Published in final edited form as:

J Subst Abuse Treat. 2009 December ; 37(4): 412–420. doi:10.1016/j.jsat.2009.04.006.

Developing an Integrated Treatment for Substance Use and Depression Using Cognitive Behavioral Therapy

Karen Chan Osilla, Ph.D.^a, Kimberly A. Hepner, Ph.D.^a, Ricardo F. Muñoz, Ph.D.^b, Stephanie Woo, Ph.D.^c, and Katherine Watkins, M.D., M.S.H.S.^a

^aRAND Corporation, 1776 Main Street, PO Box 2138, Santa Monica, CA 90407-2138

^bUniversity of California, San Francisco/San Francisco General Hospital, 1001 Potrero Avenue, Suite 7M, San Francisco, CA 94110, USA

^cPepperdine University Graduate School of Education & Psychology, 24255 Pacific Coast Highway, Malibu, CA 90263-4608, USA Received 3 April 2009; accepted 28 April 2009. Available online 21 June 2009.

Abstract

Providing a unified treatment approach to meet the substance abuse and mental health needs of clients is the preferred model for addressing co-occurring disorders. Using a Cognitive Behavioral Therapy (CBT) approach, we developed a group-based integrated treatment for depression and substance use disorders (SUD) that could be delivered by counselors in SUD treatment settings, and evaluated its feasibility and acceptability. We conducted an in-depth case study examining one implementation of the treatment using 15 focus groups with clients (N=7) and semi-structured interviews with counselors (N=2) and administrators (N=3). Using CBT as a treatment approach was widely accepted by clients, counselors and administrators. Clients stated the treatment was applicable to multiple aspects of their lives and allowed them to recognize their clinical improvements over time. Counselors and administrators discussed challenges for long-term feasibility. Key decisions used to develop the treatment and recommendations for implementing integrated care in SUD settings are discussed.

Keywords

Integrated treatment; dual diagnosis; depression; substance-related disorders; consumer attitudes

1. Introduction

Individuals with substance use disorders (SUD) are two to four times more likely to have major depression than in the general population (Gilman & Abraham, 2001; Grant et al., 2004; Hasin, Goodwin, Stinson, & Grant, 2005; Kessler et al., 1994) and often experience greater impairment than individuals with either disorder alone. Compared to patients with depression, alcoholism, or drug dependence alone, those with co-occurring disorders (COD) experience greater risk of more serious substance use (Conway, Compton, Stinson, & Grant, 2006) and higher rates of both attempted and completed suicide (Aharonovich, Liu, Nunes, & Hasin, 2002; Cornelius et al., 1995; Kingree, Thompson, & Kaslow, 1999; Lynskey et al., 2004; Sher et al., 2007). Among those who seek treatment, individuals with COD also experience poorer

mental health and SUD treatment outcomes (Bagby, Ryder, & Cristi, 2002; Brown et al., 1998; Hasin et al., 2002; Melartin et al., 2004; Watkins, Paddock, Zhang, & Wells, 2006) and higher treatment costs than persons who have only one disorder (Dickey & Azeni, 1996; Hoff & Rosenheck, 1998).

Providing a unified treatment approach to meet the substance abuse, mental health and related needs of clients is the preferred model for addressing COD (American Association of Community Psychiatrists, 2000; Minkoff, 2001). In SUD settings, however, providers have limited resources for providing evidence-based mental health treatment, and individuals with COD have few opportunities to access mental health services. Historically, mental health and substance abuse treatment models have little overlap, which may partially explain the lack of available integrated care programs (Ducharme, Knudsen, & Roman, 2006; Friedmann, Alexander, & D'Aunno, 1999; Friedmann, Alexander, Jin, & D'Aunno, 1999; Gil-Rivas & Grella, 2005; Mojtabai, 2004; Olmstead & Sindelar, 2004; Watkins, Burnam, Kung, & Paddock, 2001). Mental health models typically emphasize individual therapy or case management, whereas SUD treatment models emphasize group treatment and peer support (Grella, Gil-Rivas, & Cooper, 2004; Timko, Lesar, Calvi, & Moos, 2003). Characteristics of patients also tend to be different; patients in mental health settings tend to have more severe psychiatric problems than patients in SUD treatment (Primm et al., 2000; Timko et al., 2003). In order to help the SUD treatment system address co-morbid depression, we developed a group-based integrated treatment (or integrated CBT) for depression and SUD using a CBT approach that could be delivered by substance use counselors in SUD treatment settings and evaluated its feasibility and acceptability to clients, counselors, and SUD clinic administrators.

While research indicates the effectiveness of integrated treatment for the severely mentally ill with substance abuse problems (Drake, Mueser, Brunette, & McHugo, 2004), few studies have investigated the effectiveness of integrated treatment approaches for clients with SUD and affective or anxiety disorders who typically present to SUD settings (Primm et al., 2000; Sacks, 2000; Tiet & Mausbach, 2007; Watkins et al., 2004). The development and evaluation of integrated services for the SUD treatment setting has been complicated by the wide range of approaches used to achieve integration, ranging from an individual clinician who provides both mental health and SUD treatment, to a team of clinicians working together to provide appropriately coordinated services, or when multiple agencies join together to create a program to serve a specific population (Mueser, Noordsy, Drake, & Fox, 2003). It is unknown which approach improves individual-level outcomes the most or is the most cost-effective to deliver, and whether it is acceptable and feasible for substance use providers to deliver evidence-based mental health treatment within the SUD treatment system.

Cognitive behavioral therapy (CBT) extends cognitive therapy through the use of behavioral techniques (Beck, 2005). Cognitive therapy is based on the cognitive model, which suggests, "distorted or dysfunctional thinking (which influences the patient's mood and behavior) is common to all psychological disturbance" (Beck, 1995, p. 1). The cognitive model is a theoretical approach common across treatments for depression and substance use. The cognitive model for depression suggests that depressed mood is determined by dysfunctional beliefs and thinking (Beck, Rush, Shaw, & Emery, 1979; Beck, 1995). Similarly, the cognitive model for substance use states that substance abuse is also perpetuated by maladaptive thoughts and beliefs (Beck, Wright, Newman, & Liese, 1993). Because of these similarities, CBT may be an ideal approach to identify and modify harmful thinking and behaviors that trigger depressed mood and substance use in a single treatment.

The lack of a unifying treatment approach to join the mental health and SUD treatment fields has been a barrier to integration within the SUD treatment setting. Thus, it would be helpful to articulate a treatment approach that could be used to combine treatment for both disorders.

CBT has been used to effectively treat depression and SUDs as independent disorders. CBT prevents and reduces depressive symptoms in populations at high risk for major depression (Lewinsohn, Clarke, & Hoberman, 1989; Munoz & Ying, 1993), including individuals with minor depressive symptoms (Lewinsohn et al., 1989; Munoz et al., 1995). CBT has also been shown to reduce SUD consumption and related consequences (Carroll et al., 2008; Center for Substance Abuse Treatment, 1999; Longabaugh & Morgenstern, 1999; Project MATCH Research Group, 1997; Witkiewitz & Marlatt, 2004) and improve alcohol and mood outcomes in dual diagnosis populations (Brown, Evans, Miller, Burgess, & Mueller, 1997; Brown & Ramsey, 2000; Greanias & Siegel, 2000; Turner & Wehl, 1984). Because CBT has been used to treat both disorders separately, it may be helpful for treating depression and substance use together.

We evaluated the acceptability (usefulness, satisfaction) and feasibility (capable of being delivered) in one implementation of a group-based integrated CBT in an SUD outpatient setting. Assessing the acceptability and feasibility from both client and staff perspectives has been essential for developing optimum treatments in community settings (Campbell & Kirmani, 2000). The goals of this paper are to describe how we used a CBT approach to develop an integrated treatment and summarize the acceptability and feasibility of the new treatment.

