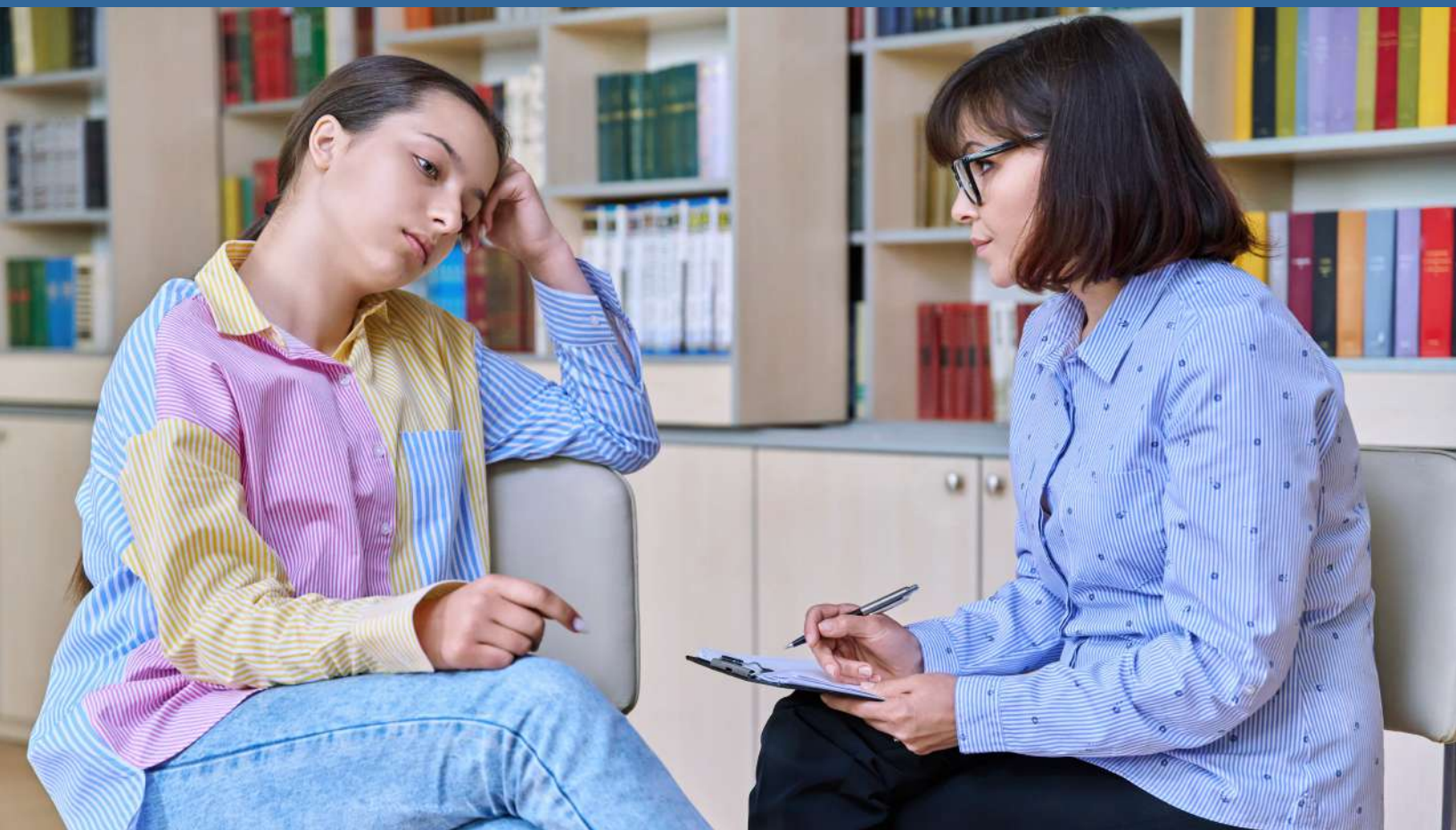
Mindful
Continuing Education

Treatment for Co-Occurring Behavioral Health Disorders



Introduction

Many individuals who struggle with substance use disorders (SUD) also have an underlying mental health issue. While neither condition actually causes the other, they often exist together, and one condition can exacerbate the symptoms of the other. Approximately half of those with a mental illness or a substance use disorder will struggle with the other at some point in their life. Research suggests that co-occurring conditions need to be treated at the same time, and early detection and treatment for both conditions can greatly improve the person's recovery and quality of life. Since individuals often present with co-occurring mental and substance use disorders (COD), professionals must be equipped with the skills and competencies necessary to treat such complex issues.

Co-occurring Disorders

When two disorders or illnesses occur in the same person, simultaneously or sequentially, they are described as comorbid. Comorbidity also implies that the illnesses interact, affecting the course and prognosis of both disorders. Research shows significant comorbidity with substance use disorders and anxiety disorders (generalized anxiety disorder, panic disorder, and post-traumatic stress disorder). Substance use disorders also have a high rate of co-occurrence with other mental health disorders, including depression, bipolar disorder, attention-deficit hyperactivity disorder, psychotic illnesses, borderline personality disorder, and antisocial personality disorder. Individuals diagnosed with schizophrenia have higher rates of alcohol, tobacco, and drug use in comparison to the general population. This is a similar theme seen among adults diagnosed with a serious mental illness (SMI). SMI is defined as a diagnosed mental, behavioral, or emotional disorder causing serious functional impairment that interferes with life activities over the past year. Major depressive disorder, schizophrenia, bipolar, and other mental disorders that cause severe impairment all fall under the SMI category. Approximately 1 in 4 people with an SMI diagnosis also have a SUD

diagnosis. Those with a co-occurring mental health and substance use disorder are at a higher risk of nonmedical use of prescription opioids, with research showing 43% of those in SUD treatment for prescription painkiller misuse also have a mental health diagnosis (most frequently, it is depression or anxiety) (NIDA, 2021).

According to the National Survey on Drug Use and Health, 47.6 million adults in the United States had a mental health illness in the past year (19.1% of the adult population), and 11.4 million had a serious mental illness (4.6% of the adult population). Of those 47.6 million adults with a mental health disorder in the past year, 9.2 million (19.3%) had co-occurring substance use disorder, compared to 5% of adults in the past year without a mental health disorder who had a substance use disorder. Of those 11.4 million adults with an SMI, 28% also had a SUD (SAMHSA, 2020).

Individuals with multiple mental health disorders, particularly mood disorders, personality disorders, and PTSD, are almost nine times more likely to have multiple SUDs in the past year. Individuals with multiple SUDs are less likely to reach remission in their substance misuse than those with a single SUD. People with a mental health disorder are more likely to report using three or more substances. When looking at those who do not complete treatment, 42% have COD compared to 36% without COD (SAMHSA, 2020).

Co-occurring disorders are significantly linked to socioeconomic challenges and health issues impacting recovery. This includes unemployment: 29% of people with CODs are unemployed, and 50% were not in the labor force (disabled, retired, or student), homelessness: 7.5%of those with a COD experience homelessness, criminal justice involvement, and incarceration: 48% of those incarcerated have a mental illness, 26% have a SUD, and 49% with a mental illness also have SUD and suicide: the leading cause of death for individuals with an addiction, 46% of those who died by suicide in the United Staes between 2014-2016 had a known mental health condition, 28% had SUD (of these people 32% also had a mental health condition). COD screening should, therefore, be

taking place in multiple community intervention programs that target unemployment, homelessness, and criminal justice programs (SAMHSA, 2020).

While there are fewer studies on adolescents, research shows a high occurrence of SUD and mental health disorders among youth. Statistically, over 60% of adolescents in community-based SUD treatment programs also meet the criteria for a mental health diagnosis (NIDA, 2021).

While there is a high co-occurrence rate between substance use disorders and mental illnesses, this does not mean one causes the other. Finding causality or directionality is difficult for numerous reasons, including that mental health problems may not be severe enough to meet diagnosis criteria but may be significant enough to result in substance use. People may also be poor historians regarding when their substance use began, making it difficult to establish what came first, the substance use or the mental health issues. While specific causes may be unclear, several factors can increase the probability that a person will struggle with the co-occurrence of substance use disorders and mental illness.

Common Risk Factors

SUD and mental illness share common risk factors such as genetic and epigenetic vulnerabilities, shared brain area issues, and environmental issues, including stress and trauma.

