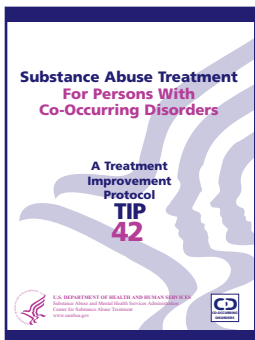


Quick Guide

For Administrators

Based on TIP 42

Substance Abuse Treatment for Persons With Co-Occurring Disorders



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

Contents

Why a Quick Guide?	2
What Is a TIP?	3
Introduction	4
Key Terminology	5
Elements of Successful Programming for Clients With COD	13
Outpatient Substance Abuse Treatment for Clients With COD	23
Residential Substance Abuse Treatment for Clients With COD	28
Dual Recovery Mutual Self-Help Programs	32
Specific Populations	35
Assessing Your Agency's Potential to Serve Clients With COD	42
Workforce Development and Staff Support	46
Resources for Professional Development	50
Funding Issues	55
Glossary	59

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Substance Abuse

Treatment for Persons With

Co-Occurring Disorders

This Quick Guide is based entirely on information contained in TIP 42, published in 2005, and based on information updated through January 2005. No additional research has been conducted to update this topic since publication of the TIP.

WHY A QUICK GUIDE?

This Quick Guide was developed to accompany *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Number 42 in the Treatment Improvement Protocol (TIP) series published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA). This Quick Guide is based entirely on TIP 42 and is designed to meet the needs of the busy administrator for concise, easily accessed “how-to” information.

The Guide is divided into 14 sections (see *Contents*) to help readers quickly locate relevant material. For key terminology relating to the treatment of co-occurring disorders, see page 5, and also refer to the *Glossary* beginning on page 59.

For more information on the topics in this Quick Guide, readers are referred to TIP 42.

WHAT IS A TIP?

The TIP series has been in production since 1991. This series provides the substance abuse treatment and related fields with consensus-based, field-reviewed guidelines on substance abuse treatment topics of vital current interest.

TIP 42, Substance Abuse Treatment for Persons With Co-Occurring Disorders

- Provides information about new developments in the rapidly growing field of co-occurring substance use and mental disorders
- Focuses on what the substance abuse treatment clinician needs to know and provides that information in an accessible manner
- Synthesizes knowledge and grounds it in the practical realities of clinical cases and real situations so the reader will come away with increased knowledge, encouragement, and resourcefulness in working with clients with co-occurring disorders

See the inside back cover for information on how to order TIPs and other related products.

INTRODUCTION

The term “co-occurring disorders” refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have co-occurring disorders (abbreviated as COD) have one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs.

By the 1990s, substance abuse treatment programs typically reported that 50 to 75 percent of clients had co-occurring mental disorders, while clinicians in mental health settings reported that between 20 and 50 percent of their clients had a co-occurring substance use disorder.

The objective of TIP 42 and this Quick Guide is to highlight the major developments in the field since the publication of TIP 9, in an effort to help substance abuse and mental health professionals develop a plan for a more integrated treatment community that can better address the needs of clients with COD.

KEY TERMINOLOGY

Levels of Service

The American Society of Addiction Medicine's Patient Placement Criteria (ASAM PPC-2R) envision treatment as a continuum within which there are five levels of care:

- Level 0.5: Early Intervention
- Level I: Outpatient Treatment
- Level II: Intensive Outpatient/Partial Hospitalization Treatment
- Level III: Residential/Inpatient Treatment
- Level IV: Medically Managed Intensive Inpatient Treatment

Each level of care can be subdivided into several levels of intensity indicated by a decimal point. For example, Level III.1 refers to "Clinically Managed Low-Intensity Residential Treatment." A client who has COD might be appropriately placed in any of these levels of service.

Substance abuse administrators should be aware that some mental health professionals may use another system, the Level of Care Utilization System for Psychiatric and Addiction Services.

This system also identifies levels of care, including

- Level 1: Recovery Maintenance Health Management
- Level 2: Low Intensity Community-Based Services
- Level 3: High Intensity Community-Based Services
- Level 4: Medically Monitored Non-Residential Services
- Level 5: Medically Monitored Residential Services
- Level 6: Medically Managed Residential Services

These levels, like the ASAM levels, use a variety of specific dimensions to describe a client in order to determine the most appropriate placement.

Program Types

The ASAM PPC-2R describes three different types of programs for people with COD:

- **Addiction-only services programs**, either by choice or due to a lack of resources, cannot accommodate patients who have psychiatric illnesses that require ongoing treatment, however stable the illness and however well-functioning the patient.

- **Dual diagnosis capable (DDC) programs** address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content, and discharge planning.
- **Dual diagnosis enhanced programs** have a higher level of integration of substance abuse and mental health treatment services. These programs are able to provide primary substance abuse treatment to clients who, as a result of their co-occurring mental disorder, are more symptomatic and/or functionally impaired than clients who are treatable in DDC programs.

Quadrants of Care

The National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders was supported by SAMHSA and two of its centers, CSAT and the Center for Mental Health Services (CMHS). Modifying a model originally developed by the State of New York, the participants in the National Dialogue developed a conceptual framework that classifies treatment settings in four basic groups based on relative symptom severity, rather than diagnosis of the clients seen in those settings.

QUADRANT I

Low severity mental disorders

Low severity substance abuse disorders

Locus of Care: Primary health care settings

Quadrant I clients can be accommodated in intermediate outpatient settings of either mental health or chemical dependency programs, with consultation or collaboration between settings if needed. Alternatively, some individuals will be identified and managed in primary care settings with consultation from mental health and/or substance abuse treatment providers. Prevention activities also take place in these settings.

QUADRANT II

High severity mental disorders

Low severity substance use disorders

Locus of Care: Mental health system

Quadrant II clients ordinarily receive continuing care in the mental health system and are likely to be well served in a variety of intermediate level mental health programs using integrated case management.

