacks, Ph.D.  
John Challis, B.A., B.S.W.  
JoAnn Sacks, Ph.D.

### *National Opinion Research Center at the University of Chicago*

Sam Schildhaus, Ph.D.

## COCE National Steering Council

Richard K. Ries, M.D., *Chair, Research Community Representative*

Richard N. Rosenthal, M.A., M.D., *Co-Chair, Department of Psychiatry, St. Luke's Roosevelt Hospital Center; American Academy of Addiction Psychiatry*

Ellen L. Bassuk, M.D., *Homelessness Community Representative*

Pat Bridgman, M.A., *CCDCIII-E, State Associations of Addiction Services*

Michael Cartwright, B.A., *Foundations Associates, Consumer/Survivor/Recovery Community Representative*

Redonna K. Chandler, Ph.D., *Ex-Officio Member, National Institute on Drug Abuse*

Joseph J. Cocozza, Ph.D., *Juvenile Justice Representative*

Gail Daumit, M.D., *Primary Care Community Representative*

Raymond Daw, M.A., *Tribal/Rural Community Representative*

Lewis E. Gallant, Ph.D., *National Association of State Alcohol and Drug Abuse Directors*

Andrew L. Homer, Ph.D., *Missouri Co-Occurring State Incentive Grant (COSIG)*

Andrew D. Hyman, J.D., *National Association of State Mental Health Program Directors*

Denise Juliano-Bult, M.S.W., *National Institute of Mental Health*

Deborah McLean Leow, M.S., *Northeast Center for the Application of Prevention Technologies*

Jennifer Michaels, M.D., *National Council for Community Behavioral Healthcare*

Lisa M. Najavits, Ph.D., *Trauma/Violence Community Representative*

Annelle B. Primm, M.D., M.P.H., *Cultural/Racial/Ethnic Populations Representative*

Deidra Roach, M.D., *Ex-Officio Member, National Institute on Alcohol Abuse and Alcoholism*

Marcia Starbecker, R.N., M.S.N., CCI, *Ex-Officio Member, Health Resources and Services Administration*

Sara Thompson, M.S.W., *National Mental Health Association*

Pamela Waters, M.Ed., *Addiction Technology Transfer Center*

Mary R. Woods, RNC, LADAC, MSHS, *National Association of Alcohol and Drug Abuse Counselors*

## COCE Senior Fellows

Barry S. Brown, M.S., Ph.D., *University of North Carolina at Wilmington*

Carlo C. DiClemente, M.A., Ph.D., *University of Maryland, Baltimore County*

Robert E. Drake, M.D., Ph.D., *New Hampshire-Dartmouth Psychiatric Research Center*

Michael Kirby, Ph.D., *Independent Consultant*

David Mee-Lee, M.S., M.D., *DML Training and Consulting*

Kenneth Minkoff, M.D., *ZiaLogic*

Bert Pepper, M.S., M.D., *Private Practice in Psychiatry*

Stephanie Perry, M.D., *Bureau of Alcohol and Drug Services, State of Tennessee*

Richard K. Ries, M.D., *Dual Disorder Program, Harborview Medical Center*

Linda Rosenberg, M.S.W., CSW, *National Council for Community Behavioral Healthcare*

Richard N. Rosenthal M.A., M.D., *Department of Psychiatry, St. Luke's Roosevelt Hospital Center*

Douglas M. Ziedonis, M.D., Ph.D., *Division of Psychiatry, Robert Wood Johnson Medical School*

Joan E. Zweben, Ph.D., *University of California - San Francisco*

## Affiliated Organizations

*Foundations Associates*

*National Addiction Technology Transfer Center*

*New England Research Institutes, Inc.*

*Northeast/IRFTA Addiction Technology Transfer Center*

*Northwest Frontier Addiction Technology Transfer Center*

*Pacific Southwest Addiction Technology Transfer Center*

*Policy Research Associates, Inc.*

*The National Center on Family Homelessness*

## COCE Overview Papers\*

*"Anchored in current science, research, and practices in the field of co-occurring disorders"*

- *Paper 1: Definitions and Terms Relating to Co-Occurring Disorders*
- *Paper 2: Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders*
- *Paper 3: Overarching Principles To Address the Needs of Persons With Co-Occurring Disorders*

\*Check the COCE Web site at [www.coce.samhsa.gov](http://www.coce.samhsa.gov) for up-to-date information on the status of overview papers in development.

For technical assistance:  
visit [www.coce.samhsa.gov](http://www.coce.samhsa.gov), e-mail [coce@samhsa.hhs.gov](mailto:coce@samhsa.hhs.gov), or call (301) 951-3369



A project funded by the  
Substance Abuse and Mental Health Services Administration's  
Center for Mental Health Services and Center for Substance Abuse Treatment



# Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders

## OVERVIEW PAPER 2



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
Substance Abuse and Mental Health Services Administration  
Center for Mental Health Services  
Center for Substance Abuse Treatment  
[www.samhsa.gov](http://www.samhsa.gov)

## About COCE and COCE Overview Papers

The Co-Occurring Center for Excellence (COCE), funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a leading national resource for the field of co-occurring mental health and substance use disorders (COD). COCE's mission is threefold: (1) to receive and transmit advances in treatment for all levels of COD severity, (2) to guide enhancements in the infrastructure and clinical capacities of service systems, and (3) to foster the infusion and adoption of evidence- and consensus-based COD treatment and program innovations into clinical practice. COCE consists of national and regional experts including COCE Senior Staff, Senior Fellows, Steering Council, affiliated organizations (see inside back cover), and a network of more than 200 senior consultants, all of whom join service recipients in shaping COCE's mission, guiding principles, and approaches. COCE accomplishes its mission through technical assistance and training, delivered through curriculums and materials online, by telephone, and through in-person consultation.

COCE Overview Papers are concise and easy-to-read introductions to state-of-the-art knowledge in COD. They are anchored in current science, research, and practices. The intended audiences for these overview papers are mental health and substance abuse administrators and policymakers at State and local levels, their counterparts in American Indian tribes, clinical providers, other providers, and agencies and systems through which clients might enter the COD treatment system. For a complete list of available overview papers, see the back cover.

For more information on COCE, including eligibility requirements and processes for receiving training or technical assistance, direct your e-mail to [coce@samhsa.hhs.gov](mailto:coce@samhsa.hhs.gov), call (301) 951-3369, or visit COCE's Web site at [www.coce.samhsa.gov](http://www.coce.samhsa.gov).

## Acknowledgments

COCE Overview Papers are produced by The CDM Group, Inc. (CDM) under Co-Occurring Center for Excellence (COCE) Contract Number 270-2003-00004, Task Order Number 270-2003-00004-0001 with the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). Jorielle R. Brown, Ph.D., Center for Substance Abuse Treatment (CSAT), serves as COCE's Task Order Officer, and Lawrence Rickards, Ph.D., Center for Mental Health Services (CMHS), serves as the Alternate Task Order Officer. George Kanuck, COCE's Task Order Officer with CSAT from September 2003 through November 2005, provided the initial Federal guidance and support for these products.

COCE Overview Papers follow a rigorous development process, including peer review. They incorporate contributions from COCE Senior Staff, Senior Fellows, consultants, and the CDM production team. Senior Staff members Michael D. Klitzner, Ph.D., Fred C. Osher, M.D., and Rose M. Urban, LCSW, J.D., co-lead the content and development process. Senior Staff member Michael D. Klitzner, Ph.D., made major writing contributions. Other major contributions were made by Project Director Jill Hensley, M.A.; Senior Fellows David Mee-Lee, M.S., M.D., Richard K. Ries, M.D., Michael Kirby, Ph.D., and Kenneth Minkoff, M.D.; and Senior Staff members Stanley Sacks, Ph.D., and Sheldon R. Weinberg, Ph.D. Editorial support was provided by CDM staff members Janet Humphrey, J. Max Gilbert, Michelle Myers, and Darlene Colbert.

## Disclaimer

The contents of this overview paper do not necessarily reflect the views or policies of CSAT, CMHS, SAMHSA, or DHHS. The guidelines in this paper should not be considered substitutes for individualized client care and treatment decisions.

## Electronic Access and Copies of Publication

impaired), (800) 487-4889, or electronically through the following Internet World Wide Web sites: [www.nacadi.samhsa.gov](http://www.nacadi.samhsa.gov) or [www.coce.samhsa.gov](http://www.coce.samhsa.gov).

## Public Domain Notice

All materials appearing in COCE Overview Papers, except those taken directly from copyrighted sources, are in the public domain and may be reproduced or copied without permission from SAMHSA/CSAT/CMHS or the authors.

## Recommended Citation

Center for Substance Abuse Treatment. *Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders*. COCE Overview Paper 2. DHHS Publication No. (SMA) 06-4164 Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2006.

## Originating Offices

Co-Occurring and Homeless Activities Branch, Division of State and Community Assistance, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

Homeless Programs Branch, Division of Service and Systems Improvement, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

## Publication History

COCE Overview Papers are revised as the need arises. For a summary of all changes made in each version, go to COCE's Web site at: [coce.samhsa.gov/cod\\_resources/papers.htm](http://coce.samhsa.gov/cod_resources/papers.htm). Printed copies of this paper may not be as current as the versions posted on the Web site.

DHHS Publication No. (SMA) 06-4164

## SUMMARY

Screening, assessment, and treatment planning (see Table 1, Key Definitions) constitute three interrelated components of a process that, when properly executed, informs and guides the provision of appropriate, client-centered services to persons with co-occurring disorders (COD). Clients with COD are best served through an integrated screening, assessment, and treatment planning process that addresses both substance use and mental disorders, each in the context of the other. This paper discusses the purpose, appropriate staffing, protocols, methods, advantages and disadvantages, and processes for integrated screening, assessment, and treatment planning for persons with COD as well as systems issues and financing.

## INTRODUCTION

Screening and assessment instruments are tools for information gathering, as are laboratory tests. However, the use of these tools alone does not constitute screening or assessment. Screening and assessment must allow flexibility within their formalized structures, balancing the need for consistency with the need to respond to important differences among clients. Screening and assessment data provide information that is evaluated and processed by the clinician and the client in the treatment planning process.

Screening, assessment, and treatment planning are not stand-alone activities. They are three components of a process that may be conducted by different agencies. Effective information sharing and following of clients most frequently occurs in systems where relevant agencies have a formal network, cross-training for staff, and formal procedures for information sharing and referral.

## LITERATURE HIGHLIGHTS

Integrated screening, assessment, and treatment planning (see Table 1, Key Definitions):

... begins at the earliest point of contact with the client, [and] continues through the relapse prevention stage. Information regarding a client's substance abuse and functional adjustment is gathered throughout the treatment process, along with evidence regarding the effects of interventions (or lack thereof). Treatment plans are then modified accordingly (Mueser et al., 2003, p. 49).

**A compendium of relevant COD screening and assessment instruments can be found in TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Appendixes G and H, pages 487–512 (Center for Substance Abuse Treatment [CSAT], 2005).**

**Table 1: Key Definitions**

|  |   |
|--|---|
| Screening  | Determines the likelihood that a client has co-occurring substance use and mental disorders or that his or her presenting signs, symptoms, or behaviors may be influenced by co-occurring issues. The purpose is not to establish the presence or specific type of such a disorder, but to establish the need for an in-depth assessment. Screening is a formal process that typically is brief and occurs soon after the client presents for services. |
| Assessment   | Gathers information and engages in a process with the client that enables the provider to establish (or rule out) the presence or absence of a co-occurring disorder. Determines the client's readiness for change, identifies client strengths or problem areas that may affect the processes of treatment and recovery, and engages the client in the development of an appropriate treatment relationship.   |
| Treatment Planning                                       | Develops a comprehensive set of staged, integrated program placements and treatment interventions for each disorder that is adjusted as needed to take into account issues related to the other disorder. The plan is matched to the individual needs, readiness, preferences, and personal goals of the client.  |
| Integrated Screening, Assessment, and Treatment Planning | Screening, assessment, and treatment planning that address both mental health and substance abuse, each in the context of the other disorder.   |

A vast amount of literature exists on screening, assessment, and treatment planning in substance abuse treatment and an equally vast amount in mental health settings. Considerably less material has been published on screening, assessment, and treatment planning specifically addressing persons with (or suspected of having) COD. However, a clinically meaningful and useful screening, assessment, and treatment planning process will necessarily include procedures, practices, and tools drawn from both the substance abuse and mental health fields.

Clients with COD are best served when screening, assessment, and treatment planning are integrated, addressing both substance abuse and mental health disorders, each in the context of the other. Diagnostic certainty cannot be the basis for service planning and design, and COCE encourages the use of a broad definition of COD based on client service needs. For example, some clients' mental health and substance abuse problems may not, at a given point in time, fully meet the criteria for diagnoses in categories from the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition Text Revision (DSM-IV-TR)* (American Psychiatric Association, 2000). Nonetheless, they would be included in a broad definition of COD to allow responses to the real needs of consumers.

The process of integrated screening, assessment, and treatment planning will vary depending on the information available at the time of initial contact with the client. The special challenge of screening, assessment, and treatment planning in COD is to explore, determine, and respond to the effects of two mutually interacting disorders. Because neither substance abuse nor mental illness should be considered primary for a person with COD (Lehman et al., 1998; Mueser et al., 2003), an existing diagnosis of mental illness or substance abuse is a point of departure only.

The complexity of COD dictates that screening, assessment, and treatment planning cannot be bound by a rigid formula. Rather, the success of this process depends on the skills and creativity of the clinician in applying available procedures, tools, and laboratory tests and on the relationships established with the client and his or her intimates.

## KEY QUESTIONS AND ANSWERS

### Overview Question

#### 1. How do screening, assessment, and treatment planning relate to one another?

Figure 1 (page 3) summarizes the relationships among screening, assessment, and treatment planning and their usual ordering in time. Note the iterative relationship between treatment planning and assessment. Rather than being one-time events, these activities constitute a process of continual refinement and adaptation to changing client

circumstances. Figure 1 introduces the concept of *Contact* (see left-hand side of the figure), which refers to the fact that there is “no wrong door” through which a client can enter the COD system of care. The capacity for screening and the ability to recognize that some form of assistance is required should be available at any point in the service system (CSAT, 2000).

### Integrated Screening (see Table 1, Key Definitions, page 1)

#### 1. What is the purpose of integrated screening?

Integrated screening addresses both mental health and substance abuse, each in the context of the other disorder. Integrated screening seeks to answer a yes/no question: “Is there sufficient evidence of a substance use and/or other mental disorder to warrant further exploration?” A comprehensive screening process also includes exploration of a variety of related service needs including medical, housing, victimization, trauma, and so on. In other words, screening expedites entry into appropriate services. At this point in the screening, assessment, and treatment planning process, the goal is to identify everyone who *might* have COD and related service needs.

#### 2. Who is responsible for integrated screening and in what settings does it occur?

There are seldom any legal or professional restraints on who can be trained to conduct a screening. If properly trained staff are available, integrated screening can occur in any health or human services context as well as within the criminal justice, homeless services, and educational systems. The broader the range of relevant contexts in which screening can occur in a given community, the greater the probability that persons with COD will be identified and referred for further assessment and treatment. Ideally, screening should take place in a wide variety of settings.

#### 3. What protocols are allowed in conducting an integrated screening?

Any screening protocols, including integrated screening, must specify the methods to be followed and the questions to be asked. If tools or instruments are to be used, integrated screening protocols must indicate what constitutes scoring positive for a specific potential problem (often called “establishing cut-off scores”). Additionally, the screening protocol must detail exactly what is to take place when the client scores in the positive range (e.g., where the client is to be referred for further assessment). Finally, a screening protocol should provide a format for recording the results of the screening, other relevant client information, and the disposition of the case. See also TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005).

4. What methods are used to conduct an integrated screening?

Information-gathering methods for screening may include screening instruments, laboratory tests, clinical interviews, and personal contact. The circumstances of contact, the client's demeanor and behavior, signs of acute intoxication, physical signs suggesting drug use or attempts at self-harm, and information offered spontaneously by the client or intimates can be indicators of substance use and/or mental disorders.

5. What are the advantages and disadvantages of screening instruments?

Screening instruments can be an efficient form of information gathering. **A compendium of relevant screening instruments can be found in TIP 42, Appendixes G and H, pages 487–512 (CSAT, 2005).** The advantages of using screening tools are the simplicity of their use and scoring, the generally limited training needed for their administration, and, for well-researched tools, a known level of reliability and the availability of cut-off scores. One disadvantage of screening instruments is that they sometimes become the *only* component of the screening process. A second disadvantage is that a routinely administered screening instrument provides little opportunity to establish a connection with the client. Such a connection may be important in motivating the client to accept a referral for assessment if needed.

6. Is there one right integrated screening process for all clients?

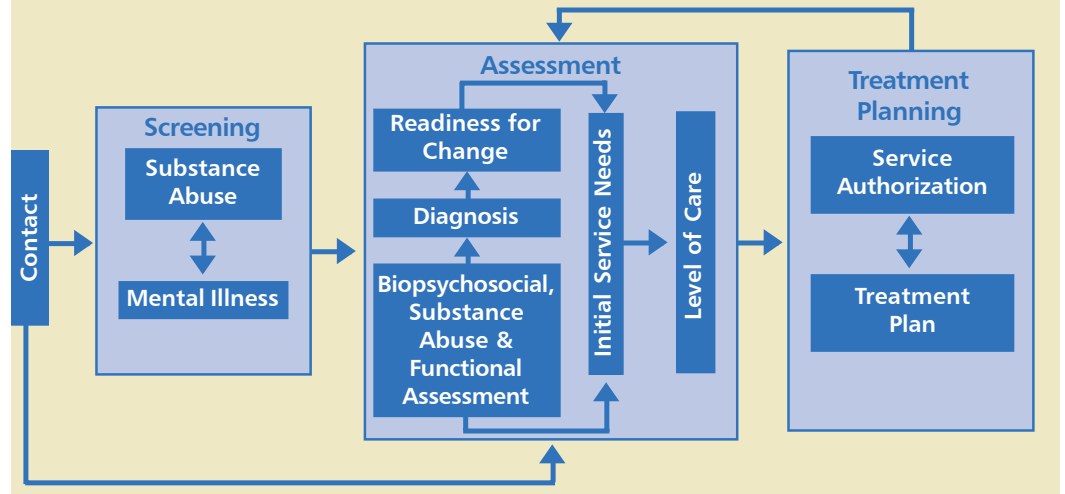
Both the screening process and the interpretation of screening information will depend on the client's language of preference, culture, and age. For all of these reasons, the screening process must allow flexibility within its formalized structure, balancing the need for consistency with the need to respond to important differences among clients.

**Integrated Assessment (see Table 1, Key Definitions, page 1)**

1. What is the purpose of integrated assessment?

Like integrated screening, integrated assessment addresses both mental health and substance abuse, each in the context of the other disorder. Integrated assessment seeks to (1) establish formal diagnoses (see the COCE Overview Paper titled "Definitions and Terms Relating to Co-Occurring

Figure 1: Relationships Among Screening, Assessment, and Treatment Planning



Disorders”), (2) evaluate level of functioning (i.e., current cognitive capacity, social skills, and other abilities) to identify factors that could interfere with the ability to function independently and/or follow treatment recommendations, (3) determine the client's readiness for change, and (4) make initial decisions about appropriate level of care. Integrated assessment also should consider cultural and linguistic issues, amount of social support, special life circumstances (e.g., women with children), and medical conditions (e.g., HIV/AIDS, tuberculosis) that may affect services choices and the client's ability to profit from them.

The assessment process should be client-centered in order to fully motivate and engage the client in the assessment and treatment process. *Client-centered* means that the client's perceptions of his or her problem(s) and the goals he or she wishes to accomplish are central to the assessment and to the recommendations that derive from it.

2. Who is responsible for integrated assessment, and in what settings does it occur?

Integrated assessment may be conducted by any mental health or substance abuse professional who has the specialized training and skills required. DSM-IV-TR diagnosis is accomplished by referral to a psychiatrist, clinical psychologist, licensed clinical social worker, or other qualified healthcare professional who is licensed by the State to diagnose mental disorders. Note that certain assessment instruments can only be obtained and administered by a licensed psychologist. In some cases (e.g., persons without a confirmed diagnosis of either a substance use or mental health disorder, and persons with additional special needs such as homeless or dependent adults), an assessment team including substance abuse and mental health professionals and other service providers may be needed to complete the assessment. Generally, assessment occurs in a mental health or substance abuse treatment

facility. In some cases, communities or large systems within communities (e.g., the corrections system) may establish freestanding assessment centers.

### 3. *What protocols are followed in conducting an integrated assessment?*

As shown in Table 2, there are 12 specific steps in the assessment process. Chapter 4 in TIP 42 (CSAT, 2005) describes these steps in detail. Through these steps, the assessment seeks to accomplish the following aims:

- Obtain a detailed chronological history of past symptoms, diagnoses, treatment, and impairment for both mental health and substance abuse.
- Obtain a detailed description of current strengths, supports, limitations, and cultural barriers related to following the recommended treatment regimen for any disorder or problem.
- Determine stage of change for *each problem*. (If a clinician is asked, “What stage of change is the client in?” the correct answer is *always*, “For which problem?”)
- Identify social supports and other factors that might help promote treatment adherence.
- Find out what clients want, in terms of their perception of the problem, what they want to change, and how they think that change will occur.

The assessment for COD is integrated by analyzing data concerning one disorder in light of data concerning the other disorder. For example, attention to mental health symptoms, impairments, diagnoses, and treatments during past episodes of substance abuse and abstinence can illuminate the role of substance abuse in maintaining, worsening, and/or interfering with the treatment of any mental disorder.

### 4. *What methods are used to conduct an integrated assessment?*

An assessment may include a variety of information-gathering methods including the administration of assessment instruments, an in-depth clinical interview, a social history, a treatment history, interviews with friends and family after receipt of appropriate client authorization(s), a review of medical and psychiatric records, a physical examination, and laboratory tests (toxicology screens, tests for infectious diseases and organ system damage, etc.).

### 5. *What are the advantages and disadvantages of assessment instruments?*

Assessment instruments constitute a structured method for gathering information in many areas, and for establishing assessment scores that define problem areas. **Appendix G, pages 487–495 of TIP 42 (CSAT, 2005) provides relevant examples of instruments that may be used in the assessment of COD.** Assessment instruments also can function as “ticklers” or memory aids to the clinician or team, assisting in making sure that all relevant topics are

**Table 2: The 12-Step Assessment Process**

1. Engage the client
2. Upon receipt of appropriate client authorization(s), identify and contact collaterals (family, friends, other treatment providers) to gather additional information
3. Screen for and detect COD
4. Determine severity of mental and substance use disorders
5. Determine appropriate care setting (e.g., inpatient, outpatient, day-treatment)
6. Determine diagnoses
7. Determine disability and functional impairment
8. Identify strengths and supports
9. Identify cultural and linguistic needs and supports
10. Identify additional problem areas to address (e.g., physical health, housing, vocational, educational, social, spiritual, cognitive, etc.)
11. Determine readiness for change
12. Plan treatment

covered. Assessment instruments should be viewed as providing information that is part of the assessment process. They do not themselves constitute an assessment. In particular, instruments do not accomplish the interpersonal goals of assessment: making the client feel welcome in the treatment system, engaging the client as an active partner in his or her care, and beginning the therapeutic alliance that will exist throughout the client’s relationship with helping resources.

### 6. *Is there one correct integrated assessment process for all clients?*

No, there is not. The integrated assessment process must be tailored to the needs of the specific client. For example:

- Cultural identity may play a significant role in determining the client’s (and his or her intimates’) view of the problem and the treatment. Ethnic culture may affect perception of what constitutes a “problem,” the meaning of help seeking, and attitudes toward caregivers and institutions.
- Members of some nonethnic subcultures (e.g., sex workers, gang members) may hold beliefs and values that are unfamiliar to nonmembers.
- Clients may participate in treatment cultures (12-Step recovery, Dual Recovery Self-Help, various alternative healing practices) that affect how they view treatment and treatment providers.
- A client’s sexual orientation and family situation will enhance understanding of the client’s personal identity, living situation, and relationships.

## Integrated Treatment Planning (See Table 1, Key Definitions, page 1)

### 1. What is the process of integrated treatment planning, and how does this process relate to integrated screening and assessment?

Integrated treatment planning addresses both mental health and substance abuse, each in the context of the other disorder. During integrated treatment planning phases, initial decisions are made about what services the client needs and wants, where these services will be provided, who will share responsibility with the client for monitoring progress, how the services of different providers will be coordinated, and how services will be reimbursed. The latter will sometimes involve seeking service authorization to obtain reimbursement, which may, in turn, place constraints on the treatment plan or require revisions of it. Treatment planning should be client centered, addressing clients' goals and using treatment strategies that are acceptable to them.

Screening and assessment data provide information that is integrated by the clinician and the client in the treatment planning process. Screening and assessment data also are useful in establishing a client's baseline of signs, symptoms, and behaviors that can then be used to assess progress.

Table 3 (adapted from Mueser et al., 2003) describes the components of a client-centered treatment plan. The treatment plan is never a static document. As changes in the client's status occur and as new relevant information comes to light, the treatment plan must be reconsidered and adjusted.

### 2. Who is responsible for integrated treatment planning?

The client-centered treatment plan is the joint responsibility of the clinician or clinical team and *the client*. The client-centered plan is guided by what the client wishes to accomplish and the methods that are acceptable to him or her. In systems where care is managed, some aspects of the plan may require authorization by payors. Securing service authorization is the responsibility of the providers. If a provider is unable to obtain service authorization, the client and the provider should explore together what possible modifications to the treatment plan will best meet the client's needs and satisfy reimbursement requirements.

## Systems Issues and Financing

### 1. Why is service integration crucial to screening, assessment, and treatment planning?

Screening, assessment, and treatment planning are not stand-alone activities. They are three components of a treatment process. Screening, assessment, and treatment planning may be conducted by multiple agencies. Information must be shared accurately and efficiently between agencies, while conforming to Federal confidentiality laws. Equally important, making referrals among agencies requires monitoring to ensure that clients referred actually arrive at the referral site and receive needed services. Effective information sharing and tracking of clients most likely occurs in systems where relevant agencies have formal relationships (e.g., memoranda of understanding), receive cross-training,

**Table 3: The Components of a Client-Centered Treatment Plan** (adapted from Mueser et al., 2003)

|   |  |
|---|--|
| <b>Acute Safety Needs</b>   | Determines the need for immediate acute stabilization to establish safety prior to routine assessment  |
| <b>Severity of Mental and Substance Use Disorders</b>                                     | Guides the choice of the most appropriate setting for treatment  |
| <b>Appropriate Care Setting</b>   | Determines the client's program assignment (see American Society of Addiction Medicine, 2001)  |
| <b>Diagnosis</b>  | Determines the recommended treatment intervention  |
| <b>Disability</b>   | Determines case management needs and whether an enhanced level of intervention is required   |
| <b>Strengths and Skills</b>   | Determines areas of prior success around which to organize future treatment interventions and determines areas of skill-building needed for management of either disorder  |
| <b>Availability and Continuity of Recovery Support</b>                                    | Determines whether continuing relationships need to be established and availability of existing relationships to provide contingencies to promote learning   |
| <b>Cultural Context</b>   | Determines most culturally appropriate treatment interventions and settings  |
| <b>Problem Priorities</b>   | Determines problems to be solved specifically, and opportunities for contingencies to promote treatment participation  |
| <b>State of Recovery/ Client's Readiness to Change Behaviors Relating to Each Problem</b> | Determines appropriate treatment interventions and outcomes for a client at a given stage of recovery or readiness for change (see TIP 35, <i>Enhancing Motivation for Change in Substance Abuse Treatment</i> [CSAT, 1991]) |

and have formal procedures for information sharing and referral.

## 2. How are screening, assessment, and treatment planning reimbursed?

In healthcare settings (mental health, substance abuse, primary care, etc.), screening may be reimbursed as part of an initial visit. In other settings (criminal justice, schools, homeless services), screening activities are not likely to be “reimbursed” as they are usually conducted by a salaried employee (e.g., probation officer, school psychologist) who is performing screening services on behalf of an agency that mandates or allows screening to be conducted in the ordinary course of its business.

Assessment is a necessary part of treatment and accordingly may be reimbursed as part of the services provided by a qualified treatment program. However, cases may arise in which the costs of assessment are not completely reimbursable.

In some instances, not all treatment services required by persons with COD will be reimbursable or reimbursable at intensities or durations commensurate with the integrated treatment plan. Significant variations exist within States and among health plans concerning the nature and type of behavioral health services that are covered. In cases where reimbursement is unavailable or inadequate, providers must arrive at alternate treatment plans in concert with their clients, and document the adequacy and goals of the alternate plan.

## 3. What is the legal exposure for a program that identifies problems in the screening and assessment process for which the program cannot provide treatment?

Not all programs are expected to be able to treat every type of disorder, even if those disorders are identified by the program’s screening and assessment procedures. To avoid negative legal consequences and fulfill ethical obligations to clients, at a minimum, programs must be able to refer clients with identified disorders or combinations of disorders for appropriate treatment.

## FUTURE DIRECTIONS

The technology of screening, assessment, and treatment planning for COD is constantly under refinement. One pressing need is for screening, assessment, and treatment planning protocols that are designed to meet the needs of a

variety of special populations, including adolescents; lesbian, gay, and bisexual individuals; women with children; and older adults. The processes of knowledge transfer and adoption must also be better refined to facilitate the widespread and informed use of valid and reliable screening and assessment instruments, and treatment planning protocols.

