Key Elements of Treatment Planning for Clients with Co-Occurring Substance Abuse and Mental Health Disorders (COD) [Treatment Improvement Protocol, TIP 42: SAMHSA/CSAT]

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

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

treated as substance abuse in this TIP. Nonetheless, because of the high numbers of the COD population addicted to nicotine as well as the devastating health consequences of tobacco use, nicotine dependency is included as an important cross-cutting issue for people with substance use disorders and mental illness.

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

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

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

treatment effectiveness and, in most instances, to result in successful treatment outcomes.

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

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

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

The integration of substance abuse treatment and mental health services for persons with COD has become a major treatment initiative. Integrated treatment

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

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

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

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

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

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

Diagnosis is an important part of the assessment process. The TIP provides a discussion of mental disorders selected from the DSM-IV-TR and the diagnostic

criteria for each disorder. Key information about substance abuse and particular mental disorders is distilled, and appropriate counselor actions and approaches are recommended for the substance abuse treatment client who manifests symptoms of one or more of these mental disorders. The consensus panel recognizes that addiction counselors are not expected to diagnose mental disorders. The limited aims of providing this material are to increase substance abuse treatment counselors' familiarity with mental disorder terminology and criteria and to provide advice on how to proceed with clients who demonstrate the symptoms of these disorders.

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

Several other features complete the list of essential components of treatment for COD, including *enhanced staffing* that incorporates professional mental health specialists, psychiatric consultation, or an onsite psychiatrist (for assessment, diagnosis, and medication); *psychoeducational classes* (e.g., mental disorders and substance abuse, relapse prevention) that provide increased awareness about the disorders and their symptoms; onsite *double trouble groups* to discuss the interrelated problems of mental and substance use disorders, which will help to

identify triggers for relapse; and participation in community-based *dual recovery mutual self-help groups*, which afford an understanding, supportive environment and a safe forum for discussing medication, mental health, and substance abuse issues.

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

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

Motivational Interviewing (MI) is a client-centered, directive method for enhancing intrinsic motivation to change (by exploring and resolving ambivalence) that has proven effective in helping clients clarify goals and commit to change. MI has been modified to meet the special circumstances of clients with COD, with promising results from initial studies to improve client engagement in treatment.

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

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

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

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

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

have demonstrated better outcomes on many variables for ACT compared to standard case management programs.

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

Residential treatment for substance abuse occurs in a variety of settings, including long- (12 months or more) and short-term residential treatment facilities, criminal justice institutions, and halfway houses. In many substance abuse treatment settings, psychological disturbances have been observed in an increasing proportion of clients over time; as a result, important initiatives have been developed to meet their needs.

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

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

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

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

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

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

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

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

well-being, and incentives or rewards for work-related achievements. Together, these elements help create the infrastructure needed for quality service.

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

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