QUADRANT III

Low severity mental disorder

High severity substance use disorders

Locus of Care: Substance abuse system

Quadrant III clients are generally well accommodated in intermediate level substance use disorder treatment programs. In some cases there is a need for coordination and collaboration with affiliated mental health programs to provide ongoing treatment of the mental disorders.

QUADRANT IV

High severity mental disorders

High severity substance use disorders

Locus of Care: State hospitals, jails/prisons, emergency rooms, etc.

Quadrant IV clients require intensive, comprehensive, and integrated services for both their substance use and mental disorders. The locus of services and/or treatment can be specialized residential substance abuse treatment programs such as a modified therapeutic community, State hospitals, jails, or even settings that provide acute care such as emergency rooms.

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

- **Consultation:** Traditional types of informal relationships among providers, from referrals to requests for exchanging information and keeping each other informed.
- **Collaboration:** Distinguished from consultation on the basis of the formal quality of collaborative agreements, such as memoranda of understanding or service contracts.
- **Integration:** Contributions of professionals in both fields are moved into a single treatment setting and treatment regimen. Depending on the needs of the client and the constraints and resources of particular systems, appropriate degrees and means of integration will differ.

Comprehensive Continuous Integrated System of Care

The Comprehensive Continuous Integrated System of Care model (CCISC) brings the mental health and substance abuse treatment systems (and potentially other systems) into an integrated planning process to develop a comprehensive, integrated system of care. The model is grounded in the following assumptions:

- The four-quadrant model is a valid model for service planning.

- Individuals with co-occurring disorders benefit from continuous, integrated treatment relationships.
- Programs should provide integrated primary treatment for substance use and mental disorders in which interventions are matched to diagnosis, phase of recovery, stage of change, level of functioning, level of care, and the presence of external supports and/or contingencies.

Integrated Interventions

Integrated interventions are specific treatment strategies or therapeutic techniques in which interventions for two or more disorders are combined in a single session or interaction, or in a series of interactions or multiple sessions. Integrated interventions can include a wide range of techniques:

- Integrated screening and assessment.
- Dual recovery mutual self-help meetings.
- Dual recovery groups (in which recovery skills for both disorders are discussed).
- Motivational enhancement interventions (individual or group) that address issues related to both mental health and substance abuse or dependence problems.
- Group interventions for persons with the triple diagnosis of mental disorder, substance use disorder, and trauma, or which are designed to

assist persons with COD and another shared problem such as homelessness or criminality.

- Combined psychopharmacological interventions, in which an individual receives medication designed to reduce cravings for substances as well as medication for a mental disorder.
- Integrated interventions can be part of a single program or can be used in multiple program settings.

ELEMENTS OF SUCCESSFUL PROGRAMMING FOR CLIENTS WITH COD

“No Wrong Door”

The “no wrong door” policy states that individuals needing treatment should be identified and assessed and receive treatment, either directly or through appropriate referral, no matter where they enter the realm of services. This approach has five major implications for service planning:

1. Assessment, referral, and treatment planning for all settings must be consistent with a “no wrong door” policy.
2. Creative outreach strategies may be needed to encourage some people to engage in treatment.
3. Programs and staff may need to change expectations and program requirements to engage reluctant and “unmotivated” clients.
4. Treatment plans should be based on clients’ needs and should respond to changes as they progress through stages of treatment.
5. The overall system of care—to include primary healthcare facilities, homeless shelters, social service agencies, emergency rooms, and criminal justice settings—needs to be seamless, providing continuity of care across the service system.

Appropriate Level of Care

Substance abuse treatment programs can classify themselves as basic, intermediate, advanced, or fully integrated in their capacity to address COD.

- **Basic:** Program has the capacity to provide treatment for one disorder, but also screens for the other disorder and is able to access necessary consultations.
- **Intermediate:** Program will tend to focus primarily on one disorder without substantial modification to its usual treatment, but will also explicitly address some specific needs of the other disorder.
- **Advanced:** Program has chosen to provide integrated substance abuse and mental health treatment for clients with COD. This usually means adding interventions such as mutual self-help and relapse prevention groups in mental health settings, or adding such services as psychoeducational classes on psychiatric symptoms and groups for medication monitoring in substance abuse treatment settings.
- **Fully Integrated:** Program actively combines substance abuse and mental health interventions to treat disorders, related problems, and the whole person more effectively.

Intake

Intake information consists of

- **Background:** Family, trauma history, marital status, legal involvement and financial situation, health, education, housing status, strengths and resources, and employment
- **Substance Use:** Age of first use, primary drugs used, patterns of drug use, treatment episodes, and family history of substance use problems
- **Mental Health Problems:** Family history of mental health problems, client history of mental health problems including diagnosis, hospitalization and other treatment, current symptoms and mental status, medications, and medication adherence

Basic information can be augmented by objective measurement, utilizing a variety of instruments discussed in Appendices G and H of TIP 42.

A centralized intake team is a useful approach to screening and assessment, providing a common point of entry for many clients. In an agency with multiple programs, centralized intake reduces duplication of referral materials and assessment.

Full Assessment

Assessment of individuals with COD involves a combination of the following:

- Screening to detect the possible presence of COD in the setting where the client is first seen for treatment.
- Evaluation of background factors (family, trauma history, marital status, health, education and work history), mental health, and substance abuse and related medical and psychosocial problems (e.g., living circumstances, employment, family) that are critical to address in treatment planning.
- Initial matching of individual client to services (often, this must be done before a full assessment is completed; also, the client's motivation to change with regard to one or more of the co-occurring disorders may not be well established).
- Appraisal of existing social and community support systems.
- Continuous evaluation (that is, re-evaluation over time as needs and symptoms change and as more information becomes available).