Genetic Vulnerabilities

Researchers estimate that 40-60% of a person's vulnerability to SUD can be attributed to genetics. It appears that the vulnerability is due to interactions among multiple genes and genetic interaction with environmental influences.

Genes can act in a direct manner, such as their influence on a person's response to a drug (ex., Is it pleasurable or not, how long it remains in the body). Research

shows there are genetic factors that predispose a person to alcohol dependence and cigarette smoking. New research is emerging that shows a genetic link for a higher risk of cocaine dependence, opioid use, and cannabis craving and withdrawal.

Genes can act in an indirect manner by impacting how a person responds to stress or increasing risk-taking behaviors. This can influence the use of substances as well as the development of mental illness. There are numerous genes that may increase a person's risk for both mental health disorders and substance use disorders. These genes can also impact neurotransmitter actions, which are also influenced by drugs and often dysregulated by mental illness, including dopamine and serotonin (NIDA, 2021).

Epigenetic Influences

Gene activity and expression can change based on environmental factors such as stress, trauma, and drug exposure. These environmental factors can impact how a gene acts; it does not change a person's DNA sequence but can determine if a gene becomes active or stays dormant. Sometimes, these gene activations can be passed down to the next generation. This may possibly be reversed with interventions or altering the environment.

The environmental impact on epigenetics is highly linked to the developmental stages. Research shows that environmental factors interact with genetic vulnerabilities during particular developmental stages, increasing the risk for mental health issues and substance use disorders (NIDA, 2021).

Brain Region Involvement

Numerous brain areas are affected by substance use and mental health disorders. Areas of the brain that involve reward centers, decision-making, impulse control, and emotions all play a role in substance use disorders and mental health

disorders. There are also overlapping neurotransmitters that play a role in mental health and substance use disorders. This includes dopamine, serotonin, glutamate, GABA, and norepinephrine (NIDA, 2021).

Environmental Influences

An array of environmental influences are linked to increased risk for substance use and mental health disorders, including stress, trauma, and adverse childhood experiences. Interventions to prevent or mediate these influences may reduce substance use and mental health disorder prevalence and severity (NIDA, 2021).

Long-term and significant stress is a risk factor for numerous mental health disorders and is associated with increased risk for substance use disorders. In addition, a major risk factor for drug use relapse is exposure to stressors. Higher levels of stress impact areas of the brain that lead to reduced behavioral control and increased impulsivity. Early life stress and chronic stress impact brain circuits that control motivation, learning, and adaptation, and those with substance use and mental health disorders generally experience impairment in these areas. Mindfulness-based stress reduction interventions have shown positive results in reducing anxiety, depression, and substance use (NIDA, 2021).

People who have experienced physical or emotional trauma are at a significantly higher risk for substance use disorders. The co-occurrence of SUD and trauma history is linked to reduced treatment outcomes. Those with PTSD may use substances to lower their anxiety and avoid dealing with their trauma experience and its consequences (NIDA, 2021).

Mental Illness Contributes to Substance Use

Experiencing mental health problems can be a substantial risk factor for substance use disorder. Some people with even mild or subclinical mental health disorders may use substances to self-medicate. While some substances can temporarily

reduce mental health symptoms, they can also exacerbate other symptoms in the short and long term. One example of this is that of cocaine use, which worsens bipolar symptoms and impacts the disorder's progression.

Developing a mental health disorder is associated with changes in brain activity that may increase the person's risk for substance use as it enhances the drug's rewarding effects, reduces the person's awareness of its negative effects, and alleviates symptoms of the mental disorder or the side effects of medications being used to treat the disorder. One example of this is ADHD, which is linked to neurobiological changes that are associated with drug cravings, which is one explanation why people with a substance use disorder and ADHD report greater cravings (NIDA, 2021).

Substance Use Contributes to Mental Illness

Substance use can cause changes in some brain areas that are the same areas impacted by mental disorders, including schizophrenia, anxiety, mood, or impulse-control disorders. Substance use occurring before the first symptoms of a mental health disorder may cause changes in the brain and its function that trigger an underlying predisposition to mental illness (NIDA, 2021).

Screening & Assessment

Screening

Screening is the process of determining if a problem is possibly or likely present, which then considers if a more in-depth assessment is needed. Screening for COD might involve the following questions: Does a substance misuse client being screened show signs of a possible mental health problem? Does the mental health client being screened show signs of a possible substance misuse problem? If

either of these screening questions were answered with a “YES,” then an assessment would be completed, which is a process identifying the details of the problem and determining specific treatment recommendations. A screening determines if additional assessment is warranted. Screening protocol should include what questions the client is asked, what screening tool(s) are used, and what happens if there is a positive screen for a potential problem. Due to the high rate of suicide amongst those diagnosed with CODs, a suicide screening should also be completed at intake (SAMHSA, 2020).

Assessment

An assessment involves identifying problem areas, determining COD diagnoses, and assessing the client’s readiness for change. An assessment usually consists of a clinical examination of the client and possibly written or verbal tests. A basic assessment would gather the following information:

Background: family, trauma history, history of domestic violence (perpetrator/ victim), marital status, legal involvement and financial situation, health, education, housing status, strengths and resources, and employment.

Substance Use: age of first use, primary substance(s) used, patterns of substance use, treatment episodes, and family history of substance use problems.

Mental Illness: family history and client history of mental illness (diagnosis, hospitalization, and other treatment), current symptoms and mental status, and medications and medication adherence.

Additional assessment tools may be used depending on the information gathered in the clinical examination. These might include the Patient Health Questionnaire (PHQ-9) for depression, Generalized Anxiety Disorder 7-item (GAD-7) for anxiety, PTSD Checklist for DSM-5 for PTSD, or the Addiction Severity Index (ASI) for measuring addictions in multiple areas, and numerous substance specific assessment tools (SAMHSA, 2020).

SAMHSA (2020) recommends a twelve-step assessment process to gather a detailed chronological history, strengths, supports, limitations, skill deficits, and cultural barriers. The following assessment steps are listed sequentially, but some will occur simultaneously or potentially in a different order, depending on the client's situation. Safety needs should always be the first issues addressed prior to any comprehensive assessment being completed. These steps are completed using a biopsychosocial approach which seeks to understand the clients and their experiences through a psychological, medical, emotional, sociocultural, and socioeconomic lens.

Step 1: Engage the Client

Engage the client in an empathic and welcoming manner. Building rapport eases anxieties around disclosing information about SUD, mental health, and other sensitive personal information.

Key aspects of effective engagement during the initial clinical interview include:

Universal access, aka "no wrong door: This concept acknowledges that individuals with CODs may enter treatment through a range of community service programs. These individuals are a high priority to engage in treatment and must be prevented from falling through the cracks. Regardless of where clients initially present, providers should assess and support them in accessing the system of care that best fits their needs.

Power

Empathic detachment: This requires assessing providers to acknowledge that they are working to support the client's best interests and to help empower clients to make changes. The provider is only there to support, even if the client does not fit into the provider's program.

Person-centered assessment: The initial contact should not be centered around completing forms or answering a list of questions, but instead is focused on understanding what the clients want, their view of the problem, and what they wish to see changed.

Cultural sensitivity: Providers must recognize the role culture may have on the client's view of the problem and treatment. Providers must also be aware of how their culture impacts their perspective of problems. Providers need to be sensitive to how gender identity and sexual orientation may play a role in personal identity, living situations, and relationships.

Trauma-informed care: There is a high prevalence of trauma among individuals with CODs. Providers need to consider trauma history prior to moving into the assessment phase and the impact the trauma may have on trusting the provider. Trauma can include early childhood emotional, physical, or sexual abuse; experiences of rape or interpersonal violence as an adult; and traumatic experiences associated with political oppression, such as with refugee or other immigrant populations.

Step 2: Identify and contact collaterals (family, friends, other providers) to gather additional information

Individuals presenting for treatment may be unable or unwilling to report past or present events accurately. For this reason, consideration should be given to contacting family or friends who may have supporting information with the client's permission. This additional information can be a helpful addition to the client's report, particularly if the person is impaired mentally or due to substances.

Step 3: Screen for and detect CODs

Since there is a high prevalence of co-occurring disorders and because treatment outcomes for individuals with multiple problems improve if each problem is

specifically addressed, it is recommended that mental health providers screen for SUD and SUD providers screen for mental health disorders.

