

SAMHSA ADVISORY

Substance Abuse and Mental Health
Services Administration

SUBSTANCE USE DISORDER TREATMENT FOR PEOPLE WITH CO-OCCURRING DISORDERS

Introduction

The term “co-occurring disorder” (COD) refers to the condition of having at least one mental disorder and at least one substance use disorder (SUD). Of the 61.2 million adults with any past-year mental disorders in 2019, 31.4 percent also had a SUD (Substance Abuse and Mental Health Services Administration, 2020).

CODs are strongly associated with socioeconomic and health factors that can challenge recovery, such as unemployment, homelessness, criminal justice system involvement, and suicide (Substance Abuse and Mental Health Services Administration, 2019). In 2018, almost half (48.6 percent) of adults aged 18 and older with CODs received no treatment. Approximately 39 percent received mental health services only, 1.9 percent received SUD treatment only, and 7.8 percent received both (Substance Abuse and Mental Health Services Administration, 2020).

Given the prevalence of CODs in the United States, providers and administrators must focus on the nuances of treating this population. It is important for providers to work with clients to create a comprehensive, individualized plan to treat both disorders and achieve better client outcomes.

This *Advisory* is based on the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Treatment Improvement Protocol (TIP) 42, [Substance Use Disorder Treatment for People With Co-Occurring Disorders](#). It highlights strategies for counselors and administrators to properly screen, assess, diagnose, and manage the treatment of individuals with CODs.

Guiding Principles for Working with Individuals with CODs

1. Use a recovery perspective
2. Adopt a multi-problem viewpoint
3. Develop a phased approach to treatment
4. Plan to address the client’s cognitive/functional concerns
5. Use support systems to maintain and extend treatment effectiveness

Key Messages

- People with SUDs are more likely than those without to have co-occurring mental disorders (SAMHSA, 2020). Mental disorders likely to co-occur with addiction include depressive disorders, bipolar I disorder, post-traumatic stress disorder (PTSD), personality disorders (PDs), anxiety disorders, schizophrenia and other psychotic disorders, ADHD, and eating disorders (Hasin & Grant, 2015).

Key Messages(cont.)

- Serious gaps exist between the treatment and service needs of people with CODs and the actual care they receive. Many factors contribute to the gap, such as lack of awareness of and training in CODs by addiction counselors, as well as workforce factors like labor shortages and professional burnout (SAMHSA, 2020).
- Failure to routinely screen clients for mental disorders and SUDs creates a problematic domino effect. A lack of screening means a lack of assessment. This results in a lack of diagnosis, which leads to a lack of treatment, and ultimately reduces a person’s chances of achieving long-term recovery for either or both disorders. Providers can prevent this cascade by understanding how to screen, perform a full assessment, and recognize the diagnostic symptoms of mental disorders and SUDs.
- CODs are treatable conditions. Providers can implement a range of treatment modalities across numerous inpatient and outpatient settings. Counselors may need to adapt interventions based on the treatment setting and the unique needs and characteristics of clients, including their gender, race, ethnicity, life circumstance (e.g., homelessness, involvement in the criminal justice system), symptoms, functioning, stage of change, risk of suicidal thoughts and behaviors, and trauma history.
- People with CODs are at an elevated risk for self-harm, especially if they have a history of trauma (Haviland et al., 2016; Wisner et al., 2013). Providers should make client safety a priority and ensure staff have the necessary training to detect and respond to suicidal thoughts and behaviors in clients with CODs.
- Essential services for people with CODs are person-centered, trauma-informed, culturally sensitive, recovery-oriented, comprehensive, and continuously offered across all levels of care and the disease course.
- There is no “wrong door” by which people with CODs arrive at treatment. Counselors and programs should have a range of interventions and services in their “toolbox” to help clients.
- Administrators and supervisors must respond to workforce challenges, such as unmet training needs, low employee retention, staff burnout, and low competency in advanced COD management skills. Such workforce issues are directly tied to treatment availability and quality and should be taken seriously and addressed actively by all COD treatment programs.