Effective Engagement

Clients with COD have particular difficulty committing to and maintaining treatment. The following guidelines can help to improve the adherence of clients with COD in outpatient settings:

- Use telephone or mail reminders.
- Provide reinforcement for attendance (e.g., snacks, lunch, or reimbursement for transportation).
- Award points (redeemable for phone cards, food, toiletries, etc.) for positive behaviors essential to the development of commitment (i.e., medication adherence, abstinence, attendance, follow-through on referrals).
- Increase the frequency and intensity of the outpatient services offered.
- Develop closer collaboration between referring staff and the outpatient program's staff.
- Reduce waiting times for outpatient appointments.
- Have outpatient programs designed particularly for clients with COD.
- Provide clients with case managers who engage in outreach and provide home visits.
- Coordinate treatment and monitoring with other systems of care providing services to the same client.
- Include the client in the formulation of a Client Action Plan designed to specify, monitor, and document short-term goals.
- Facilitate engagement and adherence by forming a core group of selected residents (pioneers) to transmit the peer mutual self-help culture and to encourage newly admitted clients to make full use of the program.

On-Site Psychiatric and Mental Health Consultation

The assessment, diagnosis, periodic reassessment, medication, and rapid response to crises that a psychiatrist can provide are crucial to sustaining recovery and stable functioning for people with COD. Adding a master's level clinical specialist with strong diagnostic skills and expertise in working with clients with COD can strengthen a substance abuse treatment program's services for these clients. In addition, these staff members can function as consultants to the rest of the team on matters related to mental disorders.

If lack of funding prevents a substance abuse treatment agency from hiring a consulting psychiatrist, the agency could utilize a memorandum of agreement to formalize collaboration with a mental health agency to provide those services. Such arrangements are widely used in the field.

Discharge Planning

Discharge planning for clients with COD should ensure continuity of psychiatric assessment and medication management, in addition to continuing care services to support substance use recovery.

Where a client's family of origin is not healthy and supportive, other networks can be accessed or developed that will support the individual. Client participation in mutual self-help groups, particu-

larly those that focus on COD (e.g., dual recovery mutual self-help programs) can also provide a continuing supportive network.

For residential programs, there are several other important points:

- Discharge planning begins upon entry into the program.
- The latter phases of residential placement should be devoted to developing with the client a specific discharge plan and beginning to follow some of its features.
- Discharge planning often involves continuing in treatment as part of continuity of care.

Continuity of Care

Treatment for persons with COD should consider rehabilitation and recovery over a significant period of time (at least 24 months).

- **Goals:** Mastering community living, developing vocational skills, obtaining gainful employment, deepening psychological understanding, increasing assumption of responsibility, resolving family difficulties, consolidating changes in values and identity

- **Key services:** Life skills education, relapse prevention, 12-Step or Double Trouble groups, case management (especially for housing), vocational training, employment

Housing

Approaches to integrating housing in treatment vary from those that provide housing at the point of entry into the service system combined with case management and supportive services, to those that provide housing as a reward contingent on successful completion of treatment or as part of a continuing care strategy that combines housing and aftercare services.

To address housing needs effectively requires an ongoing relationship with housing authorities, landlords, and other housing providers. Groups and seminars that discuss housing issues are essential as a way to prepare this population for a successful transition from residential treatment.

Another effective strategy has been organizing and coordinating housing tours with supportive housing programs. Relapse prevention efforts are also essential, as substance abuse generally disqualifies clients from public housing in the community.

Work

Work and vocational rehabilitation have long been part of the services offered to clients recovering from mental disorders and to some degree to those recovering from substance use disorders. Many individuals with COD do work, and there are some programs that stress vocational outcomes for this target population.

If work is to become an achievable goal for individuals with COD, vocational rehabilitation and substance abuse treatment must be closely integrated into mental health rehabilitation. For more information about incorporating vocational rehabilitation into treatment, see TIP 38, *Integrating Substance Abuse Treatment and Vocational Services*.

Group Therapy

Modifications of the group therapy format for clients with COD may require stronger direction, shorter duration, and smaller group size, depending on degree of illness. Psychoeducational classes on mental and substance use disorders are important elements in basic COD programs. TIP 41, *Substance Abuse Treatment: Group Therapy*, contains more information on the techniques used in group therapy.

Family Education

A family and community education and support group can be helpful, particularly in cultures that value interdependence and are community- and/or family-oriented. Programs should provide information in an interactive style that encourages questions, rather than a lecture mode.

For clients with COD, information should be added regarding mental health disorders, including the name of the relevant disorder, symptoms, prevalence, cause(s), how it interacts with substance abuse, treatment options and considerations in choosing the best treatment, the likely course of the illness and what to expect, as well as programs, resources, and individuals who can be helpful to the family and the client.

Episodes of Treatment

A client with COD may participate in recurrent episodes of treatment involving acute stabilization (e.g., crisis intervention, detoxification, psychiatric hospitalization) and specific ongoing treatment (e.g., mental health-supported housing, psychiatric day treatment, or substance abuse residential treatment). These episodes can be seen as a continuum: many individuals with COD progress gradually though repeated involvement in treatment.

OUTPATIENT SUBSTANCE ABUSE TREATMENT FOR CLIENTS WITH COD

Outpatient programs are the most prevalent treatment setting for substance use and/or mental health disorders. Outpatient treatment can be the primary treatment or can provide continuing care for clients subsequent to residential treatment.

This section focuses on two existing outpatient models originally developed in the mental health field: Assertive Community Treatment and Intensive Case Management. These specialized models have been widely disseminated and applied, and each has support from a body of empirical evidence. See Appendix E of TIP 42 for further emerging models for treatment of clients with COD in outpatient substance abuse treatment settings.

Assertive Community Treatment

Developed in the 1970s for clients who were severely mentally ill, Assertive Community Treatment (ACT) was designed as an intensive, long-term service for those who were reluctant to engage in traditional treatment approaches and who required significant outreach and engagement.