Screenings will vary by program and client situation. Standard areas to screen include:

- Acute safety risks (suicide, violence toward others, victimization, risk-taking behaviors, inability to care for oneself)
- Past or present substance misuse (including acute safety risks regarding present intoxication or withdrawal)
- Past or present mental illness symptoms or disorders
- Cognitive functioning and impairment
- Trauma
    - It is important for providers to screen for trauma as clients may not mention their past trauma since they may not recognize its relevance. They may also be reluctant to disclose trauma due to feelings of shame and guilt, fear of judgment, or concerns regarding the impact it may have on the family. It may also be due to an avoidance of traumatic memories and reminders (Spencer et al., 2021; SAMHSA, 2020)

See Appendix A for a list of screening tool options.

Step 4: Determine the quadrant and locus of responsibility

The quadrant of care is a model that places clients in one of four groups based on their symptom severity.

Using the quadrant model, the treatment matches the client's needs based on the assessment findings. Under the Four Quadrant Model, treatment decisions are determined by prioritizing the client's needs according to their symptoms, disorder, and severity.

Category 1: Less severe mental disorder, less severe SUD - level of care can typically be met in outpatient settings for either mental health or SUD programs, and collaboration between the two, if needed. For some individuals, simply being monitored regularly by a primary care provider is sufficient.

Category 2: More severe mental disorder, less severe SUD (e.g., remission or partial remission) - level of care will be addressed through the mental health system and client may benefit from integrated case management.

Category 3: Less severe mental disorder, more severe SUD - level of care will be addressed in the SUD treatment system with collaboration with mental health providers if involved.

Category 4: More severe mental disorder, more severe SUD - level of care is addressed at an intensive, comprehensive, and integrated program to meet all needs. This may involve specialized residential programs, hospitals, jails/prisons, and emergency rooms (SAMHSA, 2020).

Step 5: Determine the level of care

Placing clients in the appropriate level of care is critical in meeting their treatment needs and offers the best possibility for them to complete treatment and have positive outcomes. The LOCUS is a screening tool that can help determine the level of care the client needs. It assesses multiple areas, including the risk of harm, functional status, comorbidity (medical addictive, psychiatric), recovery environment, treatment and recovery history, and engagement and recovery status.

Step 6: Determine diagnosis

Determining a diagnosis can be challenging as there are many mixed presentations of mental symptoms and substance misuse. Substance misuse can also contribute to severe mental symptoms emerging and can confuse the

diagnostic picture. The following three principles can help providers comprehensively assess their client's past and present history of mental health symptoms and substance use problems.

1. Establishing a client history: Determining if the client has any past diagnoses or is currently receiving any treatment is the first step in gathering a comprehensive client history. If the client is unclear on history, the provider should work on obtaining collateral information. If there is a past diagnosis, this can be considered valid for initial treatment planning. Should there be existing stabilization treatment, this should be continued. Establishing the clients' histories can be helpful for recognizing behavior patterns and gaining insight into their problems. When gathering such histories, clinicians should ask about the last clients met with a primary care physician, as some physical diseases may share characteristics with mental health disorders. For example, hypothyroidism often presents with depression-like symptoms.

2. Document prior diagnoses: SUD counselors who may not be equipped to make a mental health disorder diagnosis should still document prior diagnoses. Should they believe prior diagnosis may no longer be valid, they can document current symptoms the person is experiencing that are different and collaborate with other service providers so that the client can be re-evaluated. Mental health providers need to be alert to symptoms that may only be experienced when the person is using substances, in which case these symptoms would not typically be considered when making a mental health diagnosis. For example, the client may only hear voices or experience extreme paranoia when using substances.

3. Linking mental symptoms to specific periods: Mental health diagnoses are determined based on symptoms over specific time periods and not during an active SUD. Therefore, when gathering client history, it is important to

assess the timeframe in which symptoms occurred and if/what substances were being used over that same time frame.

Step 7: Determine disability and functional impairment

Determining baseline and current functional impairment can help identify case management needs or higher levels of service needs. Identifying deficits in cognitive capabilities, social skills, and other functional abilities will also impact treatment and possible modifications to treatment. Functional assessment tools are listed in Appendix A.

Step 8: Identify strengths and supports

A comprehensive assessment would be incomplete without learning about the individuals' strengths, skills, and support systems. This positive part of the assessment can be pivotal in the engagement process, especially as much of the assessment focuses on the client's deficits and behavioral change needs. Areas to explore may include:

- Talents and interests.
- Areas of educational interest and literacy, vocational skills, interests, and abilities, such as social skills or capacity for creative self-expression.
- Areas connected with high motivation levels to change for either disorder or both.
- Existing supportive relationships (treatment, peer, or family).
- Previous mental health services and SUD treatment successes and exploration of what worked. Identification of current successes. What has the client done right recently for either disorder?

- Building treatment plans and interventions based on utilizing and reinforcing strengths and extending or supporting what has worked previously.

Step 9: Identify cultural and linguistic needs and supports

Cultural assessment for those with CODs is similar to what would be explored in standard SUDs or mental health disorders-only assessment. The areas that may be different include:

- Problems with literacy.
- Not fitting into the treatment culture (SUD or mental health culture) or conflict in treatment.
- Cultural and linguistic service barriers.

Step 10: Identify problem domains

Those with CODs may have challenges in multiple life domain areas (medical, legal, vocational, family, social). A comprehensive assessment clarifies how each disorder interacts with the problems in each life domain. It also explores exceptions that may support treatment adherence. This may include who has historically supported their treatment and how they can assist this during current treatment or who may have sabotaged their treatment and how to mitigate it this time around.

Step 11: Determine the stage of change

One evidence-based best practice for treating individuals with CODs is to match the intervention to the diagnoses, to the stage of change, and to the stage of treatment for each diagnosis/disorder. The stage of change may be identified by

presenting clients with each problem area and having them select one of the below statements based on their perceptions:

- No problem, no interest in change, or both (Pre-contemplation).
- Might be a problem, might consider change (Contemplation).
- Definitely a problem, getting ready to change (Preparation).
- Actively working on changing, even if slowly (Action).
- Has achieved stability and is trying to maintain (Maintenance).

This should be addressed for each diagnosis/disorder, as the stage of change may be different for each. For example, clients may be willing to take medication for depression but not participate in therapy or limit alcohol use but not marijuana.

Step 12: Plan treatment

A comprehensive assessment builds up to an individualized treatment plan. There is no single "right" intervention or service for individuals with CODs. Appropriate treatment may be complex, depending on what has been determined in the previous eleven steps. Most importantly, the clients are matched to the appropriate treatment for their individual needs. A treatment plan should consist of the problem, intervention, and goal.

Diagnosis

Due to the high rate of comorbidity between substance use disorders and mental health disorders, there is a need to integrate assessment, diagnosis, and interventions concurrently. Understanding the overlap of genetics, brain, and environmental influences can help to improve treatment for people with co-occurring disorders and reduce the social stigma that can cause people to be reluctant to seek treatment. Diagnosing co-occurring disorders can be challenging

as symptoms often overlap. Comprehensive assessment tools should be used to help disentangle symptoms and reduce the likelihood of misdiagnosis. People with co-occurring disorders often present with symptoms that are more severe, persistent, and resistant to treatment.

People entering mental health treatment should be screened for substance use disorders and vice versa. For those entering substance use treatment, it may be necessary to observe them once they have been abstinent from substances to be able to distinguish between the effects of their substance use or withdrawal and the symptoms of their mental health disorder. This will allow for a more accurate diagnosis and lead to an appropriate treatment plan for their needs (NIDA, 2021).

Treatment

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 14.2 million adults reported needing mental health treatment at some point in the past year and not receiving it (approximately 5.7% of the adult population in the United States). Among those with a mental health diagnosis, almost 24% reported having perceived unmet mental health needs in the past year. Among those with an SMI, approximately 45% of them reported having perceived unmet mental health needs over the past year. Over 18 million people over the age of 12 did not receive needed SUD treatment in the past year (most did not perceive themselves as needing treatment, as only 5% reported that they needed services). 48.6% of adults with a COD did not receive any treatment in the past year, 41% received mental health treatment only, 3.3% received SUD treatment only, and 7% received treatment for both. Among adults with SMI and SUD, 30.5% received no treatment, 56% received mental health treatment only, 3% received SUD treatment only, and 11% received treatment for both. As evident in the reported statistics, there is a high rate of comorbidity and treatment needs for those with a mental health disorder and a substance use disorder (SAMHSA, 2020).