Core Components for Counselors and Providers

Providing access

Access to care is the process by which an individual with COD makes initial contact with the service system, receives an initial evaluation, and begins appropriate interventions. Types of access include:

1. Routine access to treatment for individuals who are not in crisis
2. Emergency access for individuals in crisis
3. Outreach to individuals with significant needs (e.g., people experiencing homelessness) who are not seeking services or cannot access ordinary or crisis services
4. Access that is involuntary or mandated by the criminal justice system, employers, or the child welfare system

Completing a Full Assessment

Assessment involves a combination of:

- Screening to detect the presence of CODs
- Evaluating background factors, mental disorders, SUDs, and related medical and social problems critical for treatment planning
- Diagnosing the type and severity of SUDs and mental disorders
- Matching the client to initial services
- Appraising the client’s needs for social and community support services
- Conducting continuous evaluation

Providing an appropriate level of care

Whenever possible, clients should be placed in a level of care appropriate to the functional challenges, severity of symptoms, and recovery environment aligned with both their SUD and their mental disorders. Several models are available for clinicians to determine which level of care is best. [The Level of Care Utilization System \(LOCUS\)](#) by the American Association of Community Psychiatry

is a model describing six levels of care that increase in intensity based on a client’s assessment across six dimensions (American Association for Community Psychiatry, 2020). The [Four Quadrants Model](#) classifies clients into four groups based on symptom severity, as detailed in Exhibit 1 (Ries, 1993).

Exhibit 1. The Four Quadrants Model			
		Mental Disorder	
		Low	High
Substance Use Disorder	High	III—Less severe mental disorder/ more severe SUD	IV—More severe mental disorder/ more severe SUD
	Low	I—Less severe mental disorder/ less severe SUD	II—More severe mental disorder/ less severe SUD

Achieving integrated treatment

Integrated care is the preferred model of treatment for individuals with CODs. SAMHSA’s Practice Principles of Integrated Treatment for CODs are shown in the box below.

SAMHSA’s Practice Principles of Integrated Treatment for CODs
<ol style="list-style-type: none"> 1. SUDs and mental disorders are treated concurrently to meet the full range of clients’ symptoms. 2. Providers of integrated care receive training in the treatment of both SUDs and mental disorders. 3. CODs are treated with a stepwise approach tailored to the client’s stage of readiness for treatment (e.g., engagement, persuasion, active treatment, relapse prevention). 4. Motivational techniques (e.g., motivational interviewing, motivational counseling) are integrated into care to help clients reach their goals, particularly at the engagement stage of treatment. 5. Addiction counseling is used to help clients develop healthier, more adaptive thoughts and behaviors in support of long-term recovery. 6. Clients are offered multiple treatment formats, including individual, group, family, and peer support, as they move through the various stages of treatment. 7. Pharmacotherapy is discussed in multidisciplinary teams, offered to clients when appropriate, and monitored for safety (e.g., interactions with other medications), adherence, and response.

Providing comprehensive services

Along with treatment for SUDs and mental disorders, individuals with CODs often need additional services, such as life skills development, English as a second language, parenting, nutrition, vocational assistance, and others. Clinicians should help clients access these services.

Ensuring continuity of care

Continuity of care involves consistency between services, seamlessness as clients move across levels of care, and coordination of past and current treatments.

Screening and Assessment for CODs

Screening and assessment are central to identifying and treating clients with CODs in a manner that is timely, effective, and tailored to all of their needs. The assessment process helps fulfill a critical need, as most people with CODs receive treatment for only one disorder or no treatment at all.

Most counseling professionals can initiate the screening process. Understanding why, who, and when to screen and which validated tools to use are the keys to success. The assessment process is a multifactorial approach to determining which symptoms and diagnoses might be present, and how to tailor decisions about treatment and follow-up care based on assessment results. The assessment must include a review of three pertinent factors (Cardoso, 2020):

- **Biological**, such as family history and underlying medical conditions
- **Psychological**, such as previous mental health diagnoses, coping skills, and stressors
- **Social**, such as relationships, social supports, access to health care, housing, and employment

This biopsychosocial framework, mapped onto the 12 steps of the assessment process, fosters a thorough investigation of what contributes to, exacerbates, and mitigates the client's current symptomatology and functional status. Its core element is the client's chronological history of past symptoms of SUD or mental illness, as well as diagnosis, treatment, and impairment related to these issues. Counselors should get a detailed description of current strengths, supports, limitations, skill deficits, and cultural barriers. Identification of a client's stage of change and readiness to engage in services informs treatment planning.

