

MEETING REPORT

PSYCHOPHARMACOLOGY IN BEHAVIORAL HEALTHCARE: Multidisciplinary Stakeholders in Dialogue

Report of the Dialogue Meeting
October 2012

Convened by the
Substance Abuse & Mental Health Services Administration

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DISCLAIMER

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Substance Abuse and Mental Health Services Administration

An agency of the U.S. Department of Health and Human Services, the Substance Abuse and Mental Health Service Administration (SAMHSA) leads the Nation's efforts to improve prevention and treatment services related to mental health and substance use. SAMHSA works to enhance opportunities for all Americans to live a full and satisfying life in the community, with a focus on four major dimensions essential to a life in recovery:

- **Health.** Overcoming or managing one's disease(s)—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem – and, for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
- **Home.** A stable and safe place to live that supports recovery.
- **Purpose.** Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- **Community.** Relationships and social networks that provide support, friendship, love, and hope.

To accomplish this goal, SAMHSA targets its efforts to improve the supports, services, and systems that prevent mental illness and substance abuse, and that facilitate treatment and recovery for those at risk for, or who have, mental and/or substance use disorders.

1.0 Executive Summary

Since the accidental discovery of chlorpromazine in the 1950s, medications have been considered an important, if not central, treatment for a number of mental illnesses. Since that time an array of medications has been developed to address a variety of behavioral health conditions, and medication-assisted treatment for substance use disorders has played an important role in breaking the cycle of addiction. Many individuals have found medications effective in decreasing the deleterious impact of mental and substance use disorders. Not everyone benefits from medication, however, and medications do not address or ameliorate all symptoms. In addition, many medications have unpleasant, if not dangerous, side effects that may at times outweigh their benefits. As a result, the use of medication is seldom a simple or straightforward matter. Rather, it represents a complex, dynamic process that evolves over time in the lives of people with behavioral health conditions.

Renewed interest has arisen among individuals with diverse views in examining and clarifying the role and application of medication in the treatment of behavioral health conditions. Issues include:

- Possible overuse of medications in mental health and an underuse or reluctance to use medications in addiction treatment
- Impact of side effects on early mortality
- Financing of covered medication formularies in private and public health insurance, as well as the use and efficacy of medications among diverse ethnic groups
- Medication use with children and older adults
- Efficacy of medications
- Medication use within court-ordered treatment
- Prescription and monitoring practices in primary care settings

The Dialogue

To address these issues, the Substance Abuse and Mental Health Services Administration (SAMHSA) convened an expert panel of diverse stakeholders in October 2011 to:

- Share their perspectives and expertise on the use of medications in behavioral healthcare;
- Encourage and foster collaboration among these diverse stakeholders in identifying key issues to be considered in developing practice guidelines for the safe and effective use of medications in behavioral healthcare; and
- Develop initial recommendations on shared decision making and person-centered care models whereby persons with behavioral health conditions can make informed, empowered choices about potential use of medications in their recovery.¹

Dialogue participants included persons with behavioral health conditions who choose to, and not to, use medications in their recovery; practitioners who prescribe and administer medications; researchers and academic experts; advocates; and policy makers (see appendix A).

To provide the expert panelists with the most current information on these issues, SAMHSA commissioned a series of briefing papers prior to the meeting on each of the key topics. The briefing papers were used as the basis for the meeting's discussions (see appendixes B through I).

¹ SAMHSA defines recovery from mental disorders and substance use disorders 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.

Agenda

SAMHSA Administrator Pam Hyde opened the meeting by pointing out that while the role of medication in behavioral health is controversial, it also is extremely important. She stressed that individual choice is fundamental and that people need good information about the medications that are available to them. People need to be able to work carefully and collaboratively with a prescriber about the pros and cons of those medications, and the cost-benefit implications for managing their own lives. Ms. Hyde emphasized that processes of shared decision making and person-centered care would inform the discussion during the dialogue meeting.

During the meeting participants discussed the briefing papers and possible recommendations related to each topic. A concluding session elicited recommendations to ensure that persons with behavioral health conditions have the opportunity to make informed choices about their use of medication as part of their overall recovery plan.