SAMHSA provides six guiding principles for treating clients with co-occurring disorders.

1. Use a recovery perspective

   The recovery perspective acknowledges that recovery is a long-term, internal change process that proceeds through numerous stages. In practice, this means providers are creating treatment plans that provide a continuity of care over time and within the various settings the client may progress through. Treatment interventions are specific to the client's stage of recovery.

2. Adopt a multi-problem viewpoint

   Individuals with CODs typically have multiple needs, including mental, physical, substance use, family, and social problems. Treatment services must, therefore, be comprehensive to meet the multiproblem needs of each client.

3. Develop a phased approach to treatment

   By using a phased approach to treatment, providers can ensure comprehensive and appropriate services for the client's needs. Typically, phases are engagement, stabilization/persuasion, active treatment, and continuing care/relapse prevention.

4. Address specific real-life problems early in treatment

   CODs are greatly impacted by personal and social problems, and treatment should address these issues early on in the process. This may be accomplished through case management support or specialized interventions that address housing or vocational assistance. Supporting clients to solve everyday living issues can be a powerful method of engagement with clients.

5. Plan for the client's cognitive and functional impairments

   Services must be individualized to meet each client's needs and level of functioning, especially for those with SMI. Many individuals with CODs have cognitive or functional impairments that impact their ability to understand information and complete tasks. A comprehensive assessment of an individual's abilities and impairments will enable the provider to tailor the treatment plan to meet the client's needs.

6. Use support systems to maintain and extend treatment effectiveness

   Family, peers, faith community, and other resources within the individual's community can play a valuable role in recovery. This support may be especially powerful for clients who have experienced stigma and have been ostracized by their families and communities due to their SUD and/or mental health disorder (SAMHSA, 2020).

Individuals with CODs generally are treated in one of the following ways:

Sequential or Serial Treatment: The client is treated for one disorder at a time. This has been the traditional treatment choice, but its effectiveness is limited and can lead to poor outcomes in situations where treating one disorder may worsen the symptoms of another.

Simultaneous or Parallel Treatment: The client is treated for both disorders but by different providers in separate organizations. This has better results when compared to sequential treatment but is not considered a collaborative or comprehensive approach to care.

Integrated Treatment: The client is treated for all diagnoses and symptoms in one organization or program with a single team of providers working together. This is the preferred method as it addresses all the client's needs as a whole person. Integrated treatment has positive results in improving substance use and mental

illness symptoms, treatment retention, cost-effectiveness, and client satisfaction (SAMHSA, 2020).

Integrated treatment is superior for treating co-occurring substance use and mental health disorders when compared to separate treatment for each diagnosis. Cognitive behavioral therapy is often used as part of integrative treatment to improve interpersonal and coping skills while simultaneously using interventions that motivate and support recovery. Clients with co-occurring disorders have lower treatment adherence and higher rates of treatment dropout than those with a singular mental health diagnosis.

Integrative treatment often involves collaboration with multiple providers and organizations that provide supportive services to address issues of physical health, homelessness, vocational skills, and legal issues. Communication among all service providers is critical for the successful implementation of treatment services. Tactics that have been shown to increase communication among service providers include co-location, shared treatment plans and records, and case review meetings (NIDA, 2021).

Experts contend that integrated treatment is the best practice approach for treating individuals with CODs as it provides beneficial results in numerous areas, including substance use, mental health, functional, and social outcomes. Individuals in integrated treatment programs have decreased substance use and abstinence, improved mental functioning, decreased emergency department visits, inpatient stays, and overall healthcare costs, gains in independent housing and employment, and improved life satisfaction (SAMHSA, 2020).

Trauma-Informed Treatment of CODs

Failing to address trauma in people with CODs leads to more severe mental health and SUD problems. Trauma-informed care addresses trauma-related symptoms while creating an environment that is safe and responsive to the needs of the

person. The goals of trauma-informed care are to build resiliency, reestablish trust, prevent retraumatization, and provide hope for the future. Providers must be aware of how the treatment environment and their interactions with the client can impact treatment adherence, retention, and outcomes.

Trauma-informed care for those with CODs includes:

- Psychoeducation, particularly around the relationship between trauma, mental health, and substance use. Part of psychoeducation also involves normalizing symptoms and reassuring clients that their experiences are not "wrong," "bad," or unusual.
- Teaching problem-solving and coping skills to enable effective stress management.
- Discussing retraumatization and developing strategies to prevent further victimization.
- Establishing a sense of safety in treatment and in the client's daily lives.
- Helping clients feel empowered and in control of their lives.
- Promoting resilience and offering hope for change and improvement.
- Identifying and adaptively responding to triggers, like intrusive thoughts, feelings, and sensations.
- Building a therapeutic alliance that fosters trust, confidence, and self-worth, all necessary aspects of healing.
- Using trauma-specific interventions (SAMHSA, 2020).

Trauma exposure is common and, therefore, should be the expectation rather than the exception when working with at-risk clients. Trauma-informed care should be available to all clients who need these types of interventions. This type

of care is different from trauma-specific services that are targeted treatment for trauma-related distress, symptoms, and impairment.

When providing trauma-informed services, clinicians must:

1. Take the therapeutic stance that all clients are believed to be doing their best to cope, given their history, emotion regulation, interpersonal challenges, and limited support.
2. Create a safe and welcoming environment and keep patients informed of all procedures that involve physical contact.
3. Respect the strengths of survivors and the involvement of survivors (and their families if involved) in treatment planning and decision-making (Spencer et al., 2021).

Trauma-specific services are for clients with trauma-specific diagnoses such as PTSD. These services include

1. Evidence-based treatments such as Cognitive Processing Therapy, Prolonged Exposure, and EMDR.
2. Integrated treatments that dually address trauma and SUD, such as the evidence-based treatment Seeking Safety (Spencer et al., 2021).

Trauma and Adverse Childhood Experiences (ACEs), including physical or sexual abuse, neglect, or family dysfunction, are common. Those who use substances are more likely to have been exposed to trauma and are more likely to develop physical and psychological consequences. It is estimated that 75% of adults in SUD treatment have a history of abuse and trauma. ACEs are linked to worse outcomes in SUD treatment, including higher severity of use and a shorter time to relapse (Spencer et al., 2021).

Trauma-informed care incorporates knowledge of trauma even though the treatment may focus on other areas such as substance use, mental health

disorders, or physical health needs. In contrast, trauma-specific treatment is specifically designed to address traumatic experiences.

The experience of trauma and untreated symptoms related to full or partial PTSD can increase the risk for comorbid health and behavioral health issues and hinder recovery from these conditions. Trauma-informed organizations prioritize clients' safety and promote trust, collaboration, healing, empowerment, and recovery from the effects of trauma. Behavioral health providers who operate from a trauma-informed care lens exhibit the following characteristics:

- Recognize the impact of trauma on health and behavioral health and integrate trauma awareness into all practices, policies, and procedures.
- Understand the strategies that lead to recovery.
- Routinely screen and assess for the signs and symptoms of trauma
- Eliminate practices that have the potential to be re-traumatizing to clients.
- Deploy practices that are responsive to those who may have experienced trauma and that create a practice environment that promotes safety, empowerment, and healing (Mancini, 2020).

Behavioral Health

Behavioral health treatment, with or without medications, is the foundation for successful long-term outcomes for those with substance use and mental health disorders. Multiple treatment approaches have shown success in helping individuals with co-occurring disorders.

Cognitive Behavioral Therapy (CBT)

CBT treatment involves shifting harmful beliefs and maladaptive behaviors. It is an effective treatment for multiple diagnoses, including anxiety and mood disorders (NIDA, 2021).