At the system level, policies and regulations can encourage standardized, integrated screening, assessment, and treatment planning processes to increase the provision of appropriate services to people with COD and to enable outcomes-monitoring across programs. Encouraging trends in this regard are to be found in several States that are moving toward statewide screening and assessment standards.

## CITATIONS

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders*. (Text revision 4th ed.). Washington, DC: American Psychiatric Association.

American Society of Addiction Medicine. (2001). *Patient placement criteria for the treatment of substance-related disorders: ASAM PPC-2R*. (2nd revised ed.). Chevy Chase, MD: American Society of Addiction Medicine.

Center for Substance Abuse Treatment. (1999). *Enhancing motivation for change in substance abuse treatment*. Treatment Improvement Protocol (TIP) series no. 35 (DHHS Publication No. (SMA) 99-3354). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2000). *Changing the conversation: Improving substance abuse treatment: The National Treatment Improvement Plan Initiative*. (DHHS Publication No. (SMA) 00-3480). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2005). *Substance abuse treatment for persons with co-occurring disorders*. Treatment Improvement Protocol (TIP) series no. 42 (DHHS Publication No. (SMA) 05-3992). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Lehman, W. E. K., Farabee, D. J., & Bennett, J. B. (1998). Perceptions and correlates of co-worker substance use. *Employee Assistance Quarterly*, 13(4), 1–22.

Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: Guilford Press.

# Overarching Principles To Address the Needs of Persons With Co-Occurring Disorders

## OVERVIEW PAPER 3



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
Substance Abuse and Mental Health Services Administration  
Center for Mental Health Services  
Center for Substance Abuse Treatment  
[www.samhsa.gov](http://www.samhsa.gov)

## About COCE and COCE Overview Papers

The Co-Occurring Center for Excellence (COCE), funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a leading national resource for the field of co-occurring mental health and substance use disorders (COD). COCE's mission is threefold: (1) to receive and transmit advances in treatment for all levels of COD severity, (2) to guide enhancements in the infrastructure and clinical capacities of service systems, and (3) to foster the infusion and adoption of evidence- and consensus-based COD treatment and program innovations into clinical practice. COCE consists of national and regional experts including COCE Senior Staff, Senior Fellows, Steering Council, affiliated organizations (see inside back cover), and a network of more than 200 senior consultants, all of whom join service recipients in shaping COCE's mission, guiding principles, and approaches. COCE accomplishes its mission through technical assistance and training, delivered through curriculums and materials online, by telephone, and through in-person consultation.

COCE Overview Papers are concise and easy-to-read introductions to state-of-the-art knowledge in COD. They are anchored in current science, research, and practices. The intended audiences for these overview papers are mental health and substance abuse administrators and policymakers at State and local levels, their counterparts in American Indian tribes, clinical providers, other providers, and agencies and systems through which clients might enter the COD treatment system. For a complete list of available overview papers, see the back cover.

For more information on COCE, including eligibility requirements and processes for receiving training or technical assistance, direct your e-mail to [coce@samhsa.hhs.gov](mailto:coce@samhsa.hhs.gov), call (301) 951-3369, or visit COCE's Web site at [www.coce.samhsa.gov](http://www.coce.samhsa.gov).

## Acknowledgments

COCE Overview Papers are produced by The CDM Group, Inc. (CDM) under Co-Occurring Center for Excellence (COCE) Contract Number 270-2003-00004, Task Order Number 270-2003-00004-0001 with the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). Jorielle R. Brown, Ph.D., Center for Substance Abuse Treatment (CSAT), serves as COCE's Task Order Officer, and Lawrence Rickards, Ph.D., Center for Mental Health Services (CMHS), serves as the Alternate Task Order Officer. George Kanuck, COCE's Task Order Officer with CSAT from September 2003 through November 2005, provided the initial Federal guidance and support for these products.

COCE Overview Papers follow a rigorous development process, including peer review. They incorporate contributions from COCE Senior Staff, Senior Fellows, consultants, and the CDM production team. Senior Staff members Michael D. Klitzner, Ph.D., Fred C. Osher, M.D., and Rose M. Urban, LCSW, J.D., co-led the content and development process. Senior Staff member Fred C. Osher, M.D., made major writing contributions. Other major contributions were made by Project Director Jill G. Hensley, M.A.; Senior Staff Members Stanley Sacks, Ph.D., JoAnn Sacks, Ph.D., and Sheldon R. Weinberg, Ph.D.; and Senior Fellows Kenneth Minkoff, M.D., David Mee-Lee, M.S., M.D., Richard N. Rosenthal, M.A., M.D., and Joan E. Zweben, Ph.D. Editorial support was provided by CDM staff members J. Max Gilbert, Michelle Myers, and Darlene Colbert.

## Disclaimer

The contents of this overview paper do not necessarily reflect the views or policies of CSAT, CMHS, SAMHSA, or DHHS. The guidelines in this paper should not be considered substitutes for individualized client care and treatment decisions.

## Electronic Access and Copies of Publication

Copies may be obtained free of charge from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI),

impaired), (800) 487-4889, or electronically through the following Internet World Wide Web sites: [www.nacadi.samhsa.gov](http://www.nacadi.samhsa.gov) or [www.coce.samhsa.gov](http://www.coce.samhsa.gov).

## Public Domain Notice

All materials appearing in COCE Overview Papers, except those taken directly from copyrighted sources, are in the public domain and may be reproduced or copied without permission from SAMHSA/CSAT/CMHS or the authors.

## Recommended Citation

Center for Substance Abuse Treatment. *Overarching Principles To Address the Needs of Persons With Co-Occurring Disorders*. COCE Overview Paper 3. DHHS Publication No. (SMA) 06-4165 Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

## Originating Offices

Co-Occurring and Homeless Activities Branch, Division of State and Community Assistance, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

Homeless Programs Branch, Division of Service and Systems Improvement, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

## Publication History

COCE Overview Papers are revised as the need arises. For a summary of all changes made in each version, go to COCE's Web site at: [coce.samhsa.gov/cod\\_resources/papers.htm](http://coce.samhsa.gov/cod_resources/papers.htm). Printed copies of this paper may not be as current as the versions posted on the Web site.

DHHS Publication No. (SMA) 06-4165  
Printed 2006.

Revised on the Web site: 10/1/06

## SUMMARY

This overview paper outlines 12 overarching principles for working with persons with co-occurring disorders (COD). These principles are intended to help guide, but not define, systemic and clinical responses. They are grouped according to whether they guide systems of care or individual providers and can be used as benchmarks to assess whether plans in development, or programs in operation, are grounded in the field's best thinking. Definitions of key terms used in this paper may be found in Table 1, Key Definitions. (See below.)

## INTRODUCTION

Overarching principles (see Table 1, Key Definitions) for working with persons with COD serve two major purposes. First, they provide a foundation for planning, delivering, financing, and evaluating services and systems of care. These principles shape our vision, and adherence to them should help us formulate and attain our goals and objectives. Principles, by their nature, are consistent with a concern for the well-being of the client and his loved ones. Second, these consensus-based overarching principles can serve to inform system design and service intervention in the absence of other evidence-based practices. Research in the field of COD has led to the development of evidence-based practices associated with positive outcomes for consumers with COD. While these advances are critical to our efforts to improve treatment, it will be some time before evidence-based interventions are available to treat all of the many conditions and needs of persons with COD.

## LITERATURE HIGHLIGHTS

Many authors and groups have articulated principles for working with persons with COD (American Association of Community Psychiatrists, 2000; Center for Mental Health Services [CMHS], 1996, 1998; Center for Substance Abuse Treatment [CSAT], 2005; Minkoff & Cline, 2004; National Institute on Drug Abuse, 1999; Osher, 1996). Because these principles are derived from the accumulated experience of mental health and substance abuse professionals over many decades of practice, they are well established in the field. These principles for treating COD may overlap, but should not conflict with the principles that underlie the delivery of mental health or substance abuse treatment services alone. In this overview paper, COCE aggregates the wisdom of both fields in presenting 12 principles to assist in the development, delivery, and evaluation of efforts to improve the lives of persons with COD.

**Table 1: Key Definitions**

|                      |  |
|----------------------|--|
| <b>Principle</b>     | "A basic generalization that is accepted as true and that can be used as a basis for reasoning or conduct" (WordNet ® 2.0, © 2003 Princeton University). Principles serve to guide the design of systems and implementation of service interventions.  |
| <b>No Wrong Door</b> | An approach to service organization that provides individuals with or links them to appropriate service interventions regardless of where they enter the system of care. This principle commits all service agencies to respond to the individual's stated and assessed needs through either direct service or a linkage to appropriate programs, as opposed to sending the person from one agency to another.   |
| <b>Evidence</b>      | Evidence is information that suggests a clearly identified outcome will result from a clearly identified practice or intervention. Evidence can be derived from different approaches yielding different degrees of certainty. The most reliable evidence comes from multiple published, peer-reviewed studies done by different investigators using (1) rigorous design, measurement, and analysis techniques; (2) random assignment to control and experimental conditions; (3) large number of subjects; and (4) multiple settings. Departures from these optimal study characteristics will yield weaker evidence. Important observations can be made by clinicians or administrators about the relationship of outcomes to interventions. The collection of evidence from such observations is generally considered to be a first step in gathering evidence of effectiveness. |
| <b>Consensus</b>     | Consensus is general agreement among a group of experts in the field about the implications of available evidence concerning practices or interventions. When evidence for the effectiveness of a specific practice is limited, the process of achieving consensus is informed by clinical experience consistent with clear theoretical underpinnings. The judgments arrived at by most of those concerned are used to identify evidence-based, promising, and emerging practices as well as to develop practice guidelines and clinical recommendations.  |

## PRINCIPLES THAT GUIDE SYSTEMS OF CARE FOR PEOPLE WITH COD

### **Principle 1**

Co-occurring disorders are to be expected in all behavioral health settings, and system planning must address the need to serve people with COD in all policies, regulations, funding mechanisms, and programming.

This principle is established through a rich literature of epidemiologic and clinical studies that documents considerable prevalence rates of COD in the general population and high rates of COD within populations seeking treatment. Failure to address COD in either substance abuse treatment or mental health programs is tantamount to not responding to the needs of the majority of program participants.

The implications of this principle are far reaching. For mental health or substance abuse systems to be effective with their target populations, all programs within the system must be competent to screen, assess, and address COD. Policies and procedures must explicitly acknowledge COD and define requirements for addressing the needs of persons with COD. Regulations concerning program and professional licensing and certification must explicitly detail requirements regarding COD activities and skill sets. Financing mechanisms also must be developed that facilitate rather than impede meeting the multiple services needs of persons with COD. The goal of system design and implementation is to offer any person with COD access to a range of programs that provides individually matched services consistent with the rest of the principles enumerated here.

### **Principle 2**

An integrated system of mental health and addiction services that emphasizes continuity and quality is in the best interest of consumers, providers, programs, funders, and systems.

In order to plan for an ideal system of care, it is necessary to have a common vision of that system, what its goals and objectives would be, and how one would measure its effectiveness. The shared vision guides the development of programs and policies, and the allocation of scarce resources. A truly integrated system promotes the seamless delivery of mental health and substance abuse treatment services through a variety of agencies across all behavioral health settings. The strength of existing systems to serve individuals with “only” a

mental or an addictive disorder must be preserved in the transformation to integrated models.

While not all programs within a system must provide comprehensive integrated care, the system must provide consumers with services matched to their specific needs within levels of care matched to the immediate intensity of these needs. Ongoing monitoring to assess whether the services supplied meet consumer demand is integral, and systems of care must be flexible enough to shift resources based on monitored outcomes.

Administrators, providers, and consumers should be informed of the range of available mental health and addiction services to facilitate access to programs providing integrated services. Continuity of care requires mechanisms for client movement between service levels and over periods of time determined by clinical necessity rather than administrative policy. Achieving quality requires a systemic commitment to define and monitor desired outcomes, hire and train competent staff, review and regulate programs, and provide feedback within a quality improvement framework. It also requires reimbursement structures that support and encourage integrated care.

### **Principle 3**

The integrated system of care must be accessible from multiple points of entry (i.e., no wrong door) and be perceived as caring and accepting by the consumer (see Table 1, Key Definitions, page 1).

It is unreasonable to assume that consumers understand the cause(s) of their mood, thought, or behavioral problems prior to seeking help. To overcome the stigma associated with behavioral health difficulties and seek treatment is a major step on the road to resolution of these problems.

Many people with COD lack the capacity to navigate complicated service systems and often feel rejected when they try to get help. Even when sources of help are found, financial barriers may prevent them from accessing services. Discouraged, they join the ranks of the untreated, awaiting the next crisis. In addition, geographic barriers to care often are cited by people with COD who do not get the help they need. Either access to a clinic is remote (e.g., in rural settings) or transportation to local agencies is unavailable. For these reasons, any person seeking care for a substance-related and/or other mental disorder must be accepted and actively engaged wherever she seeks treatment, and financial barriers should not prevent someone who wants help from receiving it. Any time a person or her family seeks help but is turned away, an opportunity is lost and potentially devastating personal and community consequences may result.

#### **Principle 4**

The system of care for COD should not be limited to a single “correct” model or approach.

There is no single set of treatment interventions that constitute integrated screening, assessment, and treatment for COD. Integrated services comprise an array of physical, psychological, and social service interventions outlined in a single integrated treatment plan. This plan is based on an assessment of individual needs and preferences, matched to appropriate levels of care, and provided or coordinated by a single treatment team or within a comprehensive treatment model.

Services for people with COD are delivered in the context of a broad range of social services, provider networks, financial coverage, and community priorities. As such, the shaping of services for people with COD requires a flexible and responsive set of providers and programs. Mutually agreed upon responsibilities and outcomes will shape the approaches implemented. Continuous quality improvement efforts should dictate future adaptations.

#### **Principle 5**

The system of care must reflect the importance of the partnership between science and service, and support both the application of evidence- and consensus-based practices for persons with COD and evaluation of the efforts of existing programs and services (see Table 1, Key Definitions, page 1).

The advantages of evidence- and consensus-based practices have been articulated and validated across the mental health and substance abuse treatment fields. The appropriate application of these practices maximizes benefits to consumers. Evidence- and consensus-based practices generated in one field of service may require modification in their application to COD, yet the core features of these modified interventions increase the likelihood of their effectiveness.

Behavioral sciences have a rich investment in research to draw upon, but technological advances require capable providers to ensure that what works under controlled research conditions (*efficacy*) is translated into practical, high-quality, real-world services (*effectiveness*). The Surgeon General identified a gap between the development of scientific advances and their introduction to community settings, which deprives many people of up-to-date treatment (U.S. Department of Health and Human Services, 1999). System design must support providers of services to people with COD in their application of the

existing science and encourage their development of new findings and approaches through participation in research and evaluation efforts.

#### **Principle 6**

Behavioral health systems must collaborate with professionals in primary care, human services, housing, criminal justice, education, and related fields in order to meet the complex needs of persons with COD.

Having COD increases the likelihood of having additional medical, social, and legal problems. Persons with COD are often among the most disadvantaged and impoverished members of our society. At various times, employment, education, housing, and legal assistance must be provided as part of integrated COD treatment approaches. This breadth of need requires partnerships beyond the behavioral health field to allow consumers to develop and sustain recovery. It is necessary and possible to engage partners with common interests in supporting the integration of people with COD into their respective communities. Successful strategies for systems collaboration include shared case management models, the creation of local service coalitions, the State use of special waiver authorities, and interagency task forces.

### **PRINCIPLES THAT GUIDE PROVIDER ACTIVITY FOR PEOPLE WITH COD**

#### **Principle 7**

Co-occurring disorders must be expected when evaluating any person, and clinical services should incorporate this assumption into all screening, assessment, and treatment planning.

Just as systems must be designed so that all programs are competent to address COD, all providers should be cross-trained and competent to screen for COD, coordinate assessments, and develop individualized treatment plans that directly address a broad range of co-occurring conditions and disorders. The high prevalence of persons with COD in all mental health and substance abuse treatment settings requires a minimal level of competency for all clinicians. While not all providers can be expected to address the myriad issues associated with COD, they should understand how to identify COD and have a clear sense of how to assist the consumer in accessing essential services.

### **Principle 8**

Within the treatment context, both co-occurring disorders are considered primary.

For persons with COD, symptoms of either disorder may vary over time. It is possible for the person to be effectively managing one set of symptoms while the other set causes significant impairment. The interactive nature of COD requires each disorder to be continually assessed and treatment plans adjusted accordingly. It is a disservice to the person with COD to emphasize attention to one disorder at the expense of the other. There is always a relationship between the two disorders that must be evaluated and managed. While billing and financial implications of identifying and recording diagnoses and treatment interventions may require a simplification of the clinical issues, the true complexity of COD must be reflected in all treatment plans.

### **Principle 9**

Empathy, respect, and belief in the individual's capacity for recovery are fundamental provider attitudes.

In all behavioral interventions, the quality of the treatment relationship is the most important predictor of success. Persons with COD often have long histories of exclusion from treatment or exposure to ineffective treatment. They often are demoralized by the systemic barriers they encounter and/or the limitations imposed by the symptoms of their multiple disorders. Data support the capacity of persons with COD to recover, and treatment providers must believe in any consumer's capacity for behavioral change. CSAT's TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005) identifies the following essential attitudes and values for clinicians who work with this population:

- Desire and willingness to work with COD
- Appreciation of complexity
- Openness to new information
- Awareness of personal reactions and feelings
- Recognition of the provider's limitations
- Recognition of the value of consumer input
- Patience, perseverance, and therapeutic optimism
- Flexibility
- Cultural competence
- Belief in clients' ability to change
- Recognition of the rights of clients

These attitudes and values form the basis of a recovery perspective and foster treatment relationships based on

mutual respect. A recovery perspective provides a positive context for interpreting the inevitable ups and downs of treatment. A solid treatment relationship provides stability for both clinician and client through changes in the course of the client's COD and the application of specific interventions.

### **Principle 10**

Treatment should be individualized to accommodate the specific needs, personal goals, and cultural perspectives of unique individuals in different stages of change.

There can be no one clinical model of care for all people with COD. Each individual's treatment plan must be derived from a careful assessment inclusive of, but not limited to, immediate and acute needs, diagnosis, disability, motivation, and stage of readiness for change (see COCE Overview Paper titled "Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders"). Cultural differences must be ascertained, respected, and incorporated into all aspects of treatment, but the uniqueness of each individual also must be appreciated.

Each consumer's needs at a given point in time require a therapeutic response that balances care and detachment. The stages of change (Prochaska & DiClemente, 1984) and phases of treatment (Osher & Kofoed, 1989) models reflect the longitudinal process of recovery and the need for stage-specific responses. Motivation for change is a dynamic dimension influenced by the application of appropriate interventions.

At the outset of treatment, engaging the individual in the treatment process is of paramount importance. This often requires a collaborative exploration of what consumers define as their needs and goals. Motivational interventions (Miller & Rollnick, 2002) can be tailored to this shared definition and personal menus of choice constructed at multiple junctures in recovery. The iterative process of goal refinement moves treatment from the generic delivery of service to groups of consumers to a nuanced and specific plan for any individual.

### **Principle 11**

The special needs of children and adolescents must be explicitly recognized and addressed in all phases of assessment, treatment planning, and service delivery.

Children and adolescents are not simply small adults. The importance of this distinction cannot be overemphasized

(U.S. Department of Health and Human Services [DHHS], 1999). Physical and neurological development continues through the 20th year (Giedd et al., 1999) and the drives, impulses, and emotions that accompany puberty arise before self-control and judgment are fully developed (Dahl, 2000). The social roles of children and adolescents change as they grow older; societal expectations change also. The nature and severity of substance use and mental health problems must be judged against a continuum of developmental and age-appropriate thoughts and behaviors, and the range of what is “normal” is wide (DHHS, 1999). Challenges to normal development (e.g., physical problems, intellectual disabilities, low birth weight, family history of mental and addictive disorders, multigenerational poverty, and caregiver separation or abuse and neglect) constitute additional risk factors for behavioral health problems. The developmental perspective guides all aspects of screening, assessment, treatment planning, and service delivery. The question, “What is appropriate (either behavior or services)?” must always be followed by the question, “At what age?”

Family involvement is an essential part of service planning and delivery, especially for children and early adolescents, unless circumstances dictate otherwise (e.g., emancipated minors). Particular emphasis should be placed on prevention, early identification of problems, and early intervention (Klitzner et al., 1992), especially in schools, primary care settings, and the juvenile justice system.

### **Principle 12**

The contribution of the community to the course of recovery for consumers with COD and the contribution of consumers with COD to the community must be explicitly recognized in program policy, treatment planning, and consumer advocacy.

Persons with COD are fellow citizens and community members. Acceptance of and responsiveness to their needs by neighbors, policymakers, and public officials can facilitate access to care, improve functioning, and facilitate full integration into the community. However, societal attitudes regarding mental and substance use disorders currently pose significant barriers to recovery. Stigma and discrimination may prevent the person with COD from seeking treatment services and are a barrier to establishing the comprehensive services that science has demonstrated are necessary for recovery (DHHS, 1999). Community intolerance of behavioral disorders has sometimes led to the criminalization of persons with COD, resulting in incarceration instead of treatment. Post-treatment living environments, critical for long-term stabilization, may be incompatible with recovery.

*Treatment is effective and recovery is possible* for persons with COD. They can join with other citizens as workers and tax payers to build healthier, more prosperous, and more rewarding communities. Their special experiences and understanding can inform the development of services for other persons with similar disorders. They can enrich their communities with their unique gifts and talents. This can only occur if they are afforded the same opportunities that a free society guarantees to all its citizens.

## **CONCLUSION**

Principles for working with persons with COD can serve as a touchstone for transforming evolving systems and improving the quality of mature systems. These principles are being used by COCE to guide its efforts to transmit advances in treatment, promote enhancement of infrastructure and clinical capacity, and foster infusion of consensus- and evidence-based practices. Adherence to principles will advance our shared desire to support recovery from often devastating illnesses. People with COD and their families deserve no less.

## **CITATIONS**

American Association of Community Psychiatrists. (2000). *AACP principles for the care and treatment of persons with co-occurring psychiatric and substance disorders*. Pittsburgh, PA: Author.

Center for Mental Health Services. (1996). *Principles for systems of managed care*. Retrieved February 1, 2005, from <http://www.mentalhealth.org/publications/allpubs/MC96-61/default.asp>

Center for Mental Health Services Managed Care Initiative: Clinical Standards and Workforce Competencies Project Co-Occurring Mental and Substance Disorders Panel. (1998). *Co-occurring psychiatric and substance disorders in managed care systems: Standards of care, practice guidelines, workforce competencies, and training curricula*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2005). *Substance abuse treatment for persons with co-occurring disorders*. Treatment Improvement Protocol (TIP) Series 42 (DHHS Pub. No. SMA 05-3992). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Dahl, R. E. (2000). Continuing brain development during adolescence. In *Science, kids, and alcohol: Research briefs - Series 1*. Bethesda, MD: Leadership to Keep Children Alcohol Free.

Giedd, J. N., Blumenthal, J., Jeffries, N. O., Castellanos, F. X., Liu, H., Zijdenbos, A., Paus, T., Evans, A. C., & Rapoport, J. L. (1999). Brain development during childhood and adolescence: A longitudinal MRI study. *Nature Neuroscience*, 2(10), 861–863.

Klitzner, M., Fisher, D., Stewart, K., & Gilbert, S. (1992). *Substance abuse: Early intervention for adolescents*. Princeton, NJ: The Robert Wood Johnson Foundation.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.

Minkoff, K., & Cline, C. A. (2004). Changing the world: The design and implementation of comprehensive continuous, integrated systems of care for individuals with co-occurring disorders. *Psychiatric Clinics of North America*, 27, 727–743.

National Institute on Drug Abuse. (1999). *Principles of drug addiction treatment: A research-based guide*. (NIH Publication No. 99-4180). Bethesda, MD: National Institutes of Health.

Osher, F. C. (1996). A vision for the future: Toward a service system responsive to the needs of persons with co-occurring mental and addictive disorders. *American Journal of Orthopsychiatry*, 66(1), 71–76.

Osher, F. C., & Kofoed, L. L. (1989). Treatment of patients with psychiatric and psychoactive substance abuse disorders. *Hospital and Community Psychiatry*, 40, 1025–1030.

Prochaska, J. O., & DiClemente, C. C. (1984). *The transtheoretical approach: Crossing the traditional boundaries of psychotherapy*. Homewood, IL: Dow-Jones/Irwin.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

# Addressing Co-Occurring Disorders in Non-Traditional Service Settings

## OVERVIEW PAPER 4



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
Substance Abuse and Mental Health Services Administration  
Center for Mental Health Services  
Center for Substance Abuse Treatment  
[www.samhsa.gov](http://www.samhsa.gov)

## About COCE and COCE Overview Papers

The Co-Occurring Center for Excellence (COCE), funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a leading national resource for the field of co-occurring mental health and substance use disorders (COD). COCE's mission is threefold: (1) to receive and transmit advances in treatment for all levels of COD severity, (2) to guide enhancements in the infrastructure and clinical capacities of service systems, and (3) to foster the infusion and adoption of evidence- and consensus-based COD treatment and program innovations into clinical practice. COCE consists of national and regional experts including COCE Senior Staff, Senior Fellows, Steering Council, affiliated organizations (see inside back cover), and a network of more than 200 senior consultants, all of whom join service recipients in shaping COCE's mission, guiding principles, and approaches. COCE accomplishes its mission through technical assistance and training delivered through curriculums and materials on-line, by telephone, and through in-person consultation.

COCE Overview Papers are concise and easy-to-read introductions to state-of-the-art knowledge in COD. They are anchored in current science, research, and practices. The intended audiences for these overview papers are mental health and substance abuse administrators and policymakers at State and local levels, their counterparts in American Indian tribes, clinical providers, other providers, and agencies and systems through which clients might enter the COD treatment system. For a complete list of available overview papers, see the back cover.

For more information on COCE, including eligibility requirements and processes for receiving training or technical assistance, direct your e-mail to [coce@samhsa.hhs.gov](mailto:coce@samhsa.hhs.gov), call (301) 951-3369, or visit COCE's Web site at [www.coce.samhsa.gov](http://www.coce.samhsa.gov).

## Acknowledgments

COCE Overview Papers are produced by The CDM Group, Inc. (CDM) under Co-Occurring Center for Excellence (COCE) Contract Number 270-2003-00004, Task Order Number 270-2003-00004-0001 with the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). Jorielle R. Brown, Ph.D., Center for Substance Abuse Treatment (CSAT), serves as COCE's Task Order Officer, and Lawrence Rickards, Ph.D., Center for Mental Health Services (CMHS), serves as the Alternate Task Order Officer. George Kanuck, COCE's Task Order Officer with CSAT from September 2003 through November 2005, provided the initial Federal guidance and support for these products.

COCE Overview Papers follow a rigorous development process, including peer review. They incorporate contributions from COCE Senior Staff, Senior Fellows, consultants, and the CDM production team. Senior Staff members Michael D. Klitzner, Ph.D., Fred C. Osher, M.D., and Rose M. Urban, M.S.W., J.D., LCSW, LCAS, co-led the content and development process. Senior Staff member Fred C. Osher, M.D., made major writing contributions. Other major contributions were made by Project Director Jill G. Hensley, M.A.; Senior Staff Members Stanley Sacks, Ph.D., and Sheldon R. Weinberg, Ph.D.; and Senior Fellows Michael Kirby, Ph.D., Douglas M. Ziedonis, M.D., Ph.D., and Joan E. Zweben, Ph.D. Editorial support was provided by CDM staff members Jason Merritt, Janet Humphrey, Michelle Myers, and Darlene Colbert.

## Disclaimer

The contents of this overview paper do not necessarily reflect the views or policies of CSAT, CMHS, SAMHSA, or DHHS. The guidelines in this paper should not be considered substitutes for individualized client care and treatment decisions.

## Public Domain Notice

All materials appearing in COCE Overview Papers, except those taken directly from copyrighted sources, are in the public domain and may be reproduced or copied without permission.

## Electronic Access and Copies of Publication

Copies may be obtained free of charge from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686; TDD (for hearing impaired), (800) 487-4889; or electronically through the following Internet World Wide Web sites: [www.nacadi.samhsa.gov](http://www.nacadi.samhsa.gov) or [www.coce.samhsa.gov](http://www.coce.samhsa.gov).

## Recommended Citation

Center for Substance Abuse Treatment. *Addressing Co-Occurring Disorders in Non-Traditional Service Settings*. COCE Overview Paper 4. DHHS Publication No. (SMA) 07-4277. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

## Originating Offices

Co-Occurring and Homeless Activities Branch, Division of State and Community Assistance, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

Homeless Programs Branch, Division of Service and Systems Improvement, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

## Publication History

COCE Overview Papers are revised as the need arises. For a summary of all changes made in each version, go to COCE's Web site at [coce.samhsa.gov/cod\\_resources/papers.htm](http://coce.samhsa.gov/cod_resources/papers.htm). Printed copies of this paper may not be as current as the version posted on the Web site.

DHHS Publication No. (SMA) 07-4277  
Printed 2007.