This model has evolved and been modified to address the needs of clients with COD, as well as those with co-occurring homelessness and criminal justice issues.

ACT programs typically employ intensive outreach activities, active and continued engagement with clients, and a high intensity of services. ACT views shared decision-making with the client as essential to the client's engagement process.

Multidisciplinary teams composed of specialists in key areas of treatment provide a range of services to clients.

Key modifications for integrating COD

The key elements in the modification of the standard ACT model for clients with COD have been

- The use of direct substance abuse treatment interventions for clients with COD (often through the inclusion of a substance abuse treatment counselor on the multidisciplinary team)
- A team focus on clients with COD
- COD treatment groups
- Modifications of traditional mental health interventions, including a strong focus on the relationships between mental health and substance use issues

Intensive Case Management

Intensive Case Management (ICM) emerged as a strategy in the late 1980s and early 1990s, and was designed as a thorough, long-term service to assist clients with severe mental illness by establishing and maintaining linkages with community-based service providers. The goals of the ICM model are to engage individuals in a trusting relationship, assist in meeting their basic needs, and help them access and use brokered services in the community.

The fundamental element of ICM is a low case-load per case manager, allowing more intensive and consistent attention to the needs of each client. The case manager assists the client in selecting services, facilitates access to these services, and monitors the client's progress through services provided by others (inside or outside the program structure and/or by a team). Clients serve as partners in selecting treatment components.

Because case management responsibilities are so wide-ranging and require a broad knowledge of local treatment services and systems, a counselor may require some retraining and/or supervision in order to be an effective case manager.

Key modifications of ICM for clients with COD

Key ICM modifications from basic case management for clients with COD include

- Making referrals to providers of integrated substance abuse and mental health services or, if integrated services are not available or accessible, facilitating communication between separate brokered mental health and substance abuse service providers
- Coordinating with community-based services to support the client's involvement in mutual self-help groups and outpatient treatment activities

Using ACT and ICM in substance abuse treatment settings

- Use ACT and ICM for noncompliant clients with low motivation and readiness for change, and/or for clients who require considerable supervision and support.
- Develop ACT and/or ICM programs selectively to address the needs of clients with severe mental illness who have difficulty adhering to treatment regimens.
- Extend and modify ACT and ICM for other clients with COD in substance abuse treatment.
- Add substance abuse treatment components such as substance abuse education, peer mutual self-help, and greater personal responsibility to existing ACT and ICM programs.

- Extend the empirical base of ACT: Adding an evaluation component to new ACT programs in substance abuse settings can provide documentation currently lacking in the field.

RESIDENTIAL SUBSTANCE ABUSE TREATMENT FOR CLIENTS WITH COD

Residential substance abuse treatment facilities provide treatment to many clients with mental health disorders of varying severity. Most providers agree that the prevalence of people with serious mental illness entering residential substance abuse treatment facilities has risen.

A variety of residential models have been adapted for COD (see Chapter 6 of TIP 42). To design and develop residential services for clients with COD, a series of interrelated program activities are useful. These observations are applicable to both therapeutic communities (discussed below) and to other residential programs that might be developed for COD.

Therapeutic Communities

The goals of a therapeutic community (TC) are to promote abstinence from alcohol and illicit drug use, to decrease or eliminate antisocial behavior, and to effect a global change in lifestyle, including attitudes and values. The TC views drug abuse as a disorder of the whole person, reflecting problems in conduct, attitudes, moods, values, and emotional management.

At the time of this writing, the duration of residential TC treatment is typically about 12 months, although treatment duration has been decreasing under the influence of managed care and other factors. *The Therapeutic Community: Theory, Model and Method* by George De Leon, Ph.D. (Springer Publishers, 2000) provides a full description of the TC for substance abuse treatment.

Modified TCs for clients with COD

The modified therapeutic community (MTC) approach adapts the principles and methods of a TC for the COD client. The illustrative work in this area has been done with mentally ill chemical abusers (MICAs), both men and women, providing treatment based on community-as-method (that is, the community is the healing agent).

In general, to create the MTC program for MICAs, three fundamental alterations were applied within the TC structure: increased flexibility, decreased intensity, and greater individualization.

See Figure 6-5 of TIP 42 for a more detailed discussion of TC modifications for persons with COD.

Sustaining Residential Programs

A helpful vehicle for sustaining residential programs is the development of a Continuous Quality Improvement (CQI) plan, which can help to assess and ensure that a program is meeting established standards.

A sample CQI plan for an MTC in residential facilities, applicable with modified instruments to other residential programs, is as follows:

- **Fidelity of program implementation to program design and TC standards.** Program fidelity can be tested by administration of the TC Scale of Essential Elements Questionnaire (SEEQ). Any scores that fall below the level of “meets the standard” will trigger discussion and appropriate adjustments.
- **Delivery of actual program activities/elements.** Appropriate measures for success include (1) the delivery of an established number of program hours per day or week, measured by a review of staff schedules and information systems reports, (2) the delivery of an established level of specific groups and activities, assessed by a review of same, and (3) satisfactory concordance rate between program activities as designed and as delivered. This rate may be assessed using the Program Monitoring Form and the SEEQ.

- **Presence of a therapeutic environment.**

Elements that help to ensure a therapeutic environment include (1) the use of community as the healing agent, (2) the existence of trust in interpersonal relationships, and (3) the perception of the TC program as a place to facilitate recovery and change. The extent to which these elements exist may be established by participant observation, interviews, and focus groups.

DUAL RECOVERY MUTUAL SELF-HELP PROGRAMS

Dual Recovery 12-Step Fellowships

In recent years, several 12-Step fellowships for persons with COD have been established in different parts of the country. One or more may be available in major urban areas, while rural areas may not yet have access to them. Based upon the principles of AA and NA, these peer support groups have been adapted to meet the special needs of persons with COD:

- Double Trouble in Recovery (DTR)
- Dual Disorders Anonymous
- Dual Recoveries Anonymous
- Dual Diagnosis Anonymous

See Appendix J of TIP 42 for contact information for mutual self-help organizations.