Screening

Screening is a formal process of testing to determine whether a client warrants further assessment for a COD. The screening process for CODs seeks to answer a "yes" or "no" question: Does the client with substance misuse (or mental disorder) being screened show signs of a possible mental (or substance misuse) problem?

Assessment

The steps in the assessment process include:

1. Engage the client
2. Identify and contact family, friends, or other providers to gather additional information
3. Screen for and detect CODs
4. Determine quadrant and locus of responsibility
5. Determine level of care
6. Determine diagnosis
7. Determine disability and functional impairment
8. Identify strengths and supports
9. Identify cultural and linguistic needs and supports
10. Identify problem domains
11. Determine stage of change
12. Plan treatment

Treatment Models and Settings for People with CODs

Treatment leverages education, support, resources, and other services drawn from multiple sources, such as (Morisano et al., 2014):

Healthcare professionals collaborating across primary care, mental health services, and SUD treatment

- Mutual-support programs
- Professionals in the recovery community
- Peer recovery support specialists

Pharmacotherapy
Pharmacology interventions can be safe and effective for many individuals with CODs. Although prescribing is outside the practice of addiction counselors, licensed clinical social workers, and most psychologists, all providers should be familiar with common psychotropic medications, their side effects, and their potential risks.

Treatment Settings
<p>Therapeutic communities (TCs) promote abstinence from alcohol and illicit drug use, as well as a global change in lifestyle, including attitudes and values. Treatment focuses on abstinence, coupled with social and psychological change that requires a multidimensional effort, involving intensive mutual support, typically in a residential setting. Residential TC treatment is typically 6 to 12 months, although treatment duration has been decreasing under the influence of managed care and other factors.</p> <p>Outpatient SUD treatment encompasses a variety of disparate outpatient programs. Some offer high-intensity services involving several hours of treatment each week. These can include mental health and other support services, as well as individual and group counseling for substance misuse. Other programs provide minimal services, such as only one or two brief sessions, to give clients information and refer them elsewhere.</p> <p>Residential treatment for SUD comes in a variety of forms, including long-term residential treatment facilities, criminal justice-based programs, halfway houses, and short-term residential programs. Long-term residential SUD treatment facilities are the primary treatment sites. Historically, residential SUD treatment facilities have provided treatment to clients with more serious SUDs but with less severe mental disorders.</p> <p>Acute care and other medical settings refers to short-term care provided in intensive care units, brief hospital stays, and emergency departments. Acute care settings are typically used for withdrawal management or severe symptoms that require 24-hour medical supervision. Though acute care and inpatient settings might not offer integrated SUD/mental health care due to constraints, providers can conduct assessments and make referrals to integrated treatment following stabilization. SUD providers should be aware of withdrawal signs (e.g., abdominal pain, changes in body temperature, nausea or vomiting, restlessness, tremors, sweating, muscle aches, nasal congestion, lacrimation, frequent yawning) and be aware of nearby acute care settings in case of emergency.</p>

The best way to serve people with CODs is to offer services and programs that are integrated, comprehensive, person-centered, and recovery-oriented in their structures, settings, and practices. Counselors and programs need to provide effective interventions across multiple settings, because people with mental disorders and SUDs often move among levels of care.

Treatment Models

Early and effective COD treatments offer people the opportunity to live fulfilling, healthy, and productive lives. This section details evidence-based and best practice models.

Integrated care

Integrated care involves specific treatment strategies or techniques in which interventions for both the SUD and mental disorder are combined in a single session or a series of sessions. This is considered a best practice for people with CODs. SAMHSA has developed an [evidence-based practice KIT](#) for integrated treatment of CODs.

Assertive community treatment (ACT)

This model is an intensive, long-term approach to providing services for people who require significant outreach and engagement activities (Stein & Test, 1980). ACT programs typically involve a team-based approach to treatment, including intensive outreach activities, active and continued engagement with clients, and a high intensity of services.

Integrated case management (ICM)

This model is designed to engage individuals in a trusting relationship, assist in meeting their basic needs (e.g., housing), and help them access and use partnered services in the community (SAMHSA, 2015). The fundamental element of ICM is a low caseload per case manager, which translates into more intensive and consistent services for each client.

Dual recovery mutual-support programs

These programs are influenced by the 12-Step recovery movement and, more recently, the mental health consumer movement (Bogenschutz et al., 2014; Monica et al., 2010; Zweben & Ashbrook, 2012). Dual recovery mutual-support programs are fellowship groups that recognize the value of people in recovery sharing their personal experiences, strengths, and hope with one another. They do not provide specific clinical or counseling interventions, classes on psychiatric symptoms, or services like case management. The primary purpose is for members to help one another achieve and maintain recovery and carry the message of recovery to others who experience COD.

Diagnostic and Cross-cutting Topics

To engage in accurate treatment planning and offer comprehensive, effective, and responsive services (or referral for such), clinicians must be able to recognize the mental disorders most likely to co-occur with SUD (see below). It is not always readily apparent whether a co-occurring mental disorder is directly caused by substance misuse, the client uses substances to cope with their mental disorder, or if the mental disorder is independent and merely appearing alongside a SUD.

This differentiation can be difficult to make but is critically important, as it informs treatment decisions. Increased rates of suicide and trauma are common across most combinations of CODs and require special attention. Counselors have an ethical and professional responsibility to keep clients safe and provide services that are supportive, empathic, and person-centered, and reduce suffering.

Disorders Seen in People with CODs

Major Depressive Disorder (MDD): Individual exhibits five or more of the following symptoms, which have been present for the same two-week period and represent a change in functioning, and at least one of the symptoms is depressed mood or loss of pleasure: depressed mood, loss of pleasure, significant weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive/inappropriate guilt, diminished ability to concentrate or indecisiveness, recurrent thoughts of death or recurrent suicidal ideation without a specific plan or a suicide attempt or specific plan for dying by suicide.

Persistent Depressive Disorder (PDD): Individual experiences a depressed mood that lasts most of the day, more days than not, for at least two years, that presents with two or more of the following symptoms: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, feelings of hopelessness.

Bipolar I Disorder: Individual experiences at least one manic episode, a distinct period of at least a week in which symptoms include: inflated self-esteem or grandiosity, decreased need for sleep, pressured speech or more talkative than usual, flight of ideas or racing thoughts, distractibility, increase in goal-directed activity (at work/school, socially, or sexually) or psychomotor agitation, and excessive involvement in high-risk, pleasurable activities (e.g., spending sprees, unsafe sex). Besides at least one manic episode, an individual with bipolar I disorder also experiences major depressive episodes, with symptoms consistent with MDD.

Post-Traumatic Stress Disorder (PTSD): Individual experiences exposure to actual or threatened death, serious injury, or sexual violence and symptoms post-exposure. Exposure can refer to directly experiencing the trauma, witnessing the trauma in person, learning that family members or close friends experienced the trauma, and/or experiencing repeated or extreme exposure to aversive details of the traumatic event. The individual presents with symptoms secondary to the traumatic event, including: intrusive distressing memories, recurrent distressing dreams, dissociative reactions, intense or prolonged psychological distress at exposure to internal or external cues associated with the trauma, avoidance of stimuli associated with the trauma, negative alterations in cognition or mood, marked alterations in arousal and reactivity.

Personality Disorders (PD): Individual has lifelong difficulty forming healthy, functional relationships with others and fails to develop an adaptive sense of self. The pattern is manifested in two or more of the following areas: cognition, affectivity, interpersonal functioning, and impulse control.

Generalized Anxiety Disorder (GAD): Individual experiences excessive anxiety and worry (apprehensive expectation) about a range of topics or events, like everyday living, finances, relationships, or work/school performance. Anxiety is intense, frequent, chronic (i.e., lasting at least six months), and disproportionate to the actual threat posed by the subject of worry.

Panic Disorder (PD): Individual experiences repeated panic attacks that are distressing and disabling.

Strategies for Working with People with CODs

Building a positive therapeutic alliance is a cornerstone of effective, high-quality, person-centered care for all clients, especially those with CODs (Substance Abuse Mental Health Services Administration, 2014). Clients with CODs often experience stigma, mistrust, and low treatment engagement. Strategies and approaches like empathic support, motivational enhancement, techniques to prevent returning to substance use, and skill building help strengthen a client's ability to succeed and make long-term recovery more likely.