## SUMMARY

Only about half the people with co-occurring disorders (COD) receive any services within substance abuse and mental health (SA/MH) settings. Settings outside the SA/MH system, or settings where service missions do not include a primary focus on COD, are the focus of this overview paper. Primary health, public safety and criminal justice, and social service settings, where persons with COD are likely to be seen, are highlighted. These settings should be prepared to identify and effectively respond to persons with COD. The use of specialized techniques appropriate to these settings can increase the likelihood that the person with COD will access treatment.

## INTRODUCTION

Persons with COD reside throughout our communities and move through all system and service locales. While significant progress is being made within SA/MH settings to comprehensively address the complex needs of persons with COD in an integrated manner, more than half of all persons with COD do not access any SA/MH services (Office of Applied Studies, 2006). Unrecognized and untreated COD results in excess morbidity and mortality; unnecessary health and personal expenditures; and frustration for families, intimates, and service providers. However, the disabilities and social consequences associated with COD bring those affected in contact with a number of public health, public safety, and social welfare providers. These contacts, if handled with sensitivity to COD issues, afford unique opportunities for identification, initial engagement, and linkage to appropriate care systems.

## LITERATURE HIGHLIGHTS

SA/MH settings have made significant progress in addressing the needs of persons with COD. However, many persons with COD never see a SA/MH provider. The 2005 National Survey on Drug Use and Health shows that 53 percent of persons

with serious psychological distress (SPD) and a co-occurring substance use disorder received no treatment in the 12 months preceding the survey (Office of Applied Studies, 2006). Although large numbers of persons with COD are not seen in SA/MH settings, they can be found in several other settings:

- About 70 percent of the U.S. population sees a primary care physician every two years (Fleming et al., 1997). Because of the high frequency of medical conditions that co-occur with COD and the stigma associated with SA/MH disorders that leads those with the disorders to avoid formal treatment, persons with COD often seek medical care in emergency rooms and primary care settings (Curran et al., 2003; Druss et al., 2006).
- There has been considerable growth in the number of persons having contact with the criminal justice system over the past decade. More than 14 million “bookings” occur in U.S. jails each year (Bureau of Justice Statistics, 2005), and more than two million people are incarcerated in the Nation’s prisons and jails (Harrison & Beck, 2005). The overrepresentation of persons with mental illnesses and substance use disorders in criminal justice settings is well documented (CSAT, 2005b; Teplin, 1994; Teplin et al., 1996), and almost three-quarters of those in jails with

**Table 1: Key Definitions**

|   |  |
|---|--|
| Substance abuse and/or mental health (SA/MH) service settings | Agencies, programs, and facilities specifically designed to treat psychiatric and/or addictive disorders.  |
| Non-SA/MH settings  | Settings outside of the SA/MH system where persons with COD are likely to be encountered. These can be divided into three categories: <ul style="list-style-type: none"><li>• Health settings, including primary care (e.g., community health clinics, HIV/AIDS treatment programs, family practice locales) and acute care (e.g., emergency rooms, intensive care units, trauma centers) settings.</li><li>• Public safety and criminal justice settings, including police encounters, courts, jails, prisons, and community corrections settings.</li><li>• Social welfare settings, including income support, entitlement and unemployment offices, homeless shelters (as well as makeshift shelters, parks, and abandoned buildings) and the community (e.g., schools and faith and workplace settings).</li></ul> |

mental illnesses have co-occurring substance use disorders, while 15 percent of females with substance use disorders have co-occurring SPD (National GAINS Center, 2002). A conservative estimate of the prevalence of serious mental health problems among the juvenile justice population is 20 percent, with many of those youth having co-occurring substance use disorders (Cocozza & Skowyr, 2000).

- The Urban Institute estimates that 2.3–3.5 million people experience homelessness each year (Burt & Aron, 2000). Studies suggest that as many as 37 percent of homeless women and 32 percent of homeless men had co-occurring Axis I and substance use disorders in 2000, a marked increase from 1990 figures (North et al., 2001). The settings in which these persons are found include not only homeless shelters, but also streets, parks, and abandoned buildings.
- People with and at risk for COD may also be found in community settings including workplaces, places of worship, social welfare agencies, and educational institutions.

The principle of “No Wrong Door,” whereby every point of entry into the healthcare system is seen as an opportunity for outreach, education, and connection to needed services, is embraced by mental health and addiction service systems (CSAT, 2000a). This principle can be extended to a variety of public and private domains such as the non-SA/MH settings highlighted here. While non-SA/MH settings should not be expected to provide comprehensive SA/MH services, they afford important opportunities for identification and engagement of persons with COD and can serve as gateways to integrated systems of care.

## KEY QUESTIONS

### **1. Why should we be concerned about settings outside the SA/MH system or settings where service missions do not include a primary focus on COD (non-SA/MH settings)?**

Only half of persons with COD receive any service within SA/MH settings. Non-SA/MH settings associated with health care, public safety, criminal justice, social welfare, work, and education afford a critical opportunity for identification, initial engagement, and early intervention. Most persons with untreated COD cannot function optimally in school, at work, or within their families and communities. This impaired functioning leads to an overrepresentation in acute and high-cost health, public safety, criminal justice, and social welfare settings. The proper identification of SA/MH disorders that contribute to a person’s social circumstances or presenting complaint is an important step toward helping that person realize his or her full potential and live a rewarding life in the community.

### **2. In what non-SA/MH settings are people with untreated COD found?**

Persons with untreated COD are found everywhere in our communities. However, the medical, social, and psychological consequences of COD increase the likelihood of their presence in certain locations. In addition, the severity and progression of COD can determine the settings in which untreated persons may initially present, from emergency rooms to homeless camps.

Figure 1 (page 3) depicts a model that provides a framework for understanding the range of co-occurring conditions and the settings in which people with COD are likely to be found. The model provides guidance to communities in determining the settings where persons with COD present, and supports strategies to identify, engage, and respond to their needs. Descriptions of three categories of non-SA/MH settings follow.

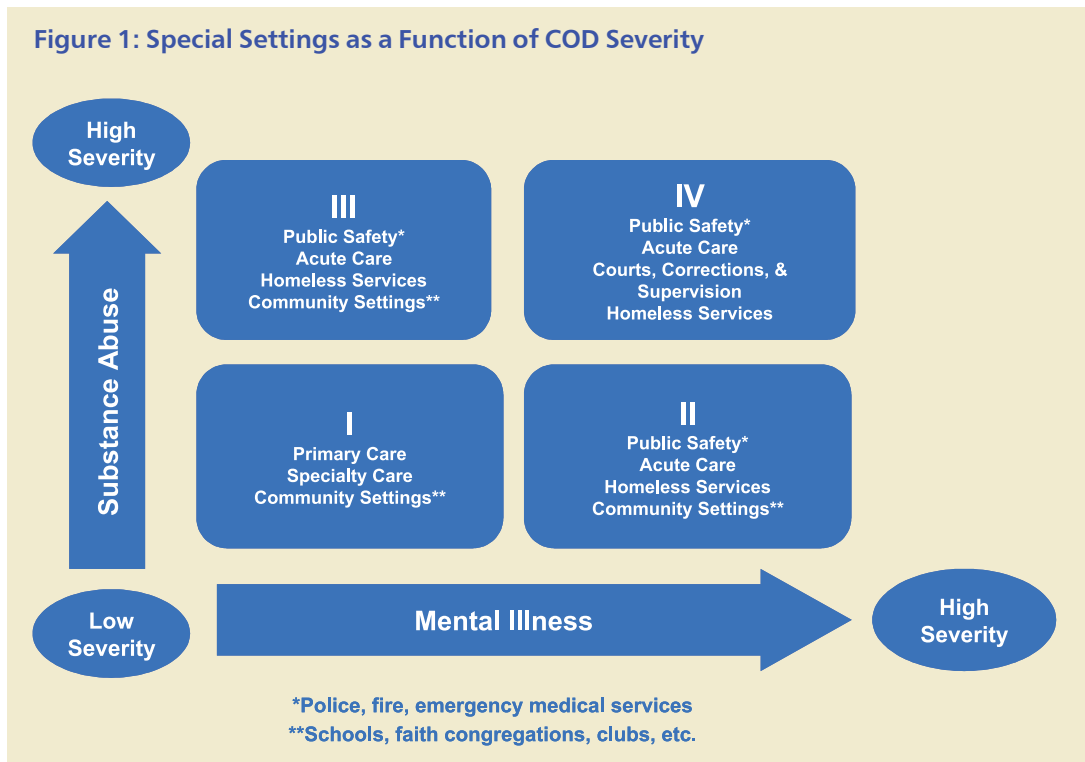
#### **Health Settings**

*Primary Care:* Well before persons with COD come to the attention of SA/MH providers, most will have seen a primary care provider (O’Connor & Schottenfeld, 1998; Simon & VonKorff, 1995). Depression and anxiety disorders frequently present as somatic symptoms such as fatigue, headaches, and pain, which in turn are the leading causes of medical visits (Kroenke, 2003). Substance use disorders frequently complicate the management of many chronic illnesses such as hypertension (Rehm et al., 2003). Conversely, the association of medical problems with mental illnesses and substance use disorders is also high. In a recent survey of persons with SPD, 74 percent had at least one diagnosed chronic health problem (Jones et al., 2004). Moreover, the effects of substance use on organ systems and the high rates of infectious disease among persons with substance use disorders ensure that large numbers of these individuals will be seen in primary care settings (Saitz, 2003).

Persons with COD tend to be in poorer physical health than persons without these disorders (Dickey et al., 2002). Within primary care outpatient settings, it is estimated that 20 percent of patients have a current psychiatric disorder and 20–25 percent have a substance use disorder (Brady, 2002). As gatekeepers to health services, primary care physicians have a powerful opportunity to identify COD early and initiate appropriate treatment—for example, counseling patients on abstinence (National Center on Addiction and Substance Abuse, 2000). While they typically do not have the resources to provide comprehensive care, they can refer patients to SA/MH specialists.

The United States Preventive Services Task Force recommends routine screening for alcohol and drug problems and depression (Agency for Healthcare Research and Quality, 2002, 2004, 2005). These recommendations have not been

**Figure 1: Special Settings as a Function of COD Severity**



Source: Adapted from National Association of State Mental Health Program Directors (NASMHPD) & National Association of State Alcohol and Drug Abuse Directors (NASADAD), 1999.

implemented in most primary care settings (Friedmann et al., 2000; Haack & Alemi, 2002; Woolf et al., 1996). Accordingly, opportunities for early identification and treatment of COD are being missed but may be better taken advantage of in the future.

*Specialty Care:* Specialty care combines primary health care with specialized services for persons with chronic physical illnesses, such as HIV/AIDS. The pressing nature of deteriorating physical conditions can motivate a person with COD to seek care and follow up with suggested treatment plans. Specialty healthcare settings may have the staff resources to provide assessment and some treatment services for COD.

*Acute Care:* Acute care refers to short-term interventions provided in emergency rooms, trauma centers, and intensive care units. Untreated COD has a significant impact on health, and persons with untreated COD will often enter the service system through contact with urgent or acute care settings. Screening and identification of SA/MH disorders in these settings may not be conducted routinely (Kushner et al., 2001; McClellan & Meyers, 2004; O'Connor & Schottenfeld, 1998; Simon & VonKorff, 1995). Given the time constraints, COD treatment beyond brief intervention is unlikely. However, if COD is suspected through screening procedures, counseling and referral can be effective in moving the person to an appropriate treatment setting.

### **Public Safety and Criminal Justice Settings**

Responding to the needs of persons with COD constitutes a major challenge for police and other public safety officials, prosecutors, courts, and corrections and supervision systems.

*Police:* Persons with COD, particularly those without access to adequate treatment, frequently come in contact with law enforcement. If illegal or criminal activity is observed, such as possession or sale of controlled substances, this contact can begin a series of appearances within criminal justice settings. Significant police manpower is required to respond to persons with SA/MH disorders, many of whom are eventually incarcerated (Reuland, 2004).

*Corrections:* A considerable number of incarcerated individuals have COD (Abram & Teplin, 1991; Hartwell, 2004; Steadman et al., 1999). As a consequence of their incarceration, persons with COD have legal rights to have access to health care, to receive any care that is ordered, and to have healthcare decisions made by medical personnel (National Commission on Correctional Health Care, 2003). Unless COD is recognized and addressed, recidivism is the likely outcome for incarcerated persons with COD (Hammett et al., 2001).

Jails may offer the first opportunity for problem identification, treatment, and community referral for those who need continued treatment (Peters & Matthews, 2001). Nonethe-

less, jails are high-volume, highly structured, high-turnover institutions with little time to initiate more than basic assessment of mental health and substance abuse issues with appropriately matched urgent care responses. Prisons are State- or federally operated facilities for inmates with sentences longer than 1 year. As such, they have more opportunities to develop integrated service programs. While the vast majority of prisons have substance abuse programs, only a small minority of prisoners with substance use disorders get access to any addiction treatment (CSAT, 2005b). The likelihood of access to COD programs is even smaller.

*Courts and Supervision:* Courts report increasing contact with offenders with COD and drug court judges have found that defendants with COD are more difficult to place into treatment than those with a single disorder (Denckla & Berman, 2001).

### **Social Welfare Settings That Afford an Opportunity for COD Interventions**

*Homeless Services:* More than two million U.S. citizens will experience homelessness in a calendar year. Nearly 40 percent of these homeless persons have alcohol problems and 26 percent have drug problems (Burt et al., 1999) with recent estimates as high as 84 percent of men and 58 percent of women (North et al., 2004). Twenty percent of homeless persons have SPD, and 25 percent have some form of disabling health condition (CMHS, 2003). One third of homeless persons have COD (North et al., 2001). While integrated care has been cited as important to the recovery of homeless persons with COD, few have access to it (CMHS, 2003). Homeless people are disaffiliated and are not often voluntary recipients of any kind of health services. Thus, homeless persons with COD may remain undiagnosed and untreated. This, in turn, can lead to continued

homelessness and further deterioration in physical, social, and economic functioning.

*Community Settings:* Persons at high risk for—or in the early stages of—SA/MH disorders often continue to function and fulfill work, school, and family obligations (Klitzner et al., 1992). The tendency of lay people to “normalize” early signs of deteriorating functioning (Mechanic, 1978), combined with the stigma attached to SA/MH problems and a lack of familiarity with warning signs on the part of teachers, supervisors, clergy, and parents, may lead to missed opportunities for early intervention. Significant levels of deterioration in functioning and/or disruption may lead to punitive actions rather than referral to helping resources.

### **3. What can be done in primary healthcare settings to help persons with COD?**

The Institute of Medicine report *Improving the Quality of Health Care for Mental and Substance-Use Conditions* (2006) highlights the strong link between mental and substance use disorders and general health care. One of the report’s overarching recommendations states, “Health care for general, mental, and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body” (p. 9). COCE takes the position that a first step in implementing this recommendation is to identify persons with COD as a routine component of care in each of the health settings discussed above. This position is based on considerations of quality of care as well as cost recovery for care providers and payors. Overview Paper 2, *Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders* (CSAT 2006), provides details on the methods and procedures by which this identification can be accomplished.

## **Figure 2: Screening For COD in Primary Care Settings**

### **Depression**

- Over the past two weeks, have you felt down, depressed, or hopeless?
- Over the past two weeks, have you felt little interest or pleasure in doing things?

### **CAGE (CAGE-AID)**

1. Have you ever felt you should **C**ut down on your drinking (or drug use)?
2. Have people **A**nnoyed you by criticizing your drinking (or drug use)?
3. Have you ever felt bad or **G**uilty about drinking (or drug use)?
4. Have you ever taken a drink (or a drug) first thing in the morning (**E**ye-opener) to steady your nerves or get rid of a hangover?

*Sources:* Agency for Healthcare Research and Quality, 2002, 2004; Fiellin et al., 2000, p.1979.

An efficient screening method for COD in primary care settings is laid out in Figure 2. It combines two questions related to depression with the four questions of the CAGE (or CAGE-AID—adapted to include drugs). If these six questions are used for screening, the depression screening items will serve as a marker for a wide range of mental health issues and the CAGE/CAGE-AID items will help identify substance-related problems. Any single positive response should lead to a thorough assessment by a mental health and/or substance abuse professional. A positive response to both an item from the depression questions and an item from the substance use questions should lead to an assessment by a COD professional.

It is recognized that resources beyond screening and identification are not readily available in most primary health settings, and inadequate financing for these basic services is often a barrier (McLellan & Meyers, 2004). As such, community mental health and substance abuse systems of care must be designed to support public and private health care settings' screening efforts with appropriately matched and readily accessible assessment and treatment services delivered within SA/MH programs.

A continuum of responses to persons with COD who appear in health settings can be identified (NASMHPD & NASADAD, 1999):

- *Identification and Initial Management* is the minimum level of responsibility. It involves screening for COD and providing brief, structured, targeted advice to patients. Referral of those with positive screens or serious symptoms, such as suicidal thoughts or trouble making sense, may be necessary. The health setting retains responsibility for the client's general health care unless or until the client is referred to a treatment facility that offers health care in addition to COD services. Upon discharge from such a facility, responsibility for general health care reverts back to the original, referring setting.
- *Collaboration* is a formal process of sharing responsibility for treating a person with COD, involving regular and planned communication, shared progress reports, or memoranda of agreement. In a collaborative relationship, different disorders may be treated by different providers, yet the roles and responsibilities of the providers are clear.
- *Integration* requires the participation of providers trained in both primary care and SA/MH services to develop a single treatment plan addressing all health conditions. These providers continue their formal interaction and cooperation in the client's ongoing reassessment and treatment.

Several considerations will determine where a given health setting operates on this continuum. While the nature and type of integration will vary by communities, it has been

proposed that the SA/MH system take the lead in developing the plan (CSAT, 2000a). Other considerations include resources, funding, clinical interest in COD, and the availability of other COD resources in the community. Treatment Improvement Protocols (TIPs) 37, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT, 2000b) and 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005a), address how providers with specialized training for "triple diagnosed" clients have been successful in addressing COD. For example, the HIV Integration Project of The CORE Center in Chicago, Illinois, (CSAT, 2005a) is a good example of a local integrated service response to health and COD needs. There are as yet no data to favor one approach over another; agencies will address COD issues to the extent that their resources allow and can participate in advocating and soliciting additional funding to support enhanced COD interventions.

#### **4. What can be done in other non-SA/MH settings to help persons with COD?**

Like primary health settings, other settings can also serve as gatekeepers for the SA/MH system. These settings provide an opportunity to recognize persons who may have COD and to engage them in a process that leads to referral for further assessment and integrated treatment. This recognition, engagement, and referral approach requires strong partnerships with community SA/MH providers. These approaches typically require the oversight of a multidisciplinary community planning group, training for frontline staff, the development of specific referral guidelines, and easy access to welcoming clinical settings.

#### **Public Safety and Criminal Justice Settings**

Innovative police responses to persons with COD illustrate a recognition, engagement, and referral approach. Law enforcement is often the initial point of contact for persons with COD who may have violated a public ordinance, committed a crime, or raised the suspicions of other citizens or police through unusual, disruptive, and/or bizarre behavior. During the last 10 years, police-based specialized responses, most notably the Crisis Intervention Team, have been implemented across the country (Reuland, 2004). In these models, police receive intensive training to recognize and engage persons with COD, with the goal of increasing access to treatment and support services and diversion from criminal justice settings.

Problem-solving courts, such as drug courts and mental health courts, have been developed as a response to the growing influx of persons with COD in the court system. These settings have recognized the need to develop specialized responses to the defendant with COD (Peters & Osher, 2004). Such responses include specialized training for court

personnel to help them identify people with SA/MH needs, implementing specialized programming, and championing community alternatives for these individuals. The goals of these initiatives include an increase in public safety, better quality of life for the consumer with COD, and a more effective use of overtaxed criminal justice resources (Council of State Governments [CSG], 2005).

Identification and management of COD within jails and prisons mirror the complexity of providing care within community settings. While the inmate with COD is legally entitled to health care and can be more easily “engaged” in treatment than those who are not confined, jail and prison treatment resources are scarce (Fellner & Abramsky, 2003), and integrated care programs are rare. Jails are attempting to improve screening procedures for COD with the use of standardized instruments administered by correctional staff (Steadman et al., 2005).

Opportunities for brief motivational interventions exist, yet the capacity of understaffed jail providers and inmates to develop a strong therapeutic alliance is limited. Such collaborative efforts as the Vermont Departments of Health and Corrections coordinate programming to identify, assess, and treat offenders with COD in their criminal justice system (CSG, 2005). Sacks and colleagues (2004) describe a modified therapeutic community model that has shown significantly lower reincarceration rates for persons with COD leaving incarcerated settings compared to those who received MH treatment only. Because of the stigma associated with the combination of COD and a criminal record, specialized programming is necessary to ensure successful transition to communities on release (CSAT, 2005a).

### **Social Welfare Settings**

Outreach is often required in order to reach individuals who are marginalized, isolated, alone, or homeless (Federal Task Force on Homelessness and Serious Mental Illness, 1992). A rich history of outreach efforts to marginalized individuals exists in the United States (Lam & Rosenheck, 1999; Tommasello et al., 1999). By starting with what the marginalized person values and desires, it is possible to develop a relationship that can address associated conditions such as mental illness and/or addiction. Once engaged, the individual will benefit from the same integrated interventions associated with positive outcomes in other clinical settings.

Central to the process of outreach and engagement is the establishment of a “helping relationship.” Core characteristics of this relationship include mutual trust and respect, tolerance and flexibility, patience and realism, and being helpful in the eyes of the consumer (Winarski, 1998). Sacks and associates (2002) have described adaptations of therapeutic communities in shelters that use the peer community and a focus on mutual self-help as a starting point to engage homeless persons with COD. Once engaged, providing access to supportive housing can have a powerful effect on outcomes for homeless persons with COD (CSAT, 2005a).

*Community Settings:* Schools, workplaces, community groups, families, and friendship networks are the settings in which individuals spend the most time. Signs of COD are likely to manifest in these settings, although they may not be recognized as such. Student and employee assistance programs, informational kiosks at community events, pastoral counseling, and other similar intervention methods offer the potential for early identification and referral of high-risk individuals before serious COD-related problems emerge (Klitzner et al., 1992).

### **FUTURE DIRECTIONS**

For a variety of reasons, COD is currently neither widely recognized nor well addressed in the settings discussed in this paper. Wider dissemination on the use of screening and identification techniques appropriate to these settings could encourage programs to develop efficient referral mechanisms and/or more onsite COD interventions. Demonstration programs have shown that identification and effective care are possible, but access to these innovations is not widespread. The activities that staff in these settings need to perform—recognizing signs and symptoms, making referrals, and the like—can be learned, although training would need to be expanded to include primary care practitioners, justice staff, and social welfare personnel. Excellent models, some of which are cited in this paper, are available for community-level adoption. Future work should address issues of dissemination and implementation of these models.

Realizing the goal of “No Wrong Door” requires increased awareness of COD in non-SA/MH settings, fostering enlightened self-interest in COD issues, and establishing the community networks, teamwork, and systems required to meet the needs of persons with COD. SA/MH providers should take the lead in creating a continuum of COD services to support efforts in non-SA/MH settings.

## CITATIONS

- Abram, K. M., & Teplin, L. A. (1991). Co-occurring disorders among mentally ill jail detainees: Implications for public policy. *American Psychologist*, 46 (10), 1036–1045.
- Agency for Healthcare Research and Quality. (2002). *Screening for depression* (What's New from the USPSTF. AHRQ Publication No. APPI02-0019). Rockville, MD: Author. Retrieved November 28, 2005, from <http://www.ahrq.gov/clinic/3rduspstf/depression/depresswh.htm>
- Agency for Healthcare Research and Quality. (2004). *Screening and behavioral counseling interventions in primary care to reduce alcohol misuse*. (What's New from the USPSTF. AHRQ Publication No. 04-IP010). Rockville, MD. Retrieved November 28, 2005, from <http://www.ahrq.gov/clinic/3rduspstf/alcohol/alcomiswh.htm>
- Agency for Healthcare Research and Quality. (2005). *Guide to clinical preventive services, 2005 – Recommendations of the U.S. Preventive Services Task Force*. Rockville, MD: Author. Retrieved July 7, 2005, from <http://www.ahrq.gov/clinic/pocketgd.htm>
- Brady, K. T. (2002). Recognizing and treating dual diagnosis in general health care settings: Core competencies and how to achieve them. In: M. R. Haack & H. Adger, Jr. (Eds.), *Strategic plan for interdisciplinary faculty development: Arming the Nation's health professional workforce for a new approach to substance use disorders* (pp. 143–154). Providence, RI: Association for Medical Education and Research in Substance Abuse (AMERSA). Retrieved November 29, 2005, from <http://www.projectmainstream.net/newsfiles/1134/SPACdocfinal.pdf>
- Bureau of Justice Statistics: Drugs and crime facts - Enforcement. (2005). Retrieved July 7, 2005, from <http://www.ojp.usdoj.gov/bjs/dcf/enforce.htm#arrests>
- Burt, M., & Aron, L. (2000). *America's homeless II: Populations and services*. Washington, DC: Urban Institute. Retrieved July 7, 2005, from [http://www.urban.org/UploadedPDF/900344\\_AmericasHomelessII.pdf](http://www.urban.org/UploadedPDF/900344_AmericasHomelessII.pdf)
- Burt, M. R., Aron, L. Y., Douglas, T., Valente, J., Lee, E., & Iwen, B. (1999). Homelessness: Programs and the people they serve. Retrieved September 28, 2006, from <http://www.urban.org/publications/310291.html>
- Center for Mental Health Services. (CMHS) (2003). *Blueprint for change: Ending chronic homelessness for persons with serious mental illnesses and/or co-occurring substance use disorders* (DHHS Publication No. SMA-04-3870). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved November 29, 2005, from <http://www.nrchmi.samhsa.gov/pdfs/publications/Blueprint.pdf>
- Center for Substance Abuse Treatment. (CSAT) (2000a). *Changing the conversation: The National treatment plan initiative*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved June 2, 2005, from <http://permanent.access.gpo.gov/lps11524/ntp.pdf>
- Center for Substance Abuse Treatment. (CSAT) (2000b). *Substance abuse treatment for persons with HIV/AIDS* (Treatment Improvement Protocol [TIP] Series No. 37, DHHS Publication No. [SMA] 00-3459). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved November 29, 2005, from <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.64746>
- Center for Substance Abuse Treatment. (CSAT) (2005a). *Substance abuse treatment for persons with co-occurring disorders* (Treatment Improvement Protocol [TIP] Series No. 42. DHHS Publication No. [SMA] 05-3992). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved November 29, 2005, from <http://media.shs.net/prevline/pdfs/bkd515.pdf>
- Center for Substance Abuse Treatment. (CSAT) (2005b). *Substance abuse treatment for adults in the criminal justice system* (Treatment Improvement Protocol [TIP] Series No. 44. DHHS Publication No. [SMA] 05-4056). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved November 29, 2005, from <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.80017>
- Center for Substance Abuse Treatment. (2006). *Screening, assessment, and treatment planning for persons with co-occurring disorders*. COCE Overview Paper 2. DHHS Publication No. (SMA) 06-4164. Rockville, MD: Substance Abuse and Mental Health Services Administration and Center for Mental Health Services.
- Cocozza, J. J., & Skowrya, K. R. (2000). Youth with mental health disorders: Issues and emerging responses. *Juvenile Justice* 7(1), 3–13.
- Council of State Governments. (2005). *Report of the re-entry policy council: Charting the safe and successful return of prisoners to the community*. New York: Author. Retrieved November 29, 2005, from [http://www.reentrypolicy.org/documents/rpc\\_report.pdf](http://www.reentrypolicy.org/documents/rpc_report.pdf)
- Curran, G. M., Sullivan, G., Williams, K., Han, X., Collins, K., Keys, J. et al. (2003). Emergency department use of persons with comorbid psychiatric and substance abuse disorders. *Annals of Emergency Medicine*, 41, 650–667.
- Denckla, D., & Berman, G. (2001). *Rethinking the revolving door: A look at mental illness in the courts*. New York: Center for Court Innovation. Retrieved November 29, 2005, from [http://www.courtinnovation.org/\\_uploads/documents/rethinkingtherevolvingdoor.pdf](http://www.courtinnovation.org/_uploads/documents/rethinkingtherevolvingdoor.pdf)

Dickey, B., Normand, S. L., Weiss, R. D., Drake, R. E., & Azeni, H. (2002). Medical morbidity, mental illness, and substance use disorders. *Psychiatric Services, 53*, 861–867. Retrieved September 27, 2006, from <http://ps.psychiatryonline/cgi/reprint/53/7/861>

Druss, B. G., Bornemann, T., Fry-Johnson, Y. W., McCombs, H. G., Politzer, R. M., & Rust, G. (2006). Trends in mental health and substance abuse services at the Nation's community health centers: 1998–2003. *American Journal of Public Health, 96*, 1779–1784.

Federal Task Force on Homelessness and Severe Mental Illness (1992). *Outcasts on main street*. Report of the Federal Task Force on Homelessness and Severe Mental Illness. Washington, DC: Interagency Council on the Homeless.

Fellner, J., & Abramsky, S. (2003). *Ill-equipped: U.S. prisons and offenders with mental illness*. New York: Human Rights Watch. Retrieved November 29, 2005, from <http://www.hrw.org/reports/2003/usa1003/usa1003.pdf>

Fiellin, D. A., Reid, M. C., & O'Connor, P. G. (2000). Screening for alcohol problems in primary care: A systematic review. *Archives of Internal Medicine, 160* (13), 1977–1989.

Fleming, M. F., Barry, K. L., Manwell, L. B., Johnson, K., & London, R. (1997). Brief physician advice for problem alcohol drinkers: A randomized controlled trial in community-based primary care practices. *JAMA, 277* (13), 1039–1045.

Friedmann, P. D., McCullough, D., Chin, M. H., & Saitz, R. (2000). Screening and intervention for alcohol problems: A national survey of primary care physicians and psychiatrists. *Journal of General Internal Medicine, 15* (2), 84–91.

Haack, M. R., & Alemi, F. (2002). Medicaid reimbursement of primary care providers for treatment of substance use disorders. In: M. R. Haack, & H. Adger, Jr., *Strategic plan for interdisciplinary faculty development: Arming the Nation's health professional workforce for a new approach to substance use disorders* (pp. 95–104). Providence, RI: AMERSA. Retrieved November 29, 2005, from <http://www.projectmainstream.net/newsfiles/1134/SPACdocfinal.pdf>

Hammett, T. M., Roberts, C., & Kennedy, S. (2001). Health-related issues in prisoner reentry. *Crime & Delinquency, 47* (3), 390–409.

Harrison, P. M., & Beck, A. J. (2005). *Prison and jail inmates at midyear 2004* (Bureau of Justice Statistics Bulletin, NCJ 208802). Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Retrieved November 29, 2005, from <http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim04.pdf>

Hartwell, S. (2004). Triple stigma: Persons with mental illness and substance abuse problems in the criminal justice system. *Criminal Justice Policy Review, 15* (1), 84–99.

Institute of Medicine (2006). *Improving the quality of health care for mental and substance-use conditions: Quality chasm series*. Washington DC: National Academy Press.

Jones, D. R., Macias, C., Barreira, P. J., Fisher, W. H., Hargreaves, W. A., & Harding, C. M. (2004). Prevalence, severity, and co-occurrence of chronic physical health problems of persons with serious mental illness. *Psychiatric Services, 55* (11), 1250–1257.

Klitzner, M., Fisher, D., Stewart, K., & Gilbert, S. (1992). *Substance abuse: Early intervention for adolescents: Theory, research, and practice*. Princeton, NJ: The Robert Wood Johnson Foundation.

Kushner, K., Diamond, R., Beasley, J. W., Mundt, M., Plane, M. B., & Robbins, K. (2001). Primary care physicians' experience with mental health consultation. *Psychiatric Services, 52* (6), 838–840.

Kroenke, K. (2003). Patients presenting with somatic complaints: Epidemiology, psychiatric co-morbidity and management. *International Journal of Methods in Psychiatric Research, 12* (1), 34–43.

Lam, J. A., & Rosenheck, R. (1999). Street outreach for homeless persons with serious mental illness: Is it effective? *Medical Care, 37* (9), 894–907.

McLellan, A. T. & Meyers, K. (2004). Contemporary addiction treatment: A review of systems problems for adults and adolescents. *Biological Psychiatry, 56* (10) 764–770.

Mechanic, D. (1986). The concept of illness behaviour: Culture, situation and personal predisposition. *Psychological Medicine, 16*, 1–7.

National Association of State Mental Health Program Directors (NASMHPD) & National Association of State Alcohol and Drug Abuse Directors (NASADAD) (1999). *National dialogue on co-occurring mental health and substance abuse disorders*. Alexandria, VA and Washington, DC: Authors, Retrieved July 27, 2005, from [http://www.nasadad.org/index.php?base\\_id=100](http://www.nasadad.org/index.php?base_id=100)

National Center on Addiction and Substance Abuse at Columbia University (2000). *Missed opportunity: CASA National survey of primary care physicians and patients on substance abuse*. New York: Author. Retrieved November 29, 2005, from <http://www.casacolumbia.org/Absolutenm/articlefiles/29109.pdf>

National Commission on Correctional Health Care (2003). *Correctional mental health care: Standards and guidelines for delivering services*. Chicago: Author.

National GAINS Center for People with Co-Occurring Disorders in the Justice System (2002). *The prevalence of co-occurring mental illness and substance use disorders in jails*. Fact Sheet Series. Delmar, NY: The National GAINS Center. Retrieved July 7, 2005, from <http://gainscenter.samhsa.gov/pdfs/disorders/gainsjailprev.pdf>

North, C. S., Eyrich, K. M., Pollio, D. E., & Spitznagel, E. L. (2001). Are rates of psychiatric disorders in the homeless population changing? Unpublished draft.

O'Connor, P. G., & Schottenfeld, R. S. (1998). Patients with alcohol problems. *New England Journal of Medicine*, *338* (9), 592–602.

Office of Applied Studies (2006). *Results from the 2005 National survey on drug use and health: National findings* (NSDUH Series H-30, DHHS Publication No. SMA 06-4194). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Peters, R. H., & Matthews, C. O. (2001). Jail treatment for drug abusers. In: C. G. Leukefeld, F. M. Tims, & D. Farabee (Eds.), *Clinical and policy responses to drug offenders* (pp. 186–203). New York: Springer Publishing Company.

Peters, R. H., & Osher, F. C. (2004). *Co-occurring disorders and specialty courts* (2nd ed.). Delmar, NY: The National GAINS Center. Retrieved July 13, 2005, from <http://gainscenter.samhsa.gov/pdfs/courts/CoOccurringSpecialty04.pdf>

Rehm, J., Room, R., Graham, K., Monteiro, M., Gmel, G. F., & Sempos, C. T. (2003). The relationship of average volume of alcohol consumption and patterns of drinking to burden of disease: An overview. *Addiction* *98* (9), 1209–1228.

Reuland, M. (2004). *A guide to implementing police-based diversion programs for people with mental illness*. Delmar, NY: Technical Assistance and Policy Analysis Center for Jail Diversion. Retrieved November 29, 2005, from [http://www.gainsctr.com/pdfs/jail\\_diversion/PERF.pdf](http://www.gainsctr.com/pdfs/jail_diversion/PERF.pdf)

Sacks, S., Sacks, J., McKendrick, K., Banks, S., & Stommel, J. (2004). Modified TC for MICA offenders. Crime outcomes. *Behavioral Sciences and the Law*, *22* (4), 477–501.

Sacks, S., Skinner, D., Sacks, J., & Peck, A. (2002). *Manual for engaging homeless mentally ill chemical abusers in a modified TC shelter program*. New York: National Development and Research Institutes.

Saitz, R. (2003). Overview of medical and surgical complications. In: A. W. Graham, T. K. Schultz, M. F. Mayo-Smith, R. K. Ries, & B. B. Wilford (Eds.), *Principles of addiction medicine* (3rd ed.) (pp. 1027–1052). Chevy Chase, MD: American Society of Addiction Medicine.

Simon, G. E., & VonKorff, M. (1995). Recognition, management, and outcomes of depression in primary care. *Archives of Family Medicine*, *4* (2), 9599–10005.

Steadman, H. J., Deane, M. W., Morrissey, J. P., Westcott, M. L., Salasin, S., & Shapiro, S. (1999). A SAMHSA research initiative assessing the effectiveness of jail diversion programs for mentally ill persons. *Psychiatric Services*, *50* (12), 1620–1623. Retrieved November 29, 2005, from <http://ps.psychiatryonline.org/cgi/reprint/50/12/1620.pdf>

Steadman, H. J., Scott, J. E., Osher, F. C., Agnese, T. K., & Robbins, P. C. (2005). Validation of the brief jail mental health screen. *Psychiatric Services*, *56* (7), 816–822.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2002). *Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders*. Retrieved November 29, 2005, from <http://alt.samhsa.gov/reports/congress2002/CoOccurringRpt.pdf>.

Teplin, L. A. (1994). Psychiatric and substance abuse disorders among male urban jail detainees. *American Journal of Public Health*, *84* (2), 290–293.

Teplin, L. A., Abram, K. M., & McClelland, G. M. (1996). Prevalence of psychiatric disorders among incarcerated women. I. Pretrial jail detainees. *Archives of General Psychiatry*, *53* (6), 505–512.

Tommasello, A. C., Myers, C. P., Gillis, L., Treherne, L. L., & Plumhoff, M. (1999). Effectiveness of outreach to homeless substance abusers. *Evaluation and Program Planning*, *22* (3), 295–303.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Author. Retrieved February 14, 2005, from <http://www.surgeongeneral.gov/library/mentalhealth/home.html>

Winarski, J. T. (1998). *Implementing interventions for homeless individuals with co-occurring mental health and substance use disorders: A PATH Technical Assistance Package* (DHHS Publication No. 1998-620-198/90758). Rockville, MD: Center for Mental Health Services. Retrieved November 29, 2005, from [http://pathprogram.samhsa.gov/pdf/implementing\\_interventions.pdf](http://pathprogram.samhsa.gov/pdf/implementing_interventions.pdf)

Woolf, S. H., DiGiuseppi, C. G., Atkins, D., & Kamerow, D. B. (1996). Developing evidence-based clinical practice guidelines: Lessons learned by the U.S. preventive services task force. *Annual Review of Public Health*, *17*, 511–538.

## COCE Senior Staff Members

### *The CDM Group, Inc.*

Rose M. Urban, LCSW, J.D., Executive Project Director  
Jill G. Hensley, M.A., Project Director  
Anthony J. Ernst, Ph.D.  
Fred C. Osher, M.D.  
Michael D. Klitzner, Ph.D.  
Sheldon R. Weinberg, Ph.D.  
Debbie Tate, M.S.W., LCSW

### *National Development & Research Institutes, Inc.*

Stanley Sacks, Ph.D.  
John Challis, B.A., B.S.W.  
JoAnn Sacks, Ph.D.

### *National Opinion Research Center at the University of Chicago*

Sam Schildhaus, Ph.D.

## COCE National Steering Council

Richard K. Ries, M.D., *Chair, Research Community Representative*  
Richard N. Rosenthal, M.A., M.D., *Co-Chair, Department of Psychiatry, St. Luke's Roosevelt Hospital Center; American Academy of Addiction Psychiatry*  
Ellen L. Bassuk, M.D., *Homelessness Community Representative*  
Pat Bridgman, M.A., *CCDCIII-E, State Associations of Addiction Services*  
Michael Cartwright, B.A., *Foundations Associates, Consumer/Survivor/Recovery Community Representative*  
Redonna K. Chandler, Ph.D., *Ex-Officio Member, National Institute on Drug Abuse*  
Joseph J. Coccozza, Ph.D., *Juvenile Justice Representative*  
Gail Daumit, M.D., *Primary Care Community Representative*  
Raymond Daw, M.A., *Tribal/Rural Community Representative*  
Lewis E. Gallant, Ph.D., *National Association of State Alcohol and Drug Abuse Directors*  
Andrew L. Homer, Ph.D., *Missouri Co-Occurring State Incentive Grant (COSIG)*

Andrew D. Hyman, J.D., *National Association of State Mental Health Program Directors*  
Denise Juliano-Bult, M.S.W., *National Institute of Mental Health*  
Deborah McLean Leow, M.S., *Northeast Center for the Application of Prevention Technologies*  
Jennifer Michaels, M.D., *National Council for Community Behavioral Healthcare*  
Lisa M. Najavits, Ph.D., *Trauma/Violence Community Representative*  
Annelle B. Primm, M.D., M.P.H., *Cultural/Racial/Ethnic Populations Representative*  
Deidra Roach, M.D., *Ex-Officio Member, National Institute on Alcohol Abuse and Alcoholism*  
Marcia Starbecker, R.N., M.S.N., *CCI, Ex-Officio Member, Health Resources and Services Administration*  
Sara Thompson, M.S.W., *National Mental Health Association*  
Pamela Waters, M.Ed., *Addiction Technology Transfer Center*  
Mary R. Woods, RNC, LADAC, MSHS, *National Association of Alcohol and Drug Abuse Counselors*

## COCE Senior Fellows

Barry S. Brown, M.S., Ph.D., *University of North Carolina at Wilmington*  
Carlo C. DiClemente, M.A., Ph.D., *University of Maryland, Baltimore County*  
Robert E. Drake, M.D., Ph.D., *New Hampshire-Dartmouth Psychiatric Research Center*  
Michael Kirby, Ph.D., *Independent Consultant*  
David Mee-Lee, M.S., M.D., *DML Training and Consulting*  
Kenneth Minkoff, M.D., *ZiaLogic*  
Bert Pepper, M.S., M.D., *Private Practice in Psychiatry*

Stephanie Perry, M.D., *Bureau of Alcohol and Drug Services, State of Tennessee*  
Richard K. Ries, M.D., *Dual Disorder Program, Harborview Medical Center*  
Linda Rosenberg, M.S.W., CSW, *National Council for Community Behavioral Healthcare*  
Richard N. Rosenthal M.A., M.D., *Department of Psychiatry, St. Luke's Roosevelt Hospital Center*  
Douglas M. Ziedonis, M.D., Ph.D., *Division of Psychiatry, Robert Wood Johnson Medical School*  
Joan E. Zweben, Ph.D., *University of California - San Francisco*

## Affiliated Organizations

*Foundations Associates*  
*National Addiction Technology Transfer Center*  
*New England Research Institutes, Inc.*

*Northwest Frontier Addiction Technology Transfer Center*  
*Pacific Southwest Addiction Technology Transfer Center*  
*Policy Research Associates, Inc.*

## COCE Overview Papers\*

*"Anchored in current science, research, and practices in the field of co-occurring disorders"*

- *Paper 1: Definitions and Terms Relating to Co-Occurring Disorders*
- *Paper 2: Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders*
- *Paper 3: Overarching Principles To Address the Needs of Persons With Co-Occurring Disorders*
- *Paper 4: Addressing Co-Occurring Disorders in Non-Traditional Service Settings*
- *Paper 5: Understanding Evidence-Based Practices for Co-Occurring Disorders*

\*Check the COCE Web site at [www.coce.samhsa.gov](http://www.coce.samhsa.gov) for up-to-date information on the status of overview papers in development.

For technical assistance:  
visit [www.coce.samhsa.gov](http://www.coce.samhsa.gov), e-mail [coce@samhsa.hhs.gov](mailto:coce@samhsa.hhs.gov), or call (301) 951-3369



A project funded by the  
Substance Abuse and Mental Health Services Administration's  
Center for Mental Health Services and Center for Substance Abuse Treatment



# Understanding Evidence-Based Practices for Co-Occurring Disorders

## OVERVIEW PAPER 5



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
Substance Abuse and Mental Health Services Administration  
Center for Mental Health Services  
Center for Substance Abuse Treatment  
[www.samhsa.gov](http://www.samhsa.gov)

## About COCE and COCE Overview Papers

The Co-Occurring Center for Excellence (COCE), funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a leading national resource for the field of co-occurring mental health and substance use disorders (COD). The mission of COCE is threefold: (1) to receive and transmit advances in treatment for all levels of COD severity, (2) to guide enhancements in the infrastructure and clinical capacities of service systems, and (3) to foster the infusion and adoption of evidence- and consensus-based COD treatment and program innovations into clinical practice. COCE consists of national and regional experts including COCE Senior Staff, Senior Fellows, Steering Council, affiliated organizations (see inside back cover), and a network of more than 200 senior consultants, all of whom join service recipients in shaping COCE's mission, guiding principles, and approaches. COCE accomplishes its mission through technical assistance and training, delivered through curriculums and materials on-line, by telephone, and through in-person consultation.

COCE Overview Papers are concise and easy-to-read introductions to state-of-the-art knowledge in COD. They are anchored in current science, research, and practices. The intended audiences for these OPs are mental health and substance abuse administrators and policymakers at State and local levels, their counterparts in American Indian tribes, clinical providers, other providers, and agencies and systems through which clients might enter the COD treatment system. For a complete list of available overview papers, see the back cover.

For more information on COCE, including eligibility requirements and processes for receiving training or technical assistance, direct your e-mail to [coce@samhsa.hhs.gov](mailto:coce@samhsa.hhs.gov), call (301) 951-3369, or visit COCE's Web site at [www.coce.samhsa.gov](http://www.coce.samhsa.gov).

## Acknowledgments

COCE Overview Papers are produced by The CDM Group, Inc. (CDM) under Co-Occurring Center for Excellence (COCE) Contract Number 270-2003-00004, Task Order Number 270-2003-00004-0001 with the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). Jorielle R. Brown, Ph.D., Center for Substance Abuse Treatment (CSAT), serves as COCE's Task Order Officer and Lawrence Rickards, Ph.D., Center for Mental Health Services (CMHS), serves as the Alternate Task Order Officer. George Kanuck, COCE's Task Order Officer with CSAT from September 2003 through November 2005, provided the initial Federal guidance and support for these products.

COCE Overview Papers follow a rigorous development process, including peer review. They incorporate contributions from COCE Senior Staff, Senior Fellows, consultants, and the CDM production team. Senior Staff members Michael D. Klitzner, Ph.D., Fred C. Osher, M.D., and Rose M. Urban, LCSW, J.D., co-led the content and development process. Senior Staff member Stanley Sacks, Ph.D., made major writing contributions. Other major contributions were made by Project Director Jill G. Hensley, M.A.; Senior Staff Member Sheldon R. Weinberg, Ph.D.; and Senior Fellows Barry S. Brown, M.S., Ph.D., Michael Kirby, Ph.D., Kenneth Minkoff, M.D., Richard K. Ries, M.D., and Joan E. Zweben, Ph.D. Editorial support was provided by CDM staff J. Max Gilbert, Jason Merritt, Michelle Myers, and Darlene Colbert.

## Disclaimer

The contents of this overview paper do not necessarily reflect the views or policies of CSAT, CMHS, SAMHSA, or DHHS. The guidelines in this paper should not be considered substitutes for individualized client care and treatment decisions.

## Public Domain Notice

All materials appearing in COCE Overview Papers, except those taken directly from copyrighted sources, are in the public domain and may be reproduced or copied without permission.

## Electronic Access and Copies of Publication

Copies may be obtained free of charge from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889, or electronically through the following Internet World Wide Web sites: [www.nacadi.samhsa.gov](http://www.nacadi.samhsa.gov) or [www.coce.samhsa.gov](http://www.coce.samhsa.gov).

## Recommended Citation

Center for Substance Abuse Treatment. *Understanding Evidence-Based Practices for Co-Occurring Disorders*. COCE Overview Paper 5. DHHS Publication No. (SMA) 07-4278. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

## Originating Offices

Co-Occurring and Homeless Activities Branch, Division of State and Community Assistance, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

Homeless Programs Branch, Division of Service and Systems Improvement, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

## Publication History

COCE Overview Papers are revised as the need arises. For a summary of all changes made in each version, go to COCE's Web site at: [coce.samhsa.gov/cod\\_resources/papers.htm](http://coce.samhsa.gov/cod_resources/papers.htm). Printed copies of this paper may not be as current as the versions posted on the Web site.

DHHS Publication No. (SMA) 07-4278  
Printed 2007.

## SUMMARY

The advantages of employing evidence-based practices (EBPs) (see Table 1, Key Definitions) are now widely acknowledged across the medical, substance abuse (SA), and mental health (MH) fields. This overview paper discusses EBPs and their role in the treatment of co-occurring disorders (COD).

Practitioners seldom have as much evidence as they would like about the best clinical approach to use in any given clinical situation. To choose the optimal approach for each client, clinicians must draw on research, theory, practical experience, and a consideration of client perspectives. Picking the best option at the moment using the best information available has been termed “evidence-based thinking” (Hyde et al., 2003) (see Table 1, Key Definitions).

This paper discusses EBPs and their use in treating persons with COD, discusses how evidence (see Table 1, Key Definitions) is used to determine if a given practice should be labeled as evidence based, and gives some brief examples of EBPs for COD.

There is still considerable debate concerning how EBPs should be defined. This paper presents various points of view and offers COCE’s perspective as a starting point for further discussion by the field.

## LITERATURE HIGHLIGHTS

Both researchers and practitioners increasingly perceive EBPs as essential for improving treatment effectiveness in the medical, SA, and MH fields. The use of EBPs permits clinicians and programs to more reliably improve services and achieve optimal outcomes. In substance abuse treatment, EBPs have influenced service delivery in areas ranging from initial engagement (e.g., in the use of motivational enhancement strategies) to community re-entry (e.g., in the focus on cognitive-behavioral strategies for relapse prevention). The National EBP Project (e.g., Torrey et al., 2001) exemplifies the focused attention on translating science to service that is taking place for the treatment of persons with serious mental illnesses in mental health systems.

The earliest definitions of EBPs emphasized scientific research and contrasted scientific evidence with approaches based on “global subjective judgment,” consensus, preference, and

other forms of “nonrigorous” assessment (Eddy, 2005). This “research only” approach was recently rearticulated for the field of mental health by Kihlstrom (2005): “Scientific research is the only process by which clinical psychologists and mental health practitioners should determine what evidence guides EBPs” (p. 23).

Critics of the “research only” approach note that the true performance of an intervention often remains uncertain even when research evidence is available (Claxton et al., 2005), that certain types of interventions are more amenable to research than are others and are therefore more likely to be supported by research evidence (Reed, 2005), and that definitions of successful outcomes are not universally shared, especially in behavioral health (Messer, 2005). Reed (2005) suggests that the dichotomy between research and “everything else” in defining EBPs unnecessarily restricts the definition of evidence and precludes important knowledge based on nonexperimental research (e.g., case studies) and clinical and patient

**Table 1: Key Definitions**

|                                |  |
|--------------------------------|--|
| <b>Evidence-Based Practice</b> | A practice which, based on research findings and expert or consensus opinion about available <i>evidence</i> , is expected to produce a specific clinical outcome (measurable change in client status).  |
| <b>Evidence-Based Thinking</b> | A process by which diverse sources of information (research, theory, practice principles, practice guidelines, and clinical experience) are synthesized by a clinician, expert, or group of experts in order to identify or choose the optimal clinical approach for a given clinical situation. |
| <b>Evidence</b>                | Facts, theory, or subject matter that support or refute the claim that a given practice produces a specific clinical outcome. Evidence may include research findings and expert or consensus opinions.   |
| <b>Expert Opinion</b>          | A determination by an expert, through a process of <i>evidence-based thinking</i> , that a given practice should or should not be labeled “evidence based.”  |
| <b>Consensus Opinion</b>       | A determination reached collectively by more than one expert, through a process of <i>evidence-based thinking</i> , that a given practice should or should not be labeled “evidence based.”  |
| <b>Strength of Evidence</b>    | A statement concerning the certainty that a given practice produces a specific clinical outcome.   |

experiences. It has also been argued that clinical decisionmaking (Messer, 2005) and health policy (Atkins et al., 2005) involve factors and trade-offs related to patient and community values, culture, and competing priorities that are not generally informed by research. An alternative to the “research only” approach that addresses these concerns is the “multiple streams of evidence” approach (Reed, 2005).

The Institute of Medicine (IOM; 2001) suggests a definition of EBPs that reflects the “multiple streams of evidence” approach. The IOM argues for three components of EBPs:

1. **Best research evidence**—the support of clinically relevant research, especially that which is patient centered
2. **Clinician expertise**—the ability to use clinical skills and past experience to identify and treat the individual client
3. **Patient values**—the integration into treatment planning of the preferences, concerns, and expectations that each client brings to the clinical encounter

These “streams of evidence” can be integrated through “evidence-based thinking” (see Table 1, Key Definitions). Evidence-based thinking may be undertaken to designate practices as evidence based or in day-to-day clinical decisionmaking. See Messer (2005) for two case-based examples of evidence-based thinking in clinical practice; see Atkins and colleagues (2005) for examples related to health policy.

## KEY QUESTIONS AND ANSWERS

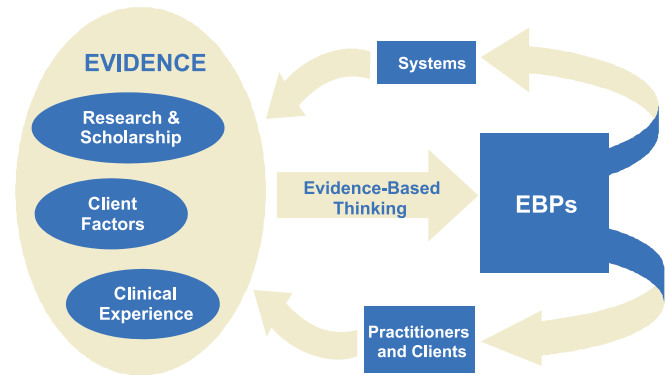
### 1. *What do we mean by evidence-based practices for co-occurring disorders?*

COCE has adopted the “multiple streams of evidence” approach to EBPs discussed above. COCE also takes the position that the integration of multiple streams of evidence requires the application of evidence-based thinking. Accordingly, EBPs are defined by COCE as practices which, based on expert or consensus opinion about available evidence, are expected to produce a specific clinical outcome (i.e., measurable change in client status). Figure 1 illustrates the process by which streams of evidence (i.e., research and scholarship, client factors, and clinical experience) are combined using evidence-based thinking to arrive at recommendations concerning EBPs. The systems, practitioners, and clients who use these EBPs contribute to the evidence base for future evidence-based thinking.

### 2. *How much evidence is needed before a practice can be called an EBP?*

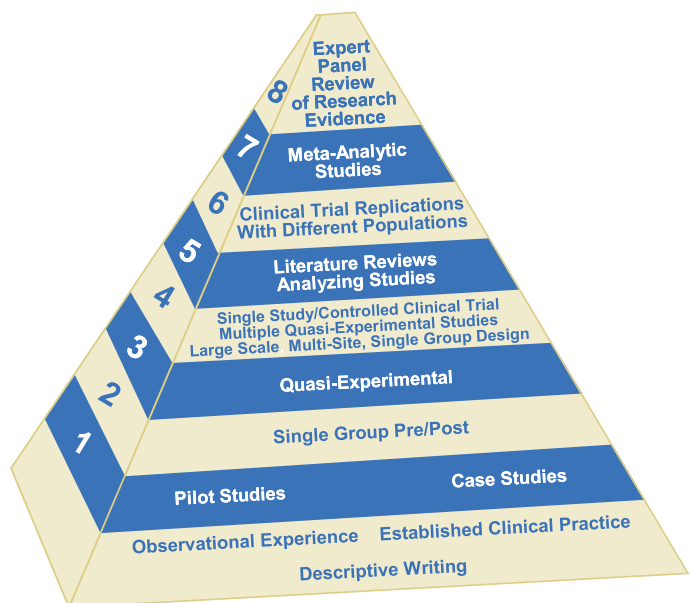
There is no simple answer to this question. In general, the designation of a practice as an EBP derives from a review of research and other evidence by experts in the field (see Question 1). Different organizations use different processes and standards to determine whether or not practices are evidence based.

**Figure 1: Evidence-Based Thinking**



The key question in determining whether a practice is evidence based is: What is the strength of evidence indicating that the practice leads to a specific clinical outcome? There is no gold standard for assessing strength of evidence, especially evidence derived from clinical experience. However, COCE has developed a pyramid to represent the level or strength of evidence derived from various research activities. As can be seen in Figure 2, evidence may be obtained from a range of studies including preliminary pilot investigations and/or case studies through rigorous clinical trials that employ experimental designs. Higher levels of research evidence derive from literature reviews that analyze studies selected for their scientific merit in a particular treatment area, clinical trial replications with different populations, and meta-analytic studies of a body of research literature. At the highest level of the pyramid are expert panel reviews of the research literature.

**Figure 2: Pyramid of Evidence-Based Practices**



In evaluating evidence, it is important to understand the distinction between efficacy and effectiveness. Efficacy means that a treatment or intervention produces positive results in a controlled experimental research trial. Effectiveness means that treatment or intervention produces positive results in a usual or routine care setting (i.e., in the real world). Efficacy established in controlled research does not necessarily equate with effectiveness in real world settings. For example, it may be impractical to provide real world clinicians with the level of training and supervision provided to clinicians in research studies, or real world target populations and community contexts may differ from those used in the research.

### **3. Why should EBPs be used?**

There are several reasons to use EBPs. Foremost, when services are informed by the best available evidence, the quality of care is improved. Second, using EBPs increases the likelihood that desired outcomes will be obtained. EBPs that are based upon research typically have carefully described service components, and many have manuals to guide their implementation. This supports consistent delivery of the practice and high fidelity to the model. Third, by employing these practices, providers will often more efficiently use available resources.

### **4. What are the differences among EBPs, “consensus-based practices,” “science-based practices,” “best practices,” “promising practices,” “emerging practices,” “effective programs,” and “model programs”?**

A number of terms have been used at different times, and by different groups, to describe practices that are expected to produce a specific clinical outcome. These terms are somewhat interchangeable. The terms “promising” and “emerging” are consistent with the notion that the strength of evidence varies among practices deemed likely to produce specific clinical outcomes. COCE avoids descriptors like “best” and “model” because they may imply that there is a single best approach to treating all persons with COD. COCE also avoids the term “effective” because no hard criterion exists for the level of evidence by which “effectiveness” is established.

The term “consensus based” refers to a process by which evidence is commonly evaluated and synthesized to determine if a given practice is an EBP. Other common processes include evaluation of evidence using standardized criteria and numerical scores, meta-analysis, and synthesis by a single scholar. COCE views the consensus process as the best way to identify and evaluate EBPs.

### **5. Is all manualized treatment evidence-based treatment? Have all EBPs been manualized?**

Just because a practice is documented in manual form does not mean it has risen to the level of an EBP. Manual development can be an early step in outcome research, and that

research may show the manualized treatment to be ineffective. Moreover, manuals are sometimes developed as marketing tools for treatments that have undergone little research.

However, once an EBP is established, the development of treatment manuals and practice guidelines are an important part of the dissemination process and help make the EBP accessible to providers. Manuals can minimize the need for costly trainings and often contain fidelity measures and outcome assessment strategies. They can also improve clinical decisionmaking by laying out guidelines for critical circumstances. Practice manuals vary in their level of detail and may not be useful as stand-alone products. Not all EBPs have manuals, but many do.

### **6. What is EBP fidelity and why does it matter?**

Fidelity is the extent to which a treatment approach as actually implemented corresponds to the treatment strategy as designed. Following the initial design with high fidelity is expected to result in greater success in achieving desired client outcomes than deviating from the design (i.e., having low fidelity).

### **7. What are some evidence-based practices for co-occurring disorders?**

Because the treatment of COD is a relatively new field, there has not been time for the development and testing of a large number of EBPs specifically for clients with COD. Clearly, EBPs developed solely for MH or SA should be considered in the treatment of people with COD.

EBPs for COD should combine both treatment elements (e.g., the use of motivational strategies) and programmatic elements (e.g., composition of multidisciplinary teams). COCE has outlined the critical components of COD practices (see Overview Paper 3, Overarching Principles) that should guide the selection of these elements.

At the *treatment level*, interventions that have their own evidence to support them as EBPs are frequently a part of a comprehensive and integrated response to persons with COD. These interventions include:

- Psychopharmacological Interventions (e.g., desipramine and bupropion for people with cocaine dependence and depression [Rounsaville, 2004])
- Motivational Interventions (e.g., motivational enhancement therapy [Miller, 1996; Miller & Rollnick, 2002])
- Behavioral Interventions (e.g., contingency management [Roth et al., 2005; Shaner et al., 1997])

At the *program level*, the following models have an evidence base for producing positive clinical outcomes for persons with COD:

- Modified Therapeutic Communities (CSAT, 2005; De Leon et al., 2000; Sacks et al., 1998, 1999)

- Integrated Dual Disorders Treatment (CMHS, 2003; Drake et al., 1998b, 2004; Mueser et al., 2003)
- Assertive Community Treatment (Drake et al., 1998a; Essock et al., 2006; Morse et al., 1997; Wingerson & Ries, 1999)

The current state of the science highlights the need for evidence-based thinking in making both programmatic and clinical decisions in the treatment of people with COD.

### **8. How can I learn about new developments in EBPs?**

At SAMHSA, the National Registry of Effective Programs and Practices (NREPP) is a decision-support tool that assesses the strength of evidence and readiness for dissemination of a variety of mental health and substance abuse prevention and treatment interventions. The NREPP system is available through a new Web site ([www.nationalregistry.samhsa.gov](http://www.nationalregistry.samhsa.gov)). In Great Britain, the Cochrane Collaborative maintains the Cochrane Library, which contains regularly updated evidence-based healthcare databases (see [www.cochrane.org](http://www.cochrane.org)) on a comprehensive array of health practices. Relevant specialty organizations (e.g., American Psychological Association) also publish lists of evidence-based practices. These compilations of programs and interventions may be generalizable to persons with COD, and the reader should look for specific reference to COD populations.

### **9. What issues should be considered in the use of EBPs?**

Most EBPs are not universally applicable to all communities, treatment settings, and clients. If communities, treatment settings, and/or clients vary from those for which the EBP is designed, or if the human and facilities resources needed for the EBP are not available, effectiveness may be reduced. The various issues that must be considered in the use of an evidence-based practice include:

- Client population characteristics including culture, socioeconomic status, and the existence of other health and social issues that may complicate service delivery (e.g., pregnancy, incarceration, disabilities)
- Staff attitudes and skills required by the EBP
- Facilities and resources required by the EBP
- Agency policies and administrative procedures needed to support the EBP
- Interagency linkages or networks to provide needed additional services (e.g., vocational, educational, housing assistance, etc.)
- State and local regulations
- Reimbursement for the specific services to be provided under the EBP

### **10. Are there financial incentives to use EBPs? Are there components of EBPs that are not reimbursable?**

The financing of EBPs for COD varies greatly by State. Some States (e.g., New York) have included evidence-based practice language in their licensing and regulation standards to create an incentive for providers receiving State support to use EBPs (New York State Office of Mental Health, 2005). Other States now require that programs demonstrate the use of EBPs in order to receive funding. In Oregon, for example, programs that receive State funds must show that a percentage of those funds are used to pay for EBPs (Oregon Department of Human Services, 2005).

For evidence-based program model EBPs, like assertive community treatment, some States will use Medicaid dollars to support a case rate, and other States use a fee-for-service methodology to reimburse providers.

### **11. What should be done to facilitate/enable program administrators and staff to adopt EBPs?**

The implementation of EBPs will present both psychological challenges (e.g., resistance to change, commitment to current practices) and practice challenges (e.g., need for training and supervision, need for organizational changes, new licensures or certifications). Several practical guides to facilitating adoption of new practices are available, including sections from SAMHSA's Evidence-Based Practice Implementation Resource Kits available at [www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/default.asp](http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/default.asp) and Module 6 of COCE's Evidence- and Consensus-Based Practice curriculum (CSAT, in development)

### **12. How can one bridge the gap between the diverse needs of people with COD and the limited number of EBPs?**

The reality is that the number of EBPs available to the clinician is insufficient to the task of treating COD. Clients with COD present a variety of disorders, and appropriate treatment covers a wide spectrum of services—screening, assessment, engagement, intensive treatment, and re-entry. The clinician will need to use evidence-based thinking to determine the optimal course of action for each patient. As discussed earlier, inputs to evidence-based thinking include research, theory, practice principles, practice guidelines, and clinical experience.

Two documents provide substantial information to inform evidence-based thinking: TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005) and *Service Planning Guidelines: Co-Occurring Psychiatric and Substance Disorders* (Minkoff, 2001). These

documents incorporate EBPs where appropriate and emphasize recommended treatment interventions for people with COD in substance abuse treatment settings.

## FUTURE DIRECTIONS

Much has been accomplished in the field of COD over the last 10 years, and a body of knowledge has been acquired that is appropriate for broad dissemination and application. There are now several well-articulated, evidence-based practices that are ready for application in clinical programs. Despite this considerable progress, far more research is needed to answer the host of questions that surround the treatment of persons with COD. Research is needed that will:

- *Survey typical treatment facilities* to understand their capabilities (with particular regard to staffing) and current activities (regarding identifying and serving clients with COD)
- *Clarify the characteristics* of those clients with COD for whom substance abuse treatment alone is not sufficient to achieve significant improvement in their substance use and mental disorders
- *Develop and test strategies to engage* clients with COD of different degrees of severity
- *Develop and test strategies to maximize adherence* to substance abuse and mental health counseling services, medication, and medical regimens
- *Clarify the optimum length of treatment* for clients with COD who manifest different severities of disorders
- *Develop and test strategies and techniques for ensuring successful transition* to continuing care (also known as aftercare) and for determining the effectiveness of different aftercare service models
- *Evaluate the dual recovery mutual self-help approaches* that are emerging nationally
- *Study the principles, practices, and processes of technology transfer* in the field of COD treatment
- *Facilitate integrated treatment through policies and workforce development strategies* that overcome legal and other barriers to the provision of a full spectrum of behavioral health services by the substance abuse treatment workforce

## CITATIONS

Atkins, D., Siegel, J., & Slutsky, J. (2005). Making policy when the evidence is in dispute. *Health Affairs, 24* (1), 102–113.

Center for Mental Health Services. (2003). *Co-occurring disorders: Integrated dual disorders treatment, implementation resource kit*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2005). *Substance abuse treatment for persons with co-occurring disorders*. Treatment Improvement Protocol (TIP) Series 42. (DHHS Publication No. SMA 05-3992). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (in development). Introduction to evidence- and consensus-based practices for co-occurring disorders. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Claxton, K., Cohen, J. T., & Neumann, P. J. (2005). When is evidence sufficient? *Health Affairs, 24*, 93–101.

De Leon, G. (1993). Modified therapeutic communities for dual disorders. In J. Solomon, S. Zimberg, & E. Shollar Eds. *Dual diagnosis: Evaluation, treatment, training, and program development*, pp. 147–170. New York: Plenum.

De Leon, G., Sacks, S., Staines, G., & McKendrick, K. (2000). Modified therapeutic community for homeless mentally ill chemical abusers: Treatment outcomes. *American Journal of Drug and Alcohol Abuse, 26*, 461–480.

Drake, R. E., McHugo, G. J., Clark, R. E., Teague, G. B., Xie, H., Miles, K., & Ackerson, T. H. (1998a). Assertive Community Treatment for patients with co-occurring severe mental illness and substance use disorder: A clinical trial. *American Journal of Orthopsychiatry, 68*, 201–215.

Drake, R. E., Mercer-McFadden, C., Mueser, K. T., McHugo, G. J., & Bond, G. R. (1998b). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin, 24*, 589–608.

Drake, R. E., Mueser, K. T., Brunette, M. F., & McHugo, G. J. (2004). A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. *Psychiatric Rehabilitation, 27*, 360–374.

Essock, S., Mueser, K. T., Drake, R. E., Covell, N., McHugo, G. J., Frisman, L. K., Kontos, N. J., Jackson, C. T., Townsend, F., & Swain, K. (2006). Comparison of ACT and standard case management for delivering integrated treatment for co-occurring disorders. *Psychiatric Services, 57*, 185–196.

Eddy, D. M. (2005). Evidence-based medicine: A unified approach. *Health Affairs, 24*, 9–17.

Hyde, P. S., Falls, K., Morris, J. A., Jr., & Schoewald, S. K. (2003). *Turning knowledge into practice: A manual for behavioral health administrators and practitioners about understanding and implementing evidence-based practices*. Boston: The Technical Assistance Collaborative.

Institute of Medicine. Committee on Quality of Health Care in America. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.

Kihlstrom, J. F. (2005). What qualifies as evidence of effective practice? Scientific research. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 23–31). Washington, DC: American Psychological Association.

Messer, S. B. (2005). What qualifies as evidence of effective practice? Patient values and preferences. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 31–40). Washington, DC: American Psychological Association.

Miller, W. R. (1996). Motivational interviewing: Research, practice, and puzzles. *Addictive Behaviors, 21*, 835–842.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change*. (2nd ed). New York: Guilford Press.

Minkoff, K. (2001). *Service planning guidelines: Co-occurring psychiatric and substance disorders*. Fayetteville, IL: Behavioral Health Recovery Management. Retrieved November 10, 2005, from <http://www.bhrm.org/guidelines/ddguidelines.htm>

Morse, G. A., Calsyn, R. J., Klinkenberg, W. D., Trusty, M. L., Gerber, F., Smith, R., Tempelhoff, B., & Ahmad, L. (1997). An experimental comparison of three types of case management for homeless mentally ill persons. *Psychiatric Services, 48*(4), 497–503.

Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: Guilford Press.

New York State Office of Mental Health. (2005). Creating an environment of quality through evidence-based practices. Retrieved November 29, 2005, from <http://www.omh.state.ny.us/omhweb/ebp/>

Oregon Department of Human Services (2005). *Evidence-based practices (EBP)*. Retrieved November 29, 2005, from <http://www.oregon.gov/DHS/mentalhealth/ebp/main.shtml>

Reed, G. M. (2005). What qualifies as evidence of effective practice? Clinical expertise. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 13–23). Washington, DC: American Psychological Association.

Roth, R. M., Brunette, M. F., & Green, A. I. (2005). Treatment of substance use disorders in schizophrenia: A unifying neurobiological mechanism? *Current Psychiatry Reports, 7*, 283–291.

Rounsaville, B. J. (2004). Treatment of cocaine dependence and depression. *Biological Psychiatry, 56*, 803–809.

Sacks, S., De Leon, G., Bernhardt, A. I., & Sacks, J. (1998). *Modified therapeutic community for homeless MICA individuals: A treatment manual (revised)*. New York: National Development and Research Institutes, Inc.

Sacks, S., Sacks, J. Y., & De Leon, G. (1999). Treatment for MICAs: Design and implementation of the modified TC. *Journal of Psychoactive Drugs, 31*, 19–30.

Shaner, A., Roberts, L. J., Eckman, T. A., Tucker, D. E., Tsuang, J. W., Wilkins, J. N., & Mintz, J. (1997). Monetary reinforcement of abstinence from cocaine among mentally ill patients with cocaine dependence. *Psychiatric Services, 48*, 807–810.

Torrey, W. C., Drake, R. E., Dixon, L., Burns, B. J., Flynn, L., Rush, A. J., Clark, R. E., & Klatzker, D. (2001). Implementing evidence-based practices for persons with severe mental illnesses. *Psychiatric Services, 52*, 45–50.

Wingerson, D., & Ries, R. K. (1999). Assertive Community Treatment for patients with chronic and severe mental illness who abuse drugs. *Journal of Psychoactive Drugs, 31*, 13–18.

# Services Integration

## OVERVIEW PAPER 6



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
Substance Abuse and Mental Health Services Administration  
Center for Mental Health Services  
Center for Substance Abuse Treatment  
[www.samhsa.gov](http://www.samhsa.gov)

## About COCE and COCE Overview Papers

The Co-Occurring Center for Excellence (COCE), funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a leading national resource for the field of co-occurring mental health and substance use disorders (COD). COCE's mission is threefold: (1) to receive and transmit advances in treatment for all levels of COD severity, (2) to guide enhancements in the infrastructure and clinical capacities of service systems, and (3) to foster the infusion and adoption of evidence- and consensus-based COD treatment and program innovations into clinical practice. COCE consists of national and regional experts including COCE Senior Staff, Senior Fellows, Steering Council, affiliated organizations (see inside back cover), and a network of more than 200 senior consultants, all of whom join service recipients in shaping COCE's mission, guiding principles, and approaches. COCE accomplishes its mission through technical assistance and training delivered through curriculums and materials online, by telephone, and through in-person consultation.

COCE Overview Papers are concise and easy-to-read introductions to state-of-the-art knowledge in COD. They are anchored in current science, research, and practices. The intended audiences for these overview papers are mental health and substance abuse administrators and policymakers at State and local levels, their counterparts in American Indian tribes, clinical providers, other providers, and agencies and systems through which clients might enter the COD treatment system. For a complete list of available overview papers, see the back cover.

For more information on COCE, including eligibility requirements and processes for receiving training or technical assistance, direct your e-mail to [coce@samhsa.hhs.gov](mailto:coce@samhsa.hhs.gov), call (301) 951-3369, or visit COCE's Web site at [www.coce.samhsa.gov](http://www.coce.samhsa.gov).

## Acknowledgments

COCE Overview Papers are produced by The CDM Group, Inc. (CDM), under Co-Occurring Center for Excellence (COCE) Contract Number 270-2003-00004, Task Order Number 270-2003-00004-0001 with the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). Jorielle R. Brown, Ph.D., Center for Substance Abuse Treatment (CSAT), serves as COCE's Task Order Officer, and Lawrence Rickards, Ph.D., Center for Mental Health Services (CMHS), serves as the Alternate Task Order Officer. George Kanuck, COCE's Task Order Officer with CSAT from September 2003 through November 2005, provided the initial Federal guidance and support for these products.

COCE Overview Papers follow a rigorous development process, including peer review. They incorporate contributions from COCE Senior Staff, Senior Fellows, consultants, and the CDM production team. Senior Staff members Michael D. Klitzner, Ph.D., Fred C. Osher, M.D., and Rose M. Urban, LCSW, J.D., co-led the content and development process. Richard N. Rosenthal, M.A., M.D., made major writing contributions. Other major contributions were made by Project Director Jill G. Hensley, M.A., and Senior Fellows Kenneth Minkoff, M.D., David Mee-Lee, M.S., M.D., and Douglas M. Ziedonis, M.D., Ph.D. Editorial support was provided by CDM staff members Janet Humphrey, J. Max Gilbert, Michelle Myers, Darlene Colbert, Susan Kimner, and Amy Conklin.

## Disclaimer

The contents of this overview paper do not necessarily reflect the views or policies of CSAT, CMHS, SAMHSA, or DHHS. The guidelines in this paper should not be considered substitutes for individualized client care and treatment decisions.

## Electronic Access and Copies of Publication

Copies may be obtained free of charge from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI),

or electronically through the following Internet World Wide Web sites: [www.nacadi.samhsa.gov](http://www.nacadi.samhsa.gov) or [www.coce.samhsa.gov](http://www.coce.samhsa.gov).

## Public Domain Notice

All materials appearing in COCE Overview Papers, except those taken directly from copyrighted sources, are in the public domain and may be reproduced or copied without permission from SAMHSA/CSAT/CMHS or the authors.

## Electronic Access and Copies of Publication

Copies may be obtained free of charge from the COCE Web site ([www.coce.samhsa.gov](http://www.coce.samhsa.gov)).

## Recommended Citation

Center for Substance Abuse Treatment. *Services Integration*. COCE Overview Paper 6. DHHS Publication No. (SMA) XX-XXXX. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

## Originating Offices

Co-Occurring and Homeless Activities Branch, Division of State and Community Assistance, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

Homeless Programs Branch, Division of Service and Systems Improvement, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

## Publication History

COCE Overview Papers are revised as the need arises. For a summary of all changes made in each version, go to COCE's Web site at [www.coce.samhsa.gov/cod\\_resources/papers.htm](http://www.coce.samhsa.gov/cod_resources/papers.htm). Printed copies of this paper may not be as current as the versions posted on the Web site.

DHHS Publication No. (SMA) XX-XXXX

## EXECUTIVE SUMMARY

This overview paper defines and explains services integration and differentiates services integration from systems integration. Services integration refers to the process of merging previously separate clinical services at the level of the individual to meet the substance abuse, mental health, and other needs of persons with co-occurring disorders (COD). The paper examines issues concerning the context, content, approaches, and processes that promote and inhibit services integration.

Persons with COD are, by definition, persons with multiple service needs. COCE takes the position that

The interactive nature of COD requires each disorder to be continually assessed and treatment plans adjusted accordingly. It is a disservice to the person with COD to emphasize attention to one disorder at the expense of the other. (See COCE Overview Paper 3, *Overarching Principles To Address the Needs of Persons With Co-Occurring Disorders*, p. 4).

Effective treatment of persons with COD can only occur when mental health and substance abuse services are, at least to some degree, integrated. Integrated services can be provided by an individual clinician, a clinical team that assumes responsibility for providing integrated services to the client, or a program that provides appropriately integrated services by all clinicians or teams to all clients. The message should always be clear that staff members will do their best to help people with all their problems.

## LITERATURE HIGHLIGHTS

The need for integrated services for persons with COD is apparent in the high community rates of COD (Grant et al., 2004; Kessler et al., 1994; Regier et al., 1990), the negative impact of one untreated disorder on recovery from the other (Rosenthal & Westreich, 1999), and the fact that most treatment settings are unprepared to effectively manage both substance use and mental disorders (SAMHSA, 2002). In the late 1990s, a four quadrant conceptual framework (National Association of State Mental Health Program Directors [NASMHPD] and National Association of State Alcohol and Drug Abuse Directors [NASADAD, 1998])

suggested the need for services integration for individuals with more severe substance use disorders and more severe mental disorders (Quadrant IV) (see also Overview Paper 1, *Definitions and Terms Relating to Co-Occurring Disorders*). Most available research has focused on the need for, and the effects of, services integration for those with severe substance use and mental disorders (e.g., Drake et al., 2001).

Little research has explored services integration for those with less severe disorders. Nonetheless, research supports the *principle* that services integration can play an important

**Table 1: Key Definitions**

|                                      |  |
|--------------------------------------|--|
| <b>Integration</b>                   | As used in this paper, integration refers to strategies for combining mental health and substance abuse services and/or systems, as well as other health and social services to address the needs of individuals with COD.   |
| <b>Services Integration</b>          | Any process by which mental health and substance abuse services are appropriately integrated or combined at either the level of direct contact with the individual client with COD or between providers or programs serving these individuals. Integrated services can be provided by an individual clinician, a clinical team that assumes responsibility for providing integrated services to the client, or an organized program in which all clinicians or teams provide appropriately integrated services to all clients. |
| <b>Dual Diagnosis Capable (DDC)</b>  | Programs that "address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning" (American Society of Addiction Medicine [ASAM], 2001, p. 362).  |
| <b>Dual Diagnosis Enhanced (DDE)</b> | Programs that provide unified substance abuse and mental health treatment to clients who are, compared to those treatable in DDC programs, "more symptomatic and/or functionally impaired as a result of their co-occurring mental disorder" (ASAM, 2001, p. 10).  |
| <b>Systems Integration</b>           | The process by which individual systems or collaborating systems organize themselves to implement services integration to clients with COD and their families.   |

role in providing appropriate and effective treatment to all persons with COD (SAMHSA, 2002). Current programs can be classified as having basic, intermediate, or advanced capacity for COD treatment, with the highest level being full integration of addiction, mental health, and related services (CSAT, 2005).

Accepted evidence-based practices such as Integrated Dual Disorders Treatment (Center for Mental Health Services, 2003), other forms of integrated treatment, and other promising models in both addiction and mental health settings have been developed as integrated service strategies for treating COD. For example, Assertive Community Treatment and cognitive-behavioral interventions have produced positive substance abuse outcomes for persons with COD (McHugo et al., 1999; Mueser et al., 2003), and research has identified specific pharmacologic treatments for specific pairs of co-occurring conditions (Noordsy & Green, 2003; Rounsaville, 2004).

## KEY QUESTIONS AND ANSWERS

### 1. What is meant by “integration” and “integrated”?

The terms “integration” and “integrated” appear throughout the literature on COD: for example, systems integration, services integration, integrated care, integrated screening, integrated assessment, integrated treatment planning, integrated interventions or treatment, integrated models, integrated systems, integration continuum, and so on. The pervasiveness of “integration” and “integrated” in the language of COD reflects the following:

- The awareness that the co-occurrence of these disorders is not simply by chance and occurs frequently
- An understanding that there is always a relationship between the disorders that affects outcomes
- The recognition that effective responses to persons with either mental illness or substance use disorders are compatible

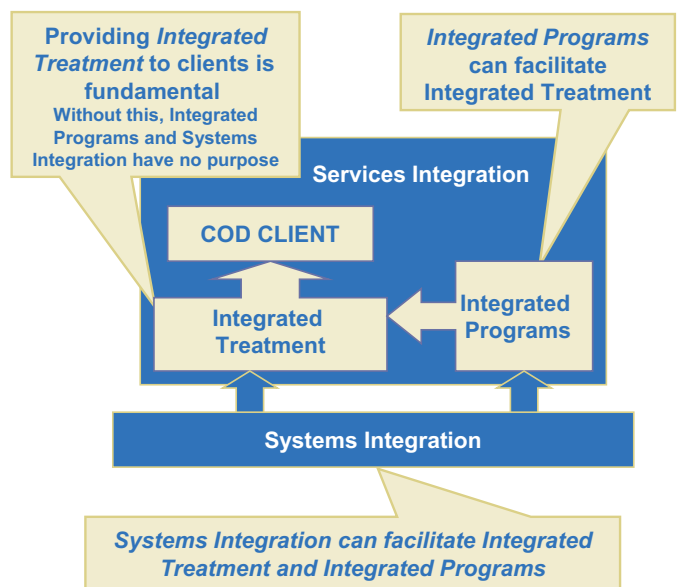
The various types of integration listed above refer to different service components (e.g., screening, assessment, treatment planning, treatment provision) or levels of the service system (e.g., individual practitioners, agencies, local systems of care, States). The specifics of what is to be integrated and the mechanisms by which integration is accomplished will, of course, be different for different service components and at different levels of care. The primary focus of integration is always the same—identifying and managing substance use and mental disorders and the interaction between them. Integration may also seek to identify and manage related health and social problems. The goal of all forms of integration is to support integrated treatment for the individual client.

### 2. What is services integration and how does it fit with other kinds of integration?

Services integration for COD (see Table 1) is defined as any process by which mental health and substance abuse services are appropriately integrated or combined at either the level of direct contact with the individual client with COD or between providers or programs serving these individuals. Integration can be implemented by single providers, teams of providers, or entire programs. Accordingly, services integration can be thought of as having two levels (see also Figure 1):

- *Integrated Treatment*, which occurs at the level of the client–clinician interaction. (This level of integration might also be called “clinician-level” integration.) Integrated treatment can be provided across agencies, within a program, or in an individual provider’s office (CSAT, 2005). Integrated treatment includes integrated assessment, active treatment, and continuing care, as well as concrete activities, such as reviewing explicitly with the client how he or she is dealing with any problem and following any set of recommendations.
- *Integrated Programs*, which are implemented within an entire provider agency or institution to enable clinicians to provide integrated treatment for COD. A COD-specific integrated program is organized to provide substance abuse, mental health, and sometimes other health and social services to persons with COD.

Figure 1: Services Integration and Other Forms of Integration



As shown in Figure 1, integrated treatment and integrated programs are supported and facilitated by systems integration. However, unless integrated treatment is provided to clients, other forms of integration serve no purpose. It is important to note that, although collaboration

among providers and programs is one important component of services integration, it is the content and structure of the collaboration that supports and facilitates integrated treatment.

### 3. *What are the benefits and challenges associated with integrated services from a programmatic, clinical, and consumer viewpoint?*

Given the high numbers of clients with COD seeking substance abuse or mental health services, failure to address COD in either substance abuse or mental health programs is tantamount to not responding to the needs of the majority of program participants. From this perspective, providing integrated services is fundamental to providing quality care.

**Benefits.** A core set of benefits of services integration to programs, clinicians, and consumers can be identified:

- Improved client outcomes (see Question 4)
- Improved adherence to treatment plans where both substance abuse and mental illness interventions are supported
- Improved efficiency because consumers do not have to shuffle between providers and clinicians do not have to make referrals and maintain communications among providers

Additional benefits to consumers include

- Better integrated information rather than conflicting advice from several sources
- Improved access to services through “one-stop shopping”

Additional benefits to programs and clinicians include

- Opportunities for agency and professional growth
- Workforce development
- Less frustration and increased job satisfaction

**Challenges.** From the perspective of the consumer, there are few, if any, disadvantages to services integration. From the perspective of programs and clinicians, implementation of integrated services involves many of the same challenges as any other form of organizational change and development. These may include the need to

- Identify and respond to gaps in workforce competencies, certifications, and licensure
- Proactively address staff concerns related to changes in roles and responsibilities
- Institute modifications in record keeping to accommodate COD
- Modify facilities to meet additional needs (e.g., space for individual or group counseling)
- Revise staffing patterns and work schedules
- Reconcile differences in confidentiality regulations, policies, and practices between substance abuse and mental health

- Revise policies, practices, and requirements regarding dispensing and managing medications
- Utilize new reimbursement sources and procedures

In-depth discussions of these and other issues related to managing organizational change are provided by Fixsen and colleagues (2005).

### 4. *What types of outcomes can be expected from services integration?*

Research evidence supports the claim that services integration leads to better client outcomes. For example, McLellan and associates (1998) report that clients receiving integrated services in addiction treatment settings are more likely to complete treatment and have better posttreatment outcomes. For clients with severe COD, integrated services have been shown to increase engagement in treatment and days of abstinence and reduce psychotic symptoms (Barrowclough et al., 2001; Drake et al., 1997, 2001; Hellerstein et al., 1995; Jerrell & Ridgely, 1995). For these clients, onsite integration may be *required* since delivery in multiple settings is associated with a rapid and significant decrease in treatment retention (Hellerstein et al., 1995).

A small but encouraging literature addresses the integration of primary care services with services for people with COD (Grazier et al., 2003; Lester et al., 2004; Weisner et al., 2001). For example, individuals with substance-related medical or psychiatric conditions show a higher rate of abstinence in integrated substance abuse and primary care treatment than those receiving nonintegrated services (Weisner et al., 2001).

Models focusing on populations such as homeless or criminal justice clients have been developed through local advocacy. For example, there are housing programs that serve clients with COD with varying levels of treatment integration—including supportive housing programs that access COD services, contingency-managed access to housing, housing first models that provide services once clients have housing, and modified therapeutic communities where homeless shelter occupants receive onsite COD treatment (SAMHSA, 2005).

### 5. *How does one decide what services to integrate?*

Services integration *minimally* means providing integrated substance abuse and mental health screening, assessment, treatment planning, treatment delivery, and continuing care, either at the level of direct contact with the client or between providers or programs serving these individuals. Services integration is a process. Accordingly, any step to increase access to and coordination with the services needed by clients with COD is a step toward the ultimate goal of unifying service delivery and better outcomes for persons

with COD. Individuals with COD typically have a wide range of other health and social service needs (New Freedom Commission on Mental Health, 2003). Providers may need to help clients access general health services, HIV/AIDS services, legal aid, English as a second language classes, nutrition services, vocational rehabilitation, or employment assistance (SAMHSA, 2005). The choice of which services to integrate may be guided by practical considerations, program philosophy, stakeholder needs and concerns, or any other legitimate inputs into program decisionmaking.

In an ideal world, persons with COD would be provided “one-stop shopping” for all their substance abuse, mental health, medical, and psychosocial needs. From a practical perspective, perhaps the best rule is when a service need becomes apparent among a significant proportion of clients (e.g., housing services), the relevant services should probably be considered for integration. A “bottom-up” clinical approach can document the need for integrated services through comprehensive client assessment.

**6. Are there some services that should not be integrated?**

There is no reason, in principle, why any service that might be needed by a particular client population cannot be integrated with the provision of COD services. As discussed in Question 5, COD services have been successfully integrated with a variety of other health and human services.

**7. How are integrated services designed and implemented?**

The design and implementation of integrated services may depend on the severity of substance abuse and mental disorders in a specific population as well as their additional medical and psychosocial needs (see Question 5). The optimal integrated service design meets the clinical needs of people with COD with a treatment team that coordinates all pertinent aspects of care. Especially for those with serious disorders, an integrated service design co-locates that care (SAMHSA, 2002). Such an approach means that a range of services is provided, including provisions for medication management, case management, addiction counseling, and psychosocial rehabilitation.

Since most existing services are not proactively designed to take COD-specific service needs into account, integration usually requires a retrofit, with the addition of new services. One advantage to this approach is that programs can build on their current knowledge, skills, and strengths while expanding gradually (SAMHSA, 2003). Incremental approaches allow treatment facilities and providers to simplify and change licensing and certification requirements

for treating COD in the context of different licensing and certification standards.

Other service strategies that facilitate integration include referral networks (“no wrong door”), physical and temporal proximity (e.g., services provided by the same clinician or in the same setting), and care coordination (e.g., services provided by a team of providers from different domains who take joint responsibility for the client).

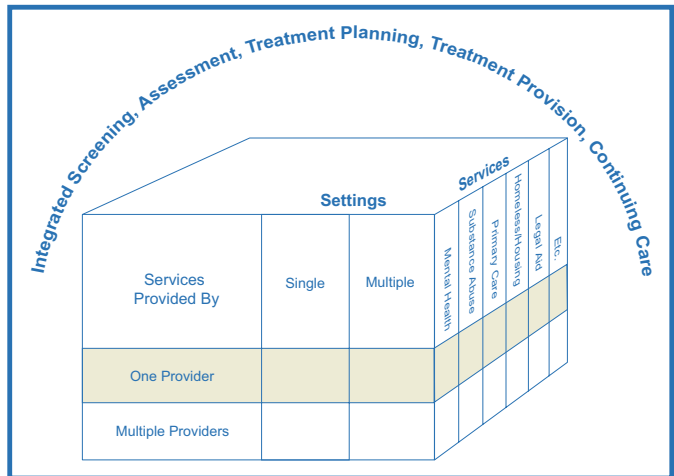
With severe disorders, it is clearly advantageous to integrate mental health and substance abuse treatment programs into a unified, seamless service. In programs serving persons with less severe COD, integration may not need to be as comprehensive, as the full array of services may not be indicated for the population served (SAMHSA, 2005).

**8. What do integrated services look like in practice?**

There is no one organizational chart for services integration. Integrated services may be implemented using a wide variety of staffing configurations and agency formats that meet the overall goal of integrated screening, assessment, treatment planning, treatment provision, and continuing care.

As can be seen in Figure 2, any given service integration initiative can be defined by some combination of three components: (1) a set of services (minimally substance abuse and mental health) that are integrated, (2) whether

**Figure 2: Integrated Services**



services are integrated within or across settings, and (3) whether integrated services are provided by one or more providers.

So, for example, integration of substance abuse and mental health services can be accomplished when both types of services are provided by the same professional or when a

substance abuse and mental health professional collaborate in the care of a client with COD. In the latter case, the substance abuse and mental health professionals can be located in the same setting or agency or in different settings. As one begins to consider services other than substance abuse and mental health, chances are that multiple providers and agencies will need to be involved.

The ASAM Patient Placement Criteria, Second Edition, Revised (ASAM, 2001) describes two levels of integrated programs for people with COD: Dual Diagnosis Capable (DDC) and Dual Diagnosis Enhanced (DDE) (see definitions, Table 1). See also COCE Overview Paper 1, *Definitions and Terms Relating to Co-Occurring Disorders*.

In practice, the arrangement through which services integration is achieved will be dictated by local availability of services, fiscal feasibility, capacity to coordinate, and administrative support.

### **9. How does one set the context for services integration?**

Services integration is the natural outgrowth of basic principles that form the foundation of COCE's approach to the care of persons with COD. Clear articulation of these principles and wide consensus among stakeholders regarding their importance are key steps toward setting the context for services integration. As noted in the Executive Summary, services for persons with COD must respond to the reality that "the interactive nature of COD requires each disorder to be continually assessed and treatment plans adjusted accordingly."

Organizations that articulate client-centered values, remove barriers, and allow staff to take appropriate risks and establish new relationships are vital for transforming services, including services integration. By contrast, rigidity, bureaucratic restraints, insufficient collegial support, change-averse culture, and demoralized staff will impede services integration (Corrigan et al., 2001). "Top-down" strategic decisions that are guided more by power structures, ingrained routines, and established resource configurations will inhibit services integration (Garvin & Roberto, 2001; Rosenheck, 2001).

Finally, workforce development is key to setting the context for services integration. Clinicians will profit from training in integrated screening, assessment, and treatment strategies for both mental and substance use disorders. Training in case management will facilitate coordination with other non-substance abuse or mental health services (McLellan et al., 1998).

### **10. What types of organizational structures and processes inhibit or promote services integration?**

The implementation of services integration will face the same organizational challenges associated with implementing any new practice (see Fixsen et al., 2005). Strong leadership is key.

Some organizational issues are specific to services integration. An integrated organizational chart, shared assessment tools, and integrated policy manuals will facilitate the process of integrating services (NASMHPD & NASADAD, 1998). Services integration will be more difficult if there is a lack of funds for cross-training, lack of incentives for clinicians to cross-train, outdated policies that do not support COD treatment, and efforts at cost containment that impede the treatment of more severe disorders (SAMHSA, 2002). At the systems level, services integration is facilitated by regulatory guidelines that allow mental health and substance abuse funds to be combined or that provide specific guidelines and instructions for how to provide integrated treatment within the context of the existing funding mechanisms (Minkoff & Cline, 2004).

### **11. How can staff burnout in integrated settings be avoided?**

Staff burnout presents a particular challenge in providing integrated services. "Compassion fatigue" may occur when the pressures of work erode a counselor's spirit and outlook and interfere with the counselor's personal life. To lessen the possibility of burnout when working with a demanding caseload that includes clients with COD, TIP 42 (*Substance Abuse Treatment for Persons With Co-Occurring Disorders* [CSAT, 2005]) recommends that clinicians providing COD services work within a team structure rather than in isolation, have opportunities to discuss feelings and issues with other staff who handle similar cases, be given a manageable caseload, and receive supportive and appropriate supervision.

### **12. What are the specific challenges to services integration from a substance abuse perspective?**

The substance abuse professional or agency may have beliefs that must be addressed to implement integrated services. These include the belief that mental health problems are secondary to substance abuse and will improve when substance use is discontinued, and that medications should not be used with persons in recovery.

The specific responsibilities that staff in substance abuse agencies may undertake with clients depend on the licenses and/or certifications they hold. Licenses and certifications define the scope of practice for given disciplines, and they

differ by State and profession. All staff members can provide integrated services consistent with their licenses. For example, although substance abuse counselors in most States cannot treat mental disorders included in the DSM-IV-TR or prescribe medications for these disorders, they can monitor client behavior for signs that medication regimens are being followed and educate and motivate clients regarding the importance of taking their medications.

In addition, some issues associated with clients with mental disorders may be less familiar to substance abuse treatment providers. These include the symptoms of mental disorders; the overlap of these symptoms with those of addiction, intoxication, or withdrawal; and techniques for distinguishing mental disorders from substance abuse symptoms. Substance abuse treatment staff may also need to become more comfortable responding to key issues in recovery from mental disorders, such as the key role of medications and the importance of accepting partial recovery as a legitimate treatment goal for persons with severe mental health problems.

### **13. What are the specific challenges to services integration from a mental health perspective?**

The mental health professional or agency may also have beliefs that must be addressed to implement integrated services, including the belief that substance abuse problems will resolve when mental disorders are addressed. In addition, some issues associated with clients with substance use disorders may be less familiar to mental health professionals. These include the common physical sequelae of substance abuse (e.g., HIV/AIDS, hepatitis) and the socio-legal issues that some clients face (e.g., court orders, conditions of release, probation, parole). Mental health staff may also need to become more comfortable responding to such substance abuse recovery issues as denial, working with a coerced client, abstinence, enabling, relapse, and peer counseling. Finally, from an agency perspective, mental health providers may find that reimbursement rates for addiction services are below rates for mental health services requiring comparable effort.

### **14. What should one do to convey to consumers that they are in an integrated services program?**

For many consumers with a history of COD, entering an integrated service setting may be the first time they feel they are working with helpers who “get it” and who are not trying to put aside issues that the consumers know or sense are important. This feeling should be nurtured by developing an atmosphere that encourages a broad view of what the client may need and what the program can offer.

From initial contact and screening through continuing care, the consumer should feel that the program is responding to her or him as a whole person. This means that issues that are

important to the consumer are important to the program and its clinicians. It also requires the program and clinicians to recognize and respect the complexities of the consumer’s substance abuse, psychosocial, and health needs and to ensure they are prepared to address a variety of issues either in-house or through referrals.

## **FUTURE DIRECTIONS**

Although there is scientific literature regarding the treatment of people with severe COD, there is little research-based guidance for the treatment of people with less severe COD (SAMHSA, 2003). Future research can inform the development of specific integrated interventions for specific combinations of substance use disorders and mental disorders, methods for integrating non-substance abuse or mental health services, and the development of integrated interventions for specific populations and service settings.

## **CITATIONS**

American Society of Addiction Medicine. (2001). *Patient placement criteria for the treatment of substance-related disorders: ASAM PPC-2R*. 2d - Revised ed. Chevy Chase, MD: Author.

Barrowclough, C., Haddock, G., Tarrier, N., Lewis, S. W., Moring, J., O’Brien, R., Schofield, N., & McGovern, J. (2001). Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. *American Journal of Psychiatry*, 158(10), 1706–1713.

Center for Mental Health Services. (2003, draft). *Co-occurring disorders: Integrated dual disorders treatment implementation resource kit*. Retrieved March 20, 2006, from <http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/>

Center for Substance Abuse Treatment. (2005). *Substance abuse treatment for persons with co-occurring disorders*. Treatment Improvement Protocol (TIP) series no. 42 (DHHS Publication No. (SMA) 05-3992). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Corrigan, P. W., Steiner, L., McCracken, S. G., Blaser, B., & Barr, M. (2001). Strategies for disseminating evidence-based practices to staff who treat people with serious mental illness. *Psychiatric Services*, 52(12), 1598–1606.

Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., Lynde, D., Osher, F. C., Clark, R. E., & Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services*, 52(4), 469–476.

- Drake, R. E., Yovetich, N. A., Bebout, R. R., Harris, M., & McHugo, G. J. (1997). Integrated treatment for dually diagnosed homeless adults. *Journal of Nervous and Mental Disease, 185*(5), 298–305.
- Fixsen, D. L., Naoom, S. F., Blasé, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI Publication #231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network. Retrieved January 25, 2006, from <http://nirn.fmhi.usf.edu/resources/publications/Monograph/>
- Garvin, D. A., & Roberto, M. A. (2001). What you don't know about making decisions. *Harvard Business Review, 79*(8), 108–116, 161.
- Grant, B. F., Stinson, F. S., Dawson, D. A., Chou, S. P., Dufour, M. C., Compton, W., Pickering, R. P., & Kaplan, K. (2004). Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry, 61*(8), 807–816.
- Grazier, K. L., Hegedus, A. M., Carli, T., Neal, D., & Reynolds, K. (2003). Integration of behavioral and physical health care for a Medicaid population through a public-public partnership. *Psychiatric Services, 54*(11), 1508–1512.
- Hellerstein, D. J., Rosenthal, R. N., & Miner, C. R. (1995). A prospective study of integrated outpatient treatment for substance-abusing schizophrenic patients. *American Journal on Addictions, 4*(1), 33–42.
- Jerrell, J. M., & Ridgely, M. S. (1995). Comparative effectiveness of three approaches to serving people with severe mental illness and substance abuse disorders. *Journal of Nervous and Mental Disease, 183*(9), 566–576.
- Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., Wittchen, H. U., & Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry, 51*(1), 8–19.
- Lester, H., Glasby, J., & Tylee, A. (2004). Integrated primary mental health care: Threat or opportunity in the new NHS? *British Journal of General Practice, 54*(501), 285–291.
- McHugo, G. J., Drake, R. E., & Teague, G. B. (1999). Fidelity of assertive community treatment and consumer outcomes in the New Hampshire dual disorders study. *Psychiatric Services, 50*, 818–824.
- McLellan, A. T., Hagan, T. A., Levine, M., Gould, F., Meyers, K., Bencivengo, M., & Durell, J. (1998). Supplemental social services improve outcomes in public addiction treatment. *Addiction, 93*(10), 1489–1499.
- Minkoff, K., & Cline, C. A. (2004). Changing the world: The design and implementation of comprehensive continuous, integrated systems of care for individuals with co-occurring disorders. *Psychiatric Clinics of North America, 27*(4), 727–743.
- Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: The Guilford Press.
- National Association of State Mental Health Program Directors (NASMHPD), & National Association of State Alcohol & Drug Abuse Directors (NASADAD). (1998). National dialogue on co-occurring mental health and substance abuse disorders. June 16–17, 1998. Washington, DC. Alexandria, VA: National Association of State Alcohol and Drug Abuse Directors (NASADAD). Retrieved February 28, 2006, from [http://www.nasadad.org/index.php?doc\\_id=101](http://www.nasadad.org/index.php?doc_id=101)
- New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report*. DHHS Publication No. SMA-03-3832. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Noordsy, D. L., & Green, A. I. (2003). Pharmacotherapy for schizophrenia and co-occurring substance use disorders. *Current Psychiatry Reports, 5*(5), 340–346.
- Regier, D. A., Farmer, M. E., Rae, D. S., Locke, B. Z., Keith, S. J., Judd, L. L., & Goodwin, F. K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiologic Catchment Area (ECA) study. *Journal of the American Medical Association, 264*(19), 2511–2518.
- Rosenheck, R. A. (2001). Organizational process: A missing link between research and practice. *Psychiatric Services, 52*(12), 1607–1612.
- Rosenthal, R. N., & Westreich, L. (1999). Treatment of persons with dual diagnoses of substance use disorder and other psychological problems. In B. S. McCrady & E. E. Epstein (Eds). *Addictions: A comprehensive guidebook* (pp. 439–476). New York: Oxford University Press.
- Rounsaville, B. J. (2004). Treatment of cocaine dependence and depression. *Biological Psychiatry, 56*(10), 803–809.
- Substance Abuse and Mental Health Services Administration. (2002). *Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders*. Rockville, MD: Author.
- Substance Abuse and Mental Health Services Administration. (2003). *Strategies for developing treatment programs for people with co-occurring substance abuse and mental disorders*. Rockville, MD: Author. Retrieved July 15, 2004, from <http://www.nccbh.org/cooccurringreport.pdf>

Substance Abuse and Mental Health Services Administration. (2005). *Transforming mental health care in America. Federal action agenda: First steps*. DHHS Pub. No. SMA-05-4060. Rockville, MD: Author.

Weisner, C., Mertens, J., Parthasarathy, S., Moore, C., & Lu, Y. (2001). Integrating primary medical care with addiction treatment. *Journal of the American Medical Association*, 286(14), 1715–1721.

# Systems Integration

## OVERVIEW PAPER 7



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
Substance Abuse and Mental Health Services Administration  
Center for Mental Health Services  
Center for Substance Abuse Treatment  
[www.samhsa.gov](http://www.samhsa.gov)

## About COCE and COCE Overview Papers

The Co-Occurring Center for Excellence (COCE), funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a leading national resource for the field of co-occurring mental health and substance use disorders (COD). COCE's mission is threefold: (1) to receive and transmit advances in treatment for all levels of COD severity, (2) to guide enhancements in the infrastructure and clinical capacities of service systems, and (3) to foster the infusion and adoption of evidence- and consensus-based COD treatment and program innovations into clinical practice. COCE consists of national and regional experts including COCE Senior Staff, Senior Fellows, Steering Council, affiliated organizations (see inside back cover), and a network of more than 200 senior consultants, all of whom join service recipients in shaping COCE's mission, guiding principles, and approaches. COCE accomplishes its mission through technical assistance and training, delivered through curriculums and other materials online, by telephone, and through in-person consultation.

COCE Overview Papers are concise and easy-to-read introductions to state-of-the-art knowledge in COD. They are anchored in current science, research, and practices. The intended audiences for these overview papers are mental health and substance abuse administrators and policymakers at State and local levels, their counterparts in American Indian tribes, clinical providers, other providers, and agencies and systems through which clients might enter the COD treatment system. For a complete list of available overview papers, see the back cover.

For more information on COCE, including eligibility requirements and processes for receiving training or technical assistance, direct your e-mail to [coce@samhsa.hhs.gov](mailto:coce@samhsa.hhs.gov), call (301) 951-3369, or visit COCE's Web site at [www.coce.samhsa.gov](http://www.coce.samhsa.gov).

## Acknowledgments

COCE Overview Papers are produced by The CDM Group, Inc. (CDM) under COCE Contract Number 270-2003-00004, Task Order Number 270-2003-00004-0001 with SAMHSA, U.S. Department of Health and Human Services (DHHS). Jorielle R. Brown, Ph.D., Center for Substance Abuse Treatment (CSAT), serves as COCE's Task Order Officer and Lawrence Rickards, Ph.D., Center for Mental Health Services (CMHS), serves as the Alternate Task Order Officer. George Kanuck, COCE's Task Order Officer with CSAT from September 2003 through November 2005, provided the initial Federal guidance and support for these products.

COCE Overview Papers follow a rigorous development process, including peer review. They incorporate contributions from COCE Senior Staff, Senior Fellows, Consultants, and the CDM production team. The development of this overview paper, *Systems Integration*, concluded in January 2006. Senior Staff members Michael D. Klitzner, Ph.D., Fred C. Osher, M.D., and Rose M. Urban, LCSW, J.D., co-led the content and development process. Senior Fellow Kenneth Minkoff, M.D., made major writing contributions. Other major contributions were made by Project Director Jill G. Hensley, M.A.; Senior Staff members Stanley Sacks, Ph.D., and Anthony J. Ernst, Ph.D.; and Senior Fellows Barry S. Brown, M.S., Ph.D., Michael Kirby, Ph.D., David Mee-Lee, M.S., M.D., and Richard N. Rosenthal, M.A., M.D. Editorial support was provided by CDM staff members J. Max Gilbert, Janet Humphrey, Michelle Myers, and Darlene Colbert.

## Disclaimer

The contents of this overview paper do not necessarily reflect the views or policies of CSAT, CMHS, SAMHSA, or DHHS. The guidelines in this paper should not be considered substitutes for individualized client care and treatment decisions.

## Public Domain Notice

All materials appearing in COCE Overview Papers, except those taken directly from copyrighted sources, are in the public

## Electronic Access and Copies of Publication

Copies may be obtained free of charge from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889, or electronically through the following Internet World Wide Web sites: [www.nacadi.samhsa.gov](http://www.nacadi.samhsa.gov) or [www.coce.samhsa.gov](http://www.coce.samhsa.gov).

## Recommended Citation

Center for Substance Abuse Treatment. *Systems Integration*. COCE Overview Paper 7. DHHS Publication No. (SMA) XXXXXX. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2006.

## Originating Offices

Co-Occurring and Homeless Activities Branch, Division of State and Community Assistance, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

Homeless Programs Branch, Division of Service and Systems Improvement, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

## Publication History

COCE Overview Papers are revised as the need arises. For a summary of all changes made in each version, go to COCE's Web site at [coce.samhsa.gov/cod\\_resources/papers.htm](http://coce.samhsa.gov/cod_resources/papers.htm). Printed copies of this paper may not be as current as the versions posted on the Web site.

DHHS Publication No. (SMA) XX-XXXX  
Printed 200X.

## EXECUTIVE SUMMARY

A growing body of research demonstrates that integrated services produce better outcomes for individuals with co-occurring disorders (COD), particularly those with more serious or complex conditions. Systems integration supports the provision of integrated services. In addition to distinguishing between systems integration and services integration, this paper describes the organizational structures and processes that can promote or inhibit systems integration. The paper encourages the use of creative thinking to obtain and effectively use funding and provides examples of successful initiatives in systems integration at the local and State levels. Although evaluation of the process of systems integration is still in its infancy, one measure of systems integration outcomes is discussed.

Systems integration involves the development of infrastructure within mental health and substance abuse systems that supports the provision of integrated mental health and substance abuse services (integrated treatment within integrated programs) to individuals with COD. Systems integration may include any or all of the following: integrated system planning and implementation; continuous quality improvement; and mechanisms for addressing financing, regulations and policies, program design and certification, interprogram collaboration and consultation, clinical “best practice” development, clinician licensure, competency and training, information systems, data collection, and outcome evaluation.

The concept of systems integration for COD is relatively new and the research base supporting its effectiveness in improving patient outcomes is limited. However, the theoretical appeal of systems integration is increasingly recognized, based in part on the critical role systems play in shaping (or constraining) the activities of those who work in these systems.

**TABLE 1: KEY DEFINITIONS**

|  |  |
|--|--|
| <b>Systems of Care</b>                   | Health and behavioral health systems (including those that address the needs of persons with COD) are composed of the State and local governmental and private agencies, organizations, and individuals who are collectively responsible for providing patient or client care. The agencies, organizations, and individuals subsumed by a given system may be defined as those who are currently involved in patient or client care for persons with COD, but may also include those who are <i>not</i> currently involved but should be in order to achieve optimal outcomes. |
| <b>Integration</b>                       | As used in this paper, integration refers to strategies for combining mental health and substance abuse services and/or systems, as well as other health and social services to address the needs of individuals with COD.   |
| <b>Services Integration</b>              | Any process by which mental health and substance abuse services are appropriately integrated or combined at either the level of direct contact with the individual client with COD or between providers or programs serving these individuals. Integrated services can be provided by an individual clinician, a clinical team that assumes responsibility for providing integrated services to the client, or an organized program in which all clinicians or teams provide appropriately integrated services to all clients.   |
| <b>Systems Integration</b>               | The process by which individual systems or collaborating systems organize themselves to implement services integration to clients with COD and their families.   |
| <b>Funding: Flexible vs. Categorical</b> | <i>Categorical funding</i> is provided to an agency or organization to be used exclusively for services related to substance abuse or mental health and may carry other restrictions related to target population, types of services, etc. <i>Flexible funding</i> provides some level of discretion to recipients concerning the disorders, target population, or services for which the funds may be used.   |
| <b>Funding: Blended and Merged</b>       | Blended or merged funding refers to a strategy by which an agency or organization pools resources or some portion of resources allocated for substance abuse and/or mental health in order to meet the needs of persons with COD. Blending or merging may occur at the level of the funding provider (e.g., a State), the funding recipients, or both.   |

## LITERATURE HIGHLIGHTS

Persons with COD are found in all service populations and settings. These clients will never be served adequately by implementing a few programs in a system with scant resources. Rather, COCE takes the position that

Co-occurring disorders are to be expected in all behavioral health settings, and system planning must address the need to serve people with COD in all policies, regulations, funding mechanisms, and programming. (See COCE Overview Paper 3, *Overarching Principles To Address the Needs of Persons with Co-Occurring Disorders*, p. 2; CSAT, 2005).

Systems integration is one important mechanism for reaching this goal. It provides support to the programs and providers who are ultimately responsible for treating persons with COD. As such, systems integration is a means to an end (improved services and outcomes for persons with COD) rather than an end in and of itself. Former SAMHSA Administrator Charles Curie and his colleagues (2005) note that meeting the needs of people with COD requires a systemic approach “that addresses the challenge of organizing the entire infrastructure of the behavioral health system.”

Systems integration is the output of the various processes by which systems work individually and collaboratively to develop structures or mechanisms to address individuals with multiple needs. Integration can occur in systems of any size (entire States, regions, counties, complex agencies, or individual programs) and in any population or funding stream (adults, elders, children, urban/rural, culturally diverse populations, Medicaid, private payors, or State block grant funds) (Minkoff & Cline, 2004; Ridgely et al., 1998).

As noted by Minkoff and Cline (2004), the implementation of a complex multilayered systems integration model requires an organized approach, incorporating principles of strategic planning and continuous quality improvement in an incremental process. All layers of the system (system, agency or program, clinical practice and policy, clinician competency and training) and all components of the system, regardless of the system’s size or complexity, must interact.

In order to guide systems integration efforts for COD, Minkoff (1991, 2002) and Minkoff and Cline (2001a, b) have developed the Comprehensive, Continuous Integrated System of Care (CCISC) model and its associated “Twelve-Step Program of Implementation” (Minkoff & Cline, 2004). Other examples of models that are intended to facilitate the development of integrated systems of care are briefly described by Ridgely and colleagues (1998) and incorporate comprehensive local planning; comprehensive screening,

assessment, and referral arrangements; and managed care strategies. Despite these advances, the concepts related to systems integration are still evolving, and the implementation of these concepts in practice is not widespread.

The literature on organizational development and the implementation of innovative practices (see Fixsen et al., 2005 for a recent review) supports the theoretical appeal of systems integration. The well-documented role of organizational structure and support in promoting and sustaining practice changes clearly suggests that activities involving the integration of mental health and substance abuse systems should increase the likelihood of integrated care for persons with COD. However, empirical support for systems integration is currently lacking. Formative evaluation of current systems integration efforts (e.g., SAMHSA’s Co-Occurring State Incentive Grants) may inform hypotheses to be tested in future formal research.

## KEY QUESTIONS AND ANSWERS

### 1. What is meant by “integration” and “integrated”?

The terms “integration” and “integrated” appear throughout the literature on COD: for example, systems integration, services integration, integrated care, integrated screening, integrated assessment, integrated treatment plan, integrated interventions or treatment, integrated models, integrated systems, integration continuum, and so on. The pervasiveness of “integration” and “integrated” in the language of COD reflects the following factors:

- The awareness that the co-occurrence of these disorders is not simply by chance and occurs frequently
- An understanding that there is always a relationship between the disorders that affects outcomes
- The recognition that effective responses to persons with either mental illness or substance use disorders are compatible

Therefore, integration is a logical strategy for unifying approaches derived from independent efforts to achieve positive outcomes with narrowly defined target populations.

COCE’s Overview Paper 3 (*Overarching Principles To Address the Needs of Persons With Co-Occurring Disorders*; CSAT, 2005) embeds these factors in the following principle:

The interactive nature of COD requires each disorder to be continually assessed and treatment plans adjusted accordingly. It is a disservice to the person with COD to emphasize attention to one disorder at the expense of the other. There is always a relationship between the two disorders that must be evaluated and managed (p. 4).

The various types of integration listed above refer to different service components (e.g., screening, assessment, treatment planning, treatment provision) or levels of the service system (e.g., individual practitioners, agencies, local systems of care, States). The specifics of what is to be integrated and the mechanisms by which integration is accomplished will, of course, be different for different service components and at different levels of care. However, the goal of integration is always the same—identifying and managing both disorders and the interaction between them. Moreover, the objective of all forms of integration is to *support integrated treatment for the individual client*. Integration that *does not result in changes in services at the client level serves no useful purpose*.

## 2. What is systems integration and how does it fit with other kinds of integration?

Systems integration (see Table 1) is a process by which individual systems (e.g., mental health) or collaborating systems (e.g., mental health and substance abuse) organize themselves to implement services integration to clients with COD and their families. The goal of this process is to promote the adoption of best practices for engaging clients with COD in care and to provide for integrated screening, integrated assessment, and integrated services and interventions, in the service of producing the best possible outcomes.

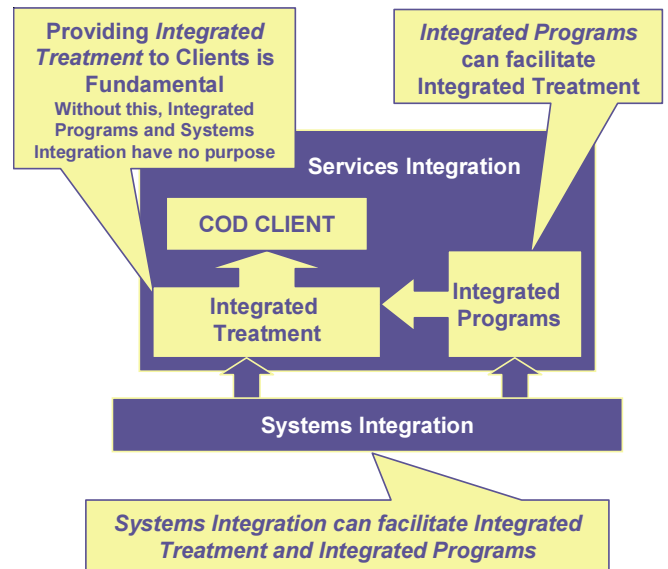
Systems outside of substance abuse and mental health may also participate in systems integration efforts, as when persons with COD are recruited into treatment from homeless shelters, emergency rooms, the criminal justice system, and so on, or when COD treatment services are located in homeless, healthcare, or correctional settings.

Systems integration initiatives range from the implementation of one or more of the strategies mentioned in Question 4 (see pages 3 and 4) to comprehensive initiatives by which mental health and substance abuse systems collaborate to create an overarching, integrated vision of system design that addresses individuals with COD, as well as those with a mental health or a substance use disorder.