Areas of General Agreement

Over the course of the dialogue, participants concurred on the following key points:

- **Shared decision making.** Persons with behavioral health conditions need ready access to up-to-date information about the safety, short-term efficacy, potential side effects, and long-term effects of the medications available to treat their conditions. Nevertheless, gaps in reliable and accurate information, especially about the long-term effects of many medications used to treat behavioral health conditions, serve as impediments to informed decision making.
- **Individualized, person-centered care.** Practitioners should view medication use as a dynamic process that constantly evolves over the course of each person's unique recovery journey, not as a one-size-fits-all panacea.
- **Holistic approach.** Practitioners should adopt a bio-psycho-social-cultural-spiritual model (as endorsed by the World Health Organization) in assessing the potential benefits a person may gain from using medications as a tool in his or her recovery, as well as the potential side effects and costs associated with doing so.
- **Relationship orientation.** Medications should be prescribed and monitored within the context of a trusting and collaborative relationship—a working alliance—within which persons with behavioral health conditions and practitioners work toward the person's optimal self-management at every stage or in every aspect of his or her recovery.
- **Integrated treatment.** Medications should be prescribed and monitored within the context of an integrated, community-based recovery plan that addresses the person's life and goals from a holistic, strength-based, trauma-informed, and culturally competent perspective.
- **Need for protocols.** Medication use should be considered on an "if needed, as needed, and seldom all that is needed basis" in combination with psychological and social supports within the context of the person's overall recovery plan.

Overarching Recommendations

Participants urged action on the following recommendations:

- **Medical records.** Ensure that people have access to their own medical records. Include people with behavioral health conditions in the design of electronic medical records to ensure accessibility.

- **Active participation and choice.** Practitioners encourage active participation of patients, allies, and family members in making decisions regarding their care, while respecting variability in the amount of choice individuals may want at different stages of their behavioral healthcare and recovery.
- **Decision-making materials and tools.** Produce and disseminate engaging materials and shared decision-making tools that educate practitioners, persons with behavioral health conditions, and their families and allies in this bio-psycho-social-cultural-spiritual model for medication use. Recognize that persons with “decisional impairments” due to mental illness may need supports and tools, and/or perhaps substitute or auxiliary decision makers, in order to participate in and receive person-centered care. Develop the supports and tools needed for this purpose.
- **Advocacy.** Increase health literacy and the activation of persons with behavioral health conditions as agents in their own care and recovery. Many people have been socialized into a passive patient role; they may need to learn and believe that they can and will benefit from taking on a more active role in their care. While respecting individual differences in the degree of either involvement or choice people may want at different times, practitioners have an obligation to encourage people to take an active role in both decision making and recovery. Choice should take into account a person’s developmental stage and preferences.
- **Medication plan.** Take steps to ensure that the “contract” between practitioner and patient includes clear and explicit targets for the medications used and a timeline for re-evaluation of the medications prescribed.
- **Research.** Encourage researchers to involve persons with experiences with behavioral health conditions and treatment in the design and conduct of their medication studies.
- **Alternative treatments.** In nonemergency situations and prior to prescribing medications, practitioners consider instituting a waiting period during which alternative interventions may be attempted.
- **Liability protection.** States provide liability protection for the use of shared decision making. In addition, structure and reimburse for healthcare visits to allow adequate time for shared decision making. This strategy may require an increase of only a few minutes (e.g., from 7 to 12 minutes), but it will have long-term payoffs and likely decrease healthcare costs.
- **Workforce.** Consider an affirmative action approach to increasing the number of persons with behavioral health conditions in all of the healthcare professions.

Conclusion

The right medication at the right dose for the right person at the right time can save a life, but the wrong medication at the wrong dose for the wrong person at the wrong time can end it. Although controversial at the present time, the safe use of medication in the effective treatment of behavioral health conditions is too important a topic to ignore. As the nation’s voice on behavioral health, SAMHSA is committed to providing guidance to practitioners and other stakeholders on ways to ensure that persons with behavioral health conditions and their loved ones are educated and empowered to make informed decisions about the safe use of effective medications as tools in the recovery process from mental and substance use disorders.

The mental health field expresses growing concern that medications may be overused and used to the exclusion of other effective approaches. At the same time, the substance use field observes a critical need to offer broad and sustained public and professional education about the nature of addiction and the key role that medications can play in long-term recovery. In an era of reform when the nation is focused on an overhaul of the healthcare delivery system, the role of medications in behavioral health must be examined critically. It is imperative that medications be used safely and wisely by knowledgeable persons in recovery in partnership with expert, attentive practitioners.

2.0 Dialogue Highlights

2.1 Decision Making and Behavioral Health Medications

Nothing about us without us . . .

Shared decision making—a collaborative, interactive process between individuals and their healthcare providers that facilitates decisions pertinent to an individual's personal recovery—reflects SAMHSA's "values of choice, self-determination, and empowerment, and provides a means of enhancing consumer involvement . . . that has recognized benefits for positive treatment outcomes" (SAMHSA, n.d.).