Dual recovery 12-Step fellowships are self-run with no outside professional assistance, and do not provide specific clinical or counseling interventions, classes on psychiatric symptoms, or any services similar to case management. Their primary purpose is to allow members to help one another achieve and maintain dual recovery, prevent relapse, and carry the message of recovery to others who experience dual disorders.

Common features

Dual recovery fellowships tend to have the following in common:

- A perspective describing dual disorders and dual recovery
- A plan to achieve and maintain dual recovery, prevent relapse, and organize resources
- Literature describing the program
- Meetings chaired by members and structured to provide acceptance and support
- Plans for establishing an organizational structure to guide the growth of the membership; that is, a central office, fellowship network of area “intergroups” (assemblies of delegates from several groups in an area), groups, and meetings

Dual Diagnosis Recovery Network (DDRN)

The DDRN is a program of Foundations Associates that provides

- Dual recovery mutual self-help information in all areas of the services that are offered
- Education and training through community programs, in-service training, workshops, and through State, regional, and national conferences
- Advocacy and coalition building through networking and coordinating a statewide task force that engages caregivers, clients, and family members

- Information dissemination through a quarterly journal and a clearinghouse

To contact the DDRN:

Dual Diagnosis Recovery Network (DDRN)

220 Venture Circle

Nashville, TN 37228

(888) 869-9230

www.dualdiagnosis.org

See Chapter 7 of TIP 42 for information on other dual recovery advocacy organizations.

SPECIFIC POPULATIONS

Awareness of COD in sub-populations and concern about its implications has been growing in recent years. This section focuses on three of these sub-groups: the homeless, those in criminal justice settings, and women.

Homelessness and COD

Homeless persons with COD are a particularly problematic subgroup, one that places unique demands on treatment systems. Homeless people

- Tend to have a variety of medical problems, including HIV
- Are frequent victims of and participants in crime
- Are disproportionately likely to use drugs and alcohol and to have some form of mental illness

Approximately 70 percent of participants in recent NIAAA demonstration projects identified alcohol and drug problems as the primary reason for their homelessness in both the first and most recent episodes.

Service models for homeless persons with COD

Several treatment models have been developed for homeless clients with COD:

Housing first

The Pathways to Housing program is designed to serve New York’s homeless COD population. The program provides clients with housing before other services are offered, but clients must agree to receive case management and accept a representative payee to ensure that rent/utilities are paid and for resource management. Pathways also uses ACT teams to offer clients their choice of a wide array of support services, including vocational, health, psychiatric, and substance abuse treatment services.

Housing contingent on treatment

This enhanced treatment program offers weekday day treatment (for 5.5 hours per day) and adds a work therapy component that provides clients with a salary sufficient to afford subsidized housing (contingent upon drug-free urine samples).

Housing and treatment integrated

In New York City there are two specialized shelters addressing the needs of homeless persons with COD: the Greenhouse Program and the Salvation Army shelter.

The Greenhouse Program is an MTC shelter for hard-to-reach clients. Staff members are trained to address both mental health and substance use disorder issues. Developed in 1991 by Bellevue Hospital, Greenhouse was one of the first specialized shelter programs in the city to treat this population.

The Salvation Army shelter was developed in 1998 in association with National Development and Research Institutes (NDRI). Designed for hard-to-reach homeless MICAs—those who are seeking shelter, but not necessarily treatment—this program brought homeless MICAs into a specialized shelter setting, utilizing strategies to engage them in mental health and substance abuse treatment and prepare them for housing.

Criminal Justice Populations

A 1999 report of the U.S. Department of Justice estimated that 16 percent of State prison inmates, 7 percent of Federal inmates, 16 percent of those in local jails, and about 16 percent of probationers reported either a mental disorder or an overnight stay in a mental hospital during their lifetime. The report also stated that one third of offenders were alcohol dependent, while 6 out of 10 were under the influence of alcohol or drugs at the time of offense.

Treatment features and approaches

Several features distinguish exemplary programs to treat inmates with COD from other substance abuse treatment programs:

- Staff are trained and experienced in treating both mental illness and substance abuse.
- Both disorders are treated as “primary.”
- Treatment services are integrated whenever possible.
- Comprehensive treatment is flexible and individualized.
- The focus of the treatment is long term.

Examples of programs in prisons

Clackamas County (Oregon)

The Clackamas County program for offenders under electronic surveillance was developed through close consultation with the criminal justice system, with staff members from that system serving as co-facilitators for treatment groups. Skill building to address such mental health issues as identifying thinking errors, anger management, and conflict resolution are emphasized and form an integral part of this intervention.

A sub-program, “Bridges,” works explicitly with clients who have COD, providing case management and treatment services. Most Bridges clients

have severe and persistent mental illness, with histories of school and work failures. Consequently, the intervention is intensive, step-wise, and structured, with the opportunity for support in developing social and work skills.

Personal Reflections (Colorado)

In response to the increasing number of inmates with severe mental illness, the Colorado Department of Corrections contracted with a private not-for-profit agency to develop Personal Reflections, a modified TC program. A separate unit with a planned stay of 15 months, Personal Reflections houses only inmates with mental illness.

Personal Reflections uses a cognitive–behavioral curriculum focused on issues of substance abuse, mental illness, and criminal thinking and activity. At the same time, a positive peer culture is employed to facilitate behavior change. Personal Reflections also uses psychoeducational classes to increase inmate understanding of such issues as mental illness, addiction, the nature of COD, and the connection between thoughts and behavior. These classes also teach emotional and behavioral coping skills.

For more information on programs for the criminal justice population, see Chapter 7 of TIP 42, as well as the forthcoming TIP *Substance Abuse Treatment for Adults in the Criminal Justice System*.