As shown in Figure 1, systems integration can facilitate services integration (integrated treatment and integrated programs) in service of the overall goal of providing integrated treatment to clients. Systems integration efforts that are not ultimately designed specifically and concretely to support services integration are not likely to have a demonstrated impact on client outcome.

Services integration can occur, at least to some degree, in the absence of systems integration. For example, individual practitioners or agencies may take it upon themselves to provide integrated services to their clients. Systems can, and frequently do, fund “special” COD programs that work

**Figure 1. Systems Integration and Other Forms of Integration**



around the lack of integration in the system. These demonstration or pilot programs are then evaluated for dissemination potential. However, absent the infrastructure supports provided by systems integration, isolated efforts at services integration may be limited in impact and difficult to sustain.

## 3. Is systems integration the same thing as the creation of an integrated State mental health and substance abuse department?

No. Creation of an “integrated” State mental health and substance abuse department is in no way synonymous with systems integration. Depending on the system, creation of an integrated mental health and substance abuse department may provide a starting place for the organized integrated planning and implementation efforts that are requisites for systems integration. Alternatively, such a merger may create resistance within the existing systems that actually impedes the operationalization of systems integration efforts.

## 4. What types of organizational structure promote or inhibit systems integration?

Systems integration is not dependent on any specific organizational structure. In general, systems integration is facilitated by organizational structures that support an integrated planning process and is complicated by organizational structures that impede such processes (see Fixsen et al., 2005; Rogers, 2003). SAMHSA’s Co-Occurring State Incentive Grants (COSIGs) have provided resources to experiment with a variety of systems integration models. However, neither the models developed by the COSIGs or other systems integration models have been well researched. Accordingly, science-based guidelines for implementation are not currently available, and systems integration should be undertaken with a clear organizational commitment to

evaluating outcomes and impacts within a process of continuous quality improvement.

Former SAMHSA Administrator Charles Curie and his colleagues (2005) describe seven organizational processes that may support systems integration:

- *Committed leadership*: individuals or teams who have the authority and vision to organize and sustain a complex change process.
- *Integrated system planning and implementation*: an organized structure or mechanism that creates a standard method for complex overarching strategic planning and stepwise strategic implementation.
- *Value-driven, evidence-based priorities*: the articulation of a rationale to drive the change process based on data demonstrating poor outcomes for the target population and high costs, and the clinical and economic value of system transformation.
- *Shared vision and integrated philosophy*: the development of a set of principles that encompasses validation and recognition of the role of mental health systems, programs, and approaches along with addiction systems, programs, and approaches (e.g., the national consensus Four Quadrant Model – See Overview Paper 1, *Definitions and Terms Relating to Co-Occurring Disorders*; CSAT, 2006).
- *Dissemination of evidence-based technology to define clinical practice and program design*: the use of technology transfer (including training and technical assistance), not as an end in itself, but as a vehicle to stimulate diverse changes in clinical practice throughout a complex delivery system, building on the burgeoning availability of evidence-based technology for a wide variety of problems and populations.
- *True partnership among all levels of the system*: a critically important reliance on a continuous quality improvement model that uses a top-down, bottom-up, linked, and empowered collaboration between every level of the system, including top administrators as well as frontline clinicians, consumers, and families, in organizing and implementing the change process.
- *Data-driven, incentivized, and interactive performance improvement processes*: using data connected to all aspects of system performance to organize the incremental implementation of complex change processes that support systems integration within a continuous quality improvement framework.

##### 5. Does systems integration rely on a specific funding model?

No, but it does rely on both improving resource availability and using resources efficiently. The Institute of Medicine

*Report on Improving the Quality of Health Care for Mental and Substance-Use Conditions* (2006) succinctly highlights the existing phenomenon of adverse selection, in which powerful economic incentives exist to *not* serve individuals with complicated clinical conditions. Because the person with COD is such an individual, these negative incentives must be acknowledged and addressed. Systems integration can proceed under a variety of funding mechanisms. However, a systems integration approach may require creative thinking on the part of both funders and systems to identify how various funding streams (including those that are categorical) can support integrated services. For example, SAMHSA has provided States with explicit instructions that both mental health and substance abuse block grant dollars could separately fund integrated services within the programs those funds were already intended to support (SAMHSA, 1999). SAMHSA's 1997 State Incentive Grant for prevention was the first cooperative agreement that promoted blended/braided funding and infrastructure change at the State agency. The overall success of the program led to the development of the COSIGs mentioned in Question 4.

Blended or merged funding streams may be a creative technique to facilitate the development of specialized programs, but reliance only on blended funding is both inefficient and likely to result in funding uncertainty and confusion. Legitimate concerns may be raised about maintaining the integrity of addiction or mental health treatment services when mental health and substance abuse dollars are merged into an "integrated" behavioral health pool. To avoid these pitfalls, systems integration strategies often begin by supporting the integrity of existing funding streams while articulating the expectation that all funding streams, whether flexible or categorical, should carry instructions for appropriate integration at the client level.

##### 6. What are some real world examples of systems integration initiatives?

Many States and communities have shared with COCE their experiences related to systems integration as part of COCE's technical assistance and training activities. The following example is a composite based on these experiences.

###### *A Local Community Mental Health Clinic Integrates To Improve COD Services*

This local community mental health clinic (publicly funded) in a medium-sized county in the Midwest recognized the need to address COD within its existing client population but did not have funds to create a specialized co-occurring program. The mental health clinic subsequently hired cross-trained clinicians with certifications or licenses in substance abuse treatment to address COD through a case management approach as a supplement to existing mental health programs. The clinicians were tasked with implementing COD therapy groups within the clinic, and existing mental

health staff rotated in as co-facilitators to develop their COD competencies. The clinic's policies were modified to support this approach by requiring integrated screenings, integrated assessments if indicated through screening, and treatment through integrated case management. A subsequent analysis of client outcomes revealed significant improvement in medication compliance and levels of abstinence for clients with COD.

### 7. What methodologies are available to evaluate systems integration, and how effective are they?

Figure 1 makes clear that the ultimate outcome of systems integration (as well as all other types of integration related to COD) is improved outcomes for clients and their families. Methods for measuring these outcomes are well documented.

However, methods for measuring and evaluating the *process* of systems integration are still in their infancy. Goldman and colleagues (2002) used a measure, based on the number of integration strategies (e.g., coordinating groups, co-location of services, pooled funding, cross-training), used by systems attempting to address COD and homelessness. The CCISC Toolkit (Minkoff & Cline, 2002) includes one, as yet unvalidated, measure of systems integration outcome (CO-FIT100). This measure of fidelity for the CCISC assesses implementation processes and achievement of welcoming, accessible, integrated, continuous, and comprehensive services for individuals with COD throughout the system. This toolkit awaits further research support.

The General Organizational Index (GOI) (Center for Mental Health Services, 2005) has been used to measure an organization's operating characteristics associated with the capacity to implement evidence-based practices, including integrated approaches to COD. The GOI provides an objective, structured method to evaluate the organizational processes associated with systems integration.

## FUTURE DIRECTIONS

The theoretical appeal of systems integration is undeniable. However, there is a need for further evaluation of the impact of systems integration on the effectiveness and efficiency of care for persons with COD. There is also a need to compare various organizational and reimbursement models and approaches and to further explore methods for overcoming barriers to systems integration.

## CITATIONS

Center for Mental Health Services. (2005). *Evidence-based practices: Shaping mental health services toward recovery*. Retrieved February 9, 2005, from <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring>

Center for Substance Abuse Treatment. *Overarching principles to address the needs of persons with co-occurring disorders*. COCE Overview Paper 3. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

Center for Substance Abuse Treatment. *Definitions and Terms Relating to Co-Occurring Disorders*. COCE Overview Paper 1. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006

Curie, C. G., Minkoff, K., Hutchings, G. P., & Cline, C. A. (2005). Strategic implementation of systems change for individuals with mental health and substance use disorders. *Journal of Dual Diagnosis* 1 (4), 75–96.

Fixsen, D. L., Naoom, S. F., Blasé, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI Publication #231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network. Retrieved January 25, 2006, from <http://nirn.fmhi.usf.edu/resources/publications/Monograph/>

Goldman, H. H., Morrissey, J. P., Rosenheck, R. A., Coccozza, J., Blasinsky, M., & Randolph, F. (2002). Lessons from the evaluation of the ACCESS program. *Access to Community Care and Effective Services. Psychiatric Services*, 53 (8), 967–969. Retrieved March 23, 2005, from <http://ps.psychiatryonline.org/cgi/reprint/53/8/967>

Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use conditions*. Washington, DC: National Academies Press.

Minkoff, K. (1991). Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders. In K. Minkoff & R. E. Drake (Eds.), *New directions for mental health services, No. 50* (pp. 13–26). San Francisco: Jossey-Bass.

Minkoff, K. (2002). *CCISC model: Comprehensive, continuous, integrated system of care model*. Retrieved March 4, 2002, from <http://www.kenminkoff.com/ccisc.html>

Minkoff, K. & Cline, C. (2001a). *COMPASS (Version 1.0): Comorbidity program audit and self-survey for behavioral health services. (Co-occurring disorders services enhancement toolkit - Tool number 5)*. Albuquerque, NM: ZiaLogic.

Minkoff, K. & Cline, C. (2001b). *New Mexico Co-occurring disorders program competency assessment tool*. Santa Fe, NM: New Mexico Department of Health.

Minkoff, K. & Cline, C. A. (2002). CO-FIT100™ Version 1.0: CCISC outcome fidelity and implementation tool. (*Co-occurring disorders services enhancement toolkit - Tool number 10*). Albuquerque, NM: ZiaLogic. Retrieved March 23, 2005, from [http://hpc.state.nm.us/ibhpc/138DOH\\_Best%20Practice-%20Co-Occurring%20DisordersB.pdf](http://hpc.state.nm.us/ibhpc/138DOH_Best%20Practice-%20Co-Occurring%20DisordersB.pdf)

Minkoff, K. & Cline, C. A. (2004). Changing the world: The design and implementation of comprehensive continuous, integrated systems of care for individuals with co-occurring disorders. *Psychiatric Clinics of North America*, 27 (4), 727–743.

Ridgely, M. S., Goldman, H. H., & Willenbring, M. (1998). Barriers to the care of persons with dual diagnoses: Organizational and financing issues. In R. E. Drake, C. Mercer-McFadden, G. J. McHugo, K. T. Mueser, S. D. Rosenberg, R. E. Clark, & M. F. Brunette (Eds.), *Readings in dual diagnosis*. (pp. 399–414). Columbia, MD: International Association of Psychosocial Rehabilitation Services.

Rogers, E. M. (2003). *Diffusion of innovation* (5th ed.). New York: The Free Press, 2003.

Substance Abuse and Mental Health Services Administration (1999). SAMHSA position statement on use of SAPTBG and CMHSBG funds to treat people with co-occurring disorders. Unpublished paper distributed at the State Systems Development Program V conference, Orlando, FL.

# The Epidemiology of Co-Occurring Substance Use and Mental Disorders

## OVERVIEW PAPER 8



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
Substance Abuse and Mental Health Services Administration  
Center for Substance Abuse Treatment  
Center for Mental Health Services  
[www.samhsa.gov](http://www.samhsa.gov)

## About COCE and COCE Overview Papers

The Co-Occurring Center for Excellence (COCE), funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), is a leading national resource for the field of co-occurring mental health and substance use disorders (COD). COCE's mission is threefold: (1) to receive and transmit advances in treatment for all levels of COD severity, (2) to guide enhancements in the infrastructure and clinical capacities of service systems, and (3) to foster the infusion and adoption of evidence- and consensus-based COD treatment and program innovations into clinical practice. COCE consists of national and regional experts including COCE Senior Staff, Senior Fellows, Steering Council, affiliated organizations (see inside back cover), and a network of more than 200 senior consultants, all of whom join service recipients in shaping COCE's mission, guiding principles, and approaches. COCE accomplishes its mission through technical assistance and training delivered through curriculums and materials online, by telephone, and through in-person consultation.

COCE Overview Papers are concise and easy-to-read introductions to state-of-the-art knowledge in COD. They are anchored in current science, research, and practices. The intended audiences for these overview papers are mental health and substance abuse administrators and policymakers at State and local levels, their counterparts in American Indian tribes, clinical providers, other providers, and agencies and systems through which clients might enter the COD treatment system. For a complete list of available overview papers, see the back cover.

For more information on COCE, including eligibility requirements and processes for receiving training or technical assistance, direct your e-mail to [coce@samhsa.hhs.gov](mailto:coce@samhsa.hhs.gov), call (301) 951-3369, or visit COCE's Web site at [www.coce.samhsa.gov](http://www.coce.samhsa.gov).

## Acknowledgments

COCE Overview Papers are produced by The CDM Group, Inc. (CDM) under COCE Contract Number 270-2003-00004, Task Order Number 270-2003-00004-0001 with SAMHSA, U.S. Department of Health and Human Services (DHHS). Jorielle R. Brown, Ph.D., Center for Substance Abuse Treatment (CSAT), serves as COCE's Task Order Officer and Lawrence Rickards, Ph.D., Center for Mental Health Services (CMHS), serves as the Alternate Task Order Officer. George Kanuck, COCE's Task Order Officer with CSAT from September 2003 through November 2005, provided the initial Federal guidance and support for these products.

COCE Overview Papers follow a rigorous development process, including peer review. They incorporate contributions from COCE Senior Staff, Senior Fellows, Consultants, and the CDM production team. The development of this overview paper, *The Epidemiology of Co-Occurring Substance Use and Mental Disorders*, concluded in January 2006. Senior Staff members Michael D. Klitzner, Ph.D., Fred C. Osher, M.D., and Rose M. Urban, LCSW, J.D., co-led the content and development process. Senior Staff member Stanley Sacks, Ph.D., made major writing contributions. Other major contributions were made by Project Director Jill G. Hensley, M.A., Senior Staff member Sheldon R. Weinberg, Ph.D., Senior Fellow Richard K. Ries, M.D. Outside review was provided by peer reviewers Bridget Grant, Ph.D., Ph.D., and Ronald Kessler, Ph.D. Editorial support was provided by CDM staff members J. Max Gilbert, Jason Merritt, Michelle Myers, and Darlene Colbert.

## Disclaimer

The contents of this overview paper do not necessarily reflect the views or policies of CSAT, CMHS, SAMHSA, or DHHS. The guidelines in this paper should not be considered substitutes for individualized client care and treatment decisions.

## Public Domain Notice

All materials appearing in COCE Overview Papers, except those taken directly from copyrighted sources, are in the public domain and may be reproduced or copied without permission from SAMHSA/CSAT/CMHS or the authors.

## Electronic Access and Copies of Publication

Copies may be obtained free of charge from the COCE Web site ([www.coce.samhsa.gov](http://www.coce.samhsa.gov)).

## Recommended Citation

Center for Substance Abuse Treatment. *The Epidemiology of Co-Occurring Substance Use and Mental Disorders*. COCE Overview Paper 8. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

## Originating Offices

Co-Occurring and Homeless Activities Branch, Division of State and Community Assistance, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

Homeless Programs Branch, Division of Service and Systems Improvement, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

## Publication History

COCE Overview Papers are revised as the need arises. For a summary of all changes made in each version, go to COCE's Web site at [coce.samhsa.gov/cod\\_resources/papers.htm](http://coce.samhsa.gov/cod_resources/papers.htm). Printed copies of this paper may not be as current as the versions posted on the Web site.

DHHS Publication No. (SMA) XX-XXXX

## EXECUTIVE SUMMARY

The paper is presented in two parts. Part 1 is intended for non-scientists and explains what epidemiology is and how it can be used by practitioners, administrators, and policymakers. Part 1 also presents some highlights from past epidemiologic studies of co-occurring disorders (COD) (see Literature Highlights) and introduces three major national studies that are regularly used as sources for information on the nature and extent of COD problems in the United States. Part 2 presents some detailed technical information on these three studies and is intended for audiences who have some familiarity with epidemiologic methods.

## INTRODUCTION

This overview paper provides an introduction to epidemiology (see Table 1, Definitions) as it relates to co-occurring substance use and other mental disorders (i.e., COD). High quality epidemiologic data are a cornerstone of planning services and building service systems for persons with COD. The purpose of this paper is not to serve as a compendium for epidemiologic data and information, nor could such a compendium be contained in this limited number of pages. Rather, this paper is intended as a starting point for those who wish to use epidemiologic data.

## PART I

### Literature Highlights

Literature that addresses the issues of how many people have COD and the nature of these disorders is limited. Most of what is known about the number of cases of COD to be found among clients in substance abuse treatment or mental health settings has been drawn from convenience samples obtained in studies conducted in the 1980s to the mid-1990s for reasons other than generating prevalence data. Of these studies (summarized by Sacks et al., 1997), those conducted in mental health settings found 20 to 50 percent of their clients had a lifetime co-occurring substance use disorder, while those conducted in substance abuse treatment agencies found 50 to 75 percent of their clients had a lifetime co-occurring mental disorder (however, usually not at a level that impairs a person's ability to function normally and safely). These latter findings are supported by another study that reports that 72 percent of persons with a drug dependence disorder in substance abuse treatment had a co-occurring mental disorder at some point during their lifetime (Compton et al., 2000).

Of the COD cases reported in substance abuse settings, a substantial proportion either had a mental disorder of low severity or an antisocial personality disorder. In the former instance, substance abuse treatment has been found to be effective (Joe et al., 1995; Woody et al., 1991); in the latter instance, substance abuse treatment is widely acknowledged as the treatment of choice. The literature also suggests elevated rates of other forms of mental disorders among clients in substance abuse settings, including major depressive disorder and other mood or affective disorders, or posttraumatic stress disorder (Compton et al., 2000; Flynn et al., 1996; Jainchill, 1994; Regier et al., 1990), and indicates the diagnosis of more than one mental disorder is not unusual (Jainchill, 1994).

## Key Questions

### 1. What is epidemiology and why is it needed?

As noted in Table 1, epidemiology is the study of the incidence, prevalence, and distribution of a disease in a population. In simple terms, this means that epidemiology answers the questions who, what, where, when, and “how much” for a particular disease. For example, an epidemiologic study might explore the number of people with COD, their demographic characteristics, their geographic distribution, where and if they are receiving services, and so on. Similarly, epidemiologic studies might look at risk factors for COD, the age of onset of COD, or the typical progression of COD.

At its core, epidemiology is *descriptive*—it tells us about the nature and extent of COD in the Nation, a State, or a community. This information is one critical component of policy, programmatic, and clinical planning and decisionmaking. Epidemiology is a way to look at the relationship of the factors that can result in the expression of COD. The classic model for

**Table 1: Key Definitions**

|                     |  |
|---------------------|--|
| <b>Prevalence</b>   | Denotes the percentage of persons who have a particular disorder at a given time within a specific population. |
| <b>Incidence</b>    | Refers to the rate of occurrence or percentage of new cases (e.g., in a 6-month period) within a population.   |
| <b>Epidemiology</b> | The study of the incidence, prevalence, and distribution of a disease in a population.                         |

studying health problems is the epidemiologic triangle with sides that consist of *the agent* (the “what” of the triangle), *the host* (the “who” of the triangle), and *the environment* (the “where” of the triangle). The epidemiologist’s lens focuses on the relationship of these factors over *time* (the “when” that covers the entire triangle) to inform the public about the parameters of health conditions. Epidemiology cannot determine the causes of COD, but it can describe the incidence, prevalence, and distribution.

Epidemiologic studies have been conducted at the national, State, and local levels. In general, the more closely matched the population of a given study is to the population you are interested in, the more useful the information will be to you. Thus, State-level information is most useful for State-level decisionmaking, local-level data is most useful for local decisionmaking, and so on.

## **2. Why should substance abuse and mental health treatment providers concern themselves with epidemiologic data?**

Epidemiologic data can be used to take some of the “guess work” out of day-to-day practice. Knowing the prevalence of COD in the population with which you work helps you keep vigilant for individuals who may need COD services. Because of the high prevalence of COD in all populations, an overarching principle articulated by COCE is that “Co-occurring disorders must be expected and clinical services should incorporate this assumption into all screening, assessment, and treatment planning” (CSAT, 2005).

Knowing that COD rates are high among specific types of individuals (e.g., the homeless, people who have experienced trauma) can assist in fine tuning your sensitivity to the possibility that a given client should be screened or assessed for COD. However, large national epidemiologic studies, such as those discussed later in the paper, may not accurately reflect what is going on in the specific population a provider serves. This is because trends at the local level may vary significantly from those at the national level. The closer the area surveyed reflects the catchment area of the program, the more valuable the data will be to that program.

## **3. Why should substance abuse and mental health treatment program administrators concern themselves with epidemiologic data?**

Epidemiologic data are key to planning services that are responsive to your target population’s needs. As already noted, the high prevalence of COD means that all substance abuse and mental health treatment programs must be prepared to address the needs of persons with COD. Epidemiologic data can assist in focusing program priorities, planning for workforce development, allocating resources,

and related activities. These data can also assist in identifying areas where specialized services and/or targeted outreach might be developed for specific populations such as pregnant/postpartum women, the homeless, incarcerated individuals, children, and adolescents.

## **4. Why should policymakers concern themselves with epidemiologic data?**

Good epidemiologic information about COD is a major source of information for effective policymaking. Policymakers must identify unmet treatment and prevention needs, set priorities, anticipate workforce demands, determine appropriate resource allocations, and so on. It is difficult to imagine fulfilling these responsibilities at the Federal, State, or local level without a clear understanding of the nature and extent of COD. Policymakers must also often set priorities among the many health, mental health, and social problems States and communities face. Epidemiologic data provide a rational basis for allocating resources and help ensure that public resources are targeted to those most in need.

Although narrowly focused epidemiologic data (i.e., local or State) will be most useful for policymakers, much can be learned from national data if these data are interpreted in light of local circumstances. For example, rough estimates of the need for adolescent COD services could be developed by considering national data in light of the age distribution of a given State or community. Similarly, the very high prevalence of COD among the homeless means that knowledge of the numbers of homeless in a given area provides a rough index of the need for COD services for that population.

## **5. What are the major national epidemiologic studies related to COD?**

Current national COD epidemiologic data are derived from three major studies:

- The National Comorbidity Survey (NCS) and its replication (NCS-R), funded by the National Institute of Mental Health
- The National Survey of Drug Use and Health (NSDUH), funded by SAMHSA
- The National Epidemiologic Study on Alcohol and Related Conditions (NESARC), funded by the National Institute on Alcohol Abuse and Alcoholism

The primary aims of these studies are given in Table 2 (see p.3).

As can be seen in the table, none of these studies is solely devoted to the issue of COD. They do, however, provide an overall picture of the current nature and extent of COD in the U.S. Results from these three studies are presented in Part 2 of this paper (see p.4).

**Table 2: Major Aims of Three National Epidemiologic Studies**

| NCS-R (2001–2002)  | NSDUH (2006)  | NESARC Wave 1 (2001–2002)   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Determine the prevalence of, and trends related to, mental disorders, including substance use disorders</li> <li>• Study patterns and predictors of the course of substance use and other mental disorders, and evaluate effects of primary mental disorders in predicting the onset and course of secondary substance disorders</li> <li>• Estimate treatment service needs and provide information on factors associated with access to treatment services</li> </ul> | <ul style="list-style-type: none"> <li>• Determine the extent of, and trends related to, licit and illicit drug use in the general population</li> <li>• Identify groups with a high risk for drug abuse</li> <li>• Estimate treatment service needs and provide information on factors associated with access to treatment services</li> </ul> | <ul style="list-style-type: none"> <li>• Determine the extent of, and trends related to, substance use and other mental disorders in the general population</li> <li>• Determine the extent to which alcohol-related mental disorders are substance-induced disorders, and differentiate these substance-induced disorders from those reflecting true, independent mental conditions</li> <li>• Estimate treatment service needs and provide information on factors associated with access to treatment services</li> </ul> |

**6. Are the national studies discussed in Question 5 the only source of epidemiologic information related to COD?**

A wide variety of Federal data sources related specifically to substance abuse epidemiology are provided by the Office of National Drug Control Policy at <http://www.whitehousedrugpolicy.gov/drugfact/sources.html>.

Some researchers have done epidemiologic studies related to COD at the regional, State, or local levels (e.g., Anderson & Gittler, 2005; Davis et al., 2003; Kilbourne et al., 2006; Watkins et al., 2004). There may also be unpublished data available in your area (e.g., New York State Office of Mental Health, 2005), although the scientific quality of unpublished studies may be a concern. As noted earlier, these localized studies may be especially useful to practitioners, administrators, and policymakers in the geographic areas they cover.

**7. Are epidemiologic reports written so non-scientists can understand them?**

Unfortunately, as with much science in mental health and substance abuse, epidemiology is often not reported in ways that non-scientists can easily understand. Key findings are often summarized in abstracts of published articles and the executive summaries of reports. However, important issues related to definitions, measurement, and methods may not be readily apparent to lay persons. These issues affect the level of confidence that can be placed in the results, the conclusions that can be drawn, and the comparability of studies to one another. Here, the assistance of a person versed in epidemiology may be needed to make appropriate use of epidemiologic studies.

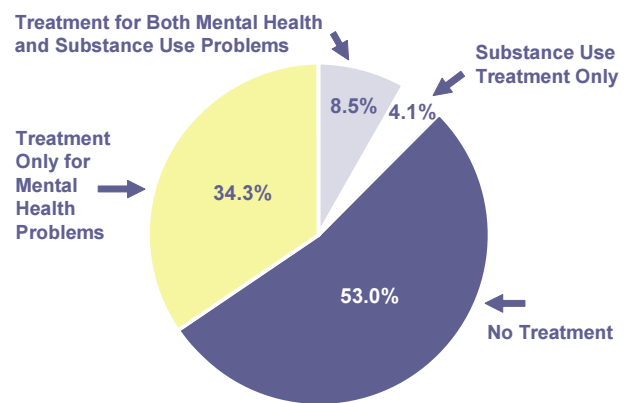
**8. What is currently known about the epidemiology of COD?**

Some detailed descriptions of data from the NCS, NSDUH, and NESARC are provided in Part 2 of this overview paper.

It is important to note that not all three of these surveys include important segments of the population such as those in the military, those who are incarcerated, and those in long-term care facilities. The surveys also do not include children and have limited data on early adolescents. Also, all three surveys use somewhat different criteria for defining substance abuse and other mental disorders and different ways of assessing these. Thus, there is some imprecision where the results of these studies are considered jointly.

Briefly, the NSDUH data estimate that within the general U.S. population, approximately 5.2 million people had COD in 2005 (SAMHSA, 2006). This estimate is very conservative since it includes only those individuals with a serious mental illness (SMI). Of those individuals with co-occurring disorders, very few receive appropriate treatment (see Figure 1).

**Figure 1: Past Year Treatment Among Adults Aged 18 or Older With Both Serious Psychological Distress and a Substance Use Disorder, 2005.**



5.2 Million Adults with Co-Occurring SPD and Substance Use Disorder  
Source: (SAMHSA, 2006)

One important preliminary finding from currently available studies is that the onset of a diagnosable mental disorder often precedes the onset of a diagnosable substance use disorder (Grant et al., 2004; Kessler, 2004; Kessler et al., 2004). For the majority, adolescence marks the onset of primary mental health disorders, with substance use disorders occurring some 5 to 10 years later, during late adolescence and early adulthood (Kessler, 2004).

## Future Directions

Clearly, more epidemiologic data related to COD are needed. In particular, practitioners, administrators, and policymakers need access to data that are relevant to the States and localities where they work. More emphasis on narrowly focused studies in addition to large national efforts would be welcome in COD as in most areas of health, mental health, and substance abuse treatment.

Practitioners, administrators, and policymakers also need access to reports that are presented in a clear and not overly technical manner. Meeting this challenge requires sensitivity to end users on the part of those who conduct and report epidemiologic studies and a commitment on the part of practitioners, administrators, and policymakers to become more familiar with the nature and limitations of epidemiology. Working alliances among epidemiologic researchers, treatment researchers, practitioners (from both the substance abuse treatment and mental health fields), administrators, and policymakers are an undeniable and immediate need. Such collaborations will help translate findings into improved services planning for clients with COD.

Future epidemiologic research should apply greater standardization of methods and reporting to permit more precise comparisons of results. COCE recommends that a standardized and minimal set of reporting categories be used in all studies. These should include reporting primary information on rates of any substance use disorder, any mental disorder, any serious or clinically significant mental disorder, any combination of mental and substance use disorders, any COD with a serious or clinically significant mental disorder, and either a substance use or a mental disorder.

## PART 2

As noted in Part 1, the NSC, NESARC, and NSDUH are the main national sources of epidemiologic data related to COD. The discussion below highlights the main similarities and differences in the methods and the findings of these studies.

### Study/Survey Summaries

The National Comorbidity Survey, funded by NIMH to build on the work of the Epidemiologic Catchment Area

study, was a longitudinal study and the first epidemiologic survey of substance use and mental disorders to use a national probability-sampling frame. At the time of this writing, reports are beginning to emerge from a series of NCS-related surveys, one of which, the NCS-R, conducted in 2001–2002, replicates the original 1991–1992 survey. Another, the NCS-2, conducts a longitudinal survey of a subset of participants from the original study, while a third, the NCS-A, focuses on adolescents. This paper reports data derived from a re-analysis that adjusted the original NCS prevalence rates and provided estimates using 1999 U.S. Census data (Narrow et al., 2002), along with data from some of the first publications associated with the NCS-R.

The National Epidemiologic Study on Alcohol and Related Conditions, a longitudinal survey funded by NIAAA, conducted its first wave of interviews in 2001–2002. A second wave of interviews was conducted in 2004–2005, but data from that wave were not available at the time this paper was written. NESARC used diagnostic guidelines from the *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> ed.* (DSM-IV) (American Psychiatric Association, 2000) to distinguish between independent and substance-induced mood and anxiety disorders. The NESARC also collected data on personality disorders and their co-occurrence with substance-related disorders.

The National Survey on Drug Use and Health provides annual data on prevalence of substance use, serious mental illness, related problems, and treatment in the United States. The NSDUH is sponsored by SAMHSA. Prior to 2002, this survey was called the National Household Survey on Drug Abuse (NHSDA). The NHSDA has been conducted periodically since 1972 and annually since 1991. The survey provides yearly national and State level estimates of alcohol, tobacco, illicit drug, and non-medical prescription drug use. Other health-related questions also appear from year to year, including questions about mental health and treatment. The estimates described in this paper derive from the 2005 NSDUH.

## Methods

### Similarities

Data from all three surveys were

- Drawn from large representative samples of the U.S. population
- Derived from multistage sampling designs
- The result of good response rates
- The product of state-of-the-art data collection and analytic techniques

## Differences

1. The *sampling frames* (i.e., the target population sampled) differed among the three surveys. In general, persons residing in institutions (e.g., prisons) and homeless shelters were excluded from all three surveys, although the NESARC used the *U.S. Bureau of Census 2000 Supplementary Survey "group quarters inventory"* to obtain information from those residing in jails, prisons, mental and medical hospitals, nursing homes, colleges, and military installations (Grant et al., 2003). The NESARC and NSDUH included Spanish speakers; the NCS was limited to English speakers. Both the NESARC and the NCS-R surveyed adults aged 18 years and older; the NSDUH sampled adults and youths 12–17 years of age. (The NCS-A surveys a sample of adolescents, but these data are not yet published and were not used in prevalence estimates for the general population.)
2. The NSDUH is a *cross-sectional* survey (i.e., surveyors contacted respondents only once; no followup was conducted); the NESARC and NCS included both *cross-sectional* and *longitudinal* components (i.e., surveyors contacted the same survey respondents at multiple points over time, allowing correlation of predictors at one point in time with the later onset of a given disorder). Estimates based on longitudinal data were not available at this writing but are forthcoming.
3. The surveys defined mental disorders differently. The NSDUH does not distinguish among various disorders, but rather identifies people with *serious psychological distress* as having a "high level of distress due to any type of mental problem" at some time in the past year (SAMHSA, 2006). The NCS and NESARC, on the other hand, characterized specific disorders using criteria from the DSM-IV (American Psychiatric Association, 2000).
4. The three surveys measured mental disorders differently. The NSDUH uses the results from the K-6, a scale of nonspecific psychological distress, to estimate the 12-month prevalence of SMI in the population studied. The K-6 asks respondents how frequently during the worst month of the last year they experienced symptoms of psychological distress in six areas of functioning; the K-6 has been found to be a valid indicator of SMI, compared to traditional clinical assessments of survey respondents (Kessler et al., 2003). However, because of concerns about the validity of the K-6 as a measure of SMI, beginning in 2004 the NSDUH used it as a measure of "serious psychological distress." The NESARC used the *Alcohol Use Disorders and Associated Disabilities Interview Schedule—DSM-IV Version* (Grant et al.,

2003) to assess DSM-IV diagnoses, and the NCS used the *Composite International Diagnostic Interview* (Kessler et al., 2004)—both of these instruments are widely used and have good psychometric properties. NCS and NESARC codebooks indicate that the surveys assessed a considerable and comparable range of disorders. Only the NCS collected retrospective data on behavioral disorders with typical onset prior to age 18 (e.g., conduct and oppositional disorders).

## Findings

Each of the surveys was concerned with individuals' prior year experiences. The information provided is adjusted to compensate for the incomplete data from the most recent NCS and NESARC surveys and for the differences among the three surveys in reporting categories. With the exception of the rates for major depressive disorder (determined using data from NCS-R), the NCS data discussed were drawn from the original data as re-analyzed (Narrow et al., 2002) using criteria to reflect clinical significance (e.g., asking respondents, "Did you take medicine more than once?" "Did your symptoms interfere with your life or activities a lot?"). Table 3 lists the key findings regarding COD that can be derived from these three surveys.

**Table 3: Key COD Findings**

- Substance use disorders are present in more than 9% of adults between the ages of 18 and 54.
- More than 9% of adults have diagnosable mood disorders.
- More than four million U.S. citizens have a serious mental illness and a co-occurring substance use disorder.

## Similarities

1. Similar prevalence rates for past year substance use disorders in the general population were obtained by NSDUH, NESARC, and the recalculation of the original NCS data:
  - NSDUH, 9.3 percent of individuals 18 and older (SAMHSA, 2006)
  - NESARC, 9.4 percent of adults 18 and older (Grant et al., 2004)
  - NCS, 6 percent for adults age 18 and older (with clinical significance criteria described above)—for adults 18 to 54, rates were 11.5 percent (without clinical significance criteria) and 7.6 (with clinical significance criteria) (Narrow et al., 2002).<sup>1</sup>

<sup>1</sup> A lower rate was reported for 12-month prevalence in a recent publication of the NCS-R data (see Kessler et al., 2004) that is less consistent with the other two surveys.

Two of the three surveys, NESARC (Grant et al., 2004) and NCS-R (Kessler, 2004), found prevalence rates for major depressive disorder to be approximately 7 percent; the NSDUH did not isolate rates for any individual mental disorder but reports only the general category of any SMI.

- Two surveys estimated that, within the general U.S. population, over 4 million people have COD. The NCS estimated that approximately 6.6 million people have a clinically significant mental disorder with a co-occurring substance use disorder. While a specific number is not available, the NCS-R is expected to find a number closer to the lower end of the 7 to 10 million range for adults with COD (SAMHSA, 2002). Similarly, the NSDUH survey from 2005 estimated that 5.2 million people have a serious psychological distress with a co-occurring substance use disorder (SAMHSA, 2006). (NESARC will provide its estimates in future publications.) It is important to remember that the operational definitions of SMI applied in the NSDUH and the assessment of "clinically significant disorder" used in the NCS data re-analysis have substantive differences.

### Differences

- The NCS and NSDUH differ in their estimates of the number of U.S. adults (18 or older) who have a substance use or other mental disorder[s]. The NCS (Narrow et al., 2002) reported that 30.2 million Americans, age 18 and older, have a mental disorder and 12.1 million have a substance use disorder. In contrast, the NSDUH (conducted in 2005) estimated the two groups to be similar in size, reporting that approximately 24.6 million adults (18 or older) have serious psychological distress and about 20.2 million have substance use disorders (SAMHSA, 2006). These differences might reflect, in part, the fact that the NCS screened some individuals out from consideration who would have been diagnosed with a substance use disorder if thoroughly evaluated.
- The prevalence of mood disorders was assessed by two of the three surveys. The NCS estimated 11.1 percent (Narrow et al., 2002) and the NESARC estimated 9.3 percent (Grant et al., 2004).
- As noted under Similarities above, two of the surveys have published conflicting estimated rates for "any mental disorder." The disparity between the NCS-R finding of 30.5 percent (the NCS finding was 29.4 percent) (Kessler et al., 2005) and the NSDUH rate of 11.3 percent (SAMHSA, 2005) is likely a consequence of the difference in the definition of mental disorders that each survey used.

### CITATIONS

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. Text Revision). Washington, DC: Author.

Anderson, R. L., & Gittler, J. (2005). Unmet need for community-based mental health and substance use treatment among rural adolescents. *Community Mental Health Journal, 41*(1), 35–49.

Center for Substance Abuse Treatment. (2005). *Overarching principles to address the needs of persons with co-occurring disorders* (COCE Overview Paper No. 3). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved January 30, 2006, from [http://coce.samhsa.gov/cod\\_resources/PDF/OverarchingPrinciples12-6-05.pdf](http://coce.samhsa.gov/cod_resources/PDF/OverarchingPrinciples12-6-05.pdf)

Compton, W. M., III, Cottler, L. B., Ben Abdallah, A., Phelps, D. L., Spitznagel, E. L., & Horton, J. C. (2000). Substance dependence and other psychiatric disorders among drug dependent subjects: Race and gender correlates. *American Journal on Addictions, 9*(2), 113–125.

Davis, T. M., Bush, K. R., Kivlahan, R. D., Dobie, D. J., & Bradley, K. A. (2003). Screening for substance abuse and psychiatric disorders among women patients in a VA Health Care System. *Psychiatric Services, 54* (2), 214–218.

Flynn, P. M., Craddock, S. G., Luckey, J. W., Hubbard, R. L., & Dunteman, G. H. (1996). Comorbidity of antisocial personality and mood disorders among psychoactive substance-dependent treatment clients. *Journal of Personality Disorders, 10*(1), 56–67.

Grant, B. F., Kaplan, K., Shepard, J., & Moore, T. C. (2003). *Source and accuracy statement for Wave 1 of the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions*. Bethesda, MD: National Institute on Alcohol Abuse & Alcoholism.

Grant, B. F., Stinson, F. S., Dawson, D. A., Chou, S. P., Dufour, M. C., Compton, W., Pickering, R. P., & Kaplan, K. (2004). Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders. Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry, 61*, 807–816.

Jainchill, N. (1994). Co-morbidity and therapeutic community treatment. In F. M. Tims, G. De Leon, & N. Jainchill (Eds.), *Therapeutic community: Advances in research and application* (NIDA Research Monograph 144, NIH Publication No. 94-3633) pp. 209–231. Bethesda, MD: National Institute on Drug Abuse.

Joe, G. W., Brown, B. S., & Simpson, D. (1995). Psychological problems and client engagement in methadone treatment. *Journal of Nervous and Mental Disease, 183*(11), 704–710.

Kessler, R. C. (2004). The epidemiology of dual diagnosis. *Biological Psychiatry, 56*, 730–737.

Kessler, R. C., Barker, P. R., Colpe, L. J., Epstein, J. F., Gfroerer, J. C., Hiripi, E., Howes, M. J., Normand, S.-L. T., Manderscheid, R. W., Walters, E. E., & Zaslavsky, A. M. (2003). Screening for serious mental illness in the general population. *Archives of General Psychiatry, 60*(2), 184–189.

Kessler, R. C., Berglund, P., Chiu, W. T., Demler, O., Heeringa, S., Hiripi, E., Jin, R., Pennell, B.-P., Walters, E. E., Zaslavsky, A., & Zheng, H. (2004). The U.S. National Comorbidity Survey Replication (NCS-R): Design and field procedures. *International Journal of Methods Psychiatry Research, 13*(2), 69–92.

Kessler, R. C., Demler, O., Frank, R.G., Olfson, M., Pincus, H.A., Walters, E. E., Wang, P., Wells, K. B., & Zaslavsky, A. (2005). Prevalence and treatment of mental disorders, 1990 to 2003. *New England Journal of Medicine, 352*(24), 2515–2523.

Kilbourne, A. M., Salloum, I., Dausey, D., Cornelius, J. R., Conigliaro, J., Xu, X., & Pincus, H. A. (2006). Quality of care for substance use disorders in patients with serious mental illness. *Journal of Substance Abuse Treatment, 30* (1), 73–77.

Narrow, W. E., Rae, D. S., Robins, L. N., & Regier, D. A. (2002). Revised prevalence estimates of mental disorders in the United States: Using a clinical significance criterion to reconcile two surveys' estimates. *Archives of General Psychiatry, 59*(2), 115–123.

New York State Office of Mental Health (2005). *2003 patient characteristics survey*. Retrieved January 30, 2006, from <http://www.omh.state.ny.us/omhweb/PCS/survey03/index.htm>

Office of Applied Studies (2006) *Results from the 2005 National Survey on Drug Use and Health: National findings* (NSDUH Series H-30, DHHS Publication No. SMA 06-4194). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved September 7, 2006, from <http://www.oas.samhsa.gov/nsduh/2k5nsduh/2k5Results.pdf>

Regier, D. A., Farmer, M. E., Rae, D. S., Locke, B. Z., Keith, S. J., Judd, L. L., & Goodwin, F. K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiologic Catchment Area (ECA) study. *Journal of the American Medical Association, 264*(19), 2511–2518.

Sacks, S., Sacks, J., De Leon, G., Bernhardt, A. I., & Staines, G. L. (1997). Modified therapeutic community for mentally ill chemical abusers: Background; influences; program description; preliminary findings. *Substance Use and Misuse, 32*(9), 1217–1259.

Substance Abuse and Mental Health Services Administration (2002). *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved November 29, 2004, from <http://www.samhsa.gov/reports/congress2002/index.html>

Watkins, K. E., Hunter, S. B., Wenzel, S. L., Tu, W., Paddock, S. M., Griffin, A., & Ebener, P. (2004). Prevalence and characteristics of clients with co-occurring disorders in outpatient substance abuse treatment. *American Journal of Drug and Alcohol Abuse, 30*(4), 749–764.

Woody, G. E., McLellan, A. T., O'Brien, C. P., & Luborsky, L. (1991). Addressing psychiatric comorbidity. In R. W. Pickens, C. G. Leukefeld, & C. R. Schuster (Eds.), *Improving Drug Abuse Treatment* (National Institute on Drug Abuse Research Monograph, No. 106, DHHS Publication No. [ADM] 91-1754) (pp. 152–166). Rockville, MD: National Institute on Drug Abuse.

## COCE Senior Staff Members

### *The CDM Group, Inc.*

Rose M. Urban, LCSW, J.D., Executive Project Director  
Jill G. Hensley, M.A., Project Director  
Anthony J. Ernst, Ph.D.  
Fred C. Osher, M.D.  
Michael D. Klitzner, Ph.D.  
Sheldon R. Weinberg, Ph.D.  
Debbie Tate, M.S.W., LCSW

### *National Development & Research Institutes, Inc.*

Stanley Sacks, Ph.D.  
John Challis, B.A., B.S.W.  
JoAnn Sacks, Ph.D.

### *National Opinion Research Center at the University of Chicago*

Sam Schildhaus, Ph.D.

## COCE National Steering Council

Richard K. Ries, M.D., *Chair, Research Community Representative*  
Richard N. Rosenthal, M.A., M.D., *Co-Chair, Department of Psychiatry, St. Luke's Roosevelt Hospital Center; American Academy of Addiction Psychiatry*  
Ellen L. Bassuk, M.D., *Homelessness Community Representative*  
Pat Bridgman, M.A., *CCDCIII-E, State Associations of Addiction Services*  
Michael Cartwright, B.A., *Foundations Associates, Consumer/Survivor/Recovery Community Representative*  
Redonna K. Chandler, Ph.D., *Ex-Officio Member, National Institute on Drug Abuse*  
Joseph J. Cocozza, Ph.D., *Juvenile Justice Representative*  
Gail Daumit, M.D., *Primary Care Community Representative*  
Raymond Daw, M.A., *Tribal/Rural Community Representative*  
Lewis E. Gallant, Ph.D., *National Association of State Alcohol and Drug Abuse Directors*  
Andrew L. Homer, Ph.D., *Missouri Co-Occurring State Incentive Grant (COSIG)*

Andrew D. Hyman, J.D., *National Association of State Mental Health Program Directors*  
Denise Juliano-Bult, M.S.W., *National Institute of Mental Health*  
Deborah McLean Leow, M.S., *Northeast Center for the Application of Prevention Technologies*  
Jennifer Michaels, M.D., *National Council for Community Behavioral Healthcare*  
Lisa M. Najavits, Ph.D., *Trauma/Violence Community Representative*  
Annelle B. Primm, M.D., M.P.H., *Cultural/Racial/Ethnic Populations Representative*  
Deidra Roach, M.D., *Ex-Officio Member, National Institute on Alcohol Abuse and Alcoholism*  
Marcia Starbecker, R.N., M.S.N., CCI, *Ex-Officio Member, Health Resources and Services Administration*  
Sara Thompson, M.S.W., *National Mental Health Association*  
Pamela Waters, M.Ed., *Addiction Technology Transfer Center*  
Mary R. Woods, RNC, LADAC, MSHS, *National Association of Alcohol and Drug Abuse Counselors*

## COCE Senior Fellows

Barry S. Brown, M.S., Ph.D., *University of North Carolina at Wilmington*  
Carlo C. DiClemente, M.A., Ph.D., *University of Maryland, Baltimore County*  
Robert E. Drake, M.D., Ph.D., *New Hampshire-Dartmouth Psychiatric Research Center*  
Michael Kirby, Ph.D., *Arapahoe House, Inc.*  
David Mee-Lee, M.S., M.D., *DML Training and Consulting*  
Kenneth Minkoff, M.D., *ZiaLogic*  
Bert Pepper, M.S., M.D., *Private Practice in Psychiatry*

Stephanie Perry, M.D., *Bureau of Alcohol and Drug Services, State of Tennessee*  
Richard K. Ries, M.D., *Dual Disorder Program, Harborview Medical Center*  
Linda Rosenberg, M.S.W., CSW, *National Council for Community Behavioral Healthcare*  
Richard N. Rosenthal M.A., M.D., *Department of Psychiatry, St. Luke's Roosevelt Hospital Center*  
Douglas M. Ziedonis, M.D., Ph.D., *Division of Psychiatry, Robert Wood Johnson Medical School*  
Joan E. Zweben, Ph.D., *University of California - San Francisco*

## Affiliated Organizations

*Foundations Associates*  
*National Addiction Technology Transfer Center*  
*New England Research Institutes, Inc.*  
*Northeast/IRFTA Addiction Technology Transfer Center*

*Northwest Frontier Addiction Technology Transfer Center*  
*Pacific Southwest Addiction Technology Transfer Center*  
*Policy Research Associates, Inc.*  
*The National Center on Family Homelessness*

## COCE Overview Papers\*

*“Anchored in current science, research, and practices in the field of co-occurring disorders”*

- *Paper 1: Definitions and Terms Relating to Co-Occurring Disorders*
- *Paper 2: Screening, Assessment, and Treatment Planning for Persons With Co-Occurring Disorders*
- *Paper 3: Overarching Principles To Address the Needs of Persons With Co-Occurring Disorders*
- *Paper 4: Addressing Co-Occurring Disorders in Non-Traditional Service Settings*
- *Paper 5: Understanding Evidence-Based Practices for Co-Occurring Disorders*

\*Check the COCE Web site at [www.coce.samhsa.gov](http://www.coce.samhsa.gov) for up-to-date information on the status of overview papers in development

For technical assistance:  
visit [www.coce.samhsa.gov](http://www.coce.samhsa.gov), e-mail [coce@samhsa.hhs.gov](mailto:coce@samhsa.hhs.gov), or call (301) 951-3369



A project funded by the  
Substance Abuse and Mental Health Services Administration's  
Center for Substance Abuse Treatment and Center for Mental Health Services

# REFERENCES

---

- Coulter, D. J., Pearce, L. A., Legge, M., Young, J. T., Preen, D. B., Heffernan, E., Jones, J., & Kinner, S. A. (2025). Prevalence of mental illness, substance use disorder, and dual diagnosis among adults in custody. *Population Health Metrics*, 23(1), 45. <https://doi.org/10.1186/s12963-025-00408-7>
- Marshall, T., Reeson, M., Loverock, A., Lewis, A. E., King, I., Ilyas, R., Caruso Dixon, C., Viste, D., Azer, B., Chow, E., Safi, F., Kennedy, M., Abba-Aji, A., & Greenshaw, A. J. (2025). Evidence-based interventions for youth with concurrent mental health and substance use disorders: A scoping review. *Canadian Journal of Psychiatry*, 70(5), 347-371. <https://doi.org/10.1177/07067437241300957>
- Membrey, D., Naren, T., Cook, J., MacCartney, P., & Brown, D. (2025). Patient factors associated with treatment completion in a 12-week inpatient dual diagnosis treatment program. *Australasian Psychiatry*, 33(3), 530-538. <https://doi.org/10.1177/10398562241312978>
- Myers, B., Da Silva, N., McLaughlin, S., Purnomo, J., Shumskaya, D., Koume, K., Suhartono, S., Campello, G., & Busse, A. (2025). The relationship between patient-centred care for substance use disorders and patient outcomes: A scoping review. *International Journal of Drug Policy*, 139, 104770. <https://doi.org/10.1016/j.drugpo.2025.104770>
- Scott, K. D., & Gorey, K. M. (2025). Concurrent disorders and treatment outcomes: A meta-analysis. *Journal of Dual Diagnosis*, 21(3), 251-265. <https://doi.org/10.1080/15504263.2025.2515015>
- Sunderland, M., Vescovi, J., Chapman, C., Arya, V., Harris, M., Burgess, P., Marel, C., Mills, K., Baillie, A., Teesson, M., & Slade, T. (2025). Co-occurring mental and substance use disorders in Australia 2020-2022: Prevalence, patterns, conditional probabilities and correlates in the general population. *Australian and New Zealand Journal of Psychiatry*, 59(6), 522-532. <https://doi.org/10.1177/00048674241284913>

## Appendix A: Post Test and Evaluation Overview of Co-Occurring Disorders Treatment

**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. Then, submit your test to us for processing. This can be done in the following manner:

*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 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 'View Lesson Quiz' 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 receive a link to the course evaluation. You will also receive a link 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.

**NOTE: THE QUESTIONS AND/OR ANSWERS MAY BE IN A DIFFERENT ORDER ON THE ONLINE EXAM.**

**Answer the following questions by selecting the most appropriate response.**

**Definitions and terms**

1. There are \_\_\_\_\_ categories of substance use disorders.
  - a. 6
  - b. 15
  - c. 11
  - d. 9
  - e. 20
  
2. There are \_\_\_\_\_ major relevant categories of mental disorders for COD.
  - a. 6
  - b. 13
  - c. 11
  - d. 9
  - e. 20
  
3. Adults or children who would have met functional criteria during the referenced year without the benefit of treatment or other support services are considered to have \_\_\_\_\_ or \_\_\_\_\_ .
  - a. DES, SIM
  - b. SIM, SAT
  - c. SMA, SAD
  - d. SMI, SED
  - e. IMS, DES
  
4. NASMHPD and NASADAD created \_\_\_\_\_ of care.
  - a. one sphere
  - b. two sections
  - c. five sections
  - d. three units
  - e. four quadrants
  
5. More severe mental disorders/less severe substance abuse disorder is in what part of the co-occurring disorders-severity model?
  - a. I
  - b. II
  - c. III
  - d. IV
  - e. V

6. \_\_\_\_\_ turns to \_\_\_\_\_ when there are formal agreements for continuing contact between providers.
- collaboration, consultation
  - minimal coordination, consultation
  - consultation, minimal coordination
  - continuation, continuity
  - consultation, collaboration

### Screening, assessment, and treatment planning

7. The concept of “contact” refers to the fact that there is \_\_\_\_\_ .
- no wrong door
  - no left door
  - no wrong quadrant
  - no wrong window
  - no right door
8. The assessment process should be \_\_\_\_\_ centered.
- client
  - science
  - agency
  - family
  - psychosocially
9. The assessment process includes \_\_\_\_\_ steps.
- 5
  - 10
  - 6
  - 8
  - 12
10. The first component of a treatment plan is:
- problem priorities
  - cultural context
  - safety needs
  - diagnosis
  - disability

## Overarching Principles

11. It is unreasonable to assume that consumers understand the \_\_\_\_\_ their mood, thought, or behavioral problems.
  - a. medications for
  - b. causes of
  - c. inter-psychic conflicts of
  - d. spirituality of
  - e. doctors for
  
12. Technological advances require capable providers to ensure that \_\_\_\_\_ is translated into \_\_\_\_\_ .
  - a. efficiency, efficacy
  - b. effluxion, efficacy
  - c. efficacy, effectiveness
  - d. effloresce, efficacy
  - e. effectiveness ,efficiency
  
13. The \_\_\_\_\_ of change and phases of treatment models reflect the need for \_\_\_\_\_ specific responses.
  - a. critical points, critically
  - b. culture, culturally
  - c. impact, focused
  - d. stages, stage
  - e. age, age
  
14. “What is appropriate?” must always be followed by the question:
  - a. What is the cost?
  - b. What are the roadblocks?
  - c. How critical is the person?
  - d. What are the needs?
  - e. At what age?
  
15. Community intolerance of behavioral disorders has sometimes led to \_\_\_\_\_ of persons with COD.
  - a. criminalization
  - b. hospitalization
  - c. degradation
  - d. incapacitation
  - e. isolation

## Addressing COD in Non-traditional Settings

16. \_\_\_\_\_ percent of persons with serious psychological distress and co-occurring substance use disorder received no treatment in the 12 months preceding the survey.
  - a. 75
  - b. 25
  - c. 53
  - d. 40
  - e. 15
  
17. Almost \_\_\_\_\_ of those in jails with mental illnesses have co-occurring substance use disorders.
  - a. two-thirds
  - b. one-half
  - c. three-quarters
  - d. one-third
  - e. one-fifth
  
18. Studies suggest that \_\_\_\_\_ percent of homeless women had co-occurring Axis I and substance use disorders in 2000.
  - a. 5
  - b. 10
  - c. 20
  - d. 50
  - e. 37
  
19. The highest level of severity for both substance abuse and mental illness is in the special setting of:
  - a. V
  - b. III
  - c. I
  - d. II
  - e. IV
  
20. An efficient screening method for COD in primary care settings is the:
  - a. SALS I
  - b. SASS I
  - c. AID-GUAGE
  - d. CAGE-AID
  - e. TCUDS

## Understanding Evidence-Based Practices

21. The earliest definitions of EBPs emphasized scientific research and contrasted it with approaches based on \_\_\_\_\_ subjective judgment.
  - a. universal
  - b. global
  - c. intuitive
  - d. extrapolated
  - e. rigorous
  
22. The pyramid of evidence-based practices indicates that evidence is obtained from \_\_\_\_\_ levels of information.
  - a. 4
  - b. 5
  - c. 6
  - d. 7
  - e. 8
  
23. The extent to which a treatment approach is actually implemented corresponding to the treatment strategy as designed is referred to as:
  - a. prototype
  - b. integrity
  - c. fidelity
  - d. truth
  - e. guaranty
  
24. Which of the following is not an EBP?
  - a. psychopharmacological interventions
  - b. Motivational interviewing
  - c. Behavioral interventions
  - d. 12-step
  - e. Modified TCs
  
25. At the program level, which of the following is not an EBP?
  - a. Modified TCs
  - b. Transactional analysis
  - c. Integrated dual disorders treatment
  - d. Assertive community treatment
  - e. none of the above

## Services Integration

26. Services integration can be thought of as having \_\_\_\_\_ levels.
  - a. 6
  - b. 5
  - c. 4
  - d. 3
  - e. 2
  
27. Clients receiving integrated services are more likely to:
  - a. complete treatment
  - b. have post-treatment outcomes
  - c. increase engagement in treatment
  - d. reduce psychotic symptoms
  - e. all of the above
  
28. Any given service integration initiative can be defined by some combination of \_\_\_\_\_ components.
  - a. 6
  - b. 5
  - c. 4
  - d. 3
  - e. 2
  
29. In practice, the arrangement through which services integration is achieved will be dictated by:
  - a. local availability of services
  - b. fiscal feasibility
  - c. capacity to coordinate
  - d. administrative support
  - e. all of the above
  
30. When the pressures of work erode a counselors spirit and outlook and interfere with the counselors personal life, it is referred to as:
  - a. neurasthenia
  - b. PTSD
  - c. compassion fatigue
  - d. chronic fatigue syndrome
  - e. fibromyalgia

## Systems Integration

31. An agency or organization can use flexible or \_\_\_\_\_ funding.
  - a. dispersed
  - b. compartmentalized
  - c. categorical
  - d. rigid
  - e. continuous
  
32. In order to guide systems integration efforts for COD, Minkoff, et al have developed the \_\_\_\_\_ model.
  - a. CCSSI
  - b. CSATA
  - c. CEISC
  - d. COCEI
  - e. CCISC
  
33. Creation of an integrated State mental health and substance abuse department is:
  - a. the same as systems integration
  - b. the same as integrated treatment
  - c. not the same as systems integration
  - d. the same as integrated programs
  - e. not likely to create resistance within the existing systems
  
34. A former SAMHSA administrator described \_\_\_\_\_ organizational processes that may support systems integration.
  - a. 7
  - b. 6
  - c. 5
  - d. 4
  - e. 3
  
35. One measure that provides an objective, structured method to evaluate the organizational processes associated with systems integration is the:
  - a. IOG
  - b. GOI
  - c. OGI
  - d. GGI
  - e. GOG

## Epidemiology

36. Which of the following questions would not be a part of epidemiology?
- who
  - what
  - where
  - when
  - why
37. The epidemiologic triangle consists of the agent, the environment, and the \_\_\_\_\_.
- cohesion
  - what
  - host
  - where
  - family
38. The three epidemiologic studies are the NCS, NSDUH, and the \_\_\_\_\_.
- NYSOMH
  - NESARC
  - SARCEN
  - NESOMH
  - SAMHSA-R
39. The percentage of adults aged 18 or older with both serious psychological distress and a substance use disorder who received no treatment was \_\_\_\_\_.
- 34
  - 8.5
  - 4.1
  - 53
  - 75
40. The percentage of adults aged 18 or older with both serious psychological distress and a substance use disorder who received treatment for both was \_\_\_\_\_.
- 34
  - 8.5
  - 4.1
  - 53
  - 75