Based on the background paper commissioned by SAMHSA (Diamond, Curtis, Gitlow, & Warren, 2011) (see appendix B) and a presentation by Ronald Diamond, M.D., this section illustrates selected cross-cutting issues that underlie shared decision making regarding the prescription, administration, continuation, and cessation of psychopharmaceuticals in the treatment of mental and substance use disorders. In the course of discussion, participants observed growing concern in the mental health arena that medications may be overused and/or used to the exclusion of other effective approaches. Conversely, the substance use field has identified the need for general and professional education about the nature of addiction and the role that both new and established medications can play in long-term recovery.

The Prescribing Relationship

Disagreement about terminology in the behavioral health field reflects underlying ideological disagreement. *Patient, client, service recipient, consumer,* and *survivor* each has a different connotation; similarly, *clinician, provider, prescriber,* and *physician* have different meanings. The *physician/patient* relationship carries connotations quite different from *provider/client* or *provider/consumer*. In a traditional doctor/patient relationship, an "expert prescriber" determines best treatment for the patient in a collaborative, respectful way. In fact, the doctor has responsibility to do what is best for the patient—and the meaning of *patient* differs from *client*. At the other end of the spectrum, the client or consumer seeks *consultation and advice* for a life or health problem. In this construct the *client takes responsibility* for defining the nature and severity of the problem and can *accept or reject options offered*.

Thus, key ideological issues in decision making revolve around who should make decisions, with what degree of input, and how expertise should "count" in different contexts. Most people agree that a medication decision should rely on the most expert medical, scientific, empirical data available—but a consumer's personal values in dealing with problems in nonmedication ways and his or her cultural context and support system also play a significant role. Tensions in the therapeutic relationship may involve a specific scientific issue, but they also may reflect divergent views of the construct of the prescribing relationship, often related to ethics and interpersonal dynamics. Determining the goal of medication represents an issue—whether to treat an illness, decrease symptoms, increase life stability, improve quality of life, devise a solution to a problem, or any combination. If the aim is to improve quality of life, it is important to determine who decides what *quality of life* means. In decisions on whether to use medication, consideration must be given to who decides on the problem to be addressed, the preferred solution, and risks that are worth taking. Medication decisions may involve prescriber and consumer, plus significant family and/or friends, plus other providers. "In all cases," Diamond and colleagues assert, "other people in the client's support system . . . play an important role in how the client feels about medication, and whether the client actually takes it."

Prescribers inevitably stress some aspects more than others—perhaps the efficacy of the medication or its side effects, perhaps the positive experiences of some consumers or the problems encountered by others.

Effective collaboration between prescriber and patient/consumer can lead to more effective medication use to address a particular problem, while barriers to obtaining and taking medication consistently may include payment or insurance issues, or an inability to afford medication. These challenges may be addressed by simplifying how medications are taken, minimizing their side effects, and packaging that provides cues to adhere to the regimen. Because of negative stereotypes associated with psychotropic medications, prescribers do well to “discuss perceptions, fears, and concerns,” and to explain the process fully.

Role of Shared Decision Making

Multiple meanings exist for *shared decision making*. Most simply, the term refers to providing information to patients/consumers/clients that equips them to participate actively in the decision-making process. Shared decision making is a structured way of organizing the exchange, perhaps using decision aids and other technological prompts, to enable the client to take part meaningfully in the decision process. Key steps include: (1) obtain, understand, and exchange complex information; (2) consider and discuss options together; and (3) make a healthcare decision.

Additional issues addressed in the background paper include structuring the medication assessment and resolving disagreements between client and prescriber; perception of coercion, pressure, and persuasion; considering discontinuation of medications; locus of responsibility for forging and fostering an effective relationship; and resource and time constraints.

Discussion Points

- **Terminology.** When providers understand and respectfully use language that resonates with consumers/people in recovery, such as *recovery*, *wellness*, and the terms that describe the consumers themselves, mutual understanding of content may be enhanced.
- **Choice of medication—or not.** The addiction field advocates for people’s choice to take medication, while some mental health advocates seek acceptance for the view that people can choose *not* to take medication. Both fields must address the issue of who makes the decision.
- **Self-medication.** Often persons addicted to substances self-medicate to treat an underlying condition. An essential treatment aspect is to educate them about the flaws in their decision making and to teach alternate ways to self-regulate.
- **Power issues.** Many practitioners have concerns about malpractice issues resulting from negative outcomes that may be exacerbated by shared decision making.
- **Alternatives.** Acquisition of coping skills and other models to manage disorders effectively in recovery may be considered as alternatives to medication. Nevertheless, many consumers reject nonmedication solutions because they are far more time consuming than taking medication.

2.2 Medication-Assisted Treatment in Addictions

If you want to see a community organize quickly, threaten to open an opioid treatment program. Neighbors who have despised each other for years and business owners in commercial districts suddenly will speak from the same hymnal. They will engage themselves and their families. They will hire attorneys. They will suddenly raise money that would defy a county tax collector.