2. Materials and methods

2.1. Treatment development

We drew from previous CBTs for depression and SUD (Hepner, Watkins, Woo, & Wiseman, 2006; Marlatt & Donovan, 2005; Miranda et al., 2006a, 2006b, 2006c; Munoz, Ippen, Rao, Le, & Dwyer, 2000) to develop a group-based integrated treatment for SUD and depression. We used a Stage 1 approach to developing the treatment manuals by focusing on techniques for early development (Carroll & Nuro, 2002). For example, we involved a treatment development team including researchers, community-based clinician stakeholders, and CBT and COD experts to determine how to apply the CBT approach to this intervention, what it would consist of (e.g., techniques, format), and how to adapt the treatment for substance use counselors (e.g., language). Our goal was to develop a treatment that could be delivered by existing substance use counselors in an outpatient SUD setting. The research team documented key decisions and lessons learned during the treatment development process. These lessons are summarized in the results section.

Using a CBT approach, we developed an 18-session group treatment that discussed the connection between mood and alcohol/drug use and provided CBT strategies for identifying and modifying harmful thoughts, activities, and interactions with people related to both mood and substance use. The treatment was divided into three modules: Thoughts, Activities, and People Interactions. New clients could enter the group at the first session of each module, which provided an introduction to the concepts of depression, alcohol/drug use problems, and CBT. Consistent with CBT, each session had an agenda starting with welcome/announcements, review of practice (i.e., homework), new topics, key messages (i.e., summarizing), assignment of new practice, client feedback, and a brief description of the next session. To reinforce new topics (e.g., identifying harmful thoughts), interactive activities were embedded (e.g., writing down harmful thoughts the last time they wanted to drink or use) lasting between 10 to 30 minutes.

2.2. Setting

Behavioral Health Services (BHS) is the largest provider of publicly funded substance abuse services in Los Angeles County. BHS serves an ethnically diverse population and provides individual case management and group therapy to clients both self-referred and court-mandated

with an SUD presenting problem. One BHS outpatient treatment setting was used to test one full implementation of the integrated treatment.

2.3. Participants and procedures

2.3.1. Client focus groups—We recruited a group of clients (N=7; 4 male, 3 female) already enrolled in outpatient SUD treatment who met criteria for mild depression symptoms by scoring 5 or greater on the 9-item Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001). These clients provided informed consent and were invited to attend the integrated treatment. Four clients received all three modules, two clients rotated in and received the last two modules, and one rotated in and received only the last module. Group sessions were co-led by two newly trained addiction counselors (counselors described below).

We conducted 15 focus groups with the same cohort of clients immediately following 15 of the 18 group sessions. Due to scheduling constraints, focus groups could not be conducted after three treatment sessions. However, feedback from each of these sessions was elicited during the next focus group. The focus groups asked their general thoughts about each session (e.g., how did the session go?), how acceptable the integrated CBT was (e.g., what was helpful, unhelpful; what did you like the most; what would you change?), and specific recommendations for improving the exercises and concepts (e.g. what are other examples of harmful thoughts not listed in this table). Each focus group had 4 to 7 clients in attendance. Clients were not paid for these focus groups, but snacks were provided during each focus group.

All focus groups were led by two clinical psychologists (the first and second authors), who had observed the group session from behind a one-way mirror. One psychologist led the group, while the other took extensive notes on a laptop. All focus groups were audio taped, lasted about 15 minutes, and followed a written protocol of open-ended questions. All procedures were approved by the RAND Human Subjects Protection Committee.

2.3.2. Counselor and administrator semi-structured interviews—We recruited two BHS counselors (one male, one female) to deliver the group CBT and participate in the semi-structured interviews. These counselors were state-certified as alcohol and drug counselors, had minimal prior exposure to CBT, and had worked with BHS for about 2 years prior to the study. One counselor had 31 years of addictions counseling experience, while the second had 3 years. We also recruited three BHS administrators (one male, two female) involved in the design of our larger clinical trial. These administrators were state-certified as alcohol and drug counselors, were involved with the day-to-day operations of the clinics, and had held administrative positions at BHS for 10 to 20 years.

After implementing one round of the group CBT, an individual semi-structured interview was conducted with each of the counselors and administrators. The interviews assessed the acceptability of the integrated treatment (e.g., what are your thoughts about integrated treatment, how do you think the integrated treatment has affected your clients, what impact has the treatment had on your staff?) and the feasibility of implementing the treatment in their clinics (e.g., what barriers are there for implementing the treatment in your clinics?). Each interview followed a protocol of open-ended questions and lasted about 30 minutes. Staff spoke from their professional capacity and verbally consented to these interviews, which were audio taped and later transcribed.