Cognitive behavioral therapy (CBT) encourages people to question and explore their recurring thoughts in order to eliminate those that are negative and unhealthy. Additionally. CBT teaches people techniques to recognize and change their maladaptive behaviors. CBT helps individuals learn coping skills, identify risky situations and what to do about them, and assists with relapse prevention. CBT can be used to treat problematic substance use as well as co-occurring mental or physical health disorders (Miller, 2023)

Cognitive behavioral therapy was developed for treating problem drinking to prevent relapse. CBT is based on the premise that an individual's learning process is critical in developing maladaptive behavior patterns like substance abuse. Individuals learn CBT strategies to identify and correct problematic behavior while applying various skills to address their substance use and mental health disorders (NIDA, 2018).

An essential element of CBT is anticipating likely problems and helping individuals develop effective coping strategies to enhance their self-control. Specific strategies include:

- Exploring the positive outcomes and negative consequences of continued drug use
- Recognizing cravings early through self-monitoring
- Identifying situations that might put one at risk for relapse for either substance use or mental health struggles, and avoiding those high-risk situations
- Developing strategies for coping with cravings (NIDA, 2018).

Studies show that the skills individuals learn through a cognitive behavioral approach remain after the completion of treatment. Current research focuses on how to produce an even more powerful effect by combining CBT with medications and with other types of behavioral therapies. CBT effectively treats alcohol, marijuana, cocaine, methamphetamine, and nicotine abuse, as well as numerous mental health disorders and their symptoms (NIDA, 2018).

Dialectical Behavior Therapy (DBT)

DBT treatment approaches focus on reducing self-harm behaviors, suicide ideation and attempts, and substance use. DBT is an effective treatment for borderline personality disorder (NIDA, 2021).

Dialectical Behavioral Therapy teaches individuals how to regulate their emotions in order to reduce their self-destructive behaviors driven by extreme, intense emotions. DBT focuses on four skill sets: distress tolerance, emotion regulation, mindfulness, and interpersonal effectiveness. DBT works to reduce cravings, help people avoid situations or triggers to relapse, support them in giving up behaviors that reinforce substance use, and help them learn healthy coping skills (Miller, 2023).

Motivational Interviewing (MI)

MI is a treatment approach based on the stages of change theory that helps clients develop intrinsic motivation to change problematic behaviors. It was initially developed for SUD treatment. MI has shown promise for use with individuals with co-occurring disorders. One study found that using an integrated model of MI along with cognitive behavioral therapy for young adults with comorbid schizophrenia and SUD led to a reduction in positive symptoms of schizophrenia and an increase in abstinent days over 12 months (Spencer et al., 2021).

MI helps people resolve their ambivalence around engaging in treatment and helps them manage their substance use and mental health disorders. The goal is to evoke rapid and internally motivated change instead of working through the steps of the recovery process. The process includes an initial assessment session, followed by two to four individual treatment sessions. The first session focuses on the therapist providing feedback on the initial assessment, encouraging discussions on personal substance use and self-motivational statements, and exploring coping strategies for high-risk situations. In future sessions, the therapist monitors change, reviews cessation strategies being used, and continues to encourage commitment to change. Motivational Interviewing is most effective for engaging individuals in treatment (NIDA, 2018).

One of the key elements of Motivational interviewing is addressing the ambivalence some people experience in recovery, allowing them to embrace their treatment efforts in a way that works best for them so that they may address their substance use. The goal is to strengthen motivation for and commitment to change in a way that is consistent with the client's values. Rather than the therapist imposing or enforcing a specific change, individuals are met where they are, and they are supported in moving toward their goals by building on their readiness to change. A benefit of MI is that while it is facilitated by a therapist, the individuals in recovery develop their own motivation and plan for change in the initial sessions, which gives them more of a sense of control over the course of their treatment (Miller, 2023).

Exposure Therapy

The goal of exposure therapy is to desensitize clients to their triggering stimulus and support them in developing coping skills, leading to a reduction or elimination of their symptoms. It is most often used to treat anxiety disorders, including phobias and PTSD. While it is effective, retention in treatment can be difficult (NIDA, 2021).

In exposure therapy, people learn to manage their fear by slowly and safely exposing themselves to the trauma they experienced. In exposure therapy treatment, the individual may think or write about the trauma, and they may visit the place where the traumatic event took place. Exposure therapy helps clients with PTSD reduce their distressing symptoms (NIMH, 2023).

Seeking Safety (SS)

Seeking Safety is a present-focused treatment that prioritizes the cognitive, behavioral, and interpersonal coping skills and case management needs of the client to address trauma issues and substance use disorder. Clients learn behavior techniques for dealing with trauma and substance use disorder either in an individual or group treatment format (NIDA, 2021; Spencer et al., 2021).

Specifically, Seeking Safety strategies help people combat trauma and substance use disorders through coping skills, grounding techniques, and education. Some of the treatment's key principles are helping people attain safety in their thinking, emotions, behaviors, and relationships, while integrating treatment of substance use and trauma, and focusing on ideals to counteract the loss of ideals that are often experienced in both trauma and substance misuse (Miller, 2023).

Assertive Community Treatment (ACT)

Assertive Community Treatment was first developed for clients with serious mental illness. The model focused on intensive, long-term services for those who were reluctant to be involved in traditional treatment approaches and required constant outreach and engagement activities. ACT has since evolved into a treatment for those with co-occurring disorders. ACT programs focus on integrating behavioral health treatments and substance use disorders. It has a focus on case management that involves small caseloads, team management, an emphasis on outreach, individualized approaches, and assertiveness in maintaining contact with clients (SAMHSA, 2020; NIDA, 2021).

ACT programs use intensive outreach services, continuous engagement with clients, and high-intensity services. The multidisciplinary teams who assist clients include providers in a range of treatment areas to meet the client's needs. Teams consist of mental health and SUD providers, case managers, nursing staff, and those providing psychiatric support. The team provides the client with practical life management assistance, and treatment is often provided in the client's home, with services being available 24 hours a day as needed. The team may provide a consistent and intense level of services, which may include multiple visits per week or even per day during times of crisis. Caseloads are small due to the intensity of the services provided. The recommended ratio is one staff to 10 clients (SAMHSA, 2020).

The goal of ACT with clients with CODs is to engage them in the helping relationship, assist them in meeting their basic needs, stabilize the clients in the community, and provide direct, integrated treatment for their SUD and mental health needs.

ACT can be successfully implemented with individuals with CODs who do not fit well in traditional treatment programs. Those who are best served with ACT are individuals with SUD and mental illness, SMI, serious functional impairments, poor response to traditional outpatient mental health and SUD treatment, homelessness, and criminal justice involvement. Individuals who are frequent users of expensive service delivery systems, such as emergency departments for immediate resources for SUD and mental health, are ideal candidates for ACT (SAMHSA, 2020).

Integrated Case Management (ICM)

ICM was first implemented with individuals with SMI who had mental and functional disabilities and were not adhering to their outpatient treatment. ICM provided support so the clients could maintain their community-based services. ICM is an alternative to traditional case management and ACT. The goal of ICM is

to engage clients in a trusting relationship, assist them in meeting their basic needs, and support them in accessing and maintaining services in the community (SAMHSA, 2020).

ICM programs involve outreach and engagement, arranging for community-based services, and providing supportive services, all of which are provided at a higher intensity than traditional case management. The ICM case manager helps the client choose services, supports them in accessing these services, and monitors their progress in the services that are provided by others. Case loads are kept small and range from 15-25 clients per case manager (SAMHSA, 2020).

Results of ICM have shown reduced hospitalizations, longer treatment compliance, improved physical health, and improved social functioning. ICM seems effective with specific population groups such as veterans, those with housing needs, and individuals with criminal justice involvement (SAMHSA, 2020).

Dual Recovery Mutual Support Programs

This program style merges the 12-step recovery program with the mental health consumer movement. The focus is on personal responsibility and peer support principles. These groups address the challenges and needs of individuals with CODs, including:

Stigma and Prejudice: Many individuals with CODs struggle with the stigma surrounding their diagnoses. This may make it challenging for them to participate in traditional groups or treatment due to a lack of trust and safety.

Inappropriate Advice: Members in other single disorder groups may offer well-intentioned advice, but that is contraindicated for those with CODs. Members in dual recovery groups have a better understanding of the multiple challenges and needs of co-occurring disorders.

Interpersonal Connectedness: People with CODs often struggle to establish and maintain close relationships. Participating in a program with other individuals with CODs may alleviate some of the individual's hesitancy to participate.

Direction for Recovery: Dual recovery programs can draw from the experiences and knowledge of the members and help support the recovery of newcomers.

Acceptance: Dual recovery programs may offer members emotional acceptance, support, and empowerment. This provides a safe space for people to share their feelings and thoughts honestly so that they are able to focus on recovery (SAMHSA, 2020).

Research shows that dual recovery mutual support programs can provide significant contributions to a person's dual recovery. Positive outcomes include lower depression scores and alcohol use among veteran participants, improved mental health scores, reduced alcohol and substance use, fewer SUD-related problems, and improved treatment attendance (SAMHSA, 2020).

Therapeutic Communities (TCs)

Therapeutic communities are a type of long-term residential programs for substance use disorders. The overall treatment focus is on resocializing people through community-based programs. The goal of TCs is to establish abstinence from alcohol and other substance use and to enact global lifestyle change, especially around attitudes and values. TCs see disorders as a whole person problem and recognize that treatment must focus on abstinence as well as social and psychological changes. This is accomplished through a multidimensional treatment strategy, including intensive mutual support, usually in a residential setting. Residential treatment usually lasts six to twelve months (SAMHSA, 2020).

Contingency Management (CM) / Motivational Incentives (MI)

CM/MI is an adjunct treatment; it involves a prize-based or voucher system that rewards clients for practicing healthy behaviors and reducing or eliminating unhealthy behaviors, such as smoking or substance use. These programs improve treatment compliance and reduce substance use. They can be integrated into the behavioral health treatment plan and can include positive mental health behaviors in addition to substance use behaviors (NIDA, 2021).

Contingency management relies on the notion that clients will respond well to tangible rewards that reinforce positive behaviors. Incentive-based interventions in methadone programs have been highly effective in increasing treatment retention and promoting drug abstinence.

One type of contingency management is a Voucher Based Reinforcement program, where those in treatment receive a voucher for every drug-free urine sample they provide. The monetary value of a voucher increases with each consecutive drug-free urine sample, and the value is reset with a positive urine sample. Vouchers can be exchanged for food, movie passes, or other goods and services.

In Prize Incentive programs, there is an element of chance to win cash prizes. During the program (usually lasting at least three months and occurring one or more times a week), those in treatment who provide a drug-free urine sample or breath test have the chance to have their name drawn to win a prize with a value of $1 to $100. Draws start at one and increase with each consecutive negative drug test. Draws are reset to one with a positive drug screen or unexcused absence. In addition, participants can earn extra draws for attending counseling sessions and completing individualized goal activities (NIDA, 2018).

Medication

Mental disorders impact brain functioning and can have a significant influence on an individual's thinking, emotions, and mood. Medications can be helpful to relieve problematic symptoms and improve functioning for the individual. Medications should be prescribed and monitored by the individual's primary care provider or a psychiatrist. When treating co-occurring disorders, it is important to take into consideration that some medications for mental health disorders have side effects that mirror the effects of substance misuse. This may be triggering to the client and those in their support system, which could then lead to non-compliance with the medication. Providers must be aware of these situations and be able to discuss concerns with their clients and their loved ones, and explore alternative medications when appropriate (SAMHSA, 2020).

The goal of medication for mental health disorders is to relieve distressing symptoms and restore functioning. The following is a brief overview of medications for some of the most common mental health disorders that are most often seen as co-occurring disorders with SUD.

Depression: Antidepressants-selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), and monoamine oxidase inhibitors (MAOIs). For some individuals, prescribers will also add a mood stabilizer or antipsychotic to target specific symptoms. As stated previously, some medications have side effects that may look like signs of intoxication or withdrawal, which may be triggering to clients or their support system.

Anxiety: Antidepressants and benzodiazepines are the most commonly prescribed medications to treat anxiety. SSRIs and SSNIs are usually the first choice for treatment, with benzodiazepine prescribed for a short amount of time only or to be taken as needed. Benzodiazepines can cause dependence, and individuals may experience withdrawal if they are stopped abruptly. Taking benzodiazepines and

opioids significantly increases the risk of overdose, so the individual should be screened for opioid use prior to prescribing.

Bipolar Disorder: Mood stabilizers are the most commonly prescribed medications to treat bipolar disorder, with lithium being one of the most commonly prescribed. If on lithium, the individual must attend regular doctor's visits and complete blood work to monitor kidney and thyroid function. Caffeine, alcohol, and other medications can all impact the person's lithium levels and potentially cause lithium toxicity. Antiseizure and antipsychotic medications are also prescribed to treat bipolar disorder.

Schizophrenia & Psychotic Disorders: Antipsychotics are the most commonly prescribed to treat these disorders. These medications are usually taken daily, but there are also some forms that can be dosed one to two times a month. Antipsychotics may have serious side effects, which in turn may lead to noncompliance with medication, so individuals must be monitored regularly by their care providers. Additionally, It is possible to overdose on antipsychotic medications, especially when combined with alcohol or sedating drugs.

ADHD: Non-stimulant and stimulant medications are typically prescribed to treat ADHD. The first line of treatment is non-stimulant medication, as it has less of a tendency to be misused. Stimulant medication should be prescribed only if non-stimulant medication was unsuccessful in treating symptoms (SAMHSA, 2020).

Approved medications currently exist to treat opioid, alcohol, and nicotine use disorders, and additional medications are available to alleviate symptoms of other substance use disorders. Ongoing research is needed to address the medication needs of comorbid populations and to explore medications that can treat multiple problems. One example of a medication that can be used for comorbidity is bupropion, which is available to treat nicotine dependence and depression.

Medications for opioid-use disorder include Buprenorphine-Naloxone, Buprenorphine Hydrochloride, Methadone, and Naltrexone. Medications for

alcohol-use disorder include Acamprosate and Disulfiram. Medications for nicotine use disorder include nicotine replacement therapies, Bupropion HCL, and Varenicline (NIDA, 2121).

Medication for co-occurring disorders without additional treatment interventions is not recommended to stabilize and manage both disorders. Medication options should be discussed with clients, and for some disorders, it may be necessary for initial stabilization and for long-term maintenance. For outcomes to be most successful, medication and therapy should be provided simultaneously (Yule & Kelly, 2019).

Family Involvement

Family involvement is an important consideration from the initial assessment, throughout assessment, treatment, and in order to prevent relapse. While each family is unique, family members may provide significant support during the recovery process, or their involvement may trigger a relapse. The provider must work with the client to determine the role that family support will play during the substance use and mental health disorder recovery process. It is also important to acknowledge that when a family member is experiencing a mental or substance use disorder, it impacts more than just that individual. Loved ones may benefit from support groups or family therapy to improve treatment effectiveness and provide assistance to the whole family. Supporting a loved one with mental health and substance use disorders is challenging and can take a toll on the caregivers. They should be encouraged to seek their own physical and mental health care (SAMHSA, 2023).

Educating family members on their loved one's mental health and substance use disorders can help them be more understanding and enable them to offer support when they see mood or behavioral changes. They can be a connection to treatment services and support throughout recovery. Family members may be

part of the relapse prevention plan and therefore need to be involved in the treatment process so they can understand their role in the plan (SAMHSA, 2023).

Family members can be reminded of the following when wanting to help loved ones with CODs:

- Express your concern and tell them that you're there to help. Create a judgment-free and loving environment to foster conversation and openness.
- Discuss your family history of mental illness or drug and alcohol use. It may help your loved one feel less alone.
- Be patient as you help your loved one locate resources and treatment services.
- Being a caregiver can be highly stressful and emotionally draining; take care of yourself, too.
- Seek support if your loved ones need help. If loved ones are threatening harm or have become a danger to themselves or others, call 911.
- Mental and substance use disorders are treatable. People can and do recover (SAMHSA, 2023).

Other recommendations on how family members can provide support include:

- Learn about their loved one's concerns, ask questions, and listen to answers.
- Make and coordinate appointments with healthcare providers.
- Educate family members, friends, and colleagues about the condition(s) their loved one is experiencing.
- Encourage loved ones to follow their treatment plans and offer support through reminders about appointments and medications.

- Help create a mental health crisis plan that makes their loved one's treatment preferences known through a psychiatric advance directive.
- Notice symptoms that may lead to a loved one having a mental health crisis.
- Organize mental and physical health records, healthcare providers contact information, medications and treatments, crisis plans, and other information.
- Provide transportation to loved one's appointments.
- Participate in treatment with their loved ones, as requested.
- Use person-first language to discuss and describe mental health conditions (SMI Advisor, 2023).

Family members also need support for themselves as caregivers and to have support and validation of the impact the family member with COD has had on the family system. There are multiple community-based and online support groups; examples include Al-Anon/Nar-Anon, and Adult Children of Alcoholics. NAMI, the National Alliance on Mental Illness, has Family Support Groups that are more structured and provide a safe space for family members to learn about their loved one's mental illness, find strength in shared experiences, learn coping skills for themselves, and reject guilty feelings they may be holding onto as caregivers. NAMI has local groups across the United States and also provides programs via Zoom (NAMI.org, 2023).

Family involvement should be tailored to the needs and preferences of the person in treatment. Some people may welcome and benefit from their family's involvement, while others may have more complex family dynamics that require careful navigation and support from the treatment team.

Relapse Prevention

Experts recommended that providers use the following relapse prevention methods with clients with CODs:

- Provide relapse prevention education for SUDs and mental health disorders, explaining how they are interrelated.
- Teach clients skills to resist pressure to stop psychiatric medication in order to increase medication adherence.
- Encourage clients to attend dual recovery groups and, if necessary, teach social skills for successful participation.
- Use daily inventory to monitor mental health symptoms and changes.

If the person experiences a relapse, use it as a learning experience to explore triggers and develop new coping skills. Reframe the relapse as an opportunity to become more self-aware and learn new steps for future success (SAMHSA, 2020).

The following ten strategies for clinical relapse prevention can easily be integrated into the treatment modality being used with the client.

1. Teach clients that a relapse is an EVENT and a PROCESS so they can learn to identify warning signs that they are struggling in their recovery process.
2. Support clients in identifying high-risk situations and developing effective coping skills.
3. Enhance the client's communication skills, interpersonal relationships, and recovery-oriented support network.
4. Help clients identify, reduce, and manage negative emotional states that are associated with relapse. Use HALT: Being Hungry, Angry, Lonely, or Tired can increase the risk of relapse.

5. Assist clients in identifying and managing cravings and urges that can trigger relapse.
6. Help clients identify and challenge cognitive distortions.
7. Support clients as they work toward a more balanced and healthier lifestyle.
8. Examine with the client the combination of the use of medication and psychotherapy treatments.
9. Facilitate smooth transitions for clients between levels of care.
10. Use strategies that improve treatment adherence, such as motivational interviewing or contingency management (VA, 2022).

See Appendix B for a Relapse Prevention Plan example.

Barriers to Treatment

Research clearly shows the need for integrated and comprehensive treatment of co-occurring disorders; however, at this time, only 18% of substance use treatment programs and 9% of mental health treatment programs serve dually diagnosed clients. Providing these services can be complicated due to:

1. In the United States, while primary care doctors may be the first to diagnose mental health disorders, SUD assessment is less likely to be addressed in general health care offices. Mental health organizations tend to focus on more severe mental illness, and SUD treatment organizations focus on addictions and recovery. Treatment interventions for physical health, mental health, and substance use disorder tend to be separated into their own systems. Each individual system or provider does not typically have the broad expertise to address the range of problems presented by dually diagnosed clients.

2. Historically, SUD treatment organizations have been opposed to using any medications, including those to treat mental illnesses such as depression or anxiety. The SUD field is shifting away from this bias. However, many SUD treatment organizations do not have a provider on staff who can prescribe, dispense, and monitor medication.

3. It must be acknowledged that individuals in the criminal justice system are extremely underserved when it comes to treatment from co-occurring disorders. Approximately 45% of people in prison and jails have comorbid mental health and substance use disorders. However, most facilities do not have adequate treatment programs for these individuals. Not only does the treatment of co-occurring disorders reduce medical comorbidities, but it also impacts negative social outcomes by reducing the return to criminal behavior and re-incarceration.

One way the United States has worked to combat barriers in the healthcare system is through the passing of the Mental Health Parity and Addiction Equity Act of 2008 and the Patient Protection and Affordable Care Act of 2010. Both of these acts have increased the number of people with insurance, which also includes coverage for addiction and mental health treatment. The Parity Act requires that insurance plans that cover behavioral health treatments do so at the same level as physical health care treatments. The Affordable Care Act mandates that addiction and mental health treatments are covered as an Essential Benefit category. As healthcare reform continues to progress, providers have support and incentives to implement evidence-based treatment and collaborate with physical healthcare, mental health care, and substance use disorder care in order to provide an integrative care plan for clients (SAMHSA, 2020).

System-level issues

There has been a significant increase in hospitalizations for inpatient detoxification of people with co-occurring mental health disorders. There has also

been an increase in the number of people with CODs in SUD treatment programs. Co-occurring disorder treatment programs have not kept pace to meet the increased needs of those with CODs. 99.8% of SUD treatment programs reported having clients diagnosed with CODs, but only 50% reported having treatment programs for clients with CODs. 46% of mental health organizations offer treatment programs for clients with CODs. While most programs screen for co-occurring disorders, most do not provide comprehensive treatment for CODs (SAMHSA, 2020).

Barriers to Care

People may avoid seeking treatment due to lack of affordability, lack of knowledge about where to access treatment, and low perceived treatment needs. Other common obstacles to accessing and benefitting from COD treatment include:

- Attitudinal and motivational barriers.
- Personal beliefs about and cultural conceptions of mental illness, addiction, and treatment.
- A lack of culturally sensitive/responsive assessments and treatments.
- Gender-specific factors. (e.g., a history of violence/abuse/trauma among women).
- Racial/ethnic factors. (e.g., lower rates of diagnosis and treatment referral for minorities than for Whites).
- Stigma.
- Impaired cognition and insight (particularly among people with serious mental illness).
- Logistical barriers (e.g., lack of transportation, childcare needs, limited access to resources).

- Limited social support.
- High levels of distress.
- Providers' inability to identify CODs because of inadequate training, lack of comprehensive screening and assessment procedures, or both.
- A dearth of COD-specialized services across inpatient and outpatient settings.
- Social, political, systemic, and legal barriers (e.g., poor service availability, insurance barriers).
- Socioeconomic factors, like low income, relying on public assistance, being uninsured, or Medicaid restrictions impacting program reimbursement.
- Organizational "red tape" leading to delays in care and a lack of service provision (SAMHSA, 2020).

Other barriers to care include misconceptions about co-occurring disorders, such as:

Co-occurring disorders are rare: As discussed previously, there are 9.2 million people in the United States alone who are living with co-occurring disorders. People with mental health disorders are twice as likely to experience a substance use disorder and vice versa.

The substance use is caused by mental health issues (or vice versa): It is a misconception that a person's mental health disorder caused that individual to also have a substance use disorder or that the substance use triggered a mental health disorder. While both disorders may interact with and exacerbate the other, it is also possible for both disorders to develop independently of each other. Co-occurring disorders are complex, and this misconception is an extreme oversimplification.

Treatment is the same for co-occurring disorders as single-issue disorders: Co-existing disorders have their own distinct challenges that require specialized care. Trying to provide the same treatment can be detrimental and can exacerbate the other disorder. This is why integrated treatment approaches are so important. The interventions can be tailored to each individual's needs, acknowledge the interconnected nature of co-occurring disorders, and provide a holistic and individualized treatment plan.

The mental health disorder will improve by treating the substance use disorder: Another oversimplified misconception is that if the substance use is treated, the mental health disorder will improve or disappear. Only treating SUD and not the mental health disorder can lead to incomplete recovery and a greater risk of relapse. Both disorders most likely impact and magnify each other, making it all the more imperative that they be treated simultaneously.

People with co-occurring disorders are unpredictable and dangerous: This is a harmful stereotype that perpetuates stigma, increases social isolation, and can lead to a person being reluctant to seek treatment. People with co-occurring disorders experience a wide range of symptoms based on their individual circumstances, their mental health disorder, their substances of choice, and an array of other factors. Educating communities on the complexity of co-occurring disorders can help diminish stereotypes and lead to more compassionate interactions.

Recovering from co-occurring disorders is impossible: This is a discouraging misconception. While recovering is challenging, it is not impossible. People involved in integrated treatment services have reduced substance use, improved mental health, improved life functioning, and a decrease in hospitalizations. Recovery may involve intense and long-term treatment, but with those supports, the person is able to have a healthy and fulfilling life (Burning Tree Programs, 2023).

Removing Barriers to Care

The following strategies are recommended when taking steps to remove barriers to care:

- Using a person-centered approach in the assessment and treatment of individuals with CODs.
- Offering harm-reduction treatment in addition to abstinence-based services.
- Providing informal pretreatment services for those on waitlists or in the contemplation or preparation stage of change.
- Adapting services to meet the logistical needs of clients (offering after-school/work appointment times, providing telehealth appointments).
- Prioritizing integrated care.
- Using a stage approach to intervention (engagement, treatment, relapse prevention) based on the client's readiness to change.
- Using assertive community outreach (ICM & ACT services).
- Prioritizing COD leadership in programs (director who oversees COD programming, services, fidelity, competence, and training) (SAMHSA, 2020).

Providers can combat stigma and prejudice by becoming familiar with the latest evidence-based treatments for those with CODs. They can also engage in honest self-reflection on their own views and attitudes about CODs. These issues can be processed in clinical supervision or through their own counseling where they may address self-awareness of their prejudices and work toward behavior change. This may help to remind themselves and other service providers that stereotypes can be dangerous and impact how providers implement care to the clients who need them. All individuals, regardless of symptoms or diagnoses, deserve to be treated with dignity and to seek health (SAMHSA, 2020).

Individuals with co-occurring disorders are increasingly seeking support through online support groups and social media. More research is needed to determine the effectiveness, important characteristics, and risks of online peer support. One advantage of online support is that it can help connect people who may not have access to services in their area or who feel restricted from accessing the services that are available due to stigma (Yule & Kelly, 2019).

Certified Community Behavioral Health Clinics

One approach that may remove barriers to care and provide integrated care in a "one-stop" model is that of Certified Community Behavioral Health Clinics (CCBHC). CCBHCs are designed around comprehensive service access and integrated care. CCBHCs must serve anyone who requests services for substance use or mental health disorders regardless of their place of residence, age, or ability to pay. CCBHCs are required to provide a range of services so individuals do not need to piece together the services they need across multiple providers or programs. Coordinated care services are also a requirement of CCBHCs to help clients navigate their mental health and substance use care, physical health care, social services, criminal justice commitments, or any other system they are involved with. The six program requirements for organizations to meet to become CCBHCs are (with examples of what that entails):

1. Staffing

   Programs must be adequately staffed to meet the needs of the community.

   Providers must be licensed and credentialed based on their state requirements.

   All staff must complete cultural competency and other trainings, such as trauma-informed care.

2. Availability and Accessibility of Services

Individuals requesting services receive them in a timely manner.

24/7 crisis management services are provided.

No refusal of services for inability to pay.

3. Care Coordination

   Support clients in accessing the services they need.

   Partner with other organizations as needed to meet the client's needs.

4. Scope of Services

   Programs are required to provide the following nine services:

   1. Crisis Services

   2. Screening, Assessment, and Diagnosis

   3. Person-Centered and Family-Centered Treatment Planning

   4. Outpatient Mental Health and Substance Use Services

   5. Primary Care Screening and Monitoring

   6. Targeted Case Management Services

   7. Psychiatric Rehabilitation Services

   8. Peer Supports and Family/Caregiver Supports

   9. Community Care for Uniformed Service Members and Veterans

5. Quality and Other Reporting

   Collect, report, track encounters, outcomes, and quality data.

   Implement and maintain a continuous quality improvement plan.

6. Organizational Authority, Governance, Accreditation

Organizations must be a legally established entity.

At least 51% of the governing board is made up of individuals who themselves or their families have experienced mental or substance use disorders.

The organization must be an enrolled Medicaid provider and accredited by their state and/or federal accrediting boards (SAMHSA, 2023).

Conclusion

Co-occurring disorders are characterized by individuals experiencing substance use and mental health disorders at the same time. This often leads to one condition exacerbating the symptoms of the other. It is for this reason that co-occurring disorders should be treated at the same time.

Approximately half the people who present with a mental health disorder also have a substance disorder, and vice versa. It is imperative that providers screen and assess for both, as early detection and treatment improve the person's recovery potential. Therefore, comprehensive assessments are essential to identify the person's needs and create an individualized treatment plan. Plans may involve inpatient or outpatient treatment and involve one or multiple treatment modalities. The recommended level of family involvement will also be determined based on the assessment. If family involvement is deemed not to be appropriate, alternate support systems will be addressed with the client. Most importantly, the individual must receive integrated care for both the SUD and the mental health disorder. Relapse prevention should also be individualized and involve the person's support system. Relapse frequently occurs, and having a plan to address it when it happens may alleviate guilt, shame, and the avoidance of treatment.

Overall, there is no one-size-fits-all approach to treating co-occurring disorders. Treatment plans should be individualized to address the unique needs and preferences of each person, and modified as necessary. The goal is to help

individuals achieve and maintain recovery, improve their quality of life, and reduce the impact of co-occurring disorders on their overall well-being.

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Appendix A: List of Screening Tools to Help Detect CODs

Substance Use Disorder Treatment for People With Co-Occurring Disorders. Treatment Improvement Protocol 42. Retrieved October 2023. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf

Client safety

- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Suicide Behaviors Questionnaire-Revised (SBQ-R)
- Risk of harm section of the LOCUS
- Humiliation, Afraid, Rape, and Kick

Past or present mental disorders

- ASI
- Mental Health Screening Form-III (MHSF-III)
- Modified Mini Screen
- Diagnostic and Statistical Manual of Mental Disorders (5th ed. [DSM-5]; American Psychiatric Association, 2013) Cross-Cutting Symptom Measure

Past or present substance misuse

- 10-item Drug Abuse Screening Test (DAST-10)

- Alcohol Use Disorders Identification Test (AUDIT) and Alcohol Use Disorders Identification Test—Concise (AUDIT-C)
- CAGE Questionnaire Adapted To Include Drugs
- Michigan Alcoholism Screening Test (MAST)
- National Institute on Drug Abuse (NIDA)-Modified Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Simple Screening Instrument for Substance Abuse (SSI-SA)

Trauma

- Adverse Childhood Experiences (ACEs)
- The Primary Care PTSD Screen for DSM-5
- The PTSD Checklist for DSM-5

Level of care

- LOCUS

Functioning and impairment

- World Health Organization (WHO) Disability Assessment Schedule 2.0

Appendix B: Integrated Relapse Prevention Plan for Co-Occurring Disorders

Minnesota Department of Human Services

Retrieved October 2023: https://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_181625.pdf

Name: _____ Date: _____

Part I: Preventing Triggers (things that were associated with relapses of my mental health symptoms in the past)

Common Trigger	**What I plan to do to prevent this trigger**
Not taking medication regularly	
Difficulty coping with high levels of stress	
Starting (or increasing) the use of substances	

Other:	

Part II. Monitoring Early Warning Signs (first signs that my mental health symptoms were coming back)

List of my most important Early Warning Signs

A.

B.

C.

Part III. Plan for Responding to Early Warning Signs (what you think would help you keep Early Warning Signs from becoming a full relapse)

Common things that help people respond to Early Warning Signs	**Action Steps I plan to take** **(include names and contact #'s)**
Contacting the doctor or member of my team	1. 2.
Getting more social support	1. 2.
Keeping track of the early warning	1. 2.
Stopping or reducing substance use	1. 2.
Using my coping Strategies:	1. 2.

Other:	1. 2.

Congratulations! You have just developed an Integrated Relapse Prevention Plan that could help you prevent a relapse. Over the next few weeks make a plan to practice the skills and strategies on your plan at least 3 times. Share it with at least one supportive person in your life. And remember, your plan is a living document. Revise it whenever you need to.

Dates I have practiced skills and strategies on my plan:

Dates	Strategies I practiced
	1. 2.
	1. 2. 1. 2.

Even when you do everything you can and follow your relapse prevention plan to prevent triggers and respond to early warning signs, there is a possibility that a crisis may develop and that you may need additional support. In this situation, it will be helpful to answer the following questions:

1. Who would you like to be contacted to help you?

Name: _____

Contact information: _____

Name: _____

Contact information: _____

2. Where can you go for help?

_____

3. When you go for help, what would you like for them to do?

_____

_____

_____

_____