Executive Summary

Key Messages

- Recovery from problematic substance use is a highly personal journey toward wellness, satisfying relationships, engagement in community, and a sense of meaning and purpose. Although setbacks happen, people can and do recover.
- Many people recover from problematic substance use without help, but individuals are more likely to experience long-term recovery if they have access to a combination of counseling services, peer- and community-based recovery supports, and medication.
- A recovery-oriented approach to counseling accepts that recovery from problematic substance use has many pathways and works with the individual's chosen recovery goal. That goal could be abstinence, controlled use, or somewhat reduced use.
- People with problematic substance use should have access to recovery-oriented systems of care (ROSCs), where providers offer these individuals treatment, recovery support, and other services and take a long-term, coordinated, and holistic approach to addressing their substance use–related problems.
- Certain counseling approaches can be effective at helping individuals with problematic substance use maintain their recovery regardless of their chosen recovery pathway. These include harm reduction, trauma-informed approaches, motivational approaches, family therapy, cognitive–behavioral therapy, contingency management, mindfulness and acceptance-based approaches, and psychoeducation.
- Peer support services enhance counseling by connecting individuals in recovery to nonclinical professionals who have lived experience with problematic substance use, behavior change, and recovery.
- Four major domains that support a life in recovery are health, home, purpose, and community. Counselors can help their clients recover from problematic substance use by connecting them to a range of tools and resources in these domains.
- An organization interested in adopting a recovery-oriented approach should reorient its mission statement, policies and procedures, staff training, and measures of client outcomes around consumers and their recovery needs and goals.
- An organization interested in becoming a member of a ROSC should take steps to actively link to other resources within the community that can provide recovery support in areas that the organization itself may not currently offer.
- Including people with lived experience in recovery from problematic substance use in an organization's staffing and treatment planning can support successful, sustainable implementation of recovery-oriented practices.

Recovery, as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[1] Recovery is a highly individualized journey. Some view recovery in terms of abstinence and remission of symptoms, whereas others may focus on controlling or reducing use. Some people may pursue multiple approaches to recovery at the same time or for overlapping periods; some may try different approaches in turn; and others may find a single approach that works for them and stick with it. Regardless, a person's recovery is built on their strengths, abilities, resources, and inherent values and is holistic, addressing the whole person and their community.[2] Although many face challenges and setbacks, with the right supports, anyone can recover successfully.

The benefits of recovery from problematic substance use are wide-ranging. They include improvements in a person's physical health, emotional well-being, relationships, school and career achievement, and financial security.[3] These benefits also extend well beyond the individual, positively affecting families, workplaces, communities, and society.

Counselors play a critical role in helping individuals in or seeking recovery achieve their recovery goals and in supporting them as they develop the skills needed for long-term recovery. Recovery-oriented counseling is essential to this process. Through recovery-oriented counseling, counselors support their clients* by:

- Identifying and building on the strengths of a client in or seeking recovery.
- Letting the client's preferred recovery goals and pathway shape their work together.
- Taking a supportive approach to addressing recurrence, should it occur.
- Connecting the client to recovery support services and other forms of assistance and activities that can strengthen their recovery and improve their well-being and quality of life for the long term.

This Treatment Improvement Protocol (TIP) provides guidance to counselors, administrators, and supervisors about recovery-oriented services, supports, and care, allowing them to better serve those individuals in or seeking recovery from problematic substance use.

The Need for a TIP on Promoting Recovery From Problematic Substance Use

Problematic substance use is a major public health and social concern in the United States. In 2021, SAMHSA estimated that 46.3 million people had a substance use disorder (SUD) in the past year.[4] Although alcohol use disorder was the most common SUD, much of the concern about problematic substance use has focused on the opioid epidemic. An estimated 5.6 million people had past-year opioid use disorder (OUD) in 2021.[5]

The rates of stimulant use and stimulant-related deaths are also quickly rising. From 2015 to 2019, overdose deaths involving psychostimulants (other than cocaine) increased 180 percent, and methamphetamine use increased 43 percent.[6] From 2019 to 2021, cocaine-involved overdose deaths increased nearly 54 percent.[7] There are no Food and Drug Administration–approved medications to treat stimulant use, highlighting the significant need for effective recovery supports for those with problematic use. Counselors, administrators, and clinical supervisors with

**Although the literature may reference "client," "consumer," "patient," and "participant" interchangeably, this TIP uses the term "client" to refer to* individuals receiving services for problematic substance use*. Counselors who provide these services frequently use the term "client," and they are the primary audience for this document.*

a strong understanding of recovery-oriented approaches and tools are necessary to address this growing national problem.

For decades, the main approach to addressing problematic substance use involved acute, episodic, specialized treatment that emphasized abstinence. The objective was always to help clients achieve and maintain long-term recovery, but treatment focused on perceived client deficits and provider-determined goals. Also, such treatment was typically siloed professionally and physically from other types of care and services.[8,9] Although this model continues to exist in much of the specialty SUD treatment field, approaches to problematic substance use are becoming more recovery oriented as a result of recent research, clinical experience, and advocacy by the recovery community.[10] With this evolution comes a need for counselors and their colleagues working with people with problematic substance use to have a strong understanding of recovery-oriented concepts and approaches. This need has prompted the publication of this TIP.

Using this TIP, counselors, administrators, and clinical supervisors who work with individuals in or seeking recovery from problematic substance use will:

- Become familiar with the main categories of recovery pathways.
- Understand how to help clients explore different pathways to recovery.
- Learn how to support their clients' choice of pathways.
- Be able to link clients to different pathways (other than natural recovery).
- Understand recovery-oriented supports and counseling approaches.
- Learn about resources and tools to help clients lead a life in long-term recovery.

Scope of This TIP

This TIP offers guidance on counseling approaches that can help support adults in or seeking recovery from problematic substance use. It is intended to help counselors, program administrators, and clinical supervisors promote recovery for their adult clients across many settings and along a continuum of recovery pathways—from harm reduction to abstinence.

Audience

The primary audience for this TIP is anyone who may provide counseling to an individual who has a problem with substance use, regardless of the reason that individual sought out the provider. This includes counselors in multiple settings, nonspecialists in training, nurses, and interns working toward clinical licensure. It also includes administrators, clinical supervisors, and other staff interested in adopting or expanding a recovery-oriented framework for the counseling offered in their programs. Although peer specialists don't provide counseling, they may also find aspects of this TIP helpful.

Organization

This TIP contains six chapters:

- **Chapter 1** presents the origins and treatment of problematic substance use and introduces recovery concepts and supports.
- **Chapter 2** offers ways counselors can work with clients to identify their natural supports, coping skills, talents, and abilities.
- **Chapter 3** explores counseling approaches that can support individuals in recovery from problematic substance use.
- **Chapter 4** discusses four major domains to support recovery (health, home, purpose, and community) and related tools to support a life in recovery for those with problematic substance use.

- **Chapter 5** is for administrators, clinical supervisors, and other staff concerned with the operation of their program who wish to adopt or expand a recovery-oriented framework using counseling approaches that promote recovery from problematic substance use.
- **Chapter 6** is a compilation of useful resources for counselors supporting clients in or seeking recovery from problematic substance use.

Exhibit ES.1 defines key terms that appear throughout the TIP. A breakdown of each chapter's key concepts and messages follows thereafter.

EXHIBIT ES.1. Key Terms

- **Addiction:** Addiction to substances is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with this type of addiction use substances or engage in substance use–related behaviors that become compulsive and often continue despite harmful consequences.
- **Mutual-help programs:** Nonprofessional groups in which members share the same or similar problems, value experiential knowledge, and support one another in recovery from those problems. Mutual-help programs may be secular (e.g., Women for Sobriety, Secular Organizations for Sobriety, Self-Management and Recovery Training [SMART] Recovery®); spiritual (e.g., 12-Step programs like Alcoholics Anonymous® [AA], Narcotics Anonymous [NA®], Double Trouble in Recovery, Medication-Assisted Recovery Anonymous [MARA®]); or religious (e.g., Celebrate Recovery®, Jewish Alcoholics, Chemically Dependent Persons, and Significant Others, Millati Islami, Refuge Recovery).
- **Peer support services (PSS):** The range of services designed, developed, and delivered by peer workers who have lived experience in recovery from problematic substance use can fill a range of roles to support other people in recovery. Examples of services that peer workers provide include advocacy and linkages to recovery services, recovery coaching, recovery support groups, and educational workshops.
- **Peer worker:** In general, any person (or in the case of a family peer worker, a close friend, family member, or other loved one of an individual) with lived experience in recovery from substance use disorders (SUDs), mental disorders, or both who provides nonclinical support in establishing and maintaining long-term recovery.[11] The term **peer worker** encompasses peers working in professional (employed) or volunteer capacities, regardless of whether their work is tied to formal, organized treatment or recovery services. Peer workers support people in recovery, including by working with them on their recovery plans; conduct strengths-based outreach and engagement; connect people in recovery with recovery resources; facilitate and lead recovery groups; and build community, among other activities. They sometimes have such titles as recovery coach, mentor, peer provider, or similar terms. **Peer specialist** (short for peer recovery support specialist) refers specifically to peer workers with some training, including those working in a professional capacity. **Certified peer specialist** refers specifically to a certified/credentialed peer worker, including one working in a professional capacity.
- **Problematic substance use:** The use of any substance in a manner, situation, amount, or frequency that causes harm to the person using the substance or to those around them; it replaces the outdated terms "substance abuse" and "substance misuse." In the case of prescription medications, problematic use is any use other than as prescribed or directed by a healthcare professional. For some substances (e.g., heroin, cocaine) or individuals (e.g., those who engage in injection drug use), any use constitutes problematic use. Problematic substance use is a broad term and can include use that constitutes an SUD. (All people with SUDs have had problematic substance use, but not all problematic use meets diagnostic criteria for an SUD.)

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- **Recovery:** SAMHSA defines recovery as "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential" and acknowledges that recovery can occur via many pathways.[12] Recovery occurs when positive changes and values become part of a voluntarily adopted lifestyle.
- **Recovery capital:** The internal and external strengths and assets available to establish and maintain an individual's recovery (e.g., access to health care, supportive relationships, work/schooling, self-esteem, safe housing).
- **Recovery-oriented system of care (ROSC):** A coordinated network of community-based, person-centered services and supports that builds on the strengths and resiliencies of individuals, families, and communities to recover and improve health, wellness, and quality of life for those who currently experience, previously experienced, or are at risk of experiencing problematic substance use.
- **Recurrence:** A recurrence of **problematic substance use** after a period of remission. Recurrences are often part of recovery; recovery does not mean an absence of recurrence. This term is preferred over **relapse**, which appears frequently in the research literature but does not reflect a person-first, recovery-oriented perspective. However, the TIP uses **relapse** on rare occasions when referring directly to the literature or to a program, service, or resource that itself uses the term.
- **Remission:** The text revision to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR) defines remission as present in people who previously met SUD criteria but no longer meet any SUD criteria (with the possible exception of craving).[13] Clients may be in early remission (not meeting any criteria for SUD for at least 3 months, but less than 12 months) or sustained remission (not meeting any criteria for SUD for 12 months or longer).[14]
- **Substance use disorder (SUD):** A medical illness caused by repeated, problematic use of a substance or substances. According to DSM-5-TR,[15] SUDs are characterized by a cluster of cognitive, behavioral, and physical symptoms that can impair health, social function, and control over substance use. SUDs range from mild to severe. They typically develop gradually over time with repeated use, leading to changes in the brain that affect reward, stress, and executive functions like decision making and self-control. Multiple factors influence whether and how rapidly a person will develop an SUD. These factors include the substance itself; the genetic vulnerability of the person using the substance; the amount, frequency, and duration of use; and environmental and psychological variables.
- **Substance use–related problems:** The range of undesirable issues that may result from problematic substance use, including poor job performance or unemployment; troubled friend, family, or intimate partner relationships; financial difficulties; accidents; mental, physical, or behavioral problems; criminal justice involvement; child custody disputes; and homelessness. The harm these ensuing problems cause may continue beyond the period of active substance use. This term is synonymous with **substance use–related issues**, issues or problems related to substance use, and similar terms.
- **Treatment:** Time-limited, paid services delivered in clinical or acute-care settings by providers who are trained in specific treatment approaches. Often, clients must meet specific qualifications to receive treatment.

Chapter 1: Introduction to Recovery From Problematic Substance Use

Chapter 1 of this TIP introduces the concept of recovery from problematic substance use, including the principles and different pathways of recovery (Exhibit ES.2). The chapter also discusses the evolving understanding and treatment of problematic substance use, the history of the modern recovery movement, and some current recovery research.

In Chapter 1, readers will learn that:

- Recovery from problematic substance use is a process of change that may or may not have abstinence as a goal. Recovery has many pathways.
- The concept of problematic substance use has evolved from misunderstanding it as a moral failure, to thinking of it as a disease, to, increasingly, applying a biopsychosocial model that considers an individual's lived context.
- The service landscape and the workforce for addressing problematic substance use are changing, as are the entry points for treatment of problematic use.
- Peer support services have been found to support individuals with problematic substance use in initiating, strengthening, and sustaining recovery.
- Any recurrence of use may be preceded by warning signs; counselors should be aware of these signs and be prepared to adjust the support they provide.
- Individuals with problematic substance use should have access to recovery-oriented systems of care (ROSCs), in which providers of treatment, recovery support, and other services take a long-term, coordinated, and holistic approach to addressing individuals' substance use–related problems.
- Recovery-oriented counseling for problematic substance use can take place in a wide variety of settings, including specialty SUD treatment settings. Some of these are:
  - Specialty SUD treatment settings (e.g., outpatient treatment programs, intensive outpatient programs).
  - Recovery settings (e.g., recovery community organizations, recovery housing, collegiate recovery programs).

EXHIBIT ES.2. Principles of Recovery

Guiding principles of recovery for people with problematic substance use were first defined on a national level by a diverse panel of stakeholders—including individuals in recovery, family members, representatives of mutual-help organizations, treatment providers, and government officials—during the 2005 National Summit on Recovery convened by SAMHSA.[16] Another meeting of stakeholders in 2010, plus a yearlong national dialog, both held by SAMHSA, further developed the principles of recovery: this time from a combined mental health and substance use perspective.[17]

The resulting principles, listed below, underscore the importance of understanding recovery from the individual's point of view and incorporating that viewpoint into the delivery of behavioral health services, including counseling.

Principles of Recovery

- Recovery emerges from hope.
- Recovery is person driven.
- Recovery occurs via many pathways.
- Recovery is holistic.
- Recovery is supported by peers and allies.
- Recovery is supported through relationships and social networks.
- Recovery is culturally based and influenced.
- Recovery is supported by addressing trauma.
- Recovery involves individual, family, and community strengths and responsibility.
- Recovery is based on respect.

A description of each principle can be found at https://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF.

- Mental health service settings (e.g., outpatient mental health facilities, psychiatric hospitals).
- Medical settings (e.g., primary care practices, hospital emergency departments).
- Harm reduction settings (e.g., syringe services programs).
- Educational settings (e.g., schools, alternative education settings).
- Criminal justice–related settings (e.g., treatment courts, probation and parole agencies).
- Social services settings (e.g., child welfare agencies, youth programs).
- Rehabilitation settings (e.g., private and public rehabilitation agencies, vocational rehabilitation agencies).[18]

Chapter 1 provides a more extensive list of settings.

Chapter 2: Framework for Supporting Recovery With Counseling

Chapter 2 of this TIP discusses how counselors can work with clients in a person-centered way to identify their natural supports, coping skills, talents, abilities, recovery goals, hopes, and dreams for the future. It also provides a framework for recovery-oriented counseling and ways that payment systems can affect the delivery of care for counselors in healthcare and behavioral health service systems.

In Chapter 2, readers will learn that:

- To provide clients with consistent and high-quality care, counselors need a common foundation of knowledge and skills, including the recovery-oriented competencies discussed in Exhibit ES.3.
- Counselors should consider sociocultural factors when working with clients with problematic substance use.

EXHIBIT ES.3. Competencies for Recovery-Oriented Counseling

The consensus panel for this TIP identified competencies for counselors working with individuals who have problematic substance use. Counselors should:

- Possess an understanding of substances, problematic substance use, and addiction treatment and recovery.
- Possess an understanding of mental conditions.
- Have a general understanding of common co-occurring medical conditions.
- Provide treatment using a trauma-informed approach.
- Understand how to establish a therapeutic alliance.
- Identify and address health disparities.
- Understand how to assess social determinants of health with individual clients.
- Use a strengths-based, person-centered approach.
- Know how to link clients to treatment and community recovery resources and actively do so.
- Adhere to professional and ethical standards.
- Engage in recovery advocacy.

Chapter 2 has more information and resources related to each of these competencies.

- Being culturally responsive, incorporating culturally appropriate knowledge and communication, and developing an awareness of treatment barriers and inequities stemming from sociocultural factors is critical. With culturally responsive approaches, clients are more likely to feel heard, empowered, and safe, which can translate into stronger engagement in treatment and recovery services.

- A strengths-based, person-centered approach is fundamental to recovery-oriented counseling, beginning with client intake and continuing throughout the duration of care. A major part of this approach is respecting clients' recovery goals, which may or may not include abstinence.
- Recurrence of problematic use does happen, but recovery-oriented counseling can help clients avoid it or return to recovery when it does occur.
- Counselors who provide recovery-oriented counseling may need to consider the ways that payment systems can affect delivery of that care as well as the potential benefits of providing counseling for people in recovery in the context of a ROSC.

Chapter 3: Counseling Approaches for Promoting Harm Reduction and Preventing Recurrence

Chapter 3 of this TIP is for counselors and discusses counseling approaches that can support people in recovery from problematic substance use. These approaches include harm reduction, trauma-informed care, motivational approaches, family therapy, cognitive–behavioral therapy, contingency management, mindfulness and acceptance-based approaches, linkages to peer and community-based support services, and psychoeducation.

In Chapter 3, readers will learn that:

- Many counseling interventions and frameworks can be effectively combined to increase the likelihood of clients maintaining their recovery, regardless of their chosen recovery pathway. Cognitive–behavioral therapy, motivational interviewing, and contingency management are among the most effective treatments for problematic substance use.
- Harm reduction is an approach designed to encourage positive change and reduce negative health-related consequences of risky behaviors that may be associated with substance use. Several evidence-based harm reduction methods can help support a client's recovery from problematic substance use, including safer injection practices, syringe services programs, overdose education and naloxone distribution, test strips to check drugs for fentanyl, sexual health education and supports, protective behavioral strategies, and client goal-setting practices.
- Family and social support are critical to the recovery of individuals with problematic substance use. Family therapy approaches can strengthen families, improving the health and well-being of both the person in recovery and their family.
- Medications to support recovery from problematic substance use can help manage withdrawal symptoms and cravings and reduce the potential of a recurrence to use. Medication is more effective when counseling and other behavioral health therapies are included. However, counseling should not be a requirement for clients to receive medications. For those with OUD, medication is the most effective treatment and standard of care.

Although mindfulness and acceptance-based approaches have been studied less rigorously, they have been used effectively with individuals in recovery.

Chapter 4: Counseling Approaches for Sustaining Recovery and Promoting a Healthy Life

Chapter 4 discusses the four major domains to support a life in recovery: health, home, purpose, and community. The chapter also offers resources and tools for counselors to use with their clients that can support their growth in these domains.

In Chapter 4, readers will learn that:

- Living a healthy lifestyle and having an overall sense of well-being is vital for individuals in recovery to manage their lives and feel they can live to their full potential. Counselors can help clients by encouraging them to eat a nutritious diet; engage in some type of exercise; develop healthy sleeping habits; obtain medical, dental, and vision care; and receive ongoing care for any chronic disease, such as diabetes, hypertension, and HIV/hepatitis C. Clients may also need support to connect with preventive and primary care and sexual health services as well as in overcoming barriers to receiving care.
- Housing is necessary to support the long-term recovery of people with problematic substance use. It sets a foundation from which an individual in recovery can thrive. However, those with problematic substance use may face barriers to obtaining and maintaining stable housing due to discrimination, systemic disenfranchisement, or having a criminal background or poor credit history. To support clients in this area, counselors should be aware of the barriers clients may face and provide information and resources about how to maintain stable housing and help clients develop life skills, including how to make and stick to a budget, how to get out of debt, and how to manage monthly bills. Counselors should also connect clients with a case manager or social worker to assist with additional housing needs.
- Developing a sense of purpose allows clients to both avoid substance use–related behaviors and engage in experiences that are enjoyable and rewarding. Counselors can support clients by offering tools so they can rewrite their personal narrative, pursue educational and employment opportunities, engage in volunteerism, and identify meaningful leisure activities.
- Relationships and social networks that provide support, friendship, love, and hope are necessary so that people in recovery can be fully engaged in the community. Counselors can help clients develop a sense of connectedness by offering resources to learn about and connect to various community and social supports.

Chapter 5: Implementing Recovery-Oriented Counseling Programs

Chapter 5 of this TIP helps administrators, clinical supervisors, and other staff interested in adopting or expanding a recovery-oriented framework using counseling approaches to promote recovery from problematic substance use. It discusses strategies for becoming a recovery-oriented service provider, workforce development issues, and strategies for linking treatment services to community resources.

In Chapter 5, readers will learn that:

- Offering recovery-oriented care means that no single program or center acts as the sole source of treatment. Rather, an entire community, acting collaboratively, serves to bolster a client's recovery efforts and empowers them to take full advantage of resources.
- An organization's mission statement, policies and procedures, adoption of evidence-based and promising counseling practices, staff training, and measures of client outcomes should focus on consumers and their self-defined recovery needs and goals.
- An organization interested in becoming a member of a ROSC should be linked to other resources within the community that can provide recovery support in areas the organization cannot, or that can complement the services currently provided.
- An organization's workforce development should be aligned with the principles of recovery-oriented care.
- Including people with lived experience in recovery from problematic substance use in an organization's staffing and treatment

planning supports successful, sustainable implementation of recovery-oriented practices.

- The key to implementing person-centered and strengths-based care in an organization is shifting from a traditional pathology-based assessment and treatment plan (based on the counselor's expertise) to a strengths-based assessment and a recovery plan (based on the client's expertise).
- Implementing a new program or service or restructuring a program into a recovery-oriented focus will require a review and revision of existing policies and procedures.
- Organizations should continually monitor their progress and try to identify solutions to any problems they face in implementing a recovery-oriented program.

Chapter 6: Resources

Chapter 6 of this TIP provides resources for counselors, administrators, clinical supervisors, and other staff to expand their recovery-oriented work to support individuals in or seeking recovery from problematic substance use. The chapter includes resources on the following topics:

- General Resources
- Publications
- Mutual-Help Groups
- Online Boards and Chat Rooms
- Treatment Locators
- Advocacy Organizations and Resources
- Harm Reduction
- Health Equity
- Recovery-Oriented Systems of Care (ROSCs)
- Counseling Approaches
- Psychoeducation
- Trauma-Informed Care
- Recovery Housing
- Employment Support
- Education
- Health and Wellness
- Digital Recovery Support Tools
- Telehealth
- Assessment and Screening
- Peer Support Services
- Funding

TIP Development Participants

Note: The information given for participants in the TIP's development indicates their affiliations at the time of their participation and may not reflect their current affiliations.

Consensus Panel

Each Treatment Improvement Protocol's (TIP) consensus panel is a group of primarily nonfederal clinical, research, administrative, and recovery support experts with deep knowledge of the TIP's topic. With the Substance Abuse and Mental Health Services Administration's Knowledge Application Program team, members of the consensus panel develop each TIP via a consensus-driven, collaborative process that blends evidence-based, best, and promising practices with the panel members' expertise and combined wealth of experience.

Chair

Deni Carise, Ph.D.
Chief Science Officer, Recovery Centers of America
Adjunct Assistant Clinical Professor, Department of Psychiatry, Perelman School of Medicine,
University of Pennsylvania
King of Prussia, PA

Panelists

Anika Alvanzo, M.D., M.S., FACP, DFASAM
Eastern Region Medical Director for Pyramid Healthcare, Inc.
Assistant Professor, Johns Hopkins School of Medicine
Founder and Managing Partner of Uzima Consulting Group, LLC
Joppa, MD

George S. Braucht, M.S., LPC, CPCS, CARES
Facilitator, Connecticut Community for Addiction Recovery
Recovery Consultant, Opioid Response Network, American Academy of Addiction Psychiatry
Curriculum Development Consultant and Lead Facilitator, Georgia Mental Health Consumer Network
Chief Mission Officer, Brauchtworks Consulting
Warner Robins, GA

Amy Dellwo, M.A.
Director and Vice President, Public Policy
NUWAY Alliance
Minneapolis, MN

Ruchi M. Fitzgerald, M.D.
Service Chief, Inpatient Addiction Medicine, PCC Community Wellness Center
Assistant Professor, Departments of Family Medicine and Psychiatry and Behavioral Sciences, Rush University
Chicago, IL

Jason Howell, M.B.A., PRS
Executive Director, RecoveryPeople
Founding Member, National Alliance for Recovery Residences
Elgin, TX

Robert Purvis, J.D.
Executive Director
Turning Point Center of Central Vermont
Barre, VT

Evan Smith, M.S.W., LICSW
Behavioral Health Services Manager, Medical Group Practice, Central Vermont Medical Center, The University of Vermont Health Network
Berlin, VT

Ruby Y. Takushi, Ph.D.
Director, Recovery Café
Clinical Psychologist
Seattle, WA

Zachary Talbott, M.S.W., LADAC, ICAADC, ICCS
President and Chief Executive Officer, Talbott Legacy Centers
President, National Alliance for Medication Assisted Recovery (NAMA) Recovery
Maryville, TN

Katie Witkiewitz, Ph.D.
Regents' Professor, Department of Psychology, University of New Mexico (UNM)
Scientist, Center on Alcohol, Substance Use, and Addictions, UNM
Albuquerque, NM

Field Reviewers

Field reviewers represent each TIP's intended audiences. They work in addiction, recovery, mental health, primary care, and adjacent fields. Their direct frontline experience related to the TIP's topic allows them to provide valuable input on a TIP's relevance, utility, accuracy, and accessibility.

Maria Bruni, Ph.D.
Senior Vice President
Family Guidance Centers
Chicago, IL

Patricia T. Caldwell, M.F.T., LPC, CCDPD, CCTP, CAADC
Senior Vice President of Clinical Services
Recovery Centers of America
King of Prussia, PA

Genevieve Casey, M.S.W.
Program Coordinator, Division of Behavioral Health, State of Alaska
Anchorage, AK

Nicole Gastala, M.D.
Medical Director, Division of Substance Use Prevention and Recovery, Illinois Department of Human Services
Assistant Professor and Senior Director of Research, Behavioral Health, and Addiction, University of Illinois Chicago College of Medicine
Chicago, IL

Margaret Jarvis, M.D., DFASAM
Medical Director, Geisinger Marworth Treatment Center
Chief of Addiction Medicine, Department of Psychiatry, Geisinger Neuroscience Institute
Waverly, PA

Julie Kmiec, D.O.
Associate Professor of Psychiatry, University of Pittsburgh School of Medicine (UPMC)
Attending Physician, UPMC Western Psychiatric Hospital
Pittsburgh, PA

Tiffany Laschkewitsch, Psy.D., LP, LADC
Practicum Director
NUWAY Alliance
Minneapolis, MN

Maeve O'Neill, M.Ed., LCDC, LPC-S, CHC, CDTLF
Executive Vice President
All Sober
Celina, TX

Beth Fisher Sanders, LCSW, LCAS, MAC, CCS, MATS
Founder and CEO
Hope Recovery Resources
Charlotte, NC

Christopher R. Smith, M.S., LCMHC, LADC
Clinical Manager
Howard Center, Inc.
Burlington, VT

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Disclaimer

The views, opinions, and content expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of SAMHSA or HHS. No official support of or endorsement by SAMHSA or HHS for these opinions or for the instruments or resources described is intended or should be inferred. The guidelines presented should not be considered substitutes for individualized client care and treatment decisions.

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Chapter 1—Introduction to Recovery From Problematic Substance Use

KEY MESSAGES

- Recovery-oriented counseling can occur in a wide variety of settings, not just in specialized substance use disorder (SUD) treatment settings.
- The conceptualization of problematic substance use has evolved from misunderstanding it as a moral failure, to thinking of it as a disease, to, increasingly, applying a biopsychosocial model that takes into account an individual's lived context.
- In a related shift, the SUD treatment field's traditional approach to problematic substance use—emphasizing acute, episodic, clinician-driven, siloed treatment—is beginning to give way to an approach that emphasizes longer term, person-driven, holistic, integrated recovery-oriented care.
- Recovery from problematic substance use is a process of change that may or may not include total abstinence as a goal. eRecovery has many pathways.
- Recurrence of substance use after a period of resolved problematic use does not mean that recovery has failed. It may mean that treatment or recovery approaches, or both, need adjusting.
- Recovery benefits not just individuals with substance use–related problems, but also their friends and family members, their communities and employers, and society.
- Ideally, people with problematic substance use have access to recovery-oriented systems of care, in which providers of treatment, recovery support, and other services take a long-term, coordinated, and holistic approach to addressing individuals' substance use–related problems.
- The relatively new field of recovery research has the neuroscience of recovery, nonabstinence approaches, the behavioral economics of recovery, and the role of recovery support services among its priorities.

Recovery from substance use–related problems involves a highly individualized journey toward wellness, satisfying relationships, engagement in community, and a sense of meaning and purpose. Despite setbacks that many face along the way, people can and do recover. This concept of recovery, which research and practice increasingly support, differs significantly from one that sees recovery only in terms of total abstinence and remission of symptoms.

Providing recovery-oriented counseling means, in the most basic sense:

- Identifying and building on the strengths of a client in or seeking recovery.

- Letting the client's preferred recovery goals and pathway shape counseling work on recovery.
- Focusing more on increasing adaptive and healthy behaviors.
- Taking a supportive approach to addressing recurrence of use, should it occur.
- Connecting the client to various recovery support services and other forms of assistance and activities that can strengthen their recovery and improve their well-being and quality of life for the long term.

All these topics and more are described in depth in this Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol (TIP). As background, this chapter looks briefly at the origins and treatment of problematic substance use and introduces recovery concepts and supports.

This TIP also applies to clients with problematic substance use who don't engage in specialized substance use disorder (SUD) treatment at all, but instead enter recovery through[19,20]:

- Participating in mutual-help organizations.
- Working with peer specialists or other nonclinical recovery professionals.
- Becoming involved in recovery-oriented activities or organizations.
- Receiving mental health services.
- Participating in harm reduction services.
- Receiving nonspecialty substance use treatment at medical settings like primary care practices.
- Becoming involved in religious or spiritual activities or organizations.
- Resolving the problematic use on their own (called unassisted or natural recovery).

Individuals may use one or more of these approaches to recovery.

What Is Recovery?

This TIP follows SAMHSA in defining recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[21] SAMHSA has set out four dimensions that support a life in recovery[22]:

- **Health.** Overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being
- **Home.** A stable and safe place to live
- **Purpose.** Meaningful daily activities and the independence, income, and resources to participate in society
- **Community.** Relationships and social networks that provide support, friendship, love, and hope

In addition to the definition and the four dimensions of recovery, SAMHSA has published 10 guiding principles that convey the essential characteristics of recovery (Exhibit 1.1). Both SAMHSA's definition and its guiding principles evolved out of a highly consultative process involving a wide variety of people in recovery and other stakeholders.[23]

EXHIBIT 1.1. Principles of Recovery

Guiding principles of recovery for people with problematic substance use were first articulated on a national level by a diverse panel of stakeholders—including individuals in recovery, family members, representatives of mutual-help organizations, treatment providers, and government officials—during the 2005 National Summit on Recovery convened by SAMHSA.[24] Another meeting of stakeholders in 2010, plus a yearlong national dialog, both held by SAMHSA, further developed the principles of recovery: this time from a combined mental health and substance use perspective.[25]

The resulting principles, listed below, underscore the importance of understanding recovery from the individual's point of view and incorporating that viewpoint into the delivery of behavioral health services, including counseling.

Principles of Recovery

- Recovery emerges from hope.
- Recovery is person driven.
- Recovery occurs via many pathways.
- Recovery is holistic.
- Recovery is supported by peers and allies.
- Recovery is supported through relationships and social networks.
- Recovery is culturally based and influenced.
- Recovery is supported by addressing trauma.
- Recovery involves individual, family, and community strengths and responsibility.
- Recovery is based on respect.

A description of each principle can be found at https://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF.

Numerous surveys of individuals in recovery have added to the understanding of the meaning and experience of recovery. The answers reinforce the idea embedded in the SAMHSA definition that to many people, recovery encompasses more than overcoming problematic substance use itself and its symptoms. For example, the 2014 "What Is Recovery" study found that of 47 elements of recovery presented to people in recovery, 3 of the 6 elements most frequently chosen as definitely belonging in their personal definition of recovery were[26]:

- A process of growth and development.
- Reacting to life's ups and downs in a more balanced way than I used to.
- Taking responsibility for the things I can change.

A substantial majority of respondents also saw "living a life that contributes to society, to your family, or to your betterment" and "giving back" as part of how they defined recovery.

At the same time, counselors should be sensitive to the fact that not every person who has overcome problematic substance use thinks of themselves as being in recovery. A 2018 nationally representative cross-sectional survey of people who reported having resolved a substance use problem found that 39.5 percent never identified as being in recovery and 15.4 percent considered themselves no longer in recovery.[27] Compared with those respondents who considered themselves in recovery, these respondents were less likely to have a history of formal SUD treatment or mutual-help participation or a substance use or mental disorder diagnosis.

Common reasons respondents gave for never or no longer identifying as being in recovery included that:

- The substance use problem was no longer an issue.
- The problem had been mild.
- They had quit without any or much assistance.
- They continued to use substances in a nonproblematic way.

The study authors suggested that people with past problematic use who don't consider themselves in recovery might respond better to terms like "problem resolution" in clinical situations.[28]

Information about recovery goals and pathways appears later in this chapter. Chapter 2 discusses the important concept of recovery capital, briefly defined as the internal and external resources available to establish and maintain an individual's recovery.

Settings for Recovery-Oriented Counseling

Recovery-oriented counseling for problematic substance use can take place in a wide variety of settings, including in specialty SUD treatment settings. Given the prevalence of problematic use in the general population, and especially among people receiving mental health services, counselors outside of specialty SUD treatment settings likely have clients at risk for or with past or active problematic use who would benefit from recovery-oriented counseling.[29]

The list for each setting category below is not exhaustive.

Specialty SUD treatment settings[30]:

- Outpatient treatment programs
- Intensive outpatient programs
- Partial hospitalization programs
- Residential treatment programs
- Inpatient hospital programs
- Opioid treatment programs
- Office-based opioid treatment

Recovery settings (the "Key Terms" in the Executive Summary and the "Recovery Support Services" subsection in this chapter describe several of these settings):

- Recovery housing
- Collegiate recovery programs
- Recovery community organizations (RCOs)
- Recovery community centers (RCCs)

Mental health service settings[31]:

- Outpatient mental health facilities
- Community mental health centers
- General hospitals with a separate psychiatric unit
- Hospitals with psychiatric consultation services
- Psychiatric hospitals
- Residential treatment centers
- Private practices

Medical settings:

- Primary care practices
- Hospital emergency departments (EDs), regular inpatient units, intensive care units, and transplant units
- Skilled nursing facilities
- Obstetrics and gynecology practices
- Infectious disease clinics

Harm reduction settings:

- Syringe services programs
- Opioid education and naloxone distribution program sites
- Street-based counseling

Educational settings:

- Schools
- Alternative education settings[32]
- Colleges
- Graduate schools

Criminal justice–related settings[33]:

- Treatment courts
- Probation and parole agencies
- Prisons and jails

Social services settings[34]:

- Child welfare agencies
- Youth programs
- Shelters

Rehabilitation settings[35]:

- Private rehabilitation agencies
- Public rehabilitation agencies
- Vocational rehabilitation agencies

Scope of Practice for Providing Counseling

A scope of practice (SOP) sets out the services and activities that a state or territory permits a licensed or certified professional to perform—including, for behavioral health service professionals, diagnosis, assessment, and treatment. SOPs for counselors vary widely by profession and state.[36,37]

A particular license or certification may limit a counselor's ability to provide substance use–related counseling to any given client and obtain reimbursement for any such counseling. One place to start looking into reimbursement is the state public health department. Links are at https://www.cdc.gov/publichealthgateway/healthdirectories/healthdepartments.html. A counselor is responsible for determining (in conjunction with their clinical supervisor, if applicable) the exact nature and scope of the recovery-oriented counseling services that they may provide in accordance with state laws, their profession's ethical requirements for competence, and their employer's policies and procedures.

PEER SPECIALISTS SUPPORTING RECOVERY FROM PROBLEMATIC SUBSTANCE USE

Peer specialists are an important audience for this TIP, but they have different roles, training, perspectives, and qualifications than counselors. Unlike counselors, peer specialists don't perform clinical work. They don't diagnose, assess, or treat behavioral health conditions, and they don't use clinical language. Instead, peer specialists draw on their lived experience with recovery, plus special training, to provide nondirective recovery support to individuals with active or past problematic use. This recovery support can take many forms and can occur at any point in the recovery process. Typical peer specialist activities range from engaging in street outreach, to providing opioid education and naloxone distribution, to leading life skills–building groups at SUD treatment programs, to checking in with people in long-term recovery.[38,39]

More information on the peer workforce is in the "Increasing Use of PSS" section later in this chapter. Information on how peer work can complement and reinforce counseling is in the "Linkages to Peer- and Community-Based Support Services" section in Chapter 3. (Counselors may also work with mental health peer specialists, but this TIP doesn't cover that segment of the peer workforce.) SAMHSA's TIP 64, *Incorporating Peer Support Into Substance Use Disorder Treatment Services* (https://store.samhsa.gov/product/tip-64-incorporating-peer-support-substance-use-disorder-treatment-services/pep23-02-01-001) also contains useful information.

Problematic Substance Use: Background and Evolving Explanations and Services for It

The prevalence of problematic substance use remains a major public health and social concern in the United States. SAMHSA's most recent National Survey on Drug Use and Health (NSDUH) found that in 2021, 46.3 million people had an SUD in the past year.[40] Although alcohol use disorder (AUD) was the most common SUD, much of the concern about problematic substance use continues to focus on the opioid epidemic. An estimated 5.6 million people had past-year opioid use disorder (OUD) in 2021.[41]

The opioid epidemic also continues to drive increases in drug overdose deaths. Of the estimated 107,622 drug overdose deaths that occurred in the United States in 2021, an estimated 80,816 involved opioids. The total number of drug overdose deaths represents a nearly 15-percent increase from 2020, which saw an estimated 93,655 drug overdose deaths, of which 70,029 were from opioids.[42]

The number of overdose deaths from the stimulants cocaine and methamphetamine also increased in 2021 compared with 2020,[43] part of an overall pattern of rising stimulant-involved overdose deaths over the past 20 years.[44] Co-occurring use of stimulants and opioids is believed to be a major driver of this increase in stimulant-involved overdose mortality.[45] Some of this co-occurring use is intentional—for example, to balance the effects of the drugs—but some happens unintentionally, such as through the consumption of a stimulant adulterated with fentanyl.[46]

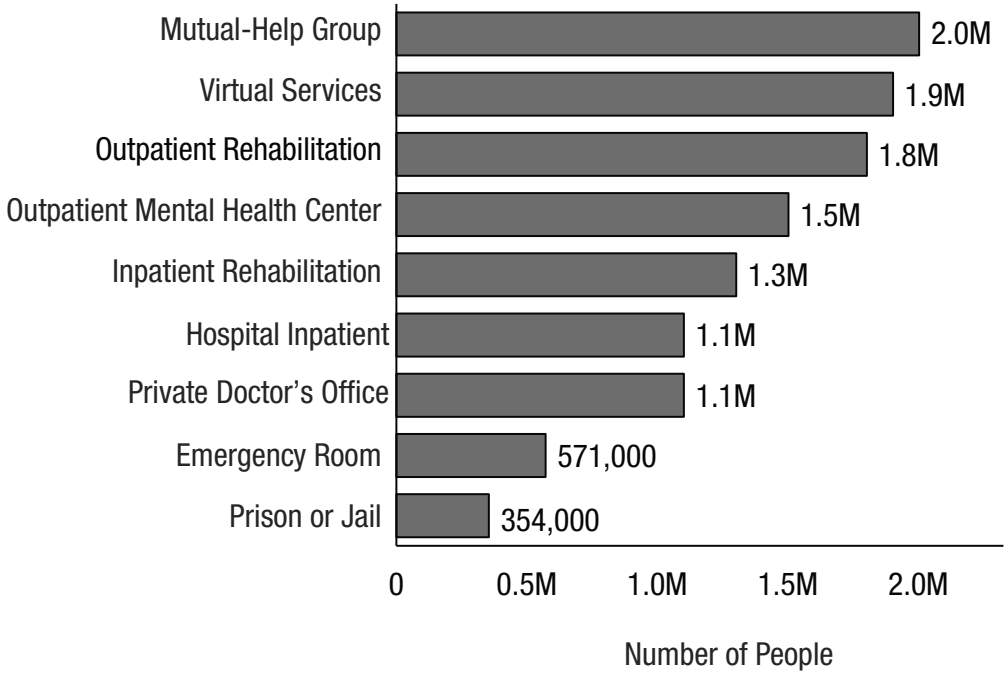
The disturbing numbers on current SUDs and drug overdose deaths need to be set against the encouraging statistics on recovery. Using 2018 NSDUH data, a 2020 study on recovery status found that of the 11.1 percent of U.S. adults who reported having ever had a substance use problem, 74.8 percent (or approximately 20.6 million adults) also reported being in recovery.[47] And a 2019 cross-sectional study looking at the number of serious quit attempts needed to resolve a significant substance use problem found that the median was 2—a surprisingly low number, as the authors noted (although they further noted that certain subgroups of people made substantially more attempts).[48]

Selected Treatment Statistics

SAMHSA's National Substance Use and Mental Health Services Survey for 2021 found that 18,615 facilities provided substance use treatment.[49] (This figure does not capture some of the settings where people receive substance use treatment, such as prisons, jails, and certain solo practices.)

SAMHSA's 2021 NSDUH looked at the **types** of locations where people received SUD treatment (Exhibit 1.2). The survey results don't indicate effectiveness of treatment but do show which types of treatment are most frequently used. Outpatient treatment predominates. (Note that the exhibit includes participation in mutual-help groups as substance use treatment, which this TIP does not.)

EXHIBIT 1.2. Locations for Substance Use Treatment in 2021



Note: Locations where people received substance use treatment are not mutually exclusive because respondents could report that they received treatment in more than one location in the past year.

Source: Adapted from material in the public domain.[50]

Note: NSDUH includes mutual-help participation as SUD treatment; this TIP does not.

TWO COMMON LEVEL-OF-CARE FRAMEWORKS

Numerous frameworks exist for assessing the level of care (LOC) appropriate for someone with or at risk for problematic substance use. *The ASAM Criteria*® and the Level of Care Utilization System (LOCUS) offer two of the most commonly used frameworks.

***The ASAM Criteria*®.** The American Society of Addiction Medicine (ASAM) framework for clinicians provides a multidimensional assessment to determine the most suitable SUD treatment LOC. The assessment has six dimensions[51]:

- Acute intoxication and/or withdrawal potential
- Biomedical conditions and complications
- Emotional, behavioral, and cognitive conditions and complications
- Readiness to change
- Relapse, continued use, or continued problem potential
- Recovering/living environment

The ASAM Criteria's LOCs range from Level .5, Early Intervention, to Level 4, Medically Managed Intensive Inpatient Services.[52] *The ASAM Criteria*® *Assessment Interview Guide* is freely available on the ASAM website at https://www.asam.org/asam-criteria/criteria-intake-assessment-form. A diagram of the ASAM LOCs and more information on them can be found at https://attcnetwork.org/centers/attc-network-coordinating-office/attc-messenger-using-asam-criteriar-modernize-and-maximize.

Note: *The ASAM Criteria*® is proprietary. (The fourth edition of *The ASAM Criteria*® was under development at the time of this TIP's publication.)

LOCUS. Developed by the American Association for Community Psychiatry, the LOCUS assessment for treatment of SUD or mental illness focuses on six dimensions[53]:

- Risk of harm
- Functional status
- Medical, addictive, and psychiatric comorbidity
- Recovery environment (stress and support in the environment)
- Treatment and recovery history
- Engagement and recovery status

A score is generated to identify an individual's needs and an LOC recommendation.[54] The tool was designed for collaborative use by clinicians, service users, and others.[55]

The LOCUS LOC framework has seven levels ranging from Level 0, Basic Community-Based Crisis and Prevention Services, to Level 6, Medically Managed Residential Services. The LOCUS includes a recovery-focused LOC: Level 1, Recovery Maintenance and Health Management. More information on the LOCUS can be found at https://www.communitypsychiatry.org/keystone-programs/locus.

Note: LOCUS is proprietary.

Selected Recovery Support and Harm Reduction Statistics

Many people with SUDs or other problematic substance use achieve recovery using other avenues alone—or in addition to—formal treatment, or use harm reduction techniques to lessen the consequences of problematic use.

Selected Recovery Support Statistics

A 2017 study on recovery prevalence and pathways found that two of the most used pathways by people in recovery involved mutual-help organizations, such as Alcoholics Anonymous® (45.1 percent of respondents), and recovery support entities, such as recovery housing and RCOs (21.8 percent of respondents).[56]

A 2021 study provided data on the recovery support services most requested at intake by participants in 20 RCOs across the United States. The most frequently requested services were direct peer support services (PSS; 79.0 percent of all participants), mutual-help meetings (51.1 percent), resource referral (49.8 percent), prosocial events (36.2 percent), and harm reduction services (24.4 percent). (RCO participants could request more than one type of service at intake.[57])

Selected Harm Reduction Statistics

A key statistic on harm reduction techniques is the number of syringe services programs (SSPs) in the country—now around 500.[58] These programs "can provide a range of services, including access to and disposal of sterile syringes and injection equipment, vaccination, testing, … linkage to infectious disease care and substance use treatment,"[59] fentanyl testing strips,[60] and naloxone (opioid overdose reversal medication).

A 2021 study on the use of fentanyl test strips by SSP participants to rapidly test drugs for the presence of fentanyl and certain fentanyl-like substances found high utilization (70 percent at one site, 77 percent at the other) and, following utilization, adoption of risk reduction behaviors among some respondents (23 percent of respondents at one site, 69 percent at the other).[61]

Evolving Views of Problematic Substance Use

Changing Models for Explaining Problematic Use

For much of the 20th century, many in the addiction field viewed problematic substance use as primarily or entirely due to moral failure or weakness of character. This moral model holds the individual solely and consciously responsible for developing as well as continuing problematic use. Much of the stigma that still surrounds problematic substance use stems from this idea of moral failure.[62]

The widespread acceptance of the moral model by the general public and treatment professionals, and the associated stigmatizing attitudes, discouraged many people with problematic substance use from seeking treatment or other paths to recovery.[63] And much of the treatment predicated on the moral model wasn't effective or evidence based.[64]

More addiction experts began promoting a chronic disease model of problematic substance use during the second half of the 20th century, in part to counteract the harmful practical effects of the moral model. If conceptualized as a chronic disease, then problematic substance use lends itself to scientifically based clinical interventions that merit insurance coverage and government funding. In recent decades, researchers have homed in on substances' harmful effects on the structures and processes of the brain in particular to explain the chronic and recurring nature of problematic use.[65,66]

The chronic disease model, including the brain disease model, has been criticized from several directions. For example, different critics argue that it[67]:

- Can lead an individual with problematic use to feel hopeless about the possibility of recovery.
- Fails to take into account the factors in an individual's environment and experience that can underlie problematic use, such as poverty or trauma.
- Doesn't explain why most people who drink alcohol don't develop AUD, or why most people who develop problematic alcohol use resolve it over time, often without treatment.[68,69]
- Overlooks research showing that use of substances is sensitive to their price and availability and to the attractiveness and availability of other activities and commodities.[70]

Some addiction researchers now apply a multifactorial approach to facilitate understanding of problematic substance use and recovery from it. This model looks at the interplay of biological, psychological, social, and environmental factors to explain the origins of problematic substance use (the biopsychosocial concept).[71,72,73,74] The same approach has been applied to schizophrenia and chronic pain, for example.[75,76,77]

The biological component largely involves the role of genetics and epigenetics in predisposing people to develop problematic use.[78] A wide range of psychosocial factors seem to put people at higher risk for problematic use, including:

- Certain personality traits, such as impulsivity and low agreeableness.[79,80]
- Mental disorders.[81]
- Pain.
- Positive outcome expectancies (perceptions that substance use will have beneficial or otherwise desirable effects).[82]
- Having parents whose attitudes and behavior endorse substance use.
- Belonging to a peer group that uses substances.
- Having a spouse or intimate partner who uses substances.[83,84]

Environmental factors range from the availability of substances to the level of neighborhood disorganization, which encompasses aspects like high crime rates, residential instability (frequent moves by households), and deteriorating buildings, streets, and public spaces.[85,86]

A 2018 systematic review of SUD treatment providers' opinions about different models suggests that many providers also endorse a combination of models, although belief in the moral model persists alongside acceptance of the disease model and biological, psychological, social, and environmental explanations.[87]

Neurological, Genetic, and Epigenetic Bases for Problematic Substance Use

It has taken decades of research to begin to develop a clear picture of the complex biological underpinnings of problematic substance use, let alone to use this picture to inform treatment. Fruitful areas of research include:

- The neurological characteristics that may predispose people to problematic use.
- The ways problematic substance use changes the brain.
- The genetic markers associated with an inborn vulnerability to certain SUDs.
- The role of epigenetics, where environmental factors can switch gene expression "on" or "off" without changing the underlying DNA.

This evolving body of knowledge can point to new pathways for prevention, diagnosis, and personalized treatments that take each person's neurological and genetic characteristics into account.

Neurological

Research has made it increasingly clear that substances change the way the brain works, and that some people's brains are naturally more vulnerable to problematic substance use.[88] An increased understanding of these mechanisms has generated, and continues to generate, more effective evidence-based treatment options.

All addictive substances cause increases in the release of the neurotransmitter dopamine, activating the reward centers of the brain.[89] Problematic use can be thought of as a repeating cycle with three stages, each associated with a specific brain region[90]:

- **Binge/intoxication** (associated with the basal ganglia), the stage at which a person consumes an intoxicating substance and experiences its rewarding or pleasurable effects

- **Withdrawal/negative affect** (associated with the extended amygdala), the stage at which a person experiences a negative emotional state in the absence of the substance, and ordinary rewards lose their power
- **Preoccupation/anticipation** (associated with the prefrontal cortex), the stage at which one craves substances again after a period of abstinence

THE MODERN RECOVERY MOVEMENT: A BRIEF HISTORY

Since the late 20th century, people in recovery from substance use–related problems have participated in and provided leadership to a growing nationwide recovery movement. The movement advocates for and organizes communities of recovery and has created diverse support approaches and institutions tailored to meet specific community and individual needs. (Note that American Indians and Alaska Natives have a long history of recovery movements.)[91]

The modern-day recovery movement can trace its origins in part to the many secular and religious mutual-help groups formed in the 19th century to address addiction. Although these efforts subsided in the early 20th century, following the establishment of alcohol and drug prohibition movements, they set the stage for the rise of Alcoholics Anonymous®, related 12-Step programs for other substances, and religious and secular alternatives to 12-Step organizations. These organizations provided a model for grassroots, person-driven, mutually supportive approaches to overcoming substance use–related problems.[92]

Today's recovery movement also developed in reaction to certain aspects of the new professional SUD treatment system that came into being during the mid-20th century. These aspects include the treatment system's typical[93]:

- Focus on individuals in treatment, rather than the individuals plus their family members and community.
- Delivery of episodic treatment ending with discharge, without provision for ongoing support.
- Reliance on professionals as the decision makers, often excluding the individuals in treatment.
- Emphasis on fixing people's problems instead of building their strengths.

Other drivers of the recovery movement included the criminalization of addiction and ongoing stigmatization of people with substance use–related problems.

In response, the 1990s saw new grassroots entities called recovery community organizations spring up around the country to enable people in recovery, and their families and allies, to come together to engage in recovery advocacy and to support each other in their recovery journeys. A national recovery summit convened in St. Paul, Minnesota, in 2001 brought together representatives of these organizations and national recovery advocacy organizations, who forged what became a national movement to elevate recovery as a focus of treatment, research, public awareness, and institution building. The summit also saw the launch of a new organization, Faces & Voices of Recovery, to represent the RCOs and people in recovery generally.[94]

SAMHSA provided significant support to the developing movement by helping fund RCOs and the 2001 summit. In 2005, SAMHSA convened the National Summit on Recovery to reach consensus on the guiding principles of recovery (Exhibit 1.1) and elements of recovery-oriented systems of care (ROSCs). ROSCs are discussed in detail at the end of this chapter. The summit had as its overarching goal promoting better integration of recovery into policy, services, and systems of care for people in or seeking recovery.[95]

New institutions—such as RCCs, recovery cafés, and collegiate recovery programs, described elsewhere in this TIP, especially Chapter 4—have come out of the recovery movement, as has a new type of service for people in or seeking recovery: PSS. The movement has become even more inclusive of families and different cultural approaches, and it focuses on developing systems of care and communities that support recovery.

INSIGHTS FROM BRAIN IMAGING

Functional magnetic resonance imaging, which measures changes in blood flow in the brain to show how it behaves in response to certain stimuli, offers many new insights about the action of substances on the brain, the effects of stress, variations in resilience and resistance to problematic substance use, and the neurobiology of craving. The results of some recent studies are described below:

- Brain activity was measured in 162 individuals, in the presence of stimulant drugs and with known levels of familial risk for SUD and/or previous drug use. The imaging studies showed that the likelihood of developing addiction, whether due to familial vulnerability or drug use, was associated with fewer connections in orbitofrontal and ventromedial prefrontal cortical-striatal circuits—pathways critical to goal-directed decision making. Resilience against SUD, on the other hand, was associated with more connections in two networks: the lateral prefrontal cortex and medial caudate nucleus, and the supplementary motor area, superior medial frontal cortex, and putamen—brain circuits involved, respectively, in top-down inhibitory control and habit regulation.[96]
- A review of more than 40 imaging studies on individuals using various substances, including alcohol, cocaine, opioids, and cannabis, found fundamental differences between individuals who sustained abstinence and individuals who had recurrences. Participants who had recurrences showed greater activation to drug-related cues and rewards, but reduced activation to non-drug–related cues and rewards in multiple brain regions as well as weakened functional connectivity in the same regions and reduced gray and white matter volume and connectivity in prefrontal regions. The authors suggested that such findings might be used to predict which individuals are at greatest risk of recurrence, and to support them with extra treatment and attention.[97]
- A meta-analysis of 99 imaging studies encompassing alcohol, cocaine, cannabis, and nicotine looked at the differences in brain activity associated with using each substance. Alcohol use altered the frontal regions of the brain more than the other substances did and was associated with impaired cognitive flexibility and attention. Cannabis use also showed more frontal alterations compared with cocaine, which showed greater dysregulation in the brain's reward circuits.[98]

Genetic

The ability to identify individual genes and study their function has transformed the understanding of the relationship between "nature" and "nurture."

It's long been recognized that the risk of developing an SUD can run in the family. Although estimates vary on how much of the risk is inherited, they average around 50 percent, and can be higher or lower depending on the substance in question. For AUD, estimates of heritability go as high as 64 percent; for cocaine use disorder, they are between 40 and 80 percent;[99] and for cannabis, they are between 51 and 74 percent.[100] Particularly useful for this type of research are studies of identical twins who have been adopted into different families, and thus offer an opportunity to study nature and nurture separately.[101]

Initially, the effort to find genetic associations with SUDs focused on identifying individual "candidate" genes. Although 99.9 percent of genetic material is the same in everyone, 0.1 percent represents millions of tiny variations.[102] These variations are called single nucleotide polymorphisms (SNPs), and they may or may not manifest themselves in individuals' appearance, abilities, health, and susceptibility or resistance to SUDs.[103]

Many researchers have looked for SNPs that can be associated with SUDs. They've discovered a few promising leads: one SNP that correlates with cocaine dependence,[104] and several that are associated with cannabis use.[105] Most often, researchers look at, or near, genes that are already known to be associated with dopamine or other neurotransmitters involved in the cycle of addiction.

A GWAS FOR CANNABIS[106]

A landmark GWAS conducted in 2019 by an international consortium of researchers found an association between cannabis use disorder (CUD) and variants of gene *CHRNA2* located on chromosome 8. The variants associated with CUD were also associated with decreased cognitive performance and increased risk of schizophrenia and attention deficit hyperactivity disorder. The study authors speculated that these multiple associations might explain why people with schizophrenia use cannabis at relatively high rates. The authors further speculated that the frequently observed relationship between poor educational performance and CUD might be due to genetic risk factors that occur together, rather than the disorder itself.

Although these discoveries are important, there's more to the story. The key to understanding SUDs and many other medical puzzles will likely be not one gene but many, each of which makes a small contribution to the relative risk of developing a condition, or the ability to resist developing it. The advent of "big data"—genomic databases that also include detailed information on the owners of the DNA—has enabled genome-wide association studies (GWAS)[107] that attempt to make these complex connections. Researchers can study which widely scattered genes contribute to substance use and the patterns of polysubstance use, and possible explanations for the observed linkages between SUDs and mental disorders like depression and schizophrenia.

Ultimately, studying the genome may point to better ways to prevent problematic substance use by helping people learn whether they are particularly vulnerable to it.

Epigenetic

Epigenetics is the study of factors that can change gene activity without changing the DNA sequence. "Epi-" means "on" or "above" in Greek. Epigenetic changes are changes to DNA that determine whether gene expression is turned on or off. Within the DNA in a cell (i.e., the genome), all of the modifications that regulate the activity, or expression, of the genes are collectively known as the epigenome.[108]

There are several types of epigenetic modification. Two common ones are DNA methylation (the attachment of small chemical groups called "methyl groups" that can "silence" a gene) and histone modification, a change in the structural protein that gives chromosomes their shape. This modification, also caused by the addition or removal of small chemical groups, determines how tightly the DNA is wrapped around histones, which affects whether gene expression is turned on or off.[109] For example, studies of rats have shown that exposure to cocaine, either acute or chronic, causes histone modifications in the nucleus accumbens, a key brain region that mediates reward and satisfaction.[110] Exposure to addicting substances has been shown to alter how this region functions, increasing its sensitivity to a given substance and decreasing its sensitivity to other types of rewards.[111]

GWAS, discussed above, have identified several gene variants linked with SUDs, but even added all together, they don't account for all of the observed heritability of these disorders. Some research suggests that environmental stressors bring about epigenetic modifications that can be inherited by the next generation. For example, children of female survivors of the Holocaust have shown increased vulnerability to posttraumatic stress and other mental disorders.[112] Although epigenetic changes don't alter the underlying DNA, they are both stable and heritable. This mechanism is thought to be one way that parents pass on to their children a predisposition toward problematic substance use, which they in turn can pass on to their own children. It's unknown whether such heritability can affect multiple generations.[113]

However, epigenetic modifications are also dynamic; it may be possible to reverse them, even if the person has inherited them. This biological flexibility has implications for SUD-related epigenetic changes, either inherited or caused by a current SUD episode.[114]

Socioenvironmental Influences on Vulnerability to Problematic Substance Use

Trauma and Problematic Substance Use

SAMHSA defines trauma through the three Es: **events**, the **experience** of those events, and the long-lasting adverse **effects** of the event.[115,116] Events include the actual or threat of physical or psychological harm and may occur as a single event or repeatedly over time. How a person experiences these events determines whether it is considered traumatic. The long-lasting adverse effects of an event can occur immediately or be delayed.[117] Thus, individual trauma is a result of an event or series of events that is physically or emotionally harmful, or life threatening, and that has lasting adverse effects on a person's mental, physical, social, emotional, or spiritual well-being.[118] Trauma that affects communities, known as community trauma, includes a range of violence and atrocities that erode the sense of safety within a given community.[119] This type of trauma can also result from attempts to dismantle systemic cultural practices, resources, and identities.[120]

People experience trauma in different ways and may experience multiple traumatic events.

Trauma can occur in three forms[121]:

- Acute trauma, referring to one incident of trauma that is relatively short in duration.
- Chronic trauma, which includes repeated and prolonged trauma.
- Complex trauma, or prolonged and repeated trauma that is invasive or interpersonal in nature.

More information about the definition of trauma can be found at https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf.

Physically or emotionally harmful or life-threatening experiences (e.g., sexual assault, exposure to gun violence), can lead to trauma that causes lasting adverse effects on a person's mental, physical, social, and emotional well-being.[122,123,124]

Evidence suggests a strong connection between the experience of trauma and problematic substance use.[125] Clients with a history of problematic substance use may also have a history of trauma that is connected to this use, even though they may not be able to recall aspects of their trauma. Chapter 3 provides guidance about trauma-informed care approaches that can help guide work with these clients. The following sections summarize some of the types of trauma that may affect clients.

Adverse childhood experiences (ACEs) and problematic substance use. ACEs include traumatic events that occur during childhood, such as physical or emotional abuse, or parental neglect.[126,127] Stress from ACEs can affect brain development, resulting in long-term negative health and emotional consequences for the person, such as problematic substance use, including SUD.[128,129,130]

Many studies have linked ACEs to problematic substance use later in life.[131,132,133,134,135,136] For example, experiencing childhood trauma, including emotional maltreatment, physical maltreatment, and sexual abuse, increases the risk of problematic substance use.[137] One study identified a history of ACEs among more than 70 percent of adolescents with problematic opioid use.[138] Clients with a history of ACEs benefit from trauma-informed and culturally sensitive approaches.[139]

RESOURCE ALERT: SCREENING FOR ACES AND TRAUMA

A discussion of when and how to screen for ACEs and trauma is in the technical assistance tool *Screening for Adverse Childhood Experiences and Trauma*, published by the nonprofit Center for Health Care Strategies and available via https://www.chcs.org/resource/screening-for-adverse-childhood-experiences-and-trauma/. The publication includes a widely used and validated questionnaire for measuring the impact of child abuse and neglect on health and well-being.

Historical, intergenerational, and racial trauma and problematic substance use. Clients may have also experienced historical, intergenerational, or racial trauma. Historical trauma refers to traumatic experiences or events shared by historically oppressed groups. Intergenerational trauma passes down from those who directly experience the trauma to subsequent generations. Intergenerational trauma can occur as a result of historical or racial trauma.[140] Racial trauma results from exposure to racism, racial bias, and discrimination. People who experience these forms of trauma may be more likely to have problematic substance use:

- **Historical trauma.** Historical trauma affects members of different population groups. For example, studies of American Indian and Alaska Native (AI/AN) individuals have found that greater frequency of thoughts about historical trauma (such as that resulting from removal from their traditional lands and forced assimilation) is associated with substance use.[141] In the case of Black individuals, historical (and intergenerational) trauma is especially associated with the experience of slavery and segregation.[142,143,144] Historical trauma, along with unresolved grief from this historical trauma and continued discrimination, affects mental health, which can result in greater problematic substance use.[145]
- **Intergenerational trauma.** One mechanism by which intergenerational trauma is thought to occur is through parents affected by their own childhood trauma, transmitting this trauma to their children via parenting behaviors and attachment difficulties.[146] It should be noted that most research on this aspect of intergenerational trauma has looked at maternal parenting.[147,148] Problematic substance use is a parental behavior that can contribute to childhood trauma and subsequent substance use,[149,150] which risk, in turn, being transmitted in a cycle of intergenerational trauma.[151]
- Racial trauma. People who experience racial discrimination and oppression may be more likely to have problematic substance use.[152,153] People experiencing racism and trauma may be more likely to have problematic substance use and face barriers to recovery.[154] Research has also shown that racial microaggressions, subtle and more frequent racist interactions, are associated with problematic substance use.[155]

RESOURCE ALERT: SAMHSA TIP ON BEHAVIORAL HEALTH SERVICES FOR AI/AN

SAMHSA's TIP 61, *Behavioral Health Services for American Indians and Alaska Natives*, provides behavioral health professionals with background on Native American history, historical trauma, and cultural perspectives to inform work with Native American clients. The TIP discusses the demographics, social challenges, and behavioral health concerns of Native Americans. It highlights the importance of providers' cultural responsiveness and culture-specific knowledge.

The document can be accessed at https://store.samhsa.gov/product/TIP-61-Behavioral-Health-Services-For-American-Indians-and-Alaska-Natives/SMA18-5070.

Awareness of historical, racial, and intergenerational trauma, along with training to deepen understanding of these types of trauma, can help counselors support affected clients in a culturally sensitive manner and avoid retraumatizing them. Using a "culture broker" (someone of the same culture as the client) as an intermediary can prove beneficial in this regard.[156,157]

Sexual orientation, gender identity, and trauma. Research indicates that individuals who identify as lesbian, gay, bisexual, transgender, queer or questioning, and intersex (LGBTQI+) report exposure to trauma, such as ACEs, more frequently than cisgender (individuals whose gender identities, expressions, and roles align with the sex assigned to them at birth and the culturally established categories of gender) and heterosexual individuals.[158] Emotional abuse and neglect are commonly reported among this population.[159]

Individuals identifying as LGBTQI+ are also more likely to be exposed to minority stress, or stress related to stigma, discrimination, and oppression that they experience due to their nonheterosexual relationships and nonbinary identities.[160,161] Exposure to minority stress and trauma have been shown to negatively affect health outcomes and coping behaviors, including substance use.[162]

RESOURCE ALERT: SAMHSA RESOURCES ON LGBTQI+ POPULATIONS

For more resources and information about LGBTQI+ populations, including national survey reports, agency and federal initiatives, and related behavioral health resources, visit https://www.samhsa.gov/behavioral-health-equity/lgbtqi.

Epigenetics and trauma. The connection between trauma and epigenetics is an important area of ongoing research. Studies suggest that trauma passes down from generation to generation through epigenetic mechanisms (epigenetics is discussed in the previous section).[163,164,165] Examples include studies of parental stress and changes in the epigenetics of offspring,[166] and the impact of childhood trauma on epigenetics. Researchers continue to explore the connection between trauma and changes to how genes work.[167]

Intimate partner violence (IPV) and problematic substance use. IPV, or abuse that occurs within a romantic relationship, is a significant public health issue.[168] IPV affects millions of people each year.[169] In fact, one in three women has experienced lifetime physical or sexual violence or stalking by a partner or ex-partner.[170] Research shows that LGBTQ individuals disproportionately experience higher rates of IPV than their cisgender heterosexual counterparts.[171,172] LGBTQ individuals who have experienced IPV also have higher rates of substance use.[173] Additionally, studies indicate that problematic substance use is common among both perpetrators and victims of IPV.[174]

Individuals who have experienced IPV may initiate substance use as a mechanism to cope with the fear or violence or with conflict in the relationship. Problematic substance use may also result from either partner in the relationship having a co-occurring mental disorder.[175] Perpetrators of violence may use substances as an "excuse" for aggression toward the victim.[176]

IPV may also be accompanied by substance use coercion, which includes such tactics as forcing a partner to use substances or to use more than they want; controlling or interfering with a partner's SUD treatment; or undermining a partner's recovery.[177] A voluntary survey conducted with 3,056 people who experienced domestic violence (or violence occurring between any two

people in a household) and who called the National Domestic Violence Hotline during a 6-week period in 2012 found that 801 reported being pressured or forced by the partner who was abusive to use substances or to use more than they wanted. And of the 306 survey respondents who had tried to get help for substance use "in the last few years," 181 said that the person who was abusive had interfered with their getting help.[178]

The Social Determinants of Health and Problematic Substance Use

The social determinants of health (SDOH) are conditions that affect a range of health and quality-of-life outcomes.[179] Counselors need to recognize and understand the connection between SDOH and problematic substance use to fully support clients in their recovery journey.[180] Chapter 2 has tools to assess SDOH.

The Department of Health and Human Services' (HHS) Office of Disease Prevention and Health Promotion groups SDOH into the following five domains[181]:

- **Healthcare access and quality:** People lacking access to health care may be unable to receive the care they need and may forgo needed preventive care or treatment for illnesses.
- **Education access and quality:** People with higher levels of education are more likely to live healthier lives because of their ability to obtain safe, high-paying jobs. People with less education and poorer quality of education have fewer employment opportunities and are more likely to face health problems, such as heart disease, diabetes, and depression.[182,183]
- **Social and community context:** Relationships and interactions with family and friends and strong ties with the community can help support health and well-being. Conversely, experiencing interactions involving racism or discrimination can negatively affect health.[184]
- **Economic stability:** A close link exists between access to financial resources and health and well-being. People living in poverty or with financial instability have poorer health. Without access to income, people may be more likely to forgo needed health care or be unable to pay for food or housing.
- **Neighborhood and built environment:** Neighborhood and the built environment encompasses safety, housing quality, access to transportation and healthy food, and environmental conditions, such as water and air quality. These factors can directly affect health. For example, people who live, work, or go to school in neighborhoods with high rates of violence or unsafe air or water may have poorer health.

A person facing challenging SDOH is more likely to develop problematic substance use.[185,186] These same unfavorable SDOH may also affect a person's recovery.[187] The following sections provide more information about SDOH and their connection with problematic substance use.

Economic stability and problematic substance use. Studies indicate that economic instability—including financial hardship, poverty, unemployment, and housing instability—is closely tied to problematic substance use.[188,189] For example, a 1-percentage-point increase in the county unemployment rate predicts a 7.0-percent increase in the opioid overdose ED visit rate and a 3.6-percent increase in the opioid death rate.[190] And annual SUD treatment admissions go up when state unemployment rates go up.[191]

Looking at housing status, homelessness is associated with an increased risk of substance use, SUD symptoms and diagnoses, and overdose mortality.[192] Renting, compared with owning a home, is associated with an increased risk of fatal opioid overdose.[193] Researchers studying the effects of residential mobility on drug

involvement among young adults found that frequent moves or changes of residence were linked to a greater likelihood of receipt of drug offers, drug use, drug selling, and drug-related arrest, particularly for young women.[194]

A 2020 study discusses the economic challenges that people who use both opioids and methamphetamine face on top of the health challenges of such use. Compared with people who use opioids only, people who use both opioids and methamphetamine (or methamphetamine only) are more likely to be unstably housed and to fall below the federal poverty line.[195]

Social and community context and problematic substance use. Weaker family and social connections may be a risk factor for problematic substance use.[196] Also, exposure to substance use by family members, or permissive substance use by family members, can lead to problematic substance use.[197] A lack of community support may also contribute to problematic substance use.[198] Counselors should support clients in recovery in developing close family and social connections, which can positively affect recovery from problematic substance use.

Social factors, such as socially determined stressors, exposure to socially toxic environments (violence, poverty, and economic stressors), and racism and discrimination, may increase vulnerability to problematic substance use. Chronic exposure to stressors resulting in overactivation of the stress response has been demonstrated to be disruptive to the body and to disturb other functions, such as the working of the brain's reward pathways—increasing the risk of substance use and SUD.[199] Similarly, exposure to traumatic events and chronic stress in childhood may lead to depression and other mental disorders, and ultimately, to problematic substance use to reduce negative emotions.[200]

Racism and discrimination can also increase vulnerability to problematic substance use. In one study, the experience of discrimination led to a greater willingness to initiate substance use. Self-reported and perceived racism and discrimination increased the risk of substance use among Black individuals.[201]

Immigration status is a stressor linked with problematic substance use in some emerging research.[202] A 2016 review of studies on psychosocial risk factors associated with the behavioral health status of undocumented immigrants in the United States found "substance use/abuse" among the "prevalent themes" identified.[203] And a 2022 study of immigration-related stressors experienced by a national sample of U.S.-born Latino individuals found that experiencing a higher number of such stressors—including ever fearing or worrying about being stopped or questioned about immigration status by immigration officials—increased the odds of problematic substance use.[204] Looking at some specific stressors, the study found that, for example:

- Ever fearing or worrying about being detained for immigration reasons was associated with a more than twofold increase in the odds of cocaine use and prescription sedative and prescription opioid "misuse" in the past year.
- Ever fearing or worrying about the possibility of being deported for immigration reasons was strongly associated with high-intensity drinking in the past year.

Neighborhood and built environment and problematic substance use. Where someone lives matters when it comes to problematic substance use. For example, researchers have established links between drug overdose and a deteriorating urban built environment with such characteristics as dilapidated or burned buildings, vandalized public property, and unclean streets.[205,206,207] As another example, research on early initiation of alcohol and cannabis use among

Black and Hispanic adolescents in families of low income suggests that a significant risk of initiation is conferred by exposure to neighborhoods with such negative aspects as robbery and assault.[208] (Adolescent initiation of substance use is concerning in part because it is associated with a greater risk of problematic substance use in adulthood.[209]) And researchers who studied SDOH, substance use, and drug overdose at the county level in the Mid-Atlantic region of the United States have shown a statistically significant positive correlation between the violent crime rate and drug overdose deaths.[210]

In addition, living in a neighborhood or community with inadequate or unaffordable public transportation can make it difficult for people with problematic substance use and limited income to participate in treatment[211] and recovery support services.

Education access and quality and problematic substance use. Studies indicate a connection between problematic substance use and poorer quality or less education.[212,213] Research indicates that education can be a protective factor in drug overdose deaths and, in fact, the highest overdose rates are among people who did not finish high school, and the lowest are among those who finished college.[214] A limited education may also keep people from accessing adequate information and resources related to substance use treatment,[215] an area where counselors may be able to step in to support clients.

Healthcare access and quality and problematic substance use. Without access to health care and insurance, or the ability to pay for health care or obtain adequate health insurance, people may be less likely to receive the health care or preventive services they need. This may result in more health problems and stress, factors related to increased risk of developing problematic substance use.[216] It can also be difficult to get treatment for problematic substance use. As one study noted, counties with a higher proportion of uninsured and Black residents are less likely to have SUD treatment programs that accept Medicaid.[217]

RESOURCE ALERT: SAMHSA'S OFFICE OF BEHAVIORAL HEALTH EQUITY

SAMHSA's Office of Behavioral Health Equity coordinates SAMHSA's efforts to reduce disparities in mental and/or substance use disorders across populations.[218] Its website offers resources about behavioral health equity, including population-specific information, data sources, and workforce development opportunities. More information is available at https://www.samhsa.gov/behavioral-health-equity.

Mental Illness and Vulnerability to Problematic Substance Use

Mental illness and problematic substance use have long been observed to occur together frequently, but whether one leads to the other remains a subject of research. A large foundational 2010 study on the role of mental disorders as risk factors for subsequent onset of substance use and SUDs stated, "Mental disorders can be conceptualized legitimately as risk factors [for substance dependence as defined by the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders;* DSM] due to the fact that they precede SUDs, are associated with increased probability of their initial onset and permit the population to be divided into high- and low-risk groups."[219] (The study acknowledged but did not examine associations between preexisting substance dependence and onset of mental illness.)

A follow-up 2016 study among adolescents by several of the same authors found that any prior lifetime mental disorder significantly increased the risk of transition from nonuse to first use of substances, and from use to substance use–related problems.[220] This finding was important, because although

some adolescents will later "age out" of problematic substance use, many will have such use persist into adulthood.

Although the pathways by which mental illness contributes to susceptibility to problematic substance use are not fully understood, evidence-based theories exist. One longstanding theory is the self-medication hypothesis, which suggests that individuals with mental disorders use substances to cope with difficult symptoms associated with these disorders, or to lessen the unpleasant side effects of medication taken for the disorders.[221] A 2018 literature review found evidence to support the self-medication hypothesis. Between 21.9 and 24.1 percent of respondents with mood disorders or anxiety disorders reported using substances to relieve the symptoms of these disorders.[222] The same study highlighted longitudinal research showing that people who report self-medicating for symptoms of mood and anxiety disorders are more likely to develop SUD.[223,224]

Other explanations are that changes in the brain caused by mental illness may increase the rewarding effects of substances or decrease awareness of their harmful consequences. And some research suggests that shared risk factors may account for co-occurring substance use and mental disorders, with such risk factors including[225]:

- Genetic and epigenetic vulnerabilities.
- Issues with similar areas of the brain.
- Environmental factors like early exposure to stress and trauma.

Whatever the relationship between co-occurring substance use and mental disorders, they should not be treated in isolation from each other.[226]

Evolving Service Landscape and Workforce

For many decades, the dominant approach to addressing problematic substance use involved acute, episodic, specialized treatment that focused narrowly on abstinence and did so from a deficits-based, clinician-driven perspective. Such treatment was typically siloed professionally and physically from other types of care and services,[227,228] such as primary care, mental health services, and assistance with applying for public benefits and finding adequate housing.

Although this model continues to characterize much of the specialty SUD treatment field, the service landscape and the workforce for addressing problematic use are evolving—partly in response to the[229,230]:

- Opioid overdose epidemic.
- Push for more integrated care.
- Emergence of new and broader services supporting recovery.
- Growth in telehealth.

This section looks at some of the ways that these developments are changing:

- How, where, and when people with problematic substance use enter and engage in treatment.
- Who provides treatment.
- What services people may receive before, in addition to, after, and instead of treatment in support of their recovery.

Some Evolving and Emerging Entry Points for Treatment

People enter formal SUD treatment through a wide variety of means. Primary care referral, self-referral, referral by a mental health service provider, hospitalization, and court order are some common paths. Other entry points include obstetrics and gynecology practices and recovery support settings such as collegiate recovery programs and RCOs. Counselors may also work with clients who entered or will enter treatment through one of these five evolving and emerging entry points: hospital EDs, crisis services, emergency medical services (EMS), infectious disease clinics, and prearrest diversion.

Hospital EDs

People with problematic substance use frequently require emergency care. The high incidence of problematic use among ED patients, and especially the increasing rate of ED visits for opioid overdose,[231] have led to growing recognition that the ED represents an important entry point for SUD treatment.[232]

Many ED patients with untreated and undetected problematic use have no other contact with the healthcare system.[233] Others have not had their problematic use identified in other clinical settings. Even people with problematic use who previously declined to enter treatment or who haven't engaged in treatment successfully can be good candidates for interventions in the ED, because the conditions that brought them there may make them receptive to engagement or re-engagement in SUD care.[234,235]

After treating people presenting with problematic substance use, some EDs don't carry out sufficient treatment referral activities. Other EDs screen patients and offer, as appropriate, brief interventions by clinicians and active linking or referrals to treatment. More recently, some EDs have also, or instead, begun connecting patients with problematic opioid use to peer specialists or other professionals trained to encourage motivation for and engagement in treatment.[236] Peer specialists in particular can also link patients to recovery resources like RCOs.

Some EDs have begun offering initial buprenorphine treatment to patients with untreated OUD, followed by direct linkage to ongoing treatment. The American College of Emergency Physicians recommended this practice in 2021; SAMHSA described it as a best practice that same year.[237,238]

A relatively small number of EDs start patients on medication for AUD, a common diagnosis in the ED.[239] This practice may increase as more EDs become accustomed to initiating medication for patients who have OUD and actively linking them to continuing treatment.

Counselors should learn about and stay updated on the SUD intervention practices of the EDs in their area.

Crisis Services

Crisis services are composed of three core elements: crisis contact services, mobile crisis teams, and crisis receiving and stabilization facilities. Not all communities have all elements. These services sometimes aren't equipped to handle crises related to problematic substance use only (as opposed to suicide or mental health–related crises), although there are calls for this to change.[240]

SAMHSA's *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* incorporates an integrated, no-wrong-door approach to crisis care.[241] A National Association of State Mental Health Program Directors' companion resource to the toolkit emphasizes that crisis response systems need to become "more inclusive of individuals with SUDs."[242] (Both documents can be found in *Crisis Services: Meeting Needs, Saving Lives* at https://store.samhsa.gov/product/crisis-services-meeting-needs-saving-lives/PEP20-08-01-001.)

Crisis contact services. 988 is a dialing and texting code that connects people anywhere in the United States to the 988 Suicide & Crisis Lifeline (formerly known as the National Suicide Prevention Lifeline). The Lifeline is staffed by trained crisis counselors who respond to calls and texts about substance use–related crises as well as suicide and mental crises. The Lifeline also accepts chats via 988lifeline.org/chat/.[243] Counselors should make sure their clients are aware of the 988 Lifeline and the availability of 24/7 services in their community.

Many people also have access to state or local crisis call centers. Some states have substance use–specific hotlines, which may be able to connect individuals to

SUD treatment providers and other SUD-related services. Some states and localities have crisis call services more oriented to mental health–related crises, although these services may have some capacity to respond to substance use–related crises. And some states and localities have crisis call services with the ability to connect people experiencing either kind of crisis or at risk of suicide to mobile crisis teams and facility-based care.[244]

Mobile crisis teams. These community-based units go to the person in crisis and seek to respond quickly and effectively in a way that de-escalates the situation. Although originally focused on mental crises, some teams also have the capacity to address substance use–related crises. Mobile crisis teams often consist of a clinician and a peer specialist, with support from police or EMS, as needed.[245,246]

Crisis receiving and stabilization facilities. These short-term facilities provide an alternative to ED care for people experiencing a substance use or mental crisis, or both. A team of behavioral health service providers assess, address acute symptoms of, and observe individuals arriving via first responders, referral, or, often, self-referral (i.e., walk-in). Not all such facilities offer withdrawal management,[247,248] although ideally they would.

EMS

Some EMS have begun actively encouraging EMS patients who have experienced substance use–related crises, especially opioid overdose, to receive SUD treatment or recovery resources. Typically, this activity involves contacting or even conducting home or community visits to EMS patients within a few days of the initial interaction to check on them and connect them to treatment facilities, office-based opioid treatment, harm reduction services, or other recovery resources if they have not already made such connections.[249]

Such visits often involve a team. The makeup of the team varies from program to program, but often includes, in addition to an EMS or other first responder, an addiction or mental health service counselor and a peer specialist. Such teams go by several different names, including Quick Response Teams and Post-Overdose Response Teams. Many people who receive on-scene overdose care from EMS refuse emergency transport or don't act on referrals to treatment if transported, making such follow-up on EMS overdose responses a critical opportunity to link these individuals to treatment and recovery resources.[250,251]

Infectious Disease Clinics

A significant percentage of the people treated in infectious disease clinics have SUDs. Because of the prevalence and negative effects of SUDs among people with HIV, for example, federal guidelines recommend routine screening for SUDs as part of HIV clinical care.[252] Viral hepatitis, tuberculosis, and syphilis are among the other infectious diseases for which people who use drugs are at higher risk.[253,254,255]

Although many infectious disease specialists haven't received training on SUD **treatment**, some in the profession have begun calling for this to change, and for SUD treatment to become more integrated into the care that infectious disease specialists provide.[256,257] One way that such integration has already been happening, although on a small scale, is through infectious disease specialists becoming qualified to prescribe buprenorphine to their patients with OUD.[258]

Prearrest Diversion

Another emerging way of entering SUD treatment is through prearrest diversion, during a law enforcement encounter, of individuals otherwise eligible for criminal charges. Largely a response to the opioid epidemic, prearrest diversion allows law enforcement officers to refer individuals with suspected or known problematic substance use for SUD diagnosis and treatment instead

of arresting them. Some prearrest diversion programs require that individuals complete an assessment for treatment, a treatment plan, or a treatment program.[259]

Prearrest diversion programs are locally led and initiated and typically involve other service partners in addition to SUD treatment programs, such as agencies and organizations providing recovery support services and case management.[260] These programs are distinct from jail- and court-based postbooking diversion programs and specialty courts, which provide for diversion after individuals have been charged but before sentencing. The programs also differ from deflection, in which law enforcement officers and other first responders link individuals, as needed, to SUD treatment during encounters not involving the possibility of arrest, as an alternative to doing nothing.[261]

SUD Treatment in Primary Care

Primary care offices are often the first point of contact for people with problematic substance use, with more providing screening and initial SUD diagnosis, and even treatment, such as some types of medication for OUD and AUD. Primary care–based SUD care offers opportunities for treatment engagement by people who[262,263,264]:

- Can't afford or access specialized care.
- Won't use specialized care, because of concerns about stigma or other personal reasons.
- Have mild SUDs that don't require more intensive interventions.

Screening, Brief Intervention, and Referral to Treatment

The United States Preventive Services Task Force (USPSTF) recommends that primary care practices screen all adults for SUDs and refer them to treatment if screening is positive.[265] It grades such screening "B" for effectiveness, which means the evidence is strong enough to justify insurance reimbursement. SAMHSA recommends the Screening, Brief Intervention, and Referral to Treatment protocol. Links to several effective screening tools are available from the National Institute on Drug Abuse (https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools).

Qualitative research suggests that universal SUD screening of adults can help alleviate patient fears about being singled out for attention.[266]

To conform to the USPSTF screening recommendation, primary care providers must be able to refer patients for appropriate treatment if necessary. Providers must therefore be aware of SUD treatment programs and other resources in their communities. Providers must also be sensitive to potential patient concerns stemming from the screening process, such as the risk of stigma or the fear of legal implications of admitting to illicit drug use. Clinicians should know their state's requirements on[267]:

- Informed consent for screening.
- Mandatory screening.
- Documentation of screening results in medical records.
- Reporting of screening results to medicolegal authorities.
- Confidentiality protections.

The brief intervention for patients who screen positive can range from 5 to 30 minutes and may employ techniques of cognitive–behavioral therapy or motivational interviewing. (Chapter 3 contains more information on these approaches.) The intervention is not meant as full treatment but is intended to encourage patients to seek treatment before a mild or moderate disorder becomes severe.[268] Reimbursement for screening and brief intervention services in primary care settings is available through commercial insurance, Medicare, and, in some states, Medicaid.[269,270]

Brief interventions may not be enough for people who have severe SUDs. One study of patients in federally qualified health centers found that an alternative protocol, recovery management checkups, significantly increased the number of patients who received SUD treatment, particularly those with OUD. The protocol requires a "linkage manager," not only to encourage entering a treatment program, but also to help patients with logistics (making appointments, arranging transportation) and to check in regularly to keep them engaged with treatment.[271] This protocol can be helpful in maintaining commitment in individuals awaiting treatment intake.[272,273]

Medication for the Treatment of SUD

Although methadone is still dispensed only through specialized clinics for the treatment of OUD, primary care providers can offer two types of medication for people with OUD: buprenorphine and naltrexone. In 2021, HHS eased the prescribing guidelines to expand the number of physicians, nurse practitioners, physician assistants, and other eligible practitioners permitted to administer buprenorphine, so that most providers with a Drug Enforcement Administration (DEA) license can treat up to 30 patients without taking special training.[274] As of early 2023, eligible clinicians no longer need to obtain a DEA X-waiver to prescribe buprenorphine for OUD.[275]

Any provider allowed to prescribe can offer medication for AUD, using acamprosate, disulfiram, or oral or extended-release injectable naltrexone.[276]

Primary care practices that offer medication to treat OUD typically coordinate or integrate OUD treatment with other medical care and offer psychosocial services, such as counseling services or referrals.[277] Some individuals with OUD may access medication through their primary care office because they consider doing so more convenient or less stigmatizing than attending a clinic exclusively for people with OUD.[278]

More information is available at the Providers Clinical Support System website (https://pcssnow.org/), funded in part by SAMHSA.

RESOURCE ALERT: TIP 63, *MEDICATIONS FOR OPIOID USE DISORDER*

SAMHSA's TIP 63, *Medications for Opioid Use Disorder*, provides an indepth review of the Food and Drug Administration–approved medications for OUD: buprenorphine, naltrexone, and methadone. The TIP also discusses prescribing guidelines. The TIP is available at https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002.

Current Limitations

Many primary care practices face challenges in providing medication and other SUD care. These challenges include[279]:

- A lack of primary care providers trained in or confident about effectively treating SUDs with psychosocial and medication interventions.[280,281]
- Lack of referral options and counseling resources because of behavioral health workforce shortages.
- Reimbursement models that do not support care coordination and psychosocial services.[282]
- Long travel times for some patients without access to adequate telehealth technology or transportation.

Another factor limiting the involvement of primary care providers in SUD treatment is stigma on the part of providers and administrators.[283] For example, one study found that providers with higher levels of bias toward people who have OUD are less likely to prescribe medications for OUD, to believe

in the effectiveness of those medications, or even to refer patients with OUD to clinicians or opioid treatment programs that **do** provide medication treatment for OUD.[284]

Integrating Primary Care With Behavioral Health Services

U.S. health care tends to silo physical health and mental health. Primary care providers aren't typically trained to provide behavioral health services, and behavioral health service providers are often prevented by systemic barriers and patient confidentiality requirements, among other things, from coordinating an individual's treatment with their primary care provider.

People with problematic substance use could benefit significantly if these silos were removed, and they could receive treatment for this use from the same team that takes care of other aspects of their health, because[285]:

- Problematic substance use, mental disorders, and other medical conditions are often interconnected.
- Integration has the potential to reduce health disparities.
- SUD service delivery in mainstream health care can be cost effective and may reduce intake/treatment wait times at SUD treatment facilities.
- Integration can lead to improved health outcomes through better care coordination.

Several possible models are available for providing more integrated care, ranging from **collaborative care** (characterized by strong relationships between primary care and behavioral health service providers in different locations) to the **primary care behavioral health model**, where behavioral health consultants and primary care providers function as members of the same clinical team, sharing health records, treatment plans, offices, support staff, and other resources.[286]

A review of 35 models for treating OUD in primary care centers in 8 countries identified several design factors common to the most successful programs. These factors include using multidisciplinary clinical teams, often with advanced-practice clinicians (nurses and pharmacists) serving as clinical care managers; incorporating patient agreements; and offering some type of counseling, although not always through trained behavioral health specialists.[287] (For example, some studies used nurses without previous training in SUD treatment.)

Virtual Approaches: How Telehealth Is Used in SUD Treatment

Telehealth—medical services provided remotely through computer and telecommunications networks—has been available for a long time, but quickly became an essential service when the COVID-19 pandemic limited many kinds of in-person care. The federal government and many states changed their regulations to require telehealth to be reimbursed at parity with in-person care.[288] (As of this TIP's publication, it remains to be seen whether such parity will become permanent.)

The online delivery of behavioral health services, in particular, expanded dramatically. According to one study, telehealth availability increased by 77 percent between 2020 and 2021 for mental health service facilities and by 143 percent for SUD treatment facilities. By January 2021, 68 percent of outpatient mental health facilities and 57 percent of SUD treatment facilities in the sample studied were offering telehealth.[289]

Although traditionally "telehealth" has meant meeting with a provider over the phone or through video, smartphones and remote monitoring technology have expanded the definition to include asynchronous encounters, such as texting or sharing data from a phone app or monitoring device.[290]

Delivering SUD Treatment Services via Telehealth

Telehealth can expand access to SUD care for people who feel stigmatized seeking treatment and prefer not to visit an office or clinic. Telehealth can also bring care to[291,292]:

- Rural residents.
- People who live far from their provider's office or lack access to reliable transportation.
- People who have medical conditions or physical disabilities that make it difficult to travel.
- People who need a provider type or service not available in their area.

For clinicians, telehealth can[293]:

- Increase their availability for clients with complex needs.
- Allow them to spend more time delivering services requiring their clinical expertise and interaction with clients.
- Enable them to spend less time during appointments going over standard but clinically important educational content by allowing clients to review this material asynchronously.

The research on SUD treatment through telehealth is mixed. Patients surveyed in one study were satisfied with their services overall, especially for individual therapy (90 percent "very satisfied"). Three out of four were very satisfied with receiving medication management for SUD via telehealth, although group therapy scored lower (only 58 percent "very satisfied"). Respondents liked the ability to receive services from home without having to travel but disliked the potential to be interrupted and felt they didn't connect well with others in group therapy.[294] One limitation of the study is that the participants were predominately male, White, and well-educated.

A review of several provider studies confirmed these patients' perceptions. Providers overall thought individual therapy could be delivered slightly more effectively via telehealth than in person, but said most other services, including intake assessments and medication prescribing, were better done in person. The biggest disparity was for group counseling, which 62 percent said was more effective in person.[295]

SUD treatment programs may benefit from a hybrid approach. One study of more than 3,000 people in intensive outpatient treatment during the pandemic showed that a hybrid approach was more effective than either all in-person or all-telehealth treatment at keeping them in the program until completion.[296]

In-person treatment may be best for several categories of people, including[297]:

- New clients.
- Clients who are homeless.
- Clients who are isolated.
- Clients who are uncomfortable with technology or lack access to reliable technology.[298]
- Clients who have challenges with paying attention.
- Clients who lack private places to talk.

Telehealth may work well for:

- People with young children.
- People who have difficulty taking time off work and traveling to appointments.
- People who prefer meeting virtually.

Even for clients who usually opt for telehealth, providers may at times want to observe them in person to monitor symptoms and build rapport.[299]

TELEHEALTH FOR MONITORING DRUG USE?

At the onset of COVID-19, many SUD providers abandoned routine urinalysis because of the risk of viral exposure involved with collecting specimens. A lab in Vermont tested a "telecollection" protocol that allowed people to collect specimens at home, with trained observers watching via the patients' smartphones.[300] The protocol required:

- Accessible technology that was easy to use.
- An experience that gave patients a sense of control.
- Detailed patient education, via video and printed instructions.
- Trauma-informed training for observers, focusing on compassion and stigma prevention.

Patients received a special phone holder to help them position their smartphone for a specific side view, and observers used a computer in a windowless room so that the collection could not be seen by anyone else. The collections were not recorded. Patients packed the samples in kits provided by the lab that included shipping materials and shipped specimens at room temperature the same day from their home or at a local drop-off site. (Specimens stay stable at room temperature for up to 2 weeks.)

Patient satisfaction averaged 9.5 on a 10-point scale for comfort and convenience.

Some SUD providers do oral swab tests via telehealth, with questionable results followed up by a laboratory urine test.[301,302,303]

Challenges for Telehealth

Although telehealth for SUD treatment will continue to develop, it faces several obstacles[304]:

- **Access to technology.** High-speed broadband Internet connections are not universal: for example, 58 percent of rural residents have reported access problems. Of adults in low-income households (less than $30,000 in income a year), 29 percent don't have a smartphone, 44 percent don't have broadband, and 46 percent don't own a computer. These barriers to telehealth can increase inequities in access to treatment.
- **Unpredictable regulatory environment.** Telehealth regulations and reimbursement requirements are still changing.
- **Privacy concerns.** Patient confidentiality rules, both federal and state, were largely developed before the Internet was used for healthcare delivery. Providers need to be vigilant to protect their clients' privacy and guard against data breaches and other threats. Providers should also carefully vet apps used to support recovery. **The consensus panel for this TIP expressed concern that such apps may not be as careful with people's data as providers are.**

Counselors using telehealth in SUD treatment need to be sensitive to the "digital divide" that may keep some clients from readily accessing this technology. As already discussed in this section, such obstacles can include the inability to access reliable digital technology because of income level or geographic location. Language and cultural barriers and lack of familiarity with digital technology because of older age can also come into play.[305,306]

Counselors should consider alternatives to telehealth for clients affected by the digital divide. Counselors should also be aware of two federal programs that may help qualifying clients of lower income to afford the necessary technology: the Affordable Connectivity Program (https://www.affordableconnectivity.gov) and Lifeline Support (https://www.lifelinesupport.org).

RESOURCE ALERT: SAMHSA *ADVISORY* ON TECHNOLOGY-BASED THERAPEUTIC TOOLS

SAMHSA's 2021 *Advisory*, Using Technology-Based Therapeutic Tools in Behavioral Health Services, summarizes the key issues in telehealth for behavioral health services, including access to technology, licensing and regulation, reimbursement, privacy, informed consent, training and support, and best practices. The *Advisory* is available via https://store.samhsa.gov/product/advisory-using-technology-based-therapeutic-tools-behavioral-health-services/pep20-06-04-001.

Increasing Use of PSS

One of the most pronounced developments in behavioral health services in recent years has been the growth in delivery of PSS to people with past or present problematic substance use.[307] These nonclinical services, provided by people with lived experience of behavior change and recovery from problematic substance use, support service recipients in initiating, strengthening, and sustaining recovery.[308]

PSS for problematic substance use evolved in part from the sort of peer-to-peer support provided by mutual-help organizations like Alcoholics Anonymous®, although the peer specialist position differs in significant ways from that of the mutual-help sponsor. A peer specialist serves as a role model for recovery to the individuals they work with, while also coaching them on[309,310]:

- Building recovery-related skills, such as coping and job-readiness skills.
- Increasing social supports (e.g., through attending substance-free gatherings together).
- Accessing needed services and resources, such as primary care and legal assistance.

Peer specialists also provide emotional support to people in recovery. For example, peers typically meet with people in person or check in by phone or some other means on a routine basis to offer encouragement and empathy.

Formal PSS for problematic substance use as known today developed in the 1990s.[311] Grant funding from SAMHSA and Medicaid reimbursement for PSS meeting certain requirements helped spur the spread of PSS, including to SUD treatment programs.[312] The opioid epidemic, and increased federal and state funding to address it, has led to further expansion of PSS. (SAMHSA's TIP 64, *Incorporating Peer Support Into Substance Use Disorder Treatment Services,* contains more information on the history of PSS; https://store.samhsa.gov/product/tip-64-incorporating-peer-support-substance-use-disorder-treatment-services/pep23-02-01-001).

Peer Specialist Training and Certification

The increase in PSS has been accompanied by greater professionalization of the peer workforce. Virtually all states now offer training and certification for peer specialists. Medicaid requires such training and certification, along with supervision by a competent mental health professional (as defined by the state) as a condition of reimbursement for PSS.[313,314] Many entities hiring peer specialists, even entities that don't bill Medicaid for PSS, make training plus certification or work toward certification a condition of employment.[315]

The training required for certification varies by state, but typically includes topics like ethics, confidentiality, documentation, recovery goal setting, and office skills.[316] For more information on state training and certification requirements for peer specialists, counselors can check with their state's peer certification body. (The "State Website Data Sources" section of the Peer Recovery Center of Excellence's *Comparative Analysis of State Requirements for Peer Support Specialist Training and Certification in the United States* at https://peerrecoverynow.org/about/coe-products.aspx has relevant links.)

SAMHSA in 2023 published the *National Model Standards for Peer Support Certification* and began encouraging their adoption by states and state certification entities to expand certification reciprocity and strengthen the peer workforce across the United States. The standards' recommendations on the certification process and certification requirements cover such topics as training, work experience, background checks, and ethics. The model standards are available at https://www.samhsa.gov/about-us/who-we-are/offices-centers/or/model-standards.

Settings for PSS

An expanding range of settings now incorporate PSS as part of their menu of programs and services. In addition to recovery support settings (e.g., RCOs, recovery residences) and specialized SUD treatment settings (e.g., outpatient, inpatient, and residential treatment), they include:

- Other clinical settings (e.g., hospital EDs, primary care practices).[317]
- Social service agencies and organizations (e.g., child welfare agencies, shelters).[318,319]
- Criminal justice settings (e.g., treatment courts, pretrial release programs, parole/probation departments, prison and jail reentry programs).[320,321,322]
- First responder agencies (e.g., police departments, EMS).[323]
- Crisis services (e.g., mobile crisis units, crisis stabilization units).[324]
- Education settings (e.g., collegiate and high school recovery programs).[325]

Role Clarity

As the peer specialist workforce has expanded and peer specialists have moved into new settings, the issue of role clarity has increasingly come up among other professionals involved in SUD treatment and recovery as well as peers themselves. Counselors working with peers need to understand peer roles, and to avoid expecting peers to carry out activities that they aren't trained to do (such as drug testing) or that are inappropriate for their position (such as menial tasks).[326] Chapter 3 provides more information on peer roles and discusses how PSS can complement counseling and extend the continuum of care for people with substance use–related problems.

TIP 64, *Incorporating Peer Support Into Substance Use Disorder Treatment Services,* has more information on peer specialists and role clarity (https://store.samhsa.gov/product/tip-64-incorporating-peer-support-substance-use-disorder-treatment-services/pep23-02-01-001).