2.4. Qualitative data analyses

These qualitative procedures and analyses drew from previous research used to develop substance abuse interventions (D'Amico, Barnes, Gilbert, Ryan, & Wenzel, 2009; D'Amico et al., 2005; Stern, Meredith, Gholson, Gore, & D'Amico, 2007). First, after all the client focus

groups were conducted, the first and second authors reviewed transcripts and notes independently. The purpose of this review was to identify, label, and group together key points that spoke to the acceptability of the integrated CBT. Following grounded theory analyses (Strauss & Corbin, 1998), key points with similar concepts were grouped together into a category if said several times by different participants over time (e.g., comments that mood and substance use influenced each other). The authors then discussed each of the categories and generated underlying themes from the data (e.g., mood and substance use were interconnected). After themes were extracted, classic content analysis was used to identify quotes that fit each of the themes (Krippendorff, 1980; Weber, 1990). Each author independently sorted quotes by theme and then together reached a consensus on any discrepancies. This analysis was then repeated for counselor and administrator interviews, respectively, for the purposes of understanding both the feasibility and acceptability of delivering integrated CBT in their SUD clinic.

3. Results

3.1. Key treatment decisions

Key decisions and lessons learned used to adapt the treatment manual are summarized here. First, we structured the manuals for substance use counselors with no prior exposure to CBT. We anticipated that substance use counselors would have none to minimal exposure to CBT and may not be accustomed to using a structured manual in treatment. Thus, we gave clear instructions throughout and structured each session using a similar outline. Consistent with CBT, we followed an agenda for each session: Welcome/announcements, purpose and outline, review of last session, review of practice/homework, new topic(s) and activity, key messages, assignment of new practice/homework, feedback from clients, and a preview of the next session. We also started each section with a “Leader Tips” box that outlined how much time was allotted for the topic, what types of things to say, what to discuss, and how to instruct clients to do an activity. We involved a communications analyst to structure and edit the treatment content in a manner that was clear, concise, and easy to follow. The sessions were highly structured and prescriptive to increase the likelihood that counselors with varying experience are able to lead the intervention with fidelity.

Second, we used language to refer to SUD and depression that would feel appropriate for different types of clients. For example, we learned from our experts to utilize the words “alcohol and drug use” instead of “substance abuse” and other diagnostic labels because substance use counselors and clients preferred to differentiate alcohol from drugs and vice versa. Also, we framed our language to account for clients with a range of problems and readiness levels to change. For example, clients may present with milder depression and more severe drinking issues or severe forms of both disorders, but with low readiness to change. We therefore wanted to be inclusive of the different types of clients that present to outpatient SUD treatment.

3.2. Treatment implementation

Using a CBT approach and framework we implemented an 18-session group treatment for depression and SUD that was delivered twice a week for 2 hours each session. While the treatment could potentially be led by one fully trained counselor, our groups were co-led by two SUD counselors because the groups were 2 hours (30 minutes longer than usual care groups) and were run as part of a pilot study, which required some additional counselor responsibilities. Group leaders received a 2-day CBT training prior to leading groups, followed by weekly 2-hour group supervision throughout the study to increase and retain CBT adherence and skill over time (Sholomskas et al., 2005). Counselors were judged as ready to begin leading the CBT group with clients after role-playing several times and demonstrating minimal competence in basic CBT concepts (e.g., could accurately and clearly explain the CBT model).

Each session was observed by the first and second authors from behind a one-way mirror. Supervision focused on reviewing audio taped portions of the sessions, discussing challenging aspects of group facilitation, and conducting role-plays to provide additional practice.

3.3. Acceptability and feasibility

3.3.1. Client focus groups—Table 1 summarizes underlying themes and respective quotes from the client focus groups. First, several clients did not realize that their mood and substance use problems were interconnected until attending this treatment. For example, a client that had been in and out of SUD treatment since she was 15 said, “I didn’t realize that my depression had a lot to do with my alcohol and drug addiction. Now I can change my activities and mood so that I don’t have to drink and use.” Clients also stated they learned how improving their mood would decrease their cravings and vice versa. For example, a client stated that, “I can have a detrimental craving, but if I have a good mood, I can suppress the craving and not act on it.” Clients stated it was helpful targeting both substance use and depression together.

Second, clients felt the treatment applied to several areas of their lives. For example, a client called the treatment “every class in one” because it pulled together topics from separate groups they had attended and said the treatment “touches everyday life.” Another client stated, “You take the drugs and alcohol away and there’s still other things left you need to cope with.” Clients endorsed how the treatment was “helpful” to broader areas of their lives that were affected by depression and substance use. Finally, several clients felt the CBT tools provided them with more solutions than a 12-step program. One client stated, “It’s good because not everyone can look to God and to a Higher Power” and another client said the treatment had “solutions in it,” which was more helpful than 12-step, where “you just stand up.”

In addition to general themes on the acceptability of the treatment, we also looked at how clients’ feedback changed over time. Over the course of the focus groups, two themes emerged. First, several clients noticed how the treatment’s structure (e.g., tracking their positive activities) allowed them to “see the progress” in themselves. For example, after attending two modules a client stated, “I liked the way you bring things in so that we notice what we are doing and give ourselves credit. Tracking activities [shows] I did something better today to feel good about myself rather than beating myself up and feeling worthless.” Another client commented about an exercise common across the three modules (i.e., writing a coping card that lists relapse prevention strategies): “Doing it again showed me that I grew some, I utilized the old [coping card] and then I learned more...the previous things I struggled with before were things I wasn’t struggling with today.” Clients also noticed their clinical improvements: “I feel so different from the first module – I’ve been honest with myself for the first time, I’ve learned a great deal, it’s basic, but it’s a struggle to look at things differently.” At the last focus group, one client stated, “When I feel like a situation is going to anger me, using tools that I’ve learned [such as ‘Catch It, Check It, Change It’] throughout the different modules, enabled me to handle the situation at hand in a more responsible and caring type of way.”

Over time, clients also reported the group process as being helpful. Clients had attended the same group with each other over several weeks and the format of the treatment helped build a cohesive group structure where each other’s opinions were valuable: “When everybody contributes to the table, it’s like ‘oh yeah, I didn’t think about that one’... having other people’s thoughts out there about what helps for them makes us think outside the box.” Another client stated, “It’s a supportive group, these books, the understanding of the group doesn’t set us apart, we understand each other here,” and near the end of the treatment, a client stated “We’re a CBT freakin’ family, we’re all addicts and alcoholics here to fulfill the same goal!” Conducting the integrated treatment in a group format helped promote acceptability of the treatment.

3.3.2. Counselor and administrator semi-structured interviews—Table 2 summarizes underlying themes and respective quotes from the counselor and administrator interviews. Overall, the counselors and administrators supported the treatment. Three underlying themes emerged. First, counselors and administrators endorsed the value and need for delivering integrated CBT for depression and SUD, stating, “Mental health and substance use providers haven’t always been the friendliest population with each other.” A counselor said, “Everyone is talking about CBT in substance use treatment. I feel like we’re on the cutting edge...because we’re doing this integrated treatment.” An administrator of over 20 years said, “Providing evidence-based treatment to communities is needed because we need an upgrade in substance use treatment.” For counselors, integrated treatment was “cutting edge” and provided clients with co-occurring disorders the “best opportunity to succeed.” Administrators also endorsed integrated treatment because it improved the clinic’s reputation: it “allows us to be one of the most progressive organizations.”

Second, improvements were noted in both clients and counselors. Counselors reported improvements in client depressive symptoms and cravings. For example, a counselor stated, “Clients who were highly depressed decreased their depression” and “This integrated treatment works in clients who I didn’t think would be receptive to it.” Administrators reported improvements and changes in a counselor who had been in the field for long time: “One staff member who had been in the field for awhile before the integrated treatment trend [was] identifying behavior, symptoms, and plans in more detail because of [this treatment].” Administrators stated that counselors were able to “articulate the CBT process...[in] terms that would not otherwise be included in [their] vocabulary.”

Finally, staff commented on the acceptability of the CBT approach for treating both depression and SUD. Among counselors, CBT “work[ed] together” to treat both disorders and made it possible to “integrate [treatment for] depression and substance use together.” In addition, counselors endorsed regular homework assignments as helpful to manage clients’ depression “because they lack discipline in their day to day lives.” Administrators were also “supportive of CBT” because it allowed clients to address both their thoughts and behaviors.

Counselors and administrators were skeptical about the long-term feasibility of implementing the treatment in their clinics. While counselors focused on the benefits of co-leading and receiving clinical supervision (e.g., “The supervision is intense and incredible. I wish we can do that for the rest of our staff.”), they reported the model would not be “cost-effective” without additional financial support. Administrators were also skeptical that the integrated treatment model could be replicated without research funding and support (e.g., “We wouldn’t have been able to do that without the research because of lack of money to train our staff.”). The time counselors spent in training, supervision, and co-leading group affected the clinic’s revenue because time spent in these activities took away from seeing new and billable clients.

4. Discussion

Clients receiving substance abuse treatment often have great difficulty accessing treatment for their co-occurring disorders. This study is unique because we developed an integrated CBT for depression and SUD that could be delivered by substance use counselors in SUD treatment settings, and evaluated its feasibility and acceptability to administrators, counselors, and clients.

The process of involving experts, stakeholders, and clients in the process of treatment development may have contributed to the wide acceptability of the treatment among clients, counselors, and administrators. Clients were able to apply their CBT skills to treat both the depression and substance use together, which also affected other areas in their daily lives.

Clients also viewed the treatment as having more solutions than 12-step. These findings are important because clients with SUD have multiple co-occurring stressors in their lives and different philosophical views about how to address them. Over time, clients made more comments about how the treatment's structure (e.g., repeated exercises) built their confidence and how the group process was helpful for learning from each other. Having a treatment approach like CBT encourages individuals to learn and practice concrete skills in an iterative fashion and seemed to benefit these clients' self-efficacy beyond the target problems of depression and SUD. In addition, these results speak to the benefits of conducting group-based CBT where clients can clearly benefit from hearing how others' experiences are similar to theirs and learn from each other how to cope with depression and SUD.

Counselors and administrators were supportive of using integrated CBT for depression and SUD. They thought the treatment was valuable and contributed to improving the clinic's reputation and services. These findings are particularly important because the integrated treatment was structured, manualized, longer than usual care groups, and required additional work. Counselors spent additional time preparing, learning the treatment, and attending weekly supervision. In community settings, counselors are often overwhelmed by busy caseloads. In spite of these challenges in the current clinic, counselors and administrators still viewed the treatment as rewarding.

Counselors and administrators agreed that the logistics of the integrated treatment model would be difficult to disseminate. Limitations in resources negatively affect how much training and supervision would be available, especially on an overburdened system of care. The two primary concerns were lack of resources for two counselors to co-lead the group, and lack of funding to provide adequate training and supervision. Despite wide acceptability of the integrated treatment by clients and staff, lack of resources often act as a common barrier to improving systems of care.

4.1. Limitations

There are limitations to the study that affect generalizability of the results. The current study evaluates a single case implementation of the treatment. While this process provided in-depth feedback over time and was helpful for understanding the usefulness of the treatment in the current setting, the results may have limited generalizability to other clinics and consumers. Future studies may examine consumer views in several clinics and over several rounds of treatment in order to capture whether integrated treatment is acceptable and feasible. For example, counselors from other clinics may prefer to have a depression only group instead of treating depression and substance use together.

4.2. Recommendations and conclusions

Integrated treatment using a CBT approach for co-occurring disorders is useful and acceptable to clients, counselors, and administrators. However, concerns were raised by SUD treatment setting counselors and administrators about the feasibility and long-term sustainability of this treatment implementation. A significant barrier to disseminating empirically supported practices is the lack of time, money, and incentives available to adapt these new approaches. In light of clinical guidelines and policy recommendations to incorporate integrated treatment into SUD settings, there is a need to make integrated treatment more feasible through additional funding, and for incentives to encourage their implementation. In addition, there is a need to develop innovative training methods, such as web-based training, that effectively train substance use counselors to reasonable proficiency in the limited time they have available and with minimal additional costs. Implementation tools are also needed to support ongoing monitoring of treatment fidelity.

SUD treatment settings need effective treatments to manage both depression and SUD. CBT provides a unified treatment approach for addressing co-morbid depression and SUD. Making integrated CBT for depression and substance use available as a routine part of SUD treatment may be widely accepted by clients and staff.

Acknowledgments

This research was supported by the National Institute of Drug Abuse (R01DA020159). We greatly appreciate the support and participation of clients and staff at Behavioral Health Services, Inc., who provided invaluable feedback in the development of the integrated treatment.

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Table 1

Themes from client focus groups

Theme	Client Quotes
Mood and substance use are interconnected	<ul style="list-style-type: none"> • “I didn’t know the difference between addiction and mental illness and now I’m starting to differentiate, before if you had mental problems it was because you were on drugs.” • “Mood does dictate the cravings.” • “I understand the connection between thoughts, feelings, and mood.”
Treatment was an “all-in-one” therapy	<ul style="list-style-type: none"> • “Every class in one...grabs a little bit of everything of every kind of class I’ve been to. This is the only class you have to take because it deals with everything not just your mood and cravings, it touches everyday life...It’s an all-in-one class.” • “The concept of the Catch it, Check it, and Change it is so basic something I feel like I can apply into everyday life that’s not complicated, it’s very helpful.”
CBT tools had more solutions than 12-step	<ul style="list-style-type: none"> • “There are other ways to address recovery than just the 12 steps.” • “[It’s] like going to a meeting, but it has solutions with it – here we get a solution to a problem, in the meeting you just stand up.”

CBT = Cognitive Behavioral Therapy

Table 2

Themes from counselor and administrator interviews

Theme	Counselor Quotes	Administrator Quotes
Integrated CBT is needed	<ul style="list-style-type: none"> • "Learning CBT and integrated treatment is really worth it." • "I would recommend to other agencies that they go ahead with integrated treatment...to provide them with the best opportunity to succeed; you should treat them both at the same time." 	<ul style="list-style-type: none"> • "Providing evidence-based treatment to communities is needed because we need an upgrade in our substance use treatment, it's behind, evidence-based practices allows us to be one of the most progressive organizations to create the state of the art treatment in California."
Integrated CBT benefitted clients and counselors	<ul style="list-style-type: none"> • "Clients highly depressed decrease their depression, which we know from the PHQ-9...they are consistent in their attendance, it works." • "The clients look more hopeful after the groups because they learn they can manage their depression and cravings." 	<ul style="list-style-type: none"> • "[Counselor's] ability to articulate the CBT process...has increased a 1000 fold. He's able to articulate the CBT process...[in] terms that would not otherwise be included in his vocabulary."
CBT is a valuable treatment approach	<ul style="list-style-type: none"> • "You can integrate depression and substance use together at the same time using CBT because the theory works together." • "CBT is based on practicing homework... and helps clients to manage depression because they have lack of discipline in their day to day lives." 	<ul style="list-style-type: none"> • "I'm very supportive of CBT, we want to make it a part of standard treatment after the study." • "Bringing CBT to our clinics was an awesome concept because the treatment for drugs and alcohol isn't just about the drugs and alcohol...[it's] addressing the behavior and thinking process."
Integrated treatment model would be difficult to disseminate	<ul style="list-style-type: none"> • "The model is different because we have 2 leaders; the supervision is intense and incredible. I wish we can do that for the rest of our staff. Funding, however, it's unlikely to use 2 leaders in the group." 	<ul style="list-style-type: none"> • "Integrated treatment has allowed us to address the client's mental health and we wouldn't have been able to do that without the research because of lack of money to train our staff." • "It's not cost-effective because our model is one counselor for an hour and a half."

CBT = Cognitive Behavioral Therapy

PHQ-9 = Patient Health Questionnaire