Women

Women with COD can be served in mixed-gender co-occurring programs. However, there are specialized programs for women with COD primarily developed to address pregnancy and childcare issues as well as certain kinds of trauma, violence, and victimization that may best be dealt with in women-only programs.

Responsibility for care of dependent children is one of the most important barriers to entering treatment. Women who enter treatment sometimes risk losing public assistance support and custody of their children, making the decision to begin treatment a difficult one.

Outpatient treatment for women with COD

Few woman-centered or women-only outpatient co-occurring programs have been described, and most outpatient groups are mixed gender. It is the responsibility of the program to address the specific needs of women, and mixed-gender programs need to be made more responsive to women's needs. Women in mixed-gender outpatient pro-

grams require very careful and appropriate counselor matching and the availability of specialized women-only groups to address sensitive issues such as trauma, parenting, stigma, and self-esteem.

Residential treatment for women with COD

The needs of women in residential care depend in part on the severity and complexity of their co-occurring psychiatric disorders. Other issues meriting attention include past or present history of domestic violence or sexual abuse, physical health, and pregnancy or parental status. Residential treatment for pregnant women with COD should provide integrated co-occurring treatment and primary medical care, as well as attention to other related problems and disorders.

For more detailed information, see Appendix E of TIP 42, as well as the forthcoming TIPs *Substance Abuse Treatment: Addressing the Specific Needs of Women* and *Substance Abuse Treatment and Trauma*.

ASSESSING YOUR AGENCY'S POTENTIAL TO SERVE CLIENTS WITH COD

The checklist that follows can help program administrators perform an informal needs assessment to gather information about the prevalence of COD in their client population, the demographics of those clients, and the nature of the disorders and accompanying problems they present.

1. Have Staff Describe Their Impressions of the Profile of Current Clients With COD, and Any Potential Changes Anticipated.

- Estimate the prevalence of persons with COD among the agency's clients (several of the screening tools recommended in Appendices G and H of TIP 42 may be appropriate).
- What are the demographics of persons with COD?
- What functional problems do they have?
- Are there clients with COD who seek care at the agency who are referred elsewhere? What is the profile of these clients?

2. Identify Services Needed.

- What services do staff feel are needed by existing and potential clients?

3. Identify and Assess Resources Available to Meet Client Needs.

- What services are immediately available to the program?
- What services could be added within the program?
- What services are available from the community that would enhance care?
- How well are outside agencies meeting clients' needs?

4. Assess Resource Gaps.

- What resources are needed to enhance treatment for persons with COD?
- What can your agency, specifically, do to enhance its capacity to serve these clients?

5. Assess Capacity.

- Realistically assess the capacity of your agency to address these resource gaps.

6. Develop a Plan to Enhance Capacity to Treat Clients With COD.

- How can the skills of existing staff be increased?
- Can additional expertise be accessed through consulting agreements or similar arrangements?
- What additional programs or services can be offered?
- What sources of funding might support such efforts?

Principles of Implementation

The following principles of program implementation can be applied in any kind of integrated treatment setting, whether outpatient or residential.

How to organize

- Identify the key person responsible for the successful implementation of the program.
- Use a field demonstration framework in which there is cross-fertilization between program design and empirical data.

How to integrate with a system

- Follow system policy, guidelines, and constraints.
- Involve system stakeholders: Changes will require an active commitment from all levels of staff as well as from members of the community, advocacy groups, and other interested parties.

How to integrate with an agency

- Select an agency that displays organizational readiness and encourages program change.
- Form collaborative relationships at all levels of the organization, including both program and executive staff.

How to design, launch, and implement

- Develop a planning group of key stakeholders that meets regularly.
- Ensure client and staff orientation to all program elements.
- Provide training and technical assistance in the context of implementation.

Training

To implement a new multi-component initiative requires both initial training and continuing technical assistance. Initial training should be conducted at the program site prior to program launch, and it should provide a model of structure and process. This training should include:

- An overview of the philosophy, history, and background of the new approach
- A review of structure, including the daily regimen, role of staff, role of peers, peer work structure, privileges, and sanctions
- A review of treatment process, including a description of the stages and phases of treatment
- Special training, where necessary, in the assessment and treatment of clients with COD and in the key modifications for clients with COD (see following section for more information)

WORKFORCE DEVELOPMENT AND STAFF SUPPORT

Staffing

Integrated treatment staffing should include both mental health specialists and psychiatric consultation, and access to onsite or off-site psychopharmacological consultation. All treatment staff should have sufficient understanding of substance use and mental health disorders to implement the Elements of Successful Programming discussed earlier in this publication.

Avoiding burnout

Assisting clients who have COD is difficult and emotionally taxing; the danger of burnout is considerable. To lessen this possibility, program directors and supervisors should assist counselors to

- Work within a team structure rather than in isolation.
- Build in opportunities to discuss feelings and issues with other staff who handle similar cases.
- Develop and use a healthy support network.
- Maintain caseloads at a manageable size.
- Incorporate time to rest and relax.
- Separate personal and professional time.

Supervision should be supportive, providing guidance and technical knowledge. Performance goals should be realistic and clearly understood. When professionals begin to exhibit signs of boredom or malaise, varying the nature of the job can be a helpful strategy.

Minimizing turnover

To decrease staff turnover, whenever possible, program administrators can

- Hire staff members who have a familiarity with, and a positive regard for, both substance abuse and mental health disorders.
- Hire staff members who are critically minded, can think independently, are willing to ask questions, listen, remain flexible and open to new ideas, work cooperatively, and creatively problem-solve.
- Provide staff with a framework of realistic expectations for the progress of clients with COD.
- Provide opportunities for consultation among staff members who share the same client (including medication providers).
- Be supportive and knowledgeable about issues specific to clients with COD.
- Provide and support opportunities for further education and training.

- Provide structured opportunities for staff feedback in the areas of program design and implementation.
- Promote sophistication about, and advocacy for, COD issues among other administrative staff, including directors and clinical directors as well as financial officers, billing personnel, and State reporting monitors.
- Provide a desirable work environment through adequate compensation, salary incentives for COD expertise, opportunities for career advancement, involvement in quality improvement or clinical research activities, and efforts to adjust workloads.

Training

Both mental health and substance abuse treatment staff require training, cross-training, and on-the-job training to adequately meet the needs of clients with COD and reach a common perspective and approach. Within substance abuse treatment settings, this means training in these areas:

- Recognizing and understanding the symptoms of the various mental disorders
- Understanding the relationships between different psychiatric symptoms, drugs of choice, and treatment history

- Individualizing and modifying approaches to meet the needs of specific clients and achieve treatment goals
- Accessing services from multiple systems and negotiating integrated treatment plans

Adding mental health staff in a substance abuse treatment setting raises the need for training to address:

- Differing perspectives regarding the characteristics of the person with COD
- The nature of addiction
- The nature of psychiatric disability
- The conduct of treatment and staff roles in the treatment process
- The interactive effects of both conditions on the person and his or her outcomes
- Staff burnout

RESOURCES FOR PROFESSIONAL DEVELOPMENT

Administrators can check with their State certification bodies to determine whether training leading to formal credentials in counseling clients with COD is available.

This list of resources is not exhaustive, and does not necessarily signify endorsement by CSAT, SAMHSA, or the U.S. Department of Health and Human Services (DHHS).

Discipline-Specific Education

Although there have been improvements in the past decade, there are still very few university-based programs that offer a formal curriculum on COD. However, many professional organizations are promoting the development of competencies and practice standards for intervening with substance abuse problems, including

- The American Society of Addiction Medicine (ASAM)
- The American Psychological Association
- The Association for Medical Education and Research on Substance Abuse
- The American Association of Obstetricians and Gynecologists

- The Alcohol, Tobacco and Other Addictions Section of the National Association of Social Workers
- The International Nurses Society on Addictions

The disciplines of medicine and psychology have recognized sub-specialties in COD with a defined process for achieving a certificate in this area. Professionals can check with the following organizations for current information on certification by discipline:

- ASAM at www.asam.org
- The American Academy of Addiction Psychiatry (AAAP) at www.aaap.org
- The American Psychological Association's College of Professional Psychology at www.apa.org/college/
- The National Association of Social Workers (NASW) at www.naswdc.org

Listservs and Discussion Lists

There are a number of e-mail listservs and Internet discussion groups dealing specifically with the topic of co-occurring disorders. These online communication networks offer members the opportunity to post suggestions or questions to a large number of people at the same time. Listservs are generally geared more toward professionals and are more closely monitored.

Discussion groups are usually open to anyone, and may not be closely monitored. See Appendix I of TIP 42 for a more detailed description.

National Mental Health Association

www.nmha.org

(800) 969-NMHA (6642)

The National Mental Health Association (NMHA) has expanded its mission to encompass COD. NMHA has a formal committee made up of board members, NMHA staff, and experts in the field. The committee reviews issues and provides recommendations for policy development and information materials. The organization continues to develop resources, documents, publications, and a designated section on its Web site (www.nmha.org). In addition, NMHA has conducted coalition-building programs for substance abuse and mental health service providers, clients, and family members.

Consumer Organization and Networking Technical Assistance Center (CONTACT)

www.contact.org

(888) 825-TECH (8324)

CONTACT has developed and offers a listing of names and contacts for resources and information on substance use disorders, COD, services, and mutual self-help support. CONTACT also offers the Leadership Academy, a training program that

is designed to help clients learn how to engage in and develop consumer services. Recently, a training component focusing on substance abuse and dependence has been developed and incorporated into the program.

National Empowerment Center

www.power2u.org

(800) power2u (769-3728)

The National Empowerment Center has prepared an information packet that includes a series of published articles, newspaper articles, and a listing of organizations and Federal agencies that provide information, resources, and technical assistance related to substance abuse and dependence, COD, services, and mutual self-help support.

SAMHSA's Co-Occurring Center for Excellence (COCE)

www.coce.samhsa.gov

(301) 951-3369

SAMHSA established the Co-Occurring Center for Excellence (COCE) in 2003 in order to provide the field with key resources needed to disseminate knowledge and increase adoption of evidence-based practices.

The COCE mission is to (1) *receive* and *transmit* advances in substance abuse and mental treat-

ment that address all levels of mental disorder severity and can be adapted to the unique needs of each client, (2) **guide** enhancements in the infrastructure and clinical capacities of the substance abuse and mental health service systems, and (3) **foster** the infusion and adoption of evidence-based treatment and program innovation into clinical practice.

SAMHSA's National Mental Health Information Center

www.mentalhealth.samhsa.gov

(800) 789-2647

SAMHSA's National Mental Health Information Center was developed for users of mental health services and their families, the general public, policymakers, providers, and the media.

Information Center staff members are skilled at listening and responding to questions from the public and professionals. The staff quickly directs callers to Federal, State, and local organizations dedicated to treating and preventing mental illness. The Information Center also has information on Federal grants, conferences, and other events.

FUNDING ISSUES

Despite efforts to integrate the fields, mental health and substance abuse treatment are still funded separately. This can cause programs to spend significant amounts of time in administrative tasks in order to acquire funds for a client's treatment through multiple streams. Also, payors in many places continue to fund treatment using an acute care model, even though treatment providers recognize that clients can present long-term disorders.

The following guidelines have been identified as key system development components and financing principles:

- **Plan to purchase together:** In most successful demonstration programs for people with COD, the State mental health agency and the State alcohol and drug abuse agency jointly planned and purchased services.
- **Define the population:** Individuals with COD may fall into any of the four quadrants (see pp. 8–9). Program services must target populations based on the severity of their mental health and substance use disorders, among other considerations.

- **Secure financing:** The following section will provide some suggestions on this admittedly challenging and often complex task.
- **Purchase effective services:** It is important to purchase services that research has shown to be effective. Unfortunately, COD research tends to focus on those with serious mental disorders. As a result, guidance on which strategies are most cost-effective in treating persons with less serious mental disorders and co-occurring substance use disorders is not readily available.
- **Purchase performance:** A program's effectiveness should be judged not only by how many people it serves or units of service it delivers, but also by the level of real change it helps bring about in the lives of clients.
- **Evaluate and improve:** It is essential to evaluate performance. Findings help providers revise protocols to get better results and give them a vital two-way channel for communicating with key stakeholders.

Federal Funding Opportunities

Available funding opportunities can be explored by visiting funder Web sites (e.g., SAMHSA's Web site at www.samhsa.gov, NIDA's Web site at www.nida.nih.gov, NIAAA's Web site at www.niaaa.nih.gov, and NIMH's Web site at www.nimh.nih.gov).

Administrators also can search the Catalog of Federal Domestic Assistance Web site (www.cfda.gov), which provides a database of all Federal programs available to State and local governments (including the District of Columbia); federally recognized Indian tribal governments; Territories (and possessions) of the United States; domestic public, quasi-public, and private profit and nonprofit organizations and institutions; specialized groups; and individuals.

State Funding Opportunities

Administrators or treatment professionals should be familiar with the funding mechanisms in their State. Information is also available through the National Association of State Alcohol/Drug Abuse Directors (www.nasdad.org) and the National Association of State Mental Health Program Directors (www.nasmhpd.org).

Co-Occurring Disorders State Incentive Grants (COSIG)

Funded through CSAT and CMHS, the COSIG program provides funding to the States to develop or enhance their infrastructure to increase their capacity to provide evidence-based treatment services to persons with COD. For more information, see www.samhsa.gov.

Private Funding Opportunities

Foundation matching funds can be used to leverage change within a system in specific areas and should increasingly be explored in the area of COD treatment. Eligibility and procedures for getting funding will vary depending on the specific foundation.

The best procedure is to use the Web site of the Foundation Center (www.fdncenter.org) to identify a possible funder, then call or write to ask for information on its current funding interests and application procedures. The Web site allows visitors to search profiles of more than 65,000 private and community foundations. The Foundation Center also produces a CD-ROM version of its database and print publications containing information on grants.

Treatment providers seeking funding should not overlook the possibility that major businesses operating in their geographic area may have charitable foundations that could be tapped for promising program initiatives, as well.

GLOSSARY

Assertive Community Treatment (ACT): Intensive, long-term treatment model developed for clients with severe mental illness who were reluctant to engage in traditional treatment approaches and who required significant outreach and engagement. Has evolved and been modified to address the needs of clients with COD, as well as those with co-occurring homelessness and criminal justice issues.

Basic Program: A treatment program that has the capacity to provide treatment for one disorder, but also screens for other disorders and is able to access necessary consultations.

Comprehensive Continuous Integrated System of Care (CCISC): A theoretical method for bringing the mental health and substance abuse treatment systems (and other systems, potentially) into an integrated planning process to develop a comprehensive, continuous integrated system of care.

Co-Occurring Disorders (COD): The presence in a single person of at least two different, specific types of disorders of any level of severity, one being a substance use disorder and the other a mental health disorder.

Dual Diagnosis Capable (DDC): Programs that address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content, and discharge planning.

Dual Diagnosis Enhanced (DDE): Programs that have a higher than average level of integration of substance abuse and mental health treatment services.

Dual Recovery Groups: Therapy groups in which recovery skills for COD disorders are discussed.

Fully Integrated Program: A treatment program that actively combines substance abuse and mental health interventions to treat disorders, related problems, and the whole person more effectively.

Integrated Interventions: Treatment strategies or therapeutic techniques in which interventions for two or more disorders are combined in a single session or interaction, or in a series of interactions or multiple sessions.

Integrated Treatment: Any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting.

Intensive Case Management (ICM): Long-term treatment model which seeks to establish and maintain linkages with community-based service providers. Originally developed to assist clients with severe mental illness, but modified to serve clients with COD.

Modified Therapeutic Community (MTC): A model adapting the principles and methods of the therapeutic community to the circumstances of the COD client. All interventions in an MTC are grouped into four categories: Community Enhancement, Therapeutic/Educative, Community/Clinical management, and Vocational.

Mutual Self-Help: Approaches to recovery that apply a broad spectrum of personal responsibility and peer support principles, usually including 12-Step methods that prescribe a planned regimen of change.

Quadrants of Care: A conceptual framework that classifies treatment settings into four groups based on relative symptom severity rather than diagnosis.

Ordering Information

TIP 42

Substance Abuse Treatment for Persons With Co-Occurring Disorders

TIP 42-Related Products

KAP Keys for Clinicians

Quick Guide for Clinicians

Quick Guide for Mental Health Professionals

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Three Ways to Obtain FREE Copies of All TIPs Products:

1. Call SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at **800-729-6686**, TDD (hearing impaired) **800-487-4889**.
2. Visit NCADI's Web site at **www.ncadi.samhsa.gov**.
3. You can also access TIPs online at:
www.kap.samhsa.gov.



Other Treatment Improvement Protocols that are relevant to this Quick Guide:

- **TIP 27:** *Comprehensive Case Management for Substance Abuse Treatment* **BKD251**
- **TIP 36:** *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* **BKD343**
- *Substance Abuse Treatment and Trauma* (Expected publication date 2005)
- *Substance Abuse Treatment: Addressing the Specific Needs of Women* (Expected publication date 2005)
- *Substance Abuse Treatment for Adults in the Criminal Justice System* (Expected publication date 2005)

See the inside back cover for ordering information for all TIPs and related products.