CODs and Special Populations

People experiencing homelessness: Housing is essential for physical, emotional, and socioeconomic wellbeing. The prevalence of substance misuse and mental illness among people experiencing homelessness is high (Solari & Khadduri, 2017). To help clients with CODs address housing needs, treatment programs should establish ongoing relationships with housing authorities, landlords, and other housing providers.

People involved in the criminal justice system: People with mental disorders and SUDs are overrepresented in the criminal justice system (Fazel et al., 2017; Mulvey & Schubert, 2017; Reingle Gonzalez & Connell, 2014). COD treatment approaches have been implemented across a range of justice settings, including pre-booking diversion programs, drug and mental health courts, reentry programs, and probation supervision (SAMHSA, 2005; Epperson et al., 2020; Pinals et al., 2019).

Workforce and Administrative Concerns in Working with People with CODs

Workforce shortages and other workforce issues directly affect treatment access, quality, and cost. Without addressing gaps in personnel and training, the behavioral healthcare field will struggle to meet the needs of the growing numbers of people living with CODs.

Recruitment and retention strategies are urgently needed to address high rates of burnout and turnover among the behavioral health workforce. Program administrators should recruit and hire trained staff with the appropriate basic competencies (see Exhibit 2). SUD treatment supervisors and administrators can confront and overcome gaps in personnel and training by creating, implementing, and sustaining professional development opportunities within their organizations. Professional education and accreditation, combined with mentoring and supervision, can help increase adoption of core and advanced clinical competencies, increase providers' comfort working with people who have CODs, reduce stigma surrounding the profession, and provide structured career development.

Program administrators should work to mitigate burnout by creating a collegial environment, promoting self-care and self-compassion, decreasing workloads, increasing provider autonomy, providing emotional support, and clarifying roles and expectations. For more information, see TAP 21, [Addiction Counseling Competencies](#) and TAP 21-A, [Competencies for Substance Abuse Treatment Clinical Supervisors](#).

Exhibit 2: Examples of Basic Competencies Needed by Staff to Treat People with CODs

- Performing a basic screening to determine whether CODs might exist and being able to refer the client for a formal diagnostic assessment by a trained clinician.
- Forming a preliminary impression of the nature of the disorder a client may have, which can be verified by someone formally trained and licensed in SUD and mental disorder diagnosis.
- Conducting a preliminary screening to determine whether a client poses an immediate danger to self or others and coordinating any subsequent assessment with appropriate staff and consultants.
- Engaging clients in such a way as to enhance and facilitate future interaction.
- Deescalating the emotional state of a client who is agitated, anxious, angry, or in another vulnerable emotional state.
- Managing a crisis involving a client with CODs, including a threat of suicide or harm to others; may involve seeking out assistance by others trained to handle certain aspects of such crises (e.g., someone trained in suicide safety planning).
- Referring a client to the appropriate mental health service or SUD treatment facility and following up to ensure the client receives needed care.
- Coordinating care with a mental health counselor serving the same client to ensure the interactions of the client's disorders are well understood and treatment plans are coordinated.

Resources

- **Substance Abuse and Mental Health Services Administration**
 - [Assertive Community Treatment \(ACT\) Evidence-Based Practices \(EBP\) KIT](#)
 - [Behavioral Health Treatment Services Locator; Self-Help, Peer Support, and Consumer Groups](#)
 - [Finding Quality Treatment for Substance Use Disorders](#)
 - [Integrated Treatment for Co-Occurring Disorders](#)
 - [TAP 21, Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice](#)
 - [TAP 21-A, Competencies for Substance Abuse Treatment Clinical Supervisors](#)
 - [TIP 42, Substance Use Disorder Treatment for People With Co-Occurring Disorders](#)
 - [TIP 50, Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment](#)
- **American Psychiatric Association**
 - [Diagnostic and Statistical Manual of Mental Disorders 5 \(DSM-5\)](#)
- **Faces & Voices of Recovery**
 - [Guide to Mutual Aid Resources](#)
- **National Institute on Drug Abuse**
 - [Therapeutic Communities Research Report](#)
- **American Association for Community Psychiatry**
 - [Level of Care Utilization System for Psychiatric and Addiction Services \(LOCUS\) and Child and Adolescent Level of Care Utilization System for Psychiatric Addiction Services \(CALOCUS\)](#)

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