Recovery Goals for Problematic Substance Use

A recovery-oriented approach to counseling accepts that recovery from problematic substance use has many pathways and works with the client's chosen recovery goal. That goal could be abstinence, controlled use (i.e., use resulting in few if any substance use–related problems), or harm reduction. (The "Harm Reduction" section in Chapter 3 discusses harm reduction strategies and benefits.) A client may even think of their recovery goal more in terms of how they want to feel, what they want to do, or how they want to grow.[327]

Research Findings on Recovery Goals

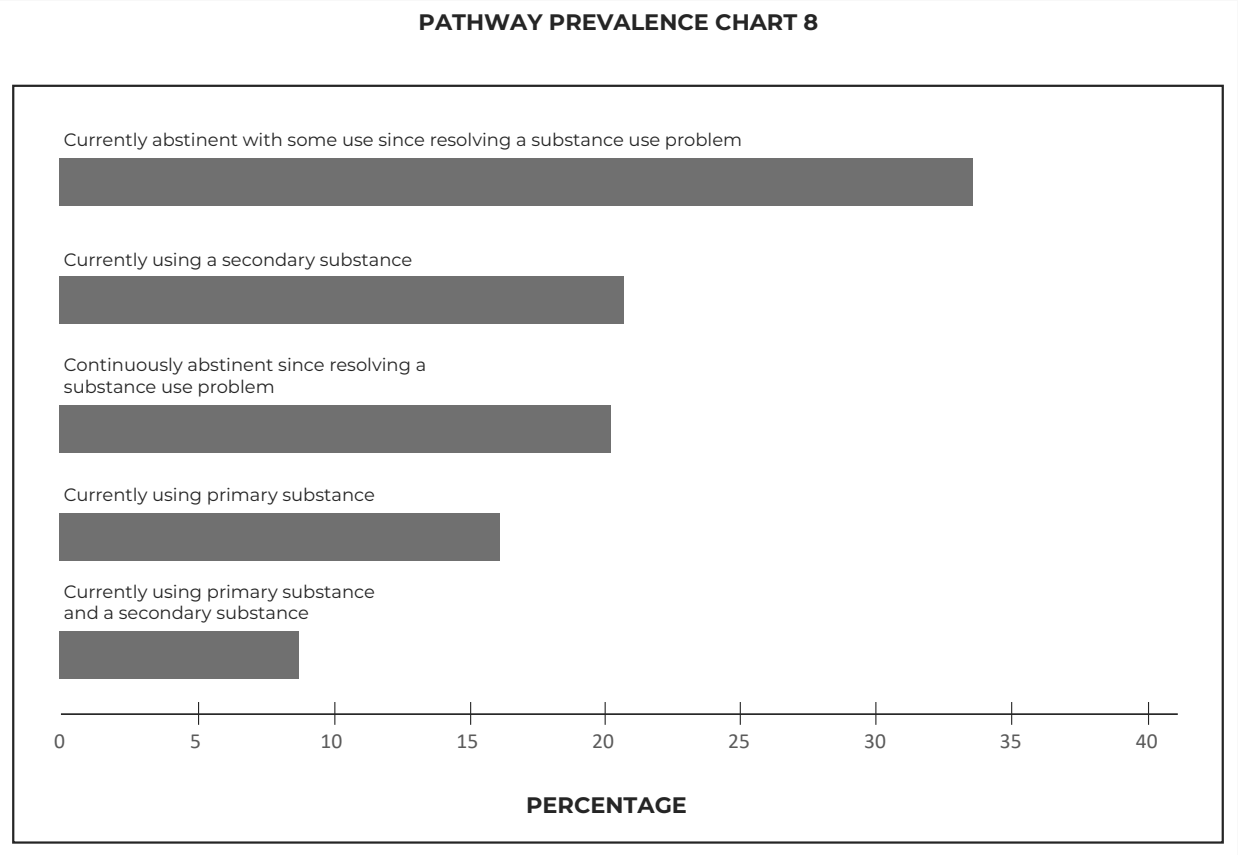
People who have or had a lower severity or shorter history of problematic substance use are especially likely to have reduced substance use, rather than abstinence, as their recovery goal.[328] The type of substance used can affect recovery goal setting, too. Recent research indicates that more than 80 percent of people seeking treatment for AUD prefer nonabstinence goals.

By comparison, roughly 20 percent of people seeking treatment for other SUDs prefer nonabstinence goals.[329] (This percentage

may be somewhat higher for people with cannabis use disorder seeking treatment and people with nonmedical use of prescription opioids likely to seek treatment in the near term.[330,331]) Surveys of people in recovery also show that some consider reduced substance use, or abstinence from a drug but continued alcohol use, consistent with recovery.[332,333] See Exhibit 1.3 for details. Recent research has demonstrated that significantly reducing substance use can improve functioning and quality of life (although not to the same extent as abstinence), which supports a client-defined approach to recovery.[334,335] The traditional abstinence-only model continues to dominate specialized SUD treatment and be central to many mutual-help approaches, such as 12 Step, however.[336] As a result, some individuals with problematic use and nonabstinence recovery goals don't seek out or stay in treatment or mutual-help groups because of their perception or the reality that abstinence will be required.[337,338]

EXHIBIT 1.3. Prevalence of Different Substance Use Statuses Among People In Recovery

A 2022 cross-sectional study[339] looked at the prevalence of different substance use statuses among a nationally representative sample of the 22.35 million U.S. adults estimated in 2017 to have resolved a substance use problem.[340] The 2022 study found the prevalences shown below, in descending order.



Source: Adapted with permission.[341]

Variability of Recovery Goals

A client who uses or used multiple substances may have a different recovery goal for each substance, or even no goal for one or more substances.[342] Also, a client's recovery goal may change over time.[343] For example, a client with severe use who originally set controlled use as their final goal may eventually decide to make abstinence the goal. This decision may result from success—or a lack of success—with controlled use.[344] Conversely, a client with a goal of abstinence may, after repeated recurrences, decide to make controlled or reduced use their goal.

> Counselors may have legal, ethical, or programmatic considerations that prevent them from working on substance use or recovery issues with clients who have nonabstinence recovery goals,[345] perhaps based on type of substance. A recovery-oriented approach to this situation would be for the counselor to advise the client that recovery has many pathways and to refer the client to another provider who can accept nonabstinence goals or to a program or organization that offers PSS for recovery from problematic substance use.

Pathways of Recovery

Recovery has many pathways, and it is ultimately up to clients in or seeking recovery to determine which pathway or pathways they follow.[346] Some clients may pursue multiple approaches to recovery at the same time or for overlapping periods; some may try different approaches in sequence; and some may find a single approach that works for them and stick with it.[347]

A recovery-oriented counselor should:

- Be familiar with the main categories of pathways listed below and discussed in more detail later in this TIP.
- Support clients' choice of pathways.
- Know how to help clients learn more about any pathways that they want to explore.
- Know how to link clients to different pathways (other than natural recovery).
- When possible, keep the door open for a client in case their exploration of an alternative pathway doesn't work out.

Categories

Natural Recovery

"Natural recovery" (sometimes called unassisted recovery) refers to achieving recovery from problematic substance use through self-management. A 2017 study found an association between this pathway and having a less severe and complex substance use and mental health history.[348] The same study found that participants who reported cannabis as their primary substance of use were more likely to achieve recovery through self-management than participants who reported other primary substances.

Clinical Approaches

These pathways comprise approaches in which an individual engages in recovery using the services of a behavioral health services professional, a medical provider, or another credentialed professional (other than a certified peer specialist), or a combination of such providers.[349] Clinical approaches can include behavioral treatment, medication, or a combination of the two depending on the type of SUD. In this TIP, medication for SUD means Food and Drug Administration (FDA)-approved medication for OUD, AUD, or both.

Recovery Support Services

These nonclinical, typically community-based services "help people enter into and navigate systems of care, remove barriers to recovery, stay engaged in the recovery process, and live full lives in communities of their choice."[350] Examples of recovery support services include recovery housing, RCOs, PSS, recovery cafés, and employment-based recovery supports, such as employer-sponsored programs to help employees access treatment for problematic substance use, or businesses created and staffed by

people in recovery.[351] Recovery support services are usually but not necessarily provided by fellow individuals in recovery.[352]

Mutual Help

This pathway involves participating in one or more of the many free, volunteer-run organizations in which members meet regularly in person or online to support each other in recovering from problematic substance use. Some follow the 12-Step abstinence-based approach pioneered by Alcoholics Anonymous® (several of which also focus on specific substances), some follow a secular non-12-Step approach, and some have a religious orientation or affiliation.[353] A hyperlinked listing of mutual-help organizations is available at https://facesandvoicesofrecovery.org/?s=mutual+aid+.

Faith-Based Recovery Support

This pathway encompasses a range of congregation-based support services, including[354]:

- Having a member of the clergy focus on recovery.
- Developing a recovery ministry, on par with other congregational "departments," that sponsors activities like retreats and educational sessions.
- Being a recovery-friendly house of worship.

Note that treatment programs and mutual-help groups can also be affiliated with specific congregations.[355]

Recovery as a Continuum

In the recovery field, recovery is now typically thought of as a process of change and not an endpoint. Some sources have conceptualized this process as divided into early recovery (less than 1 year), continuing (or sustained; 1 to 5 years), and stable (5-plus years).[356,357] The DSM, 5th Edition, Text Revision (DSM-5-TR), gives the following timeframes for remission from diagnosed SUDs: early remission (at least 3 months but less than 12 months of meeting no diagnostic criteria for SUD, except for craving) and sustained remission (12 months or longer of meeting no diagnostic criteria for SUD, except for craving).[358] (An individual can have problematic substance use needing intervention without having a diagnosable SUD.[359])

Counselors should use any such framework with caution, given that the relationship between time in recovery and strength of recovery can vary depending on the individual and the substance or substances of concern.

What Is Recurrence of Problematic Substance Use?

Recurrence is a return to problematic substance use after a period of resolved substance use–related problems. Many individuals in recovery experience recurrence, although doing so isn't inevitable.

According to the 2016 Surgeon General's report on addiction, more than 60 percent of people treated for an SUD have a recurrence within a year of being discharged from treatment—a recurrence rate that the report notes is comparable to those for other chronic diseases like diabetes and asthma.[360] A 2018 study of U.S. adults with any prior SUDs found that the prevalence of past-year persistent or recurrent SUD was 38.1 percent.[361] By comparison, the same study put the prevalence of abstinence at 14.2 percent, asymptomatic use at 36.9 percent, and symptomatic use [did not meet full criteria for any DSM-5 SUD] at 10.9 percent.

Triggers for Recurrence

Counselors should be aware of common triggers linked to recurrence of use. These triggers can directly precede a recurrence or occur months in advance. Examples of triggers include[362,363,364]:

- People, places, and things (such as drug paraphernalia) that a client associates with substance use.[365]
- Relationship difficulties, such as with family, friends, or a partner.
- Stressful situations.
- Cravings or urges.
- Anger, loneliness, boredom, or fatigue.
- Unaddressed mental health–related conditions.

Warning Signs of Recurrence

Warning signs of recurrence often precede triggers.[366,367] These warning signs can be categorized as emotional, mental, and behavioral.[368] Being aware of these warning signs can help counselors identify when clients in recovery may need more support.

Emotional signs include[369,370]:

- Feeling shame or guilt.
- Not expressing emotions.
- Becoming socially withdrawn.
- Becoming uncommunicative, such as at mutual-help meetings.

Mental signs include[371,372]:

- Craving substances.
- Downplaying the effects of past use or fantasizing about past use.
- Bargaining with oneself about use.
- Considering ways to control use.
- Looking for recurrence opportunities.
- Planning a recurrence.

Behavioral warning signs, which might also indicate recurrence of substance use, include[373]:

- Not maintaining healthy boundaries.
- Not seeking support.
- Not practicing self-care, including physical self-care like healthy sleeping[374] and eating.
- Not going to mutual-help meetings.
- Reengaging with people, places, and things associated with past use.[375]

Evolving Views of Recurrence

Just as the concept of recovery has evolved over time, so too has the concept of recurrence. A recovery orientation views recurrence not as a failure on the part of the client, but as an indication of the need to work with the client on adjusting the treatment plan or recovery plan, or both, as applicable. (Unfortunately, some SUD treatment programs still automatically discharge clients who have a recurrence.[376,377]) Recovery researchers also increasingly emphasize the possibility that a person in recovery can learn from a recurrence and apply this newfound knowledge to their recovery effort.[378]

Benefits of Promoting Recovery and Preventing Recurrences

The benefits of recovery may seem obvious, given the wide-ranging impact that problematic substance use can have on an individual's life. Physical health, emotional well-being, relationships, school and career achievement, financial security, law-abidingness, and spiritual health are all affected by such use.[379] Recovery is an opportunity to make improvements in all of these domains.

The benefits of recovery extend well beyond the individuals in recovery themselves. Recovery also positively affects families, workplaces, communities, and society as a whole.

Examples of Benefits to the Individual

- Recovery contributes to overall improved health. Individuals with problematic substance use are more likely to suffer from chronic pain, hypertension, infectious diseases (e.g., hepatitis C and HIV), injuries, poisonings, overdose, and death by suicide.[380,381]
- A landmark survey of people in recovery found that recovery from problematic substance use "is associated with dramatic improvements in all areas of life: healthier/better financial and family life, higher civic engagement, dramatic decreases in public health and safety risks, and significant increases in employment and work."[382]

Examples of Benefits to the Community and Society

- Each year, the problematic use of drugs and alcohol costs the United States an estimated $416 billion, which includes healthcare expenses, lost workplace productivity, criminal justice–related costs, and losses from motor vehicle crashes.[383,384]
- Recovery can reduce hospital costs, where the medical costs related to problematic substance use are $13.2 billion annually.[385]
- Recovery can help avoid drug overdose deaths, reported to number 100,306 from April 2020 to April 2021.[386]
- Recovery helps reduce alcohol-related driving fatalities, which occur at a rate of 1 death every 50 minutes and cost $44 billion annually.[387]
- Treatment and recovery reduce criminal justice system costs associated with people with OUD, which a 2020 study estimated at $29.9 billion annually.[388] The annual cost of methadone treatment averages about $6,550 per person,[389] compared with an annual average cost of about $34,000 to hold someone in a local jail[390] or $34,770 to incarcerate someone in a federal prison.[391]
- A 2020 update of research published in 2017 found that U.S. employees in recovery miss 13.7 fewer days annually than employees with untreated SUD and 3.6 fewer days than an average employee.[392]
- Recovery may reduce instances of IPV, which has been found to correlate with substance use.[393]
- Recovery contributes to healthier pregnancies and infants. Substance use during pregnancy can lead to fetal alcohol spectrum disorder and neonatal abstinence syndrome.[394]

Introduction to Recovery-Oriented Systems of Care

A recovery-oriented system of care (ROSC) is an integrated, easily navigated, self-defined network of community-based services and supports that offers a menu of treatment and recovery options to people in or seeking recovery from problematic substance use. In a ROSC, these options are available across the full continuum of care, from prevention through recovery management, and for the full spectrum of substance use problems, from risky use through severe SUD.[395,396]

A ROSC's overarching goal is to better support people in achieving recovery, wellness, and improved quality of life by addressing their needs holistically[397] and in the same long-term way that characterizes management of other chronic diseases, like diabetes and heart disease. Too often, people in recovery don't receive this type of long-term support.

Exhibit 1.4 lists the essential elements of a ROSC, as identified by the 2005 National Summit on Recovery.

EXHIBIT 1.4. Essential Elements of a ROSC

- Person centered
- Inclusive of family and other ally involvement
- Individualized and comprehensive services across the lifespan
- Committed to anchoring systems in the community
- Committed to continuity of care
- Based in partner–consultant relationships
- Strengths based
- Culturally responsive
- Responsive to personal belief systems
- Committed to PSS
- Inclusive of the voices and experiences of recovering individuals and their families
- Committed to integrated services
- Committed to systemwide education and training
- Committed to ongoing outreach and checkups
- Outcomes driven
- Research based
- Adequately and flexibly financed

Source: Adapted from material in the public domain.[398]

Experience with ROSCs and a greater understanding of recovery have led to the identification of other important factors. One is that ROSCs address SDOH and health disparities. Another is that ROSCs promote community inclusion of people in recovery.[399,400] A third, as noted by the consensus panel that supported the development of this TIP, is that ROSCs don't take a linear approach to recovery.

A small sampling of the many states and communities that have actively engaged in promoting ROSCs includes Connecticut; Illinois; New York; Ohio; Houston, Texas; Philadelphia, Pennsylvania; and Scott County, Indiana.[401,402,403,404,405,406]

Participating in a ROSC connects counselors to other types of providers offering recovery-oriented care, which in turn can help support clients in accessing holistic, appropriate services. Chapter 2 and Chapter 5 have more information on ROSCs.

Introduction to Recovery Research: Current Topics and Needs

Because recovery is a multidimensional process, it means different things to different people, and conducting research on it can be challenging.[407,408] Yet, recovery research is a burgeoning field of inquiry with many different topics to explore, some of which are discussed in the following sections.

Some Overarching Issues

Studying and measuring recovery is different than studying and measuring addiction, which typically looks at outcomes, such as treatment retention rates, number of days abstinent, and changes in number of heavy drinking days. Recovery research is concerned not only with these outcomes, but also with such issues as[409,410]:

- Improvement in social connectedness.
- Improvement in personal functioning.
- The effect of time in recovery on quality of life and outlook.
- The effect of treatment entry point on recovery trajectory.
- Ways to measure the subjective experience of recovery.

Neuroscience of Recovery

As discussed earlier, imaging technology can look directly at many aspects of the brain and its activity. If these techniques can reveal the effects of substance use on the brain, can they also be used to evaluate the progress of recovery? As two researchers have observed,

a group of people may abstain from substances in a 4-week treatment program but display a wide range of behaviors afterward, from immediate recurrence through lifelong abstinence.[411] It's possible that neuroscience could discover biomarkers or brain function patterns corresponding to these behaviors, which could "alert clinicians while treatment is still underway whether progress is being made and could help them design care packages that translate patients' short-term clinical gains into long-term recovery."[412]

Below are some directions currently being pursued in the neuroscience of recovery.

Brain Structure

SUDs are associated with shifts in brain architecture and structure. People with AUD show reductions in gray matter,[413] and people with other SUDs have shown changes in both gray matter and white matter.[414] Does recovery reverse these changes? One study suggests that abstinence can cause increases in brain volume in people who used methamphetamine,[415] and another found a similar result among prison inmates who had regularly used alcohol, cocaine, or cannabis.[416] However, the second study found that these reversals varied depending on the substance. Another study of people in recovery for AUD found that 8 months after an initial magnetic resonance imaging assessment, there was no difference in brain volume between people who abstained from drinking completely and people who drank at low levels.[417]

Further research is needed on the extent of possible gains, the differences depending on the type of SUD, and the changes associated with abstinence compared with reduction in substance use.

Functional Magnetic Resonance Imaging for Changing the Brain

Functional magnetic resonance imaging (fMRI) is being researched for direct use in treatment, in the form of **real-time fMRI neurofeedback** (rtfMRI-nf). The goal of this promising approach is to train people in recovery to self-regulate their brain activity by having them watch it and try to modify it: a process known as neuromodulation. For example, individuals are exposed to the substance that induces craving, watch in real-time how their brain reacts, and consciously try to alter the reaction to reduce their feelings of craving.

A review of rtfMRI-nf studies across several substances, including alcohol and cocaine, showed that the neuromodulation technique generally reduced cravings, although the effects varied depending on the part of the brain involved and the severity of the SUD. The authors identified several areas for further exploration, which include whether the training transfers to settings where the subject isn't able to watch the brain react, how long the training endures, and whether effectiveness varies depending on age, sex, and other sociodemographic factors.[418]

STIMULATION TECHNIQUES: CAN THE BRAIN BE TREATED DIRECTLY FOR SUD?

Applying small electric or electromagnetic pulses to the brain, either externally or internally, is accumulating evidence of efficacy for various brain disorders. Many studies have investigated whether these types of treatments—particularly the external ones, which are noninvasive and relatively free of side effects—could help with recovery from SUD. The evidence so far is mixed, but so are the treatment protocols, including the total number of treatments, the timespan over which they're delivered, the duration of each treatment, and the intensity of the pulses being applied. The most consistent effect across all types of SUDs was reduction in craving.[419]

The exact mechanism for the effects of these treatments is not yet clear, nor is whether they're best used by themselves or with other treatment methods.[420] In addition to lacking consistency in regimen, existing studies suffer from small sample sizes and often don't have rigorous control groups or sufficient blinding.[421] These techniques show great promise but must be studied and refined further. These are some to watch:

- **Repetitive transcranial magnetic stimulation** consists of electromagnetic pulses applied externally through the scalp. It's been studied in connection with SUDs for alcohol, methamphetamine, cocaine,[422] and cannabis.[423]
- **Transcranial electrical stimulation (tES)** can involve either direct or alternating current, applied externally through the scalp. It has been studied for treating SUDs involving alcohol, methamphetamine, cocaine, heroin, and cannabis.[424] FDA currently considers both forms of tES investigational, and both are in numerous clinical trials.
- **Deep brain stimulation (DBS)** works via devices implanted in the brain. A few studies have examined its usefulness for treating SUDs involving alcohol, stimulants, and opioids.[425] Because DBS involves surgery, it does not lend itself to large, blinded trials.

Nonabstinence Approaches to Recovery

Does recovery from problematic substance use demand abstinence? For many people, the answer is yes. But a growing body of evidence suggests that a requirement for complete abstinence may be unnecessarily restrictive, and that treatment programs that demand it may discourage people from seeking help.[426]

Analyses of participants in two large studies that tracked outcomes of AUD treatment for up to 10 years, Project MATCH and the COMBINE Study,[427,428,429] showed that a substantial number of participants returned to occasional heavy drinking after treatment. However, there was not a consistent relationship between the amount they drank and how well they functioned. Approximately half of the participants were able to drink heavily on occasion and still maintain levels of functioning similar to participants who abstained or were considered low risk. This finding suggests focusing on function, rather than drinking practices, when defining what constitutes recovery and when projecting how someone will fare long term.

In another example, a study of people in treatment for cocaine use disorder showed that some were able to achieve "problem-free functioning," while dropping down to "occasional" use during their final month of treatment, and to maintain that status and level of use during follow-up interviews.[430]

Behavioral Economic Theory and Recovery

Behavioral economics is the study of how people make decisions about how to use their resources and things they value. It

includes such elements as how a person chooses between a smaller reward available immediately and a larger one that requires waiting, and how those decisions may be influenced by state of mind, stress level, and outside events.

One characteristic feature of SUD is distorted behavioral economics: the person who has an SUD puts a higher value on the substance than on other things normally regarded as valuable, like relationships, jobs, education, or life goals.[431] In severe cases, the substance becomes the only thing valued. An important task of recovery is reconfiguring one's behavioral economic calculations to devalue the substance and shift priorities to self-care, better relationships, and meaningful participation in society.

From the perspective of behavioral economics, the COVID-19 pandemic created a "perfect storm" for SUDs. Many rewards and incentives—such as companionship, social activity, and employment—became suddenly unavailable, while substances were readily available and the need to relieve stress, loneliness, and other negative emotions was much higher than normal.[432] Restricted access to recovery services further exacerbated the problems for many. Research will need to assess the long-term impact of the pandemic on the behavioral economic structures of substance use.

One current avenue of research is refining the application of behavioral economics to recovery. For example, people in recovery could be assessed at baseline to determine how they make value-based decisions in general, and reassessed periodically to see whether their decision process has changed during treatment and recovery. Their responses could help predict the likelihood of recurrence.[433] (Contingency management, an SUD intervention grounded in behavioral economics, is discussed in Chapter 3.)

Recovery Timeframes

More research is needed on recovery timeframes. William White has suggested that "recovery durability" is achieved when a person has been in active, continuous recovery for 4 to 5 years.[434] A 2018 study found that it takes an average of 15 years of recovery to achieve the same quality of life as a sample of the general population in several Western European countries.[435,436]

This TIP's consensus panelists emphasized the lack of continuity in recovery support after treatment and the need to look at supports for people beyond the first few years of recovery. However, the consensus panelists also suggested using milestones with caution. Instead, they emphasized that recovery is an ongoing, individualized process of improving one's quality of life. (Chapter 4 has a full discussion about the pillars of recovery.)

Each person's journey will be unique and will not adhere to a strict schedule. Moreover, recovery should not be confused with "remission," the term DSM-5-TR uses to describe being free of SUD symptoms (except craving).[437] Just because someone stops using a substance does not mean they have also resolved the problems that contributed to, or arose because of, their substance use. Nor does it mean that they have achieved a quality of life acceptable to them.

Recovery Support Services

Most recovery services have developed fairly recently and some do not readily lend themselves to quantifiable measurement in the way that many formal SUD treatment services do. But research in this area is growing.

Recovery Housing

Recovery housing provides a safe, alcohol- and illicit drug–free living space for people in recovery from SUDs. The National Alliance for Recovery Residences recognizes four levels of recovery housing. Each provides a different level of structure and services. Residences may be peer-run, monitored by a house manager or senior resident, formally supervised, or operated by a clinical service provider.[438]

Living in recovery housing has been shown to reduce residents' substance use and likelihood of recurrence and increase their likelihood of being employed.[439] A 2022 study found that people in recovery housing stayed in outpatient treatment programs more than twice as long as people who weren't in recovery housing, and were twice as likely to have a satisfactory discharge from treatment.[440]

Most research to date has focused on peer-run residences.[441] Gaps still exist in fully understanding how the other levels of recovery housing affect recovery outcomes. Other research needs include understanding[442]:

- What types of people are most likely to benefit from living in recovery housing.
- How recovery housing environments influence the likelihood an individual will enter formal treatment.
- Which aspects of recovery residences (e.g., social support, linkages to mutual-help programs) have the greatest impact.

RCCs

RCCs are a growing part of the recovery ecosystem,[443] serving as social "recovery hubs" that provide social opportunities, recovery coaching, recurrence prevention skills, employment and job training linkages, and other resources. Participating in an RCC is associated with increased abstinence; lowered substance-related harms; and enhancements in recovery capital, psychological well-being, and quality of life.[444] However, RCCs are fairly new and have not yet been well studied from a systematic or longitudinal perspective.[445]

Suggested topics for further research on RCCs include[446]:

- Determining whether the increases in recovery capital are sustained over time, and whether RCC users' quality of life improves as a result.
- Identifying what barriers might prevent individuals from using RCCs.
- Exploring regional variations in RCC membership, service needs and use, and overall impact.

PSS

PSS are an expanding part of the SUD continuum of care with a growing evidence base.[447,448,449] A great deal of variation exists in the scope of peer services and in states' peer training and certification requirements. Future directions for research on peer services could include large-scale comparative studies on their overall effectiveness and their relative effectiveness in different settings.

Conclusion

This chapter has reviewed the evolving understanding and treatment of problematic substance use, discussed the principles and different pathways of recovery, and introduced some specific strategies of recovery-oriented counseling for clients with substance use–related problems. The chapter also looked back at the history of the modern recovery movement and forward to future recovery research. Finally, the chapter has emphasized that recovery-oriented counseling doesn't exist in a vacuum. Counselors working with people in recovery should be connected to peer specialists and others offering recovery-oriented services and supports, ideally through a ROSC.

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Chapter 2—Framework for Supporting Recovery With Counseling

KEY MESSAGES

- Recovery-oriented counseling calls for counselors to possess certain competencies to work with clients effectively and empathetically.
- Counselors need to take into account a range of sociocultural considerations when assessing and working with clients in or seeking recovery, which requires cultural responsiveness and an awareness of treatment barriers and inequities stemming from sociocultural factors.
- A strengths-based approach is fundamental to recovery-oriented counseling, beginning with client intake and continuing throughout the duration of care.
- Recurrence of substance use happens, but recovery-oriented counseling can help clients avoid it or confidently return to recovery when it does occur.
- Counselor participation in recovery-oriented systems of care can benefit clients by promoting holistic, coordinated, and nonepisodic services.
- Depending on the setting, counselors providing or thinking of providing recovery-oriented counseling may need to consider the ways that payment systems can affect delivery of care.

Regardless of setting and training, counselors working with clients who are in or considering recovery can provide support by helping them build their strengths, resiliencies, and resources. This approach emphasizes what is "right" or already working for clients regarding the strategies they use for coping and improving health and well-being. It emphasizes client resilience and functioning instead of client weakness and pathology.

This chapter lays the groundwork for Chapters 3 and 4 by discussing how counselors can work with clients to identify their natural supports, coping skills, talents, abilities, hopes, and dreams for the future. It provides a framework for recovery-oriented counseling by:

- Setting out competencies for counselors working with people in or considering recovery.
- Highlighting sociocultural considerations in recovery-oriented counseling.
- Discussing the elements of strengths-based counseling.
- Covering skills that are important for clients to develop in early recovery.
- Describing recovery management checkups and check-ins.

- Introducing an approach to promoting a healthy life for clients who are beyond early recovery.
- Discussing counselor responses to warning signs of a possible recurrence of use.
- Outlining some of the benefits that clients receive when counselors participate in recovery-oriented systems of care.

The chapter also looks at ways that payment systems can affect the delivery of care for counselors in healthcare and behavioral health service systems.

Exhibit ES.1 in the Executive Summary contains definitions of key terms that appear in this and other chapters.

Competencies for Recovery-Oriented Counseling

As Chapter 1 noted, counselors can provide recovery-oriented counseling in a wide range of settings. This diversity is a strength, given the need for supports for people seeking or in recovery. But to provide such clients with consistent, high-quality care, counselors need a common foundation of knowledge and skills.[450] The consensus panel identified the following competencies for working with individuals who have problematic substance use or who are in recovery.

- **Possess an understanding of substances, problematic substance use, and addiction treatment and recovery.** Counselors should:
  - Based on data, understand the substances most prevalent in clients' communities.
  - Understand concepts of problematic substance use and recovery, including factors that influence problematic substance use, who may work with individuals with problematic substance use, and recovery and recovery pathways. (Chapter 1 discusses these topics.)
  - Understand specific substance use disorders (SUDs), such as alcohol use disorder (AUD) and opioid use disorder (OUD).
  - Understand common measurements of substance use, such as standard drink sizes.
  - Know commonly used drugs and the street names for them.
  - Understand the symptoms of intoxication and withdrawal.
  - Recognize warning signs for recurrence.
  - Be familiar with common screening instruments for problematic substance use and mental health–related conditions that may co-occur with problematic substance use (e.g., Columbia Suicide Severity Rating Scale, AUDIT, PHQ, GAD, S2BI, CRAFFT, PCPTSD).
  - Understand the levels of care available for treating problematic substance use.
  - Have knowledge of Food and Drug Administration–approved medications used to treat problematic substance use.
  - Understand the principles of harm reduction and the tools used to minimize harm, such as opioid education and naloxone, fentanyl and xylazine test strip distribution, and syringe services programs.
  - Understand the impact of genetics and epigenetics on substance use.
  - Be familiar with problematic behavioral issues other than substance use, such as problematic gambling and sexual behaviors.

  Selected supporting resources:

  - Substance Abuse and Mental Health Services Administration (SAMHSA), Welcome to the Center for Behavioral Health Statistics and Quality (CBHSQ): https://www.samhsa.gov/data

  - SAMHSA, *Alcohol Use: Facts & Resources:* https://www.samhsa.gov/sites/default/files/alcohol_use_facts_and_resources_fact_sheet_2018_data.pdf
  - SAMHSA, Harm Reduction: https://www.samhsa.gov/find-help/harm-reduction
  - SAMHSA, Treatment Improvement Protocol (TIP) 42, *Substance Use Disorder Treatment for People With Co-Occurring Disorders,* Chapter 3 and Appendix B: https://store.samhsa.gov/product/tip-42-substance-use-treatment-persons-co-occurring-disorders/PEP20-02-01-004
  - SAMHSA, TIP 63, *Medications for Opioid Use Disorder:* https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002
  - State of Oklahoma, *ASAM Quick Reference:* https://oklahoma.gov/content/dam/ok/en/odmhsas/documents/a0003/asam-quick-reference.pdf
  - American Association for Community Psychiatry, *Level of Care Utilization System (LOCUS) Guide for Patients, Families, and Providers:* https://drive.google.com/file/d/1Xs3P_CABJZ_poYcf1t1cmdiD3vlZWCNt/view

- **Possess an understanding of mental health–related conditions.** Counselors should:

  - Be familiar with common co-occurring mental disorders.
  - Understand how problematic substance use may influence mental issues and suicidality.
  - Know the procedures for providing or accessing crisis services.
  - Know the procedures for the mandatory psychiatric evaluation process.
  - Have knowledge of local therapeutic resources available to clients.

  Selected supporting resources:

  - SAMHSA, TIP 42, *Substance Use Disorder Treatment for People With Co-Occurring Disorders:* https://store.samhsa.gov/product/tip-42-substance-use-treatment-persons-co-occurring-disorders/PEP20-02-01-004
  - SAMHSA, *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit:* https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

- **Have a general understanding of common co-occurring medical conditions, including:**

  - HIV.
  - Sexually transmitted infections.
  - Hepatitis A, B, and C viruses.
  - Bacterial and fungal infections, including infective endocarditis.
  - Alcohol-related liver disease.
  - Oral diseases, including tooth decay, gum disease, and dry mouth.
  - Skin manifestations of substance use (e.g., rashes, scars, dry skin, dental decay).[451]
  - Substance use–associated dementia.
  - Substance-induced mental disorders and psychoses (e.g., bipolar disorder, anxiety disorder).

Selected supporting resource:

- National Institute on Drug Abuse, *Common Comorbidities with Substance Use Disorders Research Report:* https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/introduction

- **Provide trauma-informed care.** Counselors should:
  - Ensure patients' emotional and physical safety.
  - Know the signs and symptoms of trauma.
  - Understand how chronic stress, adverse childhood experiences, and discrimination can contribute to trauma.
  - Understand the widespread impact of trauma and its relationship to substance use.
  - Understand reporting mechanisms for suspected violence or abuse.

  Selected supporting resource:

  - SAMHSA, TIP 57, *Trauma-Informed Care in Behavioral Health Services:* https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

- **Understand how to establish a therapeutic alliance.** Counselors should:
  - Know how to use motivational interviewing (MI) and motivational enhancement to promote engagement in recovery services.
  - Understand the importance of empathy, authenticity, warmth, and unconditional positive regard.
  - Use inclusive, nonstigmatizing language.
  - Maintain compassionate, consistent, respectful, and open communication.
  - Use reflection techniques to facilitate emotional awareness and insight.

  Selected supporting resource:

  - SAMHSA, TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment:* https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003

- **Identify and address health disparities.** Counselors should:
  - Understand structural competency and inequities that contribute to and perpetuate health disparities.
  - Understand race, gender, ethnicity, class, sexual orientation, gender identity, physical and mental disabilities, and other dimensions of individual and group identity.
  - Recognize and manage one's own bias, including implicit biases.
  - Present information in a culturally responsive way.
  - Understand bystander interventions for discrimination.

  Selected supporting resources:

  - Centers for Disease Control and Prevention (CDC), Social Determinants of Health at CDC: https://www.cdc.gov/socialdeterminants/about.html
  - SAMHSA, TIP 59, *Improving Cultural Competence:* https://store.samhsa.gov/product/TIP-59-Improving-Cultural-Competence/SMA15-4849
  - SAMHSA's Addiction Technology Transfer Center (ATTC) Network Southeast, *Improving African-American Retention In Substance Abuse Treatment: Implicit Racial Bias and Microaggression:* https://attcnetwork.org/sites/default/files/2019-12/SE%20ATTC%20Brochure%20IRB%26M_final.pdf

STRUCTURAL COMPETENCY

Structural competency is the ability to see and address clients' symptoms, attitudes, and conditions—not only as the product of social determinants, but also of the policies, governance, and systems (collectively, "structure") that create those determinants.[452,453,454] It also teaches providers to reframe their perceptions of clients who are receiving treatment and to see those individuals from a more holistic perspective.[455] Structural competency was developed for use with medical students but can also be applied to SUD treatment and recovery.

For example, a client may fail to receive needed services. Rather than judge the individual to be unreliable and lacking commitment to recovery, structural competency asks the counselor to reflect on factors that may have contributed to the situation. Social determinants of health, such as availability of transportation, may be a consideration. But so, too, may be a lack of case management, which may occur because providers cannot be reimbursed by insurance for time spent on those activities.

More information about structural competency and structural competency training is available at https://structuralcompetency.org/; the Structural Competency Working Group website can be accessed at https://www.structcomp.org/.

- **Understand how to assess social determinants of health (SDOH) with individual clients.** Counselors should:
  - Understand the conditions where people in the area live, learn, work, worship, and play.
  - Be familiar with relevant data available about the community served.
  - Assess clients for the impact of SDOH on their lives (The "Resource Alert: Tools for Assessing SDOH" lists helpful tools).

RESOURCE ALERT: TOOLS FOR ASSESSING SDOH

Tools to assess SDOH include the following:

- The P**rotocol for Responding to & Assessing Patients' Assets, Risks & Experiences** collects demographic information and information about a client's needs using items within the domains of money and resources, family and home, and social and emotional health.[456] The tool is available at https://prapare.org/.
- The **Health Leads Social Needs Screening Toolkit,** validated by the Centers for Medicare & Medicaid Services and CDC, includes tools to screen for social needs in various clinical settings.[457] The toolkit is available at https://healthleadsusa.org/communications-center/resources/the-health-leads-screening-toolkit/.
- The **HealthBegins Upstream Risks Screening Tool & Guide,** which is also appropriate for a variety of clinical settings, captures information about SDOH.[458] The screening tool is available at https://www.aamc.org/media/25736/download.

These and similar tools can help counselors better understand clients' SDOH to address those that are modifiable as needed. Other resources and tools related to SDOH are available at https://www.cdc.gov/socialdeterminants/tools/index.htm.

- **Use a strengths-based, person-centered approach.** Counselors should:
  - Provide services based on the client's most urgent needs (e.g., housing, food, child care).
  - Understand and work with the client's recovery capital (defined in the "Recovery Capital Assessment" section).
  - Provide individualized, age-appropriate services.
  - Understand individual preferences, needs, and values.
  - Engage in shared decision making.

Selected supporting resources:

- SAMHSA, Shared Decision-Making Tools: https://www.samhsa.gov/brss-tacs/recovery-support-tools/shared-decision-making
- SAMHSA, TIP 26, *Treating Substance Use Disorder in Older Adults:* https://store.samhsa.gov/product/treatment-improvement-protocol-tip-26-treating-substance-use-disorder-in-older-adults/PEP20-02-01-011
- SAMHSA, TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment:* https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003
- SAMHSA, TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women:* https://store.samhsa.gov/product/TIP-51-Substance-Abuse-Treatment-Addressing-the-Specific-Needs-of-Women/SMA15-4426
- SAMHSA, TIP 56, *Addressing the Specific Behavioral Health Needs of Men:* https://store.samhsa.gov/product/TIP-56-Addressing-the-Specific-Behavioral-Health-Needs-of-Men/SMA14-4736

- **Know how to link clients to treatment and community recovery resources and actively do so.** Counselors should:
  - Know the landscape of available recovery communities and services as well as mutual-help groups.
  - Know how to use 12-Step facilitation techniques to link clients to 12-Step groups as appropriate.
  - Understand when a client would benefit from a referral to another healthcare provider.
  - Be familiar with the required protocols of providers, facilities, and services.
  - Understand core principles of case management.
  - Help ensure continuity of care and integrated services.
  - Make warm handoffs when transferring clients to other providers or recovery communities.
  - Maintain communication with recovery resource partners (e.g., if a counselor links a client to peer support services, the counselor should be available to the peer provider for consultation and feedback on how the client is doing).

  Selected supporting resource:

  - SAMHSA, *Advisory,* Comprehensive Case Management for Substance Use Disorder Treatment: https://store.samhsa.gov/product/advisory-comprehensive-case-management-substance-use-disorder-treatment/pep20-02-02-013

- **Adhere to professional and ethical standards.** Counselors should:
  - Ensure client safety.
  - Understand and adhere to client confidentiality requirements.
  - Know how to establish and maintain appropriate boundaries.

  Selected supporting resources:

  - SAMHSA, Substance Abuse Confidentiality Regulations: https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs
  - SAMHSA, TIP 57, *Trauma-Informed Care in Behavioral Health Services:* https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

- **Engage in recovery advocacy.** Counselors should:
  - Become familiar with and advocate for needed recovery services and social services not available in the community.
  - Understand available state advocacy services.

  Selected supporting resource:

  - Faces & Voices of Recovery, Recovery Advocacy Movement: https://facesandvoicesofrecovery.org/?s=Recovery+Advocacy+Movement+

Sociocultural Considerations in Recovery-Oriented Counseling

Importance of Cultural Responsiveness

Each person embraces culture in a unique way, and considerable diversity exists within and across races, ethnicities, and cultural heritages.[459] Counselors should recognize these differences and incorporate culturally appropriate knowledge, understanding, and attitudes into culturally responsive communication and services to support clients.[460]

With culturally responsive approaches, clients are more likely to feel heard, empowered, and safe, which can translate into stronger engagement in treatment and recovery services. Research suggests that SUD treatment programs with a higher degree of cultural responsiveness are associated with improved access and longer retention among certain underrepresented populations. These practices may also improve minority client treatment engagement.[461] Cultural responsiveness decreases disparities in treatment and recovery services among people with problematic substance use.[462]

Culturally responsive services require counselors to develop an understanding of the cultures of the specific clients with whom they are working, including how these cultures tend to view problematic substance use and its treatment.[463] Becoming culturally responsive begins with a self-evaluation of personal biases, including how they may affect one's own ability to provide services. Counselors should then use this self-awareness to address their biases and provide inclusive care. This is an ongoing process that requires constant monitoring and learning.

RESOURCE ALERT: NATIONAL CLAS STANDARDS

The *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care* (https://thinkculturalhealth.hhs.gov/CLAS/) contain 15 action steps designed to promote health equity, improve quality, and help end healthcare disparities by providing a blueprint for individuals and healthcare organizations to implement CLAS.

Awareness of SUD Treatment Barriers and Inequities

Research indicates that such factors as race and ethnicity, gender and sexual orientation, disability, and community can affect the ability of someone to receive appropriate SUD treatment and other services.[464] Counselors should be sensitive to the needs of the special populations they are working with on recovery, and the plan of care may need to be adapted based on these needs. SAMHSA's publication *Adapting Evidence-Based Practices for Under-Resourced Populations* (https://www.samhsa.gov/resource/ebp/adapting-evidence-based-practices-under-resourced-populations) contains useful adaptation strategies; that publication's "Resources on Treating Particular Populations" section contains information on working with specific special populations—including individuals with co-occurring disorders and women—which is beyond the scope of this TIP. The following table lists some other relevant SAMHSA publications on special populations.

Population	Resource
American Indian and Alaska Native individuals	TIP 61, *Behavioral Health Services for American Indians and Alaska Natives* (https://store.samhsa.gov/product/TIP-61-Behavioral-Health-Services-For-American-Indians-and-Alaska-Natives/SMA18-5070)
Black/African American individuals	*The Opioid Crisis and the Black/African American Population: An Urgent Issue* (https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001)
Hispanic/Latino individuals	*The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue* (https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Hispanic-Latino-Population-An-Urgent-Issue/PEP20-05-02-002)
Individuals with HIV	*Advisory*, Treating Substance Use Disorders Among People With HIV (https://store.samhsa.gov/product/advisory-treating-substance-use-disorders-among-people-hiv/pep20-06-04-007)
Older adults	TIP 26, *Treating Substance Use Disorder in Older Adults* (https://store.samhsa.gov/product/treatment-improvement-protocol-tip-26-treating-substance-use-disorder-in-older-adults/PEP20-02-01-011)

Links to SAMHSA's Practitioner Training and Centers of Excellence for special populations can be found at https://www.samhsa.gov/practitioner-training.

Race and Ethnicity

The prevalence of problematic substance use and SUDs varies by race and ethnicity. Research has shown that although Black individuals have lower levels of SUDs during adolescence compared with Hispanic people and White people, after age 25, Black individuals have a higher prevalence of substance use and SUDs than other populations. After age 35, Black men have a higher prevalence of overall substance use. Black women over 35 also report a higher prevalence of heavy drinking compared with Hispanic or White individuals.[465] SAMHSA's 2021 National Survey on Drug Use and Health found that the percentage of individuals ages 12 or older with a past-year SUD was higher among American Indian and Alaska Native or multiracial individuals than among Black, White, Hispanic, or Asian individuals.[466]

Researchers have noted the relationship between historical trauma, discrimination, and problematic substance use among minorities, suggesting that systemic effects of racial and ethnic discrimination may result in increased rates of SUDs later in life for these populations.[467,468] In addition, minority populations are more affected by the consequences of SUDs "in terms of incarceration, health problems, stigma, and violence."[469]

The SUD treatment gap is significantly greater for Black and Hispanic adults than for White adults.[470] Minority populations also face more barriers to SUD treatment completion and satisfaction than White populations do.[471,472]

For example, in a small 2022 cross-sectional study of Black individuals seeking SUD treatment, more past experiences of racial discrimination in healthcare settings were connected to self-reported delay in seeking SUD care and anticipation of discrimination during SUD treatment.[473] A small qualitative 2018 study of Hispanic individuals meeting diagnostic criteria for a recent SUD found that major reasons for avoiding specialty SUD treatment included[474]:

- A lack of interest in abstinence as a recovery goal.
- Concerns that providers wouldn't treat problematic substance use effectively or in a culturally responsive way.

Findings indicate that bias is an ongoing concern for other minority groups as well, including Asian Americans and Native Americans, who report along with Black and Hispanic individuals that they still experience everyday forms of discrimination.[475]

Research also indicates that prescriptions for buprenorphine to treat OUD are concentrated among White individuals and people who self-pay or use private insurance for buprenorphine treatment. This disparity represents a significant inequity and barrier, given that buprenorphine treatment is effective and, unlike methadone, doesn't require regular in-person dispensing at a special clinic (opioid treatment program)[476,477,478] that may require greater travel than other dispensing sites.[479]

Gender and Sexual Orientation

Like race and ethnicity, gender and sexual orientation affect SUD treatment engagement. Research finds that women have less access to SUD treatment than men do.[480] Barriers thought to contribute to this disparity include childcare obligations, pregnancy, and greater financial limitations.[481,482] Women are also more likely than men to report concern about the effect of being in treatment on their reputation or job.[483]

Gender disparities in SUD treatment participation have long been noted in treatment for AUD, the most prevalent SUD, with a lower percentage of women receiving needed AUD care.[484] Findings from a study of patients at a large community health center in the Northeast suggest that one factor in this disparity in treatment participation may be that women who screen positive for AUD are less likely to receive a diagnosis of AUD compared with men who screen positive.[485]

Sexual and gender minorities are at elevated risk of problematic substance use compared with their heterosexual peers.[486] Research indicates that sexual minority adults have between 1.6 and 3.1 times the odds of lifetime SUDs compared with their heterosexual counterparts.[487]

Although sexual and gender minorities overall are more likely to seek out SUD treatment than their heterosexual peers, they face barriers in accessing quality treatment. These barriers include stigma and bias as well as lack of provider knowledge about specific needs.[488,489]

Only a limited number of programs are designed to serve LGBTQI+ populations. A 2020 national study looking at the availability of LGBT-specific services in mental health service and SUD treatment facilities found that fewer than one in five SUD treatment facilities reported programs specific to LGBT people.[490]

Rural Communities

People living in rural communities face distinct challenges related to problematic substance use and SUD treatment. Rural residents have fewer treatment options, including a relative lack of access to opioid treatment programs and buprenorphine treatment.[491] Compounding this issue, rural providers report feeling underprepared to deliver SUD treatment because of a lack of necessary supports and resources.[492] And rural residents are less likely than urban residents to be administered naloxone during an opioid overdose in the emergency department.[493] The decision by the Drug Enforcement Administration in June 2021 to allow opioid treatment programs to operate mobile units may help to create increased access to care in rural areas where distance and transportation may have otherwise been significant obstacles for someone seeking treatment.[494]

Rural residents can also face social and cultural barriers to receiving SUD treatment, including stigma around drug use and treatment seeking in general, concerns about treatment anonymity in small communities, a lack of treatment coordination and integration in rural settings,[495] and mistrust among some treatment seekers about the use of medications for SUDs.[496] Many people living in rural areas also face economic

barriers and have health insurance gaps that affect their ability to afford SUD treatment. Lack of broadband Internet has also been cited as a barrier to telehealth treatment options in rural areas,[497] although recent data suggest that significant progress has been made in increasing rural Internet access.[498]

The Health Resources & Services Administration's (HRSA) Federal Office of Rural Health Policy webpage (https://www.hrsa.gov/rural-health) provides and links to more information on problematic substance use in rural areas and federal and state responses to it. HRSA's Opioid Response webpage at https://www.hrsa.gov/rural-health/opioid-response contains substance use–related topics, as does the Rural Health Information Hub (https://www.ruralhealthinfo.org/topics).

Socioeconomic Status

A lower socioeconomic status increases a person's risk of SUDs and can affect treatment options. Socioeconomic disparities affect access and utilization of behavioral health services as well as substance use prevalence and patterns.[499] An analysis of national survey data showed that among people who reported ever using illicit substances, those with a lower income (family income less than $20,000) were 34 percent more likely to report having substance use–related problems compared with people in the highest income category.[500] Also, insurance coverage, specifically lack of insurance among men of color and low socioeconomic status, creates barriers to accessing treatment.[501]

Disability

People with disabilities are more likely to have problematic substance use than people without disabilities.[502,503] Yet people with disabilities are less likely to receive treatment,[504] in part because they can face a range of barriers to participating, including[505,506]:

- Lack of accessible programs.
- Lack of specialized programs for people with co-occurring conditions, including individualized treatment plans that account for diverse literacy or cognitive capabilities.
- Transportation issues.
- Difficulty accessing treatment locations.
- Stigma and stereotypes.
- Insufficient clinician training on providing services to clients with disabilities.
- Lack of access to affordable quality care.[507]

People With Chronic Medical Conditions

People living with certain medical conditions, including HIV, hepatitis C virus (HCV), or chronic pain are more likely to have difficulties in accessing and receiving SUD treatment. Provider stigma may be a contributor to these barriers to SUD treatment.[508,509] A study of people with HCV who inject drugs indicated that stigma negatively affected their ability to navigate and receive treatment.[510] Patients with chronic pain and SUDs also face barriers to treatment, including OUD medication, because of stigma.[511]

Lack of knowledge of appropriate referrals was another type of barrier to SUD treatment found by a qualitative study of HIV and SUD treatment providers' perspectives on treatment barriers to people living with both HIV and SUDs.[512] Some of the HIV treatment providers interviewed were unfamiliar with the different levels of SUD care and reported that they had never referred a patient to SUD treatment.

People With Intersecting Identities

Limited research has looked at the effects of intersecting identities on SUD treatment.[513] More is known about the associations between intersecting identities and substance use, information that is useful for counselors.

For example, a study of the links between intersectional stigma and specific behavioral health outcomes among Black, Hispanic, and multiracial gay and bisexual men found a

significant combined effect of gay rejection sensitivity (anxious expectation of rejection for being gay) and racial discrimination on heavy drinking, through emotional regulation difficulties and internalizing symptoms of depression and anxiety.[514] In another example, the authors of a study on disparities in heavy episodic drinking, cannabis use, and smoking found greater prevalence of such substance use among Black and Hispanic LGB women compared with White LGB women.[515]

Awareness of Stigma, Implicit Bias, and Discrimination

Stigma and Discrimination Among Healthcare Providers

Stigma, bias, and discrimination on the part of providers may play a key role in perpetuating healthcare disparities, including in the treatment of problematic substance use.[516] Healthcare providers may have biases against people with problematic substance use, which may affect the quality of care provided.[517]

Research on hospitalized patients who have SUDs has found that these individuals experience stigma and discrimination from clinicians and other hospital staff.[518] In a study of emergency department physicians' attitudes toward patients with SUDs, physicians reported a lower regard for patients with SUDs than patients with other conditions. In fact, 54 percent of physicians who participated in the study said they at least "somewhat agree" that they "prefer not to work with patients with substance use who have pain."[519]

Individuals who use illicit drugs while in a hospital can face an inconsistent and informal range of non-person-centered responses from individual providers, including use of security staff as responders to first instances of illicit use, increased monitoring, and administrative discharge. These responses do not take into account survey findings that some patients with illicit in-hospital use report that it stems from experiencing stigma and inadequately treated pain or withdrawal.[520,521,522] These findings highlight a need for more patient-centered, appropriate, and formalized institutional policies related to in-hospital patient drug use.[523,524,525]

Counselors and Implicit Bias

Implicit bias is a prejudice or bias outside one's conscious awareness that can lead to a negative evaluation of a person based on such characteristics as race or gender. Counselors need to identify any implicit biases they may have against people with problematic substance use or in recovery, as these biases can have a negative effect on care and client rapport.[526] If medication-assisted recovery is not part of the counselor's practice or their personal orientation regarding treatment, then the counselor should be conscious of any biases they may have toward individuals seeking or currently using medication for the treatment of SUD.

As one step in addressing any implicit bias they might have, counselors should take care with the language they use with and about clients who have problematic substance use. For example, counselors should[527]:

- **Use person-first language.** Someone actively using substances in a problematic way should not be referred to as a "substance abuser" or "addict," which can suggest that they, the person, are the problem. Instead, they can be referred to as a "person with problematic substance use," which indicates that they have a problem that can be addressed.
- **Not confuse substance use with SUD.** Counselors should refer to someone as having SUD only if they have received a clinical diagnosis.
- **Use neutral technical terms, rather than stigmatizing slang terms.** The classic example of this guidance is to refer to drug test results as "negative" or "positive," rather than "clean" or "dirty."

BYSTANDER INTERVENTIONS

An active bystander is a person who witnesses a situation, acknowledges the potential problem, and speaks up about it.[528]

Individuals can choose to be active bystanders when they encounter bias in a situation. The strategies below can help in situations where bias is observed. Counselors should approach these situations as opportunities to educate, rather than to criticize, by[529]:

- Using humor.
- Being literal or refusing to rely on the assumption being made.
- Asking questions that invite discussion.
- Stating that they are uncomfortable.
- Using direct communication.
- Reminding people of personal or institutional values, or both.

Strengths-Based Counseling

Strengths-based, person-centered counseling at its core involves[530,531]:

- Focusing on clients' resources, rather than their deficits.
- Working with clients on enhancing their lives, rather than simply helping them manage problems or illness.
- Respecting clients' perspectives on their goals and needs, rather than determining these priorities for clients.

Principles of Strengths-Based Counseling

No single, agreed-upon set of principles for strengths-based counseling exists. Several leading theorists of the strengths-based model have articulated principles relevant for counseling people recovering from problematic substance use. Two somewhat overlapping examples appear below.

Two prominent theorists, Charles A. Rapp and Richard J. Goscha, developed six basic principles for using the model in mental health services[532]:

- Principle #1: People can recover, reclaim, and transform their lives.
- Principle #2: The focus is on an individual's strengths, rather than deficits.
- Principle #3: The community is viewed as an oasis of resources.
- Principle #4: The client is the director of the helping process.
- Principle #5: The worker–client relationship is primary and essential.
- Principle #6: The primary setting for our work is in the community.

Rapp and Goscha noted that the principle of viewing the community as an oasis of resources (Principle #3) entails looking for the opportunities and strengths that exist in all communities, even those that lack resources or whose resources may not be obvious. By "primary and essential" in Principle #5, Rapp and Goscha meant that a strong and trusting relationship with the practitioner is needed to create the right environment for mobilizing a client's resources and goals for recovery.[533]

Dennis Saleebey, another prominent theorist of the strengths-based model, set out these six principles in 2012 for social work practice[534]:

- Principle #1: Every individual, group, family, and community has strengths.
- Principle #2: Trauma and abuse, illness and struggle may be injurious, but they may also be sources of challenge and opportunity.
- Principle #3: Assume that you do not know the upper limits of the capacity to grow and change and take individual, group, and community aspirations seriously.
- Principle #4: We best serve clients by collaborating with them.

- Principle #5: Every environment is full of resources.
- Principle #6: Caring, caretaking, and context.

Principle #6 underscores the importance of caring relationships as strengths, including the therapeutic relationship.[535]

Strengths-based counseling doesn't call for counselors or their clients in recovery to ignore reality. This approach is **NOT** about[536]:

- Assuming that clients already have all the resources they need to change.
- Focusing only on clients' strengths.[537]
- Encouraging clients in recovery to "just think positive."

A strengths-based, person-centered approach acknowledges and addresses clients' problems, but doesn't let these problems drive clients' or counselors' expectations for what clients can ultimately achieve in recovery.

Strengths-Based, Person-Centered Assessment

A collaborative strengths-based, person-centered assessment identifies clients' current coping skills and abilities; family, social, and recovery supports; motivation; and other sources of recovery capital (discussed in "Recovery Capital Assessment" below). Counselors should view strengths broadly to include people's values; interpersonal skills; talents; knowledge and resilience gained from previous efforts to overcome problematic substance use, stressful life events, or adversity (including trauma); spirituality and faith; personal hopes, dreams, and goals; family, friend, and community connections; cultural and family narratives of resilience; and general skills in daily living.

Strengths-Based, Person-Centered Intake Approaches

A strengths-based, person-centered approach to counseling recognizes that even the questions asked at intake, whether on a form or in person, can influence clients' perceptions of their situation and their interest in engaging with a counselor. For example, a 2014 randomized study found that marriage and family therapy clients completing a strengths-based intake form listed significantly fewer problems and proposed significantly more solutions than did clients completing a problem-focused form.[538]

Examples of strengths-based, person-centered intake questions include[539,540]:

- What do you do well?
- Tell me about a time when you felt like most things were going well. What were you doing to make them go well?
- How can I best help you?

Maslow's Hierarchy of Needs

The last question above reflects the fact that some clients will not regard addressing past or present problematic substance use as their top priority. Psychologist Abraham Maslow's Hierarchy of Needs, originally published in 1943 and now a staple of motivational theory, is based on his observation that people are motivated by unsatisfied needs and tend to want to fulfill basic needs—such as food, water, and shelter—before moving on to higher level needs. The five levels of Maslow's Hierarchy, often displayed as a pyramid, are, from basic to most complex[541,542]:

- **Physiological needs,** such as food, water, and air.
- **Security and safety needs,** such as financial security, housing, and health care.

- **Social needs,** such as love and healthy social relationships.
- **Esteem needs,** such as appreciation and respect.
- **Self-actualization needs,** or the process of fulfilling personal potential.

Although the process of recovery does not always reflect this kind of linear order,[543] the Hierarchy does effectively communicate that clients with substance use–related problems who have basic, pressing needs may be more focused on meeting those needs than on changing their substance use.[544] A strengths-based, person-centered approach should include consideration of a client's hierarchy of needs, while acknowledging that there is a complex relationship between the levels.[545] Clients may identify needs in various areas throughout their recovery, from managing withdrawal to establishing healthy social connections. Counselors should identify what needs matter most to clients by asking open-ended questions such as[546]:

- What are your most important needs right now?
- What areas of your life do you want to focus on to address these needs?

Chapter 4 contains an indepth discussion of resources that are available to individuals in recovery to help them meet their personal needs in areas such as health care, affordable housing (e.g., Housing First), nutrition, employment, and social connection.

Hopes and Dreams

Counselors can also ask clients to explore their hopes and dreams. Envisioning the future can help people look ahead in a positive way and identify their core values. This exploration can also help clients identify their recovery goals and recognize how risk behaviors may get in the way of reaching these goals. Some questions include:

- What are your hopes for the future?
- What would you like your life to look like in 5 years?
- What recovery goals fit with your vision of the future?

Values Exercises

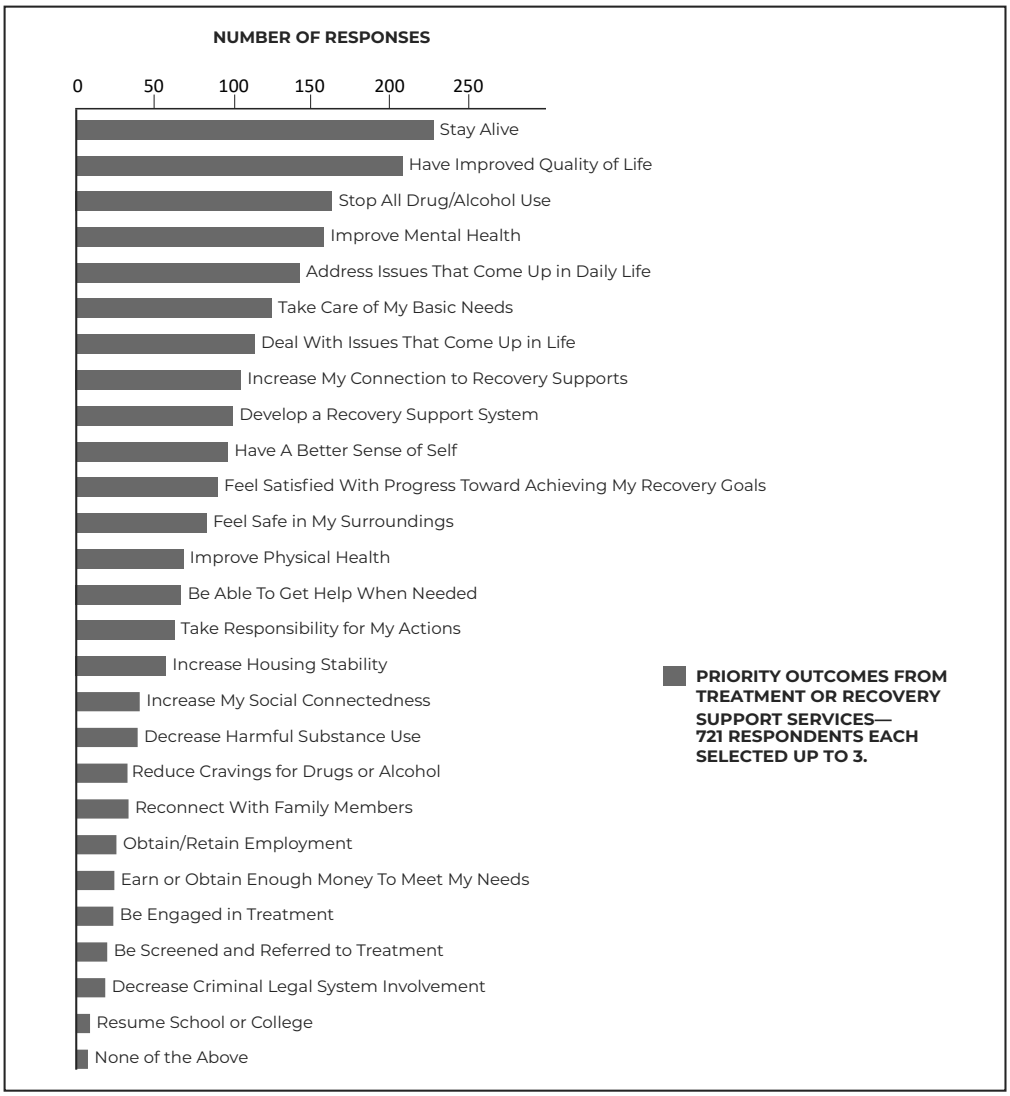
As part of a strengths-based, person-centered counseling approach, the consensus panel recommends conducting a values exercise with a client seeking or in recovery. Values can be thought of as the principles, qualities, and beliefs that are most important to an individual and that the individual most wants their life to reflect. The exercise of identifying values can help a client build motivation to enter or maintain recovery by making them more aware of how substance use conflicts with their values.[547,548] This sort of values work is a key part of Acceptance and Commitment Therapy (discussed in Chapter 3),[549] but also fits with other counseling approaches.[550]

One widely used instrument is the Bull's Eye Exercise,[551,552] available at https://webster.uaa.washington.edu/asp/website/site/assets/files/2367/values_exercise_bulls_eye.pdf. Another tool is the My Personal Values Worksheet (Exhibits 2.1 and 2.2). Having a client use values sort cards offers another way of conducting a values exercise.

PRIORITY OUTCOMES FOR RECIPIENTS OF SUD TREATMENT AND RECOVERY SUPPORT SERVICES

As part of a 2020 national survey on the relative importance of different SUD treatment and recovery support service outcomes, survey respondents with past or present substance use "challenges" (including SUDs) each chose up to three top outcomes from a list of options, without ranking their choices.[553] The chart below shows the full list of options by the number of responses received. Although the survey results aren't nationally representative, they do underscore that people with problematic substance use have diverse priorities for SUD treatment and recovery support service outcomes.[554] Notably, people with lived experience of problematic substance use contributed to and reviewed the survey design.

PRIORITY OUTCOMES RANKED HIGHEST TO LOWEST BASED ON NUMBER OF RESPONSES



Source: Adapted with permission.[555]

EXHIBIT 2.1. My Personal Values (Worksheet Part 1)

Deep down inside, what is important to you? What do you want your life to stand for?

Personal values are principles and beliefs we have about how we want to live our life and what kind of person we want to be. Values are directions we keep moving in. Values are an ongoing process. For example, if you want to be a loving, caring, supportive partner, that is a value—an ongoing process.

Use this diagram to help you look at your personal values. In each blank circle, fill in a value you hold. You do not have to use every circle, and you may add more circles as needed. **For help thinking about your values, take a look at the questions on the next page.**

Source: Reprinted with permission from PracticeMBRP.

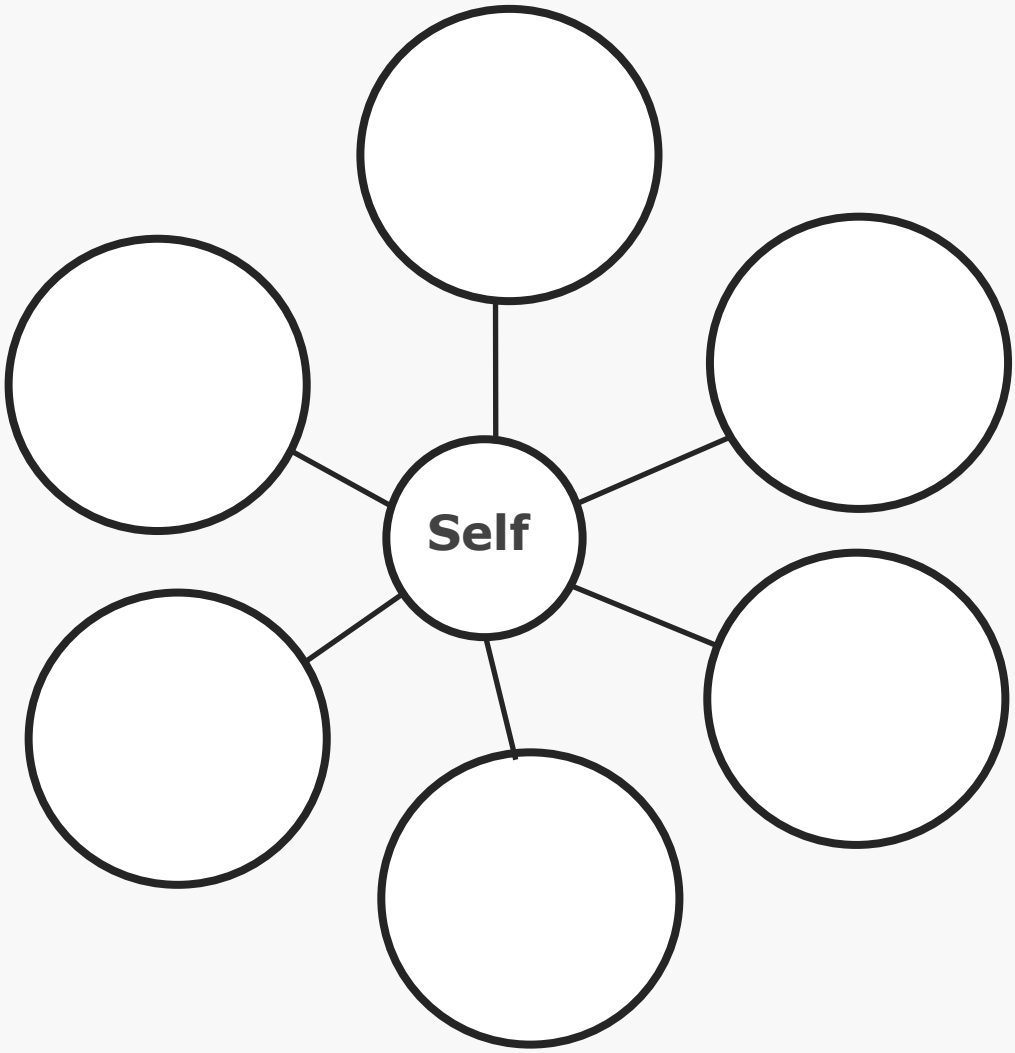


EXHIBIT 2.2. My Personal Values (Worksheet Part 2)

The following are areas of life that are valued by some people. Not everyone has the same values, and this is not a test to see whether you have the "correct" values. There may be certain areas that you don't value much; you may skip them if you wish.

Family. What sort of brother/sister, son/daughter, uncle/aunt, family member do you want to be? What personal qualities would you like to bring to those relationships? What sort of relationships would you like to build? How would you interact with others if you were the "ideal you" in these relationships?

Marriage/couples/intimate relations. What sort of partner would you like to be in an intimate relationship? What personal qualities would you like to develop? What sort of relationship would you like to build? How would you interact with your partner if you were the "ideal you" in this relationship?

Parenting. What sort of parent would you like to be? What sort of qualities would you like to have? What sort of relationships would you like to build with your children? How would you behave if you were the "ideal you" as a parent?

Friendships. What sort of qualities would you like to bring to your friendships? If you could be the best friend possible, how would you behave towards your friends? What friendships would you like to build?

Career/employment. What do you value in your work? What would make it more meaningful? What kind of worker would you like to be? If you were living up to your own ideal standards, what personal qualities would you like to bring to your work? What sort of work relations would you like to build?

Education/personal growth and development. What do you value about learning, education, training, or personal growth? What new skills would you like to learn? What knowledge would you like to gain? What further education/learning appeals to you? What sort of student would you like to be? What personal qualities would you like to apply?

Recreation/fun/leisure. What sorts of hobbies, sports, or leisure activities do you enjoy? How would you like to relax/unwind? How would you like to have fun? What sorts of activities would you like to do?

Spirituality. Spirituality means different things to everyone. It may be connecting with nature, or it may be participation in an organized religious group. What is important to you in this area of life?

Citizenship/environment/community life. How would you like to contribute to your community or environment (e.g., through volunteering, or recycling, or supporting a group/charity/cause/political party)? What sort of environments would you like to create at home, at work, in your community? What environments would you like to spend more time in?

Health. What are your values related to maintaining your physical well-being? How do you want to look after your health, with regard to sleep, diet, exercise, smoking, alcohol, etc.? Why is this important?

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Decisional Balancing To Address Ambivalence About Changing Problematic Use

Motivation is a critical element of behavior change[556] that can predict recovery from problematic substance use.[557,558] As part of strengths-based, person-centered counseling, counselors can use a strategy from MI called decisional balancing to learn what clients with active problematic substance use think they are getting out of such use and to help them find reasons to address it. MI is an evidence-based, person-centered counseling approach for helping people resolve ambivalence about changing behaviors. When clients observe that the costs of substance use outweigh the benefits, they may be motivated to reduce or stop it.[559]

Decisional balancing must be used carefully, as it may instead increase ambivalence among clients who are contemplating change. It is generally preferable to explore with clients what they get out of substance use before exploring possible reasons for change, as this allows the discussion to conclude with the arguments for change.[560,561] More on decisional balancing and related MI strategies can be found in Chapter 3 and SAMHSA's TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment*, at https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003.

Recovery Capital Assessment

"Recovery capital" refers to the quantity and quality of resources available to individuals to begin and maintain long-term recovery from problematic substance use. These resources may be internal (e.g., physical health, values, hope) or external (e.g., community and cultural support, employment), and they can increase.[562,563] The concept of recovery capital reflects the belief that everyone has strengths and resilience and that building on them is central to the recovery process. Having greater recovery capital is associated with positive outcomes, such as SUD treatment completion, attendance at follow-up appointments, and meeting one's recovery plan goals.[564,565]

As part of providing recovery-oriented counseling, counselors need to understand the concept of recovery capital and incorporate it into their practice by working with clients seeking recovery to help them identify, access, and build their own recovery capital. Recovery capital is usually divided into four categories.

- **Personal recovery capital** includes "physical recovery capital," such as food, access to transportation, and safe housing as well as "human recovery capital," such as values, knowledge, educational/job skills, problem-solving skills, internal motivation or commitment to recovery, and self-awareness.[566]
- **Family/social recovery capital** includes intimate relationships; biological family; family of choice; friends; and relationships at school, work, faith-based institutions, and community organizations that support individuals' recovery efforts.[567]
- **Community recovery capital** includes attitudes, policies, and resources in clients' communities that promote recovery from substance use–related problems through multiple pathways.
- **Cultural recovery capital** includes the availability of traditional and other culturally based pathways of recovery that help support clients from that culture. Cultural recovery capital also includes the values and beliefs associated with a culture that support recovery.[568]

Clients who have worked with peer specialists are likely to have already completed a recovery capital assessment at least once as part of receiving peer support services. Because recovery capital can change over time and no one universally accepted measure of it exists, including a recovery capital assessment as part of the overall assessment of clients with present or past problematic substance use can give counselors a better understanding of their recovery resources.

Some clients may find it challenging to identify their strengths or may say that they don't have any. Counselors can ask these clients how they have overcome adversity in the past, and how they have previously managed problematic substance use. Counselors can also reframe as potential strengths what these clients—and the counselors themselves—may think of as deficits. Some examples are in the following table.

Deficit	Reframed as a Strength
Client continues to spend time with friends who have problematic substance use.	Client desires connection with others.
Client's family is always in crisis.	Family has stayed together under stressful circumstances.
Client has a long history of problematic substance use, with multiple treatment episodes.	Client has continued to seek recovery support.

The consensus panel recommends asking clients to look at the skills they used to obtain substances and reframing those as strengths.

Assessing Recovery Capital

Several tools are available for assessing recovery capital. Clients can often complete assessments themselves. Some tools may be more appropriate for use in certain settings or with specific populations. Below is a description of several of these tools, including information about how to access them and limitations.

Substance Use Recovery Evaluator (SURE). SURE is a brief, easy-to-complete, validated assessment that can help clients monitor and reflect on their recovery journey or their treatment outcomes. SURE collects information on 21 items within these categories: substance use, material resources, outlook on life, self-care, and relationships.[569] A strength of the measure is that only 6 of the 21 items refer directly to the use of substances, highlighting how it is possible to be in recovery without focusing on abstinence.[570]

The SURE measure is not for use in settings such as residential rehabilitation or prisons. And because the tool was developed in Britain, the developers recommend substituting culturally appropriate terms as needed when it is used in other countries.[571]

More information about SURE can be found at https://www.kcl.ac.uk/research/sure-substance-use-recovery-evaluator.

Assessment of Recovery Capital (ARC). ARC is a 50-item self-report measure validated for predicting recovery. ARC assesses recovery strengths using 10 domains:[572]

- Substance use
- Psychological health
- Physical health
- Community involvement
- Social support
- Meaningful activities
- Housing and safety
- Risk taking
- Coping and life functioning
- Recovery experience

Counselors can use ARC to identify SUD treatment barriers or interventions to increase recovery capital. Rehabilitation professionals in SUD treatment programs also can use ARC to assess recovery capital, informing the development of treatment plans with a focus on recovery capital.[573]

Brief Assessment of Recovery Capital-10 (BARC-10). BARC-10 is a brief measure of recovery capital based on the ARC. The measure examines client responses to 10 items across all the original domains of ARC.[574]

This validated measure takes about a minute to complete and provides a single unified dimension of recovery capital. It is appropriate for use in diverse settings, such as recovery support service settings or health clinics.[575] More information is available in the BARC-10 information sheet developed for the Virginia Department of Behavioral Health & Developmental Services at https://static1.squarespace.com/static/5cd33914797f74080d793b95/t/60678b620d8b4e517e4ca0b8/1617398627765/BARC-10+Information+Sheet.pdf.

Strengths and Barriers Recovery Scale (SABRS). SABRS is an index of recovery capital based on the Life in Recovery survey. SABRS assesses five domains—work, finances, legal status, family and social relations, and citizenship—and includes retrospective information about strengths and barriers in active addiction and in recovery.[576]

More information on SABRS is available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7298842/.

Some Limitations of and Further Work on Recovery Capital Assessments

Although widely used, the ARC and BARC-10 tools assume abstinence is the recovery goal, which doesn't align with current recovery approaches recognizing multiple pathways, and these instruments may not be generalizable to diverse populations.[577,578]

Work is underway on a new assessment tool, the *Multidimensional Inventory of Recovery Capital* (MIRC). The items in the pilot measure were developed with feedback from service providers and people in recovery from problematic alcohol use, with significant participation by people identifying as LGBTQ+ and by people in recovery who are of color or low income. The participants in recovery also collectively reported using a variety of recovery pathways, and many reported having problems with other substances besides alcohol. The inventory can capture information about the effect on recovery outcomes of poverty, discrimination, and other disadvantages.[579] The inventory covers these domains:

- Human
- Financial
- Social
- Community and cultural

More information about MIRC is available at https://www.recoveryanswers.org/research-post/reflections-from-asking-recovering-individuals-about-how-best-measure-recovery-capital/.

Chapter 4 has recommendations on practices to help build recovery capital.

Unconditional Positive Regard

Providing clients with unconditional positive regard from the outset of counseling work with them is a key aspect of strengths-based, person-centered counseling, regardless of the therapeutic approach used. (Unconditional positive regard refers to caring about, accepting, and valuing someone regardless of what they do or say.[580]) A 2018 meta-analysis found a small but positive association between the provision of positive regard and improved clinical outcomes that support positive regard's status as a central element of the therapeutic relationship for clients generally.[581]

The authors of a 2019 study of emotional intelligence among addiction counselors noted that clients with substance use–related problems can face (and may pick up on) counselor frustration with the high rate of recurrence in the SUD treatment population. The authors emphasized the importance of providing clients in SUD treatment "with a nonjudgmental environment and an attitude of unconditional positive regard," saying, "This corrective experience can be especially therapeutic for these clients."[582]

The authors of the 2018 meta-analysis offered several reasons and recommendations for incorporating positive regard into clinical practice, including the following:[583]

- Consider that affirming clients can have many useful impacts, such as strengthening clients' engagement in therapy and sense of agency.
- Don't just feel good about clients, but express positive feelings toward them (within clinical boundaries) to support their sense of worth.
- Express regard in different ways, such as offering reassurance, creating positive narratives, and using positive body language.

- Be open, receptive, curious, and valuing of the client.[584]
- Let the client know that they are understood, known, and seen, which can help to release their potential for growth and reconfiguration.[585]

Cues for Health and Well-Being in Early Recovery

Traditional approaches to recovery have focused on identifying and reducing the impact of cues that can trigger substance use, and have suggested that individuals may return to such use when reintroduced to environments full of substance-related cues. More recent research suggests that another important element of recovery is identifying client-specific cues for healthy behaviors and positive thoughts. Such personalized "recovery cues" include images, objects, and sensory experiences that a client associates with recovery commitment and that produce positive cognitive–affective states.[586]

A recovery cue can be as simple as a pair of running shoes left by the door as a reminder to run. Other examples of visual recovery cues are:[587,588]

- An image of a nature scene that the client associates with serenity.
- Photos of loved ones.
- A photo of a sponsor.
- Supportive text messages that the counselor has sent to the client.

Examples of audio recovery cues are:[589]

- Meditations.
- Nature sounds.
- Music recordings.
- An audio clip of the client reading a gratitude list.

Counselors can help clients identify a collection of such cues.

Coping and Avoidance Skills for Clients in Early Recovery

During early recovery, clients need to develop coping and avoidance skills to reduce risk of recurrence to use.[590] Clients should determine which coping and avoidance skills work best for them.

Coping skills are helpful ways of thinking and acting that can manage impulses and cravings, reduce stress, and support problem-solving in early recovery.[591] Common strategies include:[592]

- Learning and practicing stress reduction techniques.
- Scheduling time for relaxation.
- Getting more sleep.
- Learning and applying problem-solving techniques.
- Identifying recreational activities.[593]
- Engaging in positive reframing.[594] Positive reframing occurs when a client considers an alternative positive meaning of or perspective on a situation.[595]
- Writing or journaling.[596,597]
- Using urge surfing techniques, or an approach to manage urges by observing the craving without overreacting to it.[598] (Chapter 3 has a description and guided exercises.)

Clients in early recovery will also want to avoid high-risk situations through avoidance strategies or skills, which can help them divert their attention from urges and identify alternative activities to engage in.[599] Common avoidance coping strategies include:

- Trying not to think about a problem.
- Distracting oneself with other activities.
- Avoiding people associated with past substance use.
- Altering travel routes to avoid triggering places.
- Removing drug paraphernalia from the home.[600]

Clients in early recovery may also need to be aware of coping mechanisms that can potentially become unhealthy, such as high or significantly increased caffeine or nicotine intake or binge eating. Chapter 3 provides more details about how counselors can help clients identify and develop positive coping and avoidance skills that fit into their treatment plan.

Self-Efficacy

Self-efficacy is commonly understood as a person's belief in their ability to take action to achieve a desired outcome.[601] In the context of substance use, a person with high self-efficacy has confidence in their ability to abstain or reduce such use in high-risk situations. An individual with low self-efficacy, on the other hand, is unsure of their ability to do so.[602] Research indicates that people in recovery with higher levels of self-efficacy have a greater likelihood of achieving their recovery goals.[603]

Enhancing a client's self-efficacy may be critical to fostering long-lasting behavior change and may help to sustain their recovery.[604] A first step can be using validated instruments to assess the client's self-efficacy. Several examples follow:

- The **Alcohol Abstinence Self-Efficacy Scale** measures self-efficacy related to problematic alcohol use. The scale assesses both temptation to drink as well as confidence to abstain from alcohol use in 20 situations, using a 5-point Likert-type scale.[605] The scale can be found in Appendix B of SAMHSA's TIP 35, Enhancing Motivation for Change in Substance Use Disorder Treatment, at https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003.
- The **Drug-Taking Confidence Questionnaire** assesses self-efficacy related to use of a particular substance. The 50-item, fee-based questionnaire measures how likely people are to resist urges in specific situations, using a 6-point Likert-type scale.[606,607]
- The **Drug Avoidance Self-Efficacy Scale (DASE)** measures self-efficacy for multiple substances. The scale includes 16 questions rated from 1 to 7 from "certainly yes" to "certainly no" in relation to how likely people are to avoid or resist the urge to use substances.[608] The DASE instrument can be found at https://adai.uw.edu/instruments/pdf/Drug_Avoidance_Self_Efficacy_Scale_438.pdf.

Chapter 3 discusses another useful tool: the Confidence Ruler.

After evaluating a client's self-efficacy, the counselor can help them improve their self-efficacy by identifying their natural coping skills, teaching them new ones, and helping them practice the use of these skills. These assessments can also help the counselor identify the unique and personally relevant high-risk situations in which the client feels a greater sense of confidence or lacks confidence.[609] Comparing situations in which a client has low and high confidence can help them recognize and apply helpful coping skills to low-confidence situations.

Importance of Substance-Free Activities in Recovery

Helping clients access low-cost, substance-free activities will support them on their recovery journey, in part by helping satisfy the needs that substance use filled. Research has highlighted the importance of engaging in substance-free activities as an alternative to use.[610,611,612,613] Substance use **increases** in the absence of substance-free alternatives.[614] Looking specifically at harmful alcohol use, research indicates that it's less likely to occur in conditions where substance-free alternatives are low cost and readily available.[615,616] As one study notes, people **recover** from problematic substance use when the availability of substance-free rewarding activities **increases**.[617]

Counselors should help clients in recovery discover new ways (or rediscover past ways) to engage in rewarding substance-free activities that are safe, enjoyable, accessible, affordable, and personally meaningful for them.[618] Care should be taken to avoid activities that the client associates with their substance use. Examples of substance-free activities include:[619,620]

- Praying or meditating.
- Attending religious services.
- Taking relaxing outdoor walks.
- Exercising.
- Doing low-cost home improvement activities.
- Crafting.
- Cleaning or decluttering one's personal space.
- Playing a musical instrument.
- Writing.

Socializing with friends and family members may also be a good option, as long as they do not have their own problematic substance use.[621] A client's ability to socialize can be affected by a variety of factors (e.g., a global pandemic that calls for social distancing, a client's physical limitations or lack of transportation), so flexibility in terms of what constitutes "social interaction" may be needed (e.g., interactive and digital socializing as opposed to in-person socializing).[622]

Counselors can also help clients structure their days to incorporate enjoyable activities and encourage healthy choices during a period when they would normally engage in problematic substance use. For example, counselors could encourage clients to go for an outdoor walk or attend an exercise class in the evenings, if this is a time when problematic substance use would normally occur. Even small changes in the timing of activities may help deter problematic substance use[623] and promote wellness.

Approach to Promoting a Healthy Life for Clients Beyond Early Recovery

This TIP takes the perspective that recovery extends beyond resolving problematic substance use to encompass living a healthy life. Counselors should help clients gain or further develop the resources, skills, and confidence to advance and even thrive in the four dimensions outlined below:[624,625]

- **Health.** Maintaining good health by overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way
- **Home.** Building a stable and safe place to live
- **Purpose.** Identifying meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors
- **Community.** Developing relationships and social networks that provide support, friendship, love, and hope

Chapter 4 discusses ways to encourage clients to work on these four domains so they can become more independent, build on their strengths, and enter into the life they want.[626]

Recovery Management Check-Ins and Checkups

Telephone check-ins and recovery management checkups (RMCs) are effective, proactive strategies for counselors to stay apprised of clients' recovery status and intervene early in actual recurrence of use.

Telephone check-ins involve regular telephone calls with clients in recovery to ask how things are going. Such check-ins typically take place frequently during early recovery or at other times when need for frequent contact is high; they become less frequent as an individual's recovery strengthens.[627,628] To be recovery-oriented, such check-ins should include a focus on clients' development and application of their strengths and avoid being overly directive.[629,630] Peer specialists often use telephone or text check-ins as part of their work with individuals in recovery.[631]

RMCs are modeled after methods for providing long-term management of chronic medical conditions like diabetes and heart disease. RMCs involve post–SUD treatment in person or with telephone interviews to determine whether individuals need to reengage in treatment. The intervention provides the individual with tailored feedback on their recovery and, if return to treatment is needed, incorporates MI, problem-solving techniques, and assertive linkage. Major studies on implementing this intervention used quarterly checkups.[632]

Approach to Recurrence and Its Warning Signs

Counselors should be supportive of clients, regardless of whether they experience recurrence.[633] Shaming clients or withholding counseling after a recurrence will only limit clients' progress toward their long-term goals. Instead, counselors have an opportunity to help clients put a recurrence in perspective and reinforce that a recurrence does not mean they can't achieve recovery. Nor does it mean that the client is back at square one. Many people who have experienced recurrence one or more times go on to maintain long-term recovery.[634]

Using a person-centered, strengths-based approach and unconditional positive regard, counselors should affirm clients' efforts to continue in recovery and encourage them to reflect on their goals and how the recurrence could be an opportunity to gain greater insight and adjust their action plan. Clients who have a recurrence should hear from their counselors that they are not alone, because the counselors can offer continuous support while they navigate a path back to recovery.

When clients who take medication to support their recovery have a recurrence, a recovery-oriented approach views this event not as a reason for automatic discharge, but as a sign that dosage and other aspects of the treatment plan may need adjusting.[635,636] Individuals taking medication for OUD are at especially high risk for overdose and death should their medication be discontinued. Counselors should refer to their facility policies for guidance in these situations.

As discussed in Chapter 1, recurrence, like recovery, is not an event but a process.[637] Counselors and their clients can look out for warning signs that a recurrence may occur within months or weeks and take steps to avert it.[638] Stressful life events such as divorce and legal troubles are also associated with recurrence.[639]

THE ABSTINENCE VIOLATION EFFECT

The abstinence violation effect (AVE) is a construct for explaining why some people who use a substance again after a period of abstinence experience more serious recurrence of use. People susceptible to AVE are theorized to engage in all-or-nothing thinking in which they interpret any use as total failure and not as a temporary setback. According to the theory, the internal conflict over this disconnect between their behavior and values and the associated feelings of guilt, shame, and hopelessness increase the risk of severe and continued recurrence.[640,641,642] More information on AVE is in "Dealing With the Abstinence Violation Effect" in Chapter 3.

Counselor Responses to Warning Signs of a Recurrence

Awareness of common triggers and warning signs of a recurrence will help counselors proactively address them with a client if they arise. To respond to warning signs, counselors should:

- Talk to the client about outcome expectancies and urges.
- Identify triggers for recurrence to use.
- Assess the client's confidence in high-risk situations.
- Evaluate the client's motivation to continue with a treatment or recovery plan.
- Consider working with the client and any providers involved in developing the client's treatment or recovery plan (such as a peer specialist) to incorporate approaches for avoiding a recurrence, or provide additional services, as needed.

Talking to the Client About Outcome Expectancies and Urges

Outcome expectancies are anticipated consequences, positive or negative, that result from engaging in substance use.[643,644] Research indicates that a recurrence to problematic substance use can result when outcome expectancies are too positive or are not addressed.[645] Higher levels of positive outcome expectancies combined with higher levels of negative urgency (behaving impulsively when in a negative mood[646]) may increase the risk of a recurrence to use.[647]

Counselors can work with clients to identify the outcome expectancies (both positive and negative) for substance use. Counselors can also help clients identify goals and objectives that will help them avoid a recurrence.

Suggested steps to support a client in recognizing and addressing outcome expectancies include:[648]

- Listing the outcome expectancies for the substance use and resolved behavior (e.g., reduced use of substances).
- Discussing the reality of each expectation.
- Asking about the benefits of changing behavior (e.g., better quality of life).
- Asking the client to identify reasons to stop the behavior.
- Working with the client to develop specific goals and objectives.

Clients are more likely to adhere to a treatment or recovery plan if they think it will bring desirable outcomes that outweigh the benefits of engaging or reengaging in problematic substance use.[649]

RESOURCE ALERT: ADVANCE WARNING OF RELAPSE QUESTIONNAIRE

The Advance WArning of RElapse (AWARE) questionnaire assesses the potential for a recurrence to problematic alcohol use based on certain warning signs. The self-reported questionnaire includes 28 items scored on a 7-point Likert scale.[650] The higher the score, the higher the probability that the individual will recur to problematic alcohol use within the next 2 months.[651]

Although the scale was originally designed to identify problematic alcohol use specifically, research has shown that it can be modified to identify the risk of substance use recurrence more generally.[652] Counselors should also discuss results of the questionnaire with clients in a nonjudgmental manner that offers neutral feedback about potential risk for a recurrence to use.

The AWARE questionnaire can be accessed at https://casaa.unm.edu/inst/Aware.pdf.

Identifying Triggers for Recurrence to Use

Counselors should also help clients identify their triggers for problematic substance use based on what they experienced in the past. Help them identify the following:[653]

- High-risk situations (i.e., who, where, when)
- External triggers (e.g., smells, sounds)
- Internal triggers (e.g., thoughts, feelings, physical cravings)

Once a client identifies these triggers, the counselor's role is to help them develop coping strategies that worked in the past and that might work again.[654] To do this, the counselor should:

- Ask the client about strategies they could use now to avoid high-risk situations or external triggers as well as ways to manage internal triggers without engaging in problematic substance use.
- Ask the client to describe additional coping strategies.
- Evaluate the client's confidence in applying these coping strategies.

HUNGRY, ANGRY, LONELY, TIRED

The acronym HALT (Hungry, Angry, Lonely, Tired), from Alcoholics Anonymous®, offers a useful tool to give clients to help them remember to address important needs early on:[655]

- Don't get too **H**ungry can include an awareness—not only of avoiding being too hungry, but also focusing on healthy eating.
- Don't get too **A**ngry is a reminder to understand the causes of your anger and find healthy ways to feel and express that anger.
- Don't get too **L**onely is a reminder to connect with safe people, engage in social and recreational activities with others, and attend recovery support groups.
- Don't get too **T**ired is a reminder to get enough sleep and rest when fatigued.

Invite clients to say "HALT" to themselves when feeling stressed and then take appropriate action before the impulse to use or reengage in risk behaviors becomes overwhelming.[656]

Assessing the Client's Feelings of Confidence in High-Risk Situations

The Brief Situational Confidence Questionnaire (BSCQ) is a tool that can help assess clients' level of confidence in how well they would cope in common high-risk situations. The BSCQ is an eight-question measure that asks people to rate how confident they are in their ability at that moment to resist the urge to drink heavily or use drugs in eight situations. The questionnaire's scale ranges from 0 percent to 100 percent, with 0 percent indicating not at all confident and 100 percent indicating totally confident.[657]

The BSCQ form is available at https://www.nova.edu/gsc/forms/appendix_d_brief_situational_confidence_questionnaire.pdf. The instructions are available at https://www.nova.edu/gsc/forms/BSCQ%20Instructions.pdf.

Using a tool like the BSCQ can help clients better understand their confidence level in high-risk situations, which can be useful in setting realistic goals and developing individualized coping strategies.[658]

Assessing the Client's Motivation To Continue With a Treatment or Recovery Plan

Motivation is fluid, changing over time and by situation. As discussed above, motivation to change can increase when reasons for change and specific goals become clear.[659] Motivation can decrease when a person feels doubt or ambivalence about change.

Motivation to change includes another construct: "commitment to change." A commitment to change implies the presence of a stronger desire that may help someone maintain recovery in the face of adverse circumstances. By assessing a client's commitment to change, a counselor can evaluate the client's motivation to continue with treatment or recovery.[660]

Several tools exist to assess commitment to change, including the following:

- **Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES):** SOCRATES measures readiness to change and motivation to continue with treatment or recovery. The SOCRATES 8A is for alcohol use, and the SOCRATES 8D is for other substance use. The SOCRATES uses a 5-point scale ranging from 5 (strongly agree) to 1 (strongly disagree) and can assess recognition of the problem, ambivalence, and efforts to take steps. Changes in scores over time can help clients understand the impact of an intervention on problem recognition, ambivalence, and progress toward goals.[661]
- **Commitment to Sobriety Scale:** This 5-item measure assesses level of commitment to recovery from problematic substance use. The scale rates agreement with statements concerning substance use (e.g., "I will do whatever it takes to recover from my addiction" and "I never want to return to alcohol/drug use again"). It includes a 6-point scale ranging from strongly disagree (1) to strongly agree (6).[662] Use this tool with clients who have abstinence as their recovery goal.
- **Addiction Treatment Attitudes Questionnaire:** This measure assesses attitudes toward treatment and recovery. The questionnaire includes questions about commitment to lifelong abstinence (e.g., "I should never have another drink/drug" or "I believe I should never use alcohol or any mood-altering chemicals again"). Respondents rate their agreement with each statement, from 1 (strongly disagree) to 5 (strongly agree). Higher scores indicate more positive attitudes toward treatment.[663] This tool is appropriate for use with clients who have abstinence as their recovery goal.

Through these tools, a counselor can explore a client's internal and external reasons for entering and staying in treatment and recovery.

Reassessing the Client's Treatment Plan or Recovery Plan and Support Services

When a client experiences a recurrence, it may be time to bolster or update their treatment or recovery plan and goals and reevaluate their need for other support services. Through an examination of triggers, coping strategies, warning signs, and motivation, the counselor and the client can explore revising the plan. Updates may include additional strategies for managing thoughts, urges, and impulses related to problematic use.[664] Other revisions may include starting or increasing attendance at mutual-help meetings, participating in more recreational activities, and initiating or expanding delivery of peer support services.

A recurrence can lower a client's motivation and confidence about continuing their recovery journey. The client may also need

support and guidance about ways to manage the negative thoughts and feelings caused by the recurrence itself. The counselor's role is to remind the client of their previous progress and to support them in moving forward through a recommitment to their recovery.[665]

Ways That Payment Systems Can Affect the Delivery of Care

SAMHSA recognizes that counselors in healthcare and behavioral health services must work within the realities and constraints of the payment systems that reimburse or fund their services. Variations in insurance plans and reimbursement rates and limitations on certain services can potentially act as barriers to receiving payment or make the payment process labor intensive and difficult, affecting the delivery of care. Being aware of these potential roadblocks can help providers who want to implement or increase recovery-oriented services plan and deliver care that not only meets the needs of the client but also can be reliably funded or paid for.

The literature on SUDs and payment processes identifies a variety of issues that providers should consider when planning services. These include:

- **Types of treatment covered.** Significant variation exists from one state to another and even within states regarding which services are covered by private insurance or such federal resources as Medicaid and Medicare, and which services are partially or entirely out-of-pocket costs for the client. For example, such core services as medically supervised withdrawal and residential or intensive outpatient treatment as well as some types of medication, may not be eligible for coverage.[666]
- **"Medical necessity."** Certain states will not cover services that are not considered to be a "medical necessity." For example, some states do not consider opioid withdrawal to be life threatening; therefore, treatment for opioid withdrawal is not covered under Medicaid in those states.[667] Providers need to be aware of "medical necessity" criteria in their state or locality, or under the terms of the client's insurance provider.
- **Reimbursement rates and limits.** Services may be reimbursed at varying rates, even within the same state. In addition, some insurance providers limit the number of certain kinds of treatment sessions or screenings a client can receive,[668] potentially denying that client the duration of treatment they truly need. This issue can be further complicated by insurance providers that reimburse services based on the number of "events" (e.g., face-to-face meetings), rather than on a value-based approach that rewards sustained positive outcomes.[669]
- **Service silos.** SUD treatment has historically been delivered separately from medical and psychiatric services, which can potentially disincentivize the collaborative approach and effective case management that are necessary to meet all the needs of individuals in recovery.[670,671]
- **Fee schedules.** Certain fee schedules make it difficult or impossible to be reimbursed for needed services. For instance, if an individual sees a primary care provider and an addiction specialist on the same day, both providers may not be able to obtain reimbursement.[672] This may discourage, or even disincentivize, the use of integrated and multisystem care, which is fundamental to effective recovery-oriented services.
- **Prior authorization.** Some insurance providers and health plans require patients to obtain approval for certain types of care or medications prior to receiving them. Services and medications for the treatment of SUD have been subject to this requirement more frequently than other kinds of services, although some states are passing laws to change this.[673] If a client's

insurance plan requires prior authorization, it may delay their ability to begin taking medication needed to treat OUD or AUD.

- **Lack of insurance.** Individuals seeking treatment for problematic substance use—particularly those who are also involved with the criminal justice system—are more likely than other populations to be uninsured.[674,675]

To ensure adequate and appropriate delivery of care, providers need to be willing to work with their colleagues, supervisors, and resources in the community to find creative solutions to these issues. These may include:

- **Accessing federal grant funding.** Although the process of securing and implementing these resources can be lengthy, and the finite funding periods may limit the ability to plan long term,[676] federal dollars remain a significant source of support for substance use treatment and recovery services. Funding opportunities can be located through the federal grants portal (https://www.grants.gov/), the Department of Health and Human Services' grants webpage (https://www.grants.gov/web/grants/learn-grants/grant-making-agencies/department-of-health-and-human-services.html), SAMHSA (https://www.samhsa.gov/grants), HRSA, (https://bhw.hrsa.gov/funding/apply-grant#behavioral-mental-health), the National Institutes of Health (https://www.nih.gov/grants-funding), and CDC (https://www.cdc.gov/grants/).
- **Collecting program-level data to support funding applications.** A 2021 article in a National Academy of Medicine periodical identified the importance of formalized and thorough data collection at the program level, as this can be key to securing funding on an ongoing basis.[677]
- E**ducating criminal justice–involved clients about Medicaid requirements.** Data from 2017 indicates that one in three referrals to SUD treatment come from the criminal justice system.[678] Individuals who are incarcerated are not eligible for Medicaid reimbursements for addiction services during incarceration; however, they can apply for restored eligibility while still incarcerated. This may speed up their ability to receive services after release.[679]
- **Increasing collaboration between, and the integration of, systems of care.** Providers can consistently advocate for systemic change that increases collaboration, improves coordination of care, and facilitates fuller case management. The Surgeon General's report on addiction notes that closer integration of SUD treatment services with mainstream healthcare systems can help address health disparities, reduce healthcare costs, and improve general health outcomes.[680]
- **Promoting awareness of the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act (MHPAEA).** This legislation,[681] signed into law in 2008, mandates that mental and substance use disorder treatment benefits under group and individual health insurance plans be comparable to medical benefits in terms of financial requirements and treatment limitations. The 2010 Patient Protection and Affordable Care Act expanded the reach of MHPAEA. Counselors and administrators can look for ways that this legislation can support enhanced program services.

Recovery-Oriented Systems of Care and Strengths-Based Counseling

Ideally, counseling for people in recovery takes place in the context of a recovery-oriented system of care (ROSC). **The consensus panel emphasizes that the ROSC concept applies across settings (e.g., behavioral health, primary care,**

criminal justice, social services) and across the recovery continuum. The benefits of participating in a ROSC can include:[682,683,684,685]

- Opportunities to have better coordination with clients' other providers, thereby promoting continuing, holistic care.
- Collaboration with other providers from multiple disciplines who have a recovery-oriented approach to care.
- Connections to other services and supports for clients in recovery, such as housing resources and child care.

Although no centralized listing of ROSCs exists, member centers of SAMHSA's ATTC Network share information on ROSCs and, in some cases, provide technical assistance with establishing them. (ATTC contact information is at https://attcnetwork.org/centers/selection.) If no ROSC exists in a given area, a counselor can partner with like-minded providers and organizations to work toward developing one. Chapter 5 provides more information.

Conclusion

The competencies, strategies, and resources discussed in this chapter apply to recovery-oriented counseling, regardless of the setting or the particular counseling approach used in work with individuals considering or in recovery. Chapters 3 and 4 further discuss how to incorporate the concepts in this chapter into practice. Ideally, counseling is provided in the context of a ROSC that supports people before, during, and after SUD treatment, and, in some cases, even instead of treatment.