The addiction treatment field has used pharmaceuticals effectively for decades, but persistent controversy has limited their acceptance and widespread adoption. With millions of persons newly eligible for treatment services under healthcare reform, additional medications under development and entering the

market, and a workforce insufficient to meet demand, the need has intensified to provide evidence-based medication-assisted treatment for addictions. This section synthesizes the background paper prepared for the dialogue meeting (White, Ginter, & Parrino, 2011) (see appendix C), presentations by Walter Ginter and Mark Parrino, and participant discussions.

Acceptance of Medication-Assisted Treatment for Addictions

Acceptance of medication-assisted treatment for addictions has been impeded by cultural ambivalence in viewing the addictive person as a patient, a sinner, or a criminal; negative stereotypes of addiction and its treatment; lack of acceptance of the scientific validation of a medication's positive effects on clinical and recovery outcomes by policy makers, professionals, patients, families, and others; absence of role models for recovery; and fear of harm because pharmaceuticals initially hailed as “miracle drugs”—cannabis, cocaine, heroin, amphetamines, barbiturates, and LSD—now constitute the underground drug culture.

To achieve greater acceptance of effective medications—and to negate tensions spanning more than a century and a half in the addictions treatment and recovery field—efforts to reduce stigma related to medication must incorporate both scientific proof and the faces and voices of people in recovery. Moreover, misperceptions must be corrected that methadone and other opioid agonists are “replacement drugs” that allow people to get high and that do not represent “real” recovery.

Current Status of Medication-Assisted Treatment of Substance Use Disorders

Medication-assisted treatment currently relies on a number of effective pharmaceuticals. Opioid agonists such as methadone assist in withdrawal, maintenance of metabolic stability, suppression of cravings, and reduction in relapse. Partial agonists include buprenorphine and a buprenorphine and naloxone combination. The opioid antagonist naltrexone blocks the pharmacological effects of heroin and other opioids for 24–60 hours, and injected or implanted (depot) forms can extend those effects for up to a month. Other pharmaceuticals include aldehyde dehydrogenase inhibitors, which elicit toxic reactions to alcohol; medications for co-occurring psychiatric disorders, such as antidepressants, mood stabilizers, and antipsychotics; and medications to reduce nicotine dependence. Medications currently used to treat opioid addiction are methadone, buprenorphine, and naltrexone. While heroin use has declined sharply, OxyContin has become a substance of choice. Administering suboptimal doses of methadone represents a pervasive theme within modern treatment history and remains a significant concern. Other emerging trends include medications used in combination and the mainstreaming of addiction medications into primary care.

Strategies to Increase Medication Acceptance

Prescription opioid use, abuse, and addiction all drive the need for expanded access to medication-assisted treatment. Public funding for treatment programs has shrunk dramatically in the past decade, and private-sector programs currently attempt to fill the void. Policy questions arise with the development of new medications, including whether, and the extent to which, use of medication-assisted treatment embraces recovery principles; whether medications *become* the treatment and whether this is an acceptable scenario for systems of care; and, in expanding access to care, determining the characteristics of that care.

Only about 600,000 people in the United States either participate in opioid treatment programs that administer methadone or visit private practices that use mainly buprenorphine. Strategies to promote acceptance of medication-assisted treatment may include designing and evaluating a national education campaign, encouraging and supporting patient advocacy, continuing research on clinical effectiveness, promoting quality improvement in treatment programs, conceptualizing addiction as a chronic disease, and promoting recovery-oriented methadone, buprenorphine, or other medication-assisted treatment.

Discussion Points

- Dialogue participants offered perspectives on a range of issues, including whether addiction is a medical disease or a behavioral choice. Studies show that people with addictions who receive recovery support services and mutual support have better outcomes, and consulting and other services provided in conjunction with medication-assisted treatment lead to positive outcomes. Rigorous research has not yet investigated the effectiveness of specific recovery-support modalities in concert with medication-assisted treatment.
- Because primary care physicians are the primary prescribers of medications for mental health conditions, it is important to promote collaboration and integration of behavioral and primary healthcare.
- Some funders hesitate to support addiction recovery programs due to negative stereotypes associated with people who use drugs, who may be seen as hedonists who choose to abuse drugs.
- Researchers have published scientific knowledge on medication-assisted treatment in peer-reviewed journals, but dissemination efforts have not kept pace. Most research focuses on adverse impacts, not contributions to quality of life; some studies have flaws in their choice of outcome measures and short timeframes.
- Persons involved in criminal justice systems typically lack access to adequate behavioral health treatment.

2.3 Behavioral Health Medications in Primary Care Settings

Demand for psychiatric medications has risen markedly and long-standing stigma associated with mental health disorders has declined as pharmaceutical industry advertising has convinced people of medications' effectiveness. This section, based on presentations by Joe Parks, M.D., Peggy Swarbrick, Ph.D., and William Reidy, and a background paper commissioned by SAMHSA (Swarbrick, Reidy, & Parks, 2011) (see appendix D), describes the medication management environment for adults with behavioral health disorders in primary care settings.

Most prescriptions for psychiatric medications currently are written in primary care settings rather than in specialty clinics. More than 1,200 community health centers (CHC) across the United States provide 20 million individuals with increasingly integrated primary care and behavioral health services that offer service co-location, community-based coordination of treatment among providers, shared treatment plans, shared problem lists, shared medication and lab results, and joint decision making on patient care. Thus, many CHCs effectively address behavioral health problems in the context of everyday primary care, including routine screening for depression, routine prescribing to treat common mental health problems, and quick access to specialty consultation as needed.

While substance use treatment in CHCs is on the rise, it has not reached the level of integration observed for mental health. Most CHCs conduct routine substance use screening, but fewer than half provide substance use treatment onsite, and only 15% of CHCs prescribe buprenorphine.

Consumers' View of Obtaining Behavioral Health Services in Primary Care Clinics

Advantages for consumers of accessing behavioral health medications in primary care clinics include easier access to behavioral health medications, attention to medical causes of behavioral health symptoms, and medical care that addresses consumers' chronic medical illnesses and routinely offers healthy lifestyle advice. Disadvantages include providers less knowledgeable about the diagnosis and treatment of mental illnesses other than depression and anxiety; a *medical* culture, not necessarily a

recovery culture, where people who seek treatment are *patients*, not *consumers* (but where providers do focus on *self-management* and deliver *person-centered treatment*); less awareness of and access to nonmedication interventions; simple, not comprehensive, biopsychosocial assessments; and lack of emphasis on understanding people's historical context, including the experience of trauma.

Psychiatrists' View of Working in Primary Care Clinics

Psychiatrists who practice in primary care settings can treat more patients, work more often at the peak of their expertise, offer timely access to services, access physicians' records of prior treatments immediately, and enjoy considerable practice support from nurses, primary care physicians, lab personnel, and others. Disadvantages of working in primary care clinics include a role as intermittent consultant, interrupted schedules and variable appointment times, less access to specialty services and interactions with behavioral health colleagues, lack of continuity with patients, and isolation of psychiatry within the primary care setting.

Wellness and Good Health Matter

Because wellness seems central to effective medication management in either a primary care or mental health setting, it is essential to promote wellness and consider how social determinants, including the role of trauma, impact recovery and disability. Characteristics of a wellness approach include taking a holistic view of the person, fostering personal responsibility, fostering self-management to create and sustain well-being, avoiding overreliance on medications, and considering the key influence of social determinants of health.

Social determinants of health include income and social status; social support networks; education, literacy, and health literacy; social and physical environments, personal health practices, and coping skills; access to health services; gender; and culture. Social determinants can affect health, healing, and quality of life for people with behavioral health disorders, who may be at greater risk of under- and unemployment, social isolation, limited access to services, and the negative impacts of trauma and early adverse events in their lives.

In primary care settings, linkages to additional social services, self-help, self-management groups, and other resources are considered important, as is adequate time to gain a full medical and psychosocial history. Although peer support currently is unavailable in many primary care settings, opportunities exist for peer-delivered wellness coaching to promote wellness and recovery.

Primary Care Field's View of Managing Psychiatric Medications

CHCs take a community-based approach, and healthcare reform has offered opportunities to accelerate primary care integration with behavioral health treatment. Chronic disease management benefits from patient/caregiver partnerships, shared decision making, effective self-management support, collaboration with neighborhood specialty services and resources, and navigation and other supports. Community health workers are present in most CHCs, offering prospects to incorporate the supportive role of peers. Primary care providers can address more routine problems of mental health and addictions when proper supports are in place. Systems of care must focus on good connections at care transition points to enable the service user seamlessly to receive the right level of care, at the right time, and in the right place.

Discussion Points

- Participants debated whether *some* behavioral health treatment in primary care settings for *many* people is preferable to *standard-of-care* treatment for *fewer* people in specialty treatment systems.

Participants noted that further research is needed on lessons learned from SAMHSA's Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiative, an intervention shown to work better for alcohol than for illicit drug use and for people with less severity than dependence or abuse.

- People with serious mental illnesses served in the public mental health sector on average die decades before their life expectancy, primarily because of inadequate healthcare. The Department of Veterans Affairs health system generates better outcomes with integrated primary care and specialty services.
- Training of primary care teams should address development of the following skills: comprehensive assessment and diagnosis of mental health problems; management of both pharmacological and nonpharmacological treatment options; recognition of the need for additional treatment steps, pharmacogenomic and other tests, and/or referral to specialty care; care team coordination; state-of-the-science psychopharmacology, including adverse side effects; and strategies to conduct ongoing conversations with consumers about treatment options and shared decision-making tools.

2.4 Behavioral Health Medications and Court-Ordered Treatment

More than half of states operate outpatient commitment programs for people with serious mental illnesses deemed unlikely to participate in treatment without a court order. Mandatory outpatient treatment ostensibly aims to prevent relapse or deterioration in people who, though they currently may not meet criteria for inpatient commitment, predictably would meet those criteria in the foreseeable future absent such commitment (American Psychiatric Association, 1999). This section presents highlights of the background paper on court-ordered treatment and behavioral health medications prepared by Patricia R. Recupero, M.D. (2011), for the SAMHSA dialogue (see appendix E).

Modeled on specialty drug courts commonplace nationwide, mental health courts typically require people with serious mental health problems who are charged with a crime to participate in a treatment program to enable them to avoid criminal conviction. Some states make parole contingent on participation. Involuntary outpatient commitment may be instituted in response to a tragedy when a person with a serious mental illness has committed a violent act against another person.

To invoke mandatory commitment in North Carolina, as an example, a person must have a serious mental illness, have a history of not taking medications outside hospital settings, and have benefited from medications in the past. There must be a perception or assessment that, without medication, the person is at risk of becoming incapacitated or dangerous. In applying the involuntary commitment statute, a person can be taken to a mental health clinic for evaluation. Despite concerns about the effectiveness of outpatient commitment procedures that lack provisions for psychopharmaceuticals, medication currently cannot be administered against a person's will unless an emergency situation exists.

Recupero reports that clinicians often prefer terms such as *mandatory outpatient treatment* or *assisted outpatient treatment*, terms that do not emphasize coercion. Nevertheless, most individuals who enter treatment for substance use problems do so as a consequence of coercion. Coerced treatment for substance use disorders may improve rates of retention in treatment, but ultimate outcomes for individuals in coerced treatment are similar to outcomes in uncoerced treatment. Researchers have found little difference in adherence to a medication regimen between patients who perceive that medication was forced and those who did not feel coerced, and a review of involuntary outpatient commitment studies revealed no significant difference in outcomes, other than for rates of victimization.

Issues and Alternatives

Involuntary outpatient commitment involves several key issues, including prescription, administration, and monitoring of psychotropic medications, and addressing nonadherence; criminal justice issues (for

example, administration of involuntary psychotropic medication in prisons); forcible administration of medications, generally permissible only in psychiatric emergencies; and assessment and analysis of the effectiveness of involuntary outpatient commitment.

Persons with psychiatric illnesses retain their capacity to make an informed decision about their treatment, and typically court-ordered treatment is sought only when decision-making capacity is impaired and risk of serious harm to the individual or others is present. As an alternative to coercive treatment in behavioral health services, a person may use an advance directive to express a preference for certain treatments during a period of temporary incapacity, as well as proxy decision making or a mental health power of attorney. A person may waive the right to revoke an advance directive during periods of impaired judgment or decision-making capacity.

As an alternative to coercive treatment or involuntary outpatient commitment, the Bazelon Center for Mental Health Law advocates for integrated care delivery and service systems such as peer outreach, assertive community treatment (ACT), supported employment, and supportive housing. While not universally available, these programs target factors that can help avert a crisis and improve treatment compliance by incorporating consumer choice and community support.

Discussion Points

- Addiction medications and related legal issues differ from issues pertinent to psychiatric pharmaceuticals, underscoring the importance of avoiding generalizations about court-ordered treatment.
- Mental health centers in some states may administer injectible antipsychotic medications under court order in severe circumstances. A physician who provides mental health treatment under a court mandate to enforce use of medications, but who chooses not to treat under that court order, faces increased exposure to liability. Vermont has considered the role of alternatives to hospitalization under its involuntary treatment/commitment statutes in emergency situations or to prevent emergency situations.
- For 17% of the 2.3 million individuals in U.S. jails and prisons, incarceration is a function of serious mental illness. Nearly 40% of persons in the public treatment system for substance use have a court status.
- Drug court personnel typically have limited knowledge of addiction and medications, and in most drug courts representatives of inpatient treatment facilities tend to set the practice. Providers who favor medication-assisted treatment advocate for judges to make that decision, but many drug courts have deemed attendance at Alcoholics Anonymous meetings to be sufficient treatment.
- Half of U.S. drug courts require termination of methadone or buprenorphine treatment as a prerequisite for participation in those courts—a controversial, contentious issue based in part on the perception of these medications as addictive substitutes for other drugs. Fewer than 5% of persons in drug courts receive medications, and court monitoring does not address treatment issues. The National Association of Drug Court Professionals in 2011 asserted that drug courts should not compel people to leave treatment, a controversial position among many judges.
- Challenges include devising effective strategies to enforce court-ordered treatment provisions, manage access to medications in the transition from court-ordered into community treatment, and mediate between conflicting court-ordered provisions and appropriate treatment plans.

2.5 Efficacy of Behavioral Health Medications

The mental health consumer movement advocates to reduce pervasive automatic, unlimited reliance on medications to achieve and sustain recovery. As provision of medication-assisted treatment for addictions

has begun to increase and advocacy has intensified for wide implementation of successful models, consideration of medications' efficacy and self-efficacy warrant careful attention. Keris Jän Myrick, Ph.D., Dona D. Dmitrovic, and Dan Fisher, M.D. (2011), described their perspectives on these issues in both their presentations and their background paper (see appendix F).

Perspectives on Efficacy

In the healthcare field, *efficacy* refers to beneficial change of a given intervention (such as a medication), and *efficacy* in pharmacology refers to the greatest response achievable from a drug. Exploration of the efficacy of psychotropic medications is crucial, particularly from the mental health consumer's perspective, in that a person's beliefs about efficacy (*self-efficacy*) influence decisions to initiate (or not) a health behavior change, how much energy to expend, and for how long to sustain effort in the face of challenges or failures. Self-efficacy represents a critical issue in managing chronic disease, particularly because individuals do not unflinchingly take medications as prescribed.

Beyond medications' effects per se, many factors impact self-efficacy, including consumers' expectations, social network, and rituals—factors on which drug companies do not focus in their customary 6-week studies. Additional influences on self-efficacy include publicity regarding unethical drug research practices and consumers' understanding of, and the intent of, the diagnostic process.

Notions of the efficacy of psychiatric medications stem from the pervasive belief, shared by both practitioners and consumers, that highly effective medications correct a chemical imbalance that causes depression and other mental illnesses. But evidence of chemical imbalance as a precipitating factor has a questionable basis; studies show, for example, that reserpine may relieve depression as often as it causes it. Underlying this faulty assumption is the mental health field's underestimate of a placebo effect related to psychotropic medications. For people with milder forms of depression, studies show that just *doing something* (such as therapy or taking sugar pills) yields improvement. Many questions surround the methodology of current research, and scientists have conducted little or no research on the long-term effects of psychotropic medications.

Efficacy of Medications in Treatment of Mental Illnesses

Some studies have questioned the benefits of antipsychotic medications in treating schizophrenia. Schizophrenia researchers have found, for example, that participants who did not take medications had the best outcomes and that unmedicated patients were discharged sooner than medicated patients. Other studies reveal that prescribers must weigh medications' effectiveness in treating mental illnesses against long-term side effects of antipsychotic medications such as delayed onset psychosis, increased suicide rate, shrinkage of brain tissue, metabolic syndrome, and truncated life span. The existing research does not provide sufficient information, may be affected by pharmaceutical company bias, and fails to examine adequately the long-term effects of psychotropic medications. The government could play a role as a steward of research on medications used to treat psychiatric conditions.

Although this discussion criticizes research regarding psychiatric medications, it does not deny them a place in treatment or advocate that people should discontinue them. Only by critically examining their strengths and weaknesses can medications be used sensibly in a balanced fashion. In addition, the presenters emphasized, recovery from mental illness depends heavily on relationships, hope, and deriving meaning from life.

Efficacy of Medication-Assisted Treatment for Addiction

Medications to treat addictions have been available since the mid-1800s. These include the “miracle cures” enumerated in section 2.2, thyroid treatment, tranquilizers, and amphetamines. Medication-assisted treatment today refers to the use of medications in combination with counseling and behavioral therapies to provide a whole-patient approach—shown to be the most successful approach to significantly improve individuals’ chances of remaining abstinent. Today’s medications help the brain establish normal functioning, prevent relapse, and assist in reducing drug cravings. Methadone, buprenorphine, and naltrexone are the most commonly used medications for opioid addictions. For tobacco addiction, most-used medications include bupropion and varenicline. To treat alcohol addiction, practitioners use naltrexone, acamprosate, and disulfiram, and topiramate shows encouraging results in a clinical trial.

Many in the addiction field believe there is little evidence on efficacy in treating addiction with medications, although, in fact, scientists have conducted a number of studies. One study on opioid addiction established the efficacy of buprenorphine both alone and compared to methadone, and found fewer adverse events with buprenorphine. Another study established efficacy for long-acting naltrexone to treat alcohol dependence. Thirty years of studies have demonstrated methadone’s effectiveness and the absence of serious, long-term side effects. Methadone’s outcomes include reduction in consumption of all illicit drugs to less than 40% of pretreatment levels during the first year and further reduction to 15% for patients in treatment for 2 years or more. A U.S. government study has shown that a majority of people addicted to alcohol recover without medications.

Studies suggest that the most successful outcomes with medication-assisted treatment occur when a person engages in counseling and enjoys strong community and family support. Thus, SAMHSA’s National Outcome Measures for persons in recovery include resiliency and recovery, stable housing, education/employment, decreased substance use, and social connectedness. Medication-assisted treatment for addictions faces the ongoing challenge that although increasing numbers of programs and practices have been deemed evidence-based, their adoption into practice has lagged.

Discussion Points

- Companies lack incentives to conduct meaningful, well-designed, peer-reviewed studies that assess medications’ efficacy and effectiveness, and their safety for pediatric use.
- Overmedication represents dangers for young people with behavioral problems in foster care and in schools that lack resources for smaller classes, in-class supports, and social support for foster parents.
- Scientific research on methadone treatment over four decades and in many countries shows that withdrawal of methadone results in 80% relapse rates. Better education and understanding of addiction treatment issues are needed to avoid misunderstandings by state policy leaders, federal legislators, judges, criminal justice system regulators and administrators, and others.
- Reevaluation is needed for people initially admitted into treatment with diagnoses of co-occurring mental and substance use disorders whose diagnoses may have been influenced more by reimbursement regulations than by clinical assessment. Therefore, some individuals may have been treated only for their mental health problems and not for their substance use disorder and still need treatment for addiction.
- Nursing staff, primary care physicians, and insurers typically pressure psychiatrists to prescribe medications immediately when a mental health problem arises. By contrast, Finland’s Open Dialogue approach avoids antipsychotic medications for an initial 3 weeks after a first psychotic episode. Based on a paradigm shift in both treatment and philosophy—a philosophy that views no individual as ill—teams of therapeutic personnel visit a person’s home and conduct a series of meetings with family, friends, caregivers, and others to help resolve precipitating factors. Over the course of 20 years, this

approach has generated profound reductions in both short- and long-term schizophrenia and in the use of antipsychotics. On a separate, but related, note, World Health Organization studies in developing countries show recovery rates double those of industrialized countries with dramatically lower medication use.

2.6 Impact of Culture and Behavioral Health Medications

We have a way to go to make sure that culturally competent care becomes the standard of care rather than special care.

Racial and ethnic groups in the United States experience healthcare disparities in diagnosis, treatment, and access to care, according to the Institute of Medicine (2005). William B. Lawson, M.D., discussed the evidence on disparities in the African American community in both his presentation and background paper (Lawson, 2011) (see appendix G). Dr. Dolores Subia BigFoot's (2011) paper (see appendix G) illuminated disparities that affect American Indian and Alaska Native (AI/AN) populations.¹

Ethnopsychopharmacology: African Americans

Growing mental health disparities for African Americans may exceed those for other ethnic groups. Although no genetic evidence explains behavioral health disparities, small genetic differences can generate important clinical pharmacological consequences (Sankar & Kahn, 2005). In addition, cultural factors may impact treatment availability, acceptance, and outcomes, and culture and genetics may interact to determine outcomes in ways not solely related to race. Though medications may affect ethnic groups differently, some clinicians expect people of African descent to respond to medication in ways similar to other racial and ethnic groups. Other providers mistakenly believe that African Americans require more medication than other groups (Lawson, 2002). Disparate responses by population groups to psychiatric medications highlight the need to address disparity in ethnic minority representation in clinical drug trials (Smedley, Stith, & Nelson, 2003).

Many Americans turn to substance use as self-medication, and ethnic minorities frequently do so based on cultural beliefs, deep suspicion of standard treatment, or medications' intolerable side effects. Social and cultural barriers between providers and patients may affect healthcare quality, as can distrust of providers and institutions due to historical or ongoing discrimination and providers' biases.

Cultural issues contribute in particular to under-recognition of depression and over-diagnosis of psychosis among African Americans. Impediments to appropriate care involve erroneous beliefs held by providers that depression and suicide are rare among African Americans, stereotypical views of African Americans, and sociological, economic, and educational distance that separates investigators or providers from people who participate in studies or receive treatment. Clinicians often fail to elicit sufficient information from and about African American patients to develop a meaningful diagnosis, ignore mood symptoms in cases with evidence of psychotic symptoms, or recognize characteristic idioms of distress. Many African Americans do not receive antidepressants, in part due to feelings about the causes of depression and to far greater willingness to accept counseling rather than medications (Blazer et al., 2000, and others). African Americans at all income levels are less likely to receive newer treatments or prescriptions for evidence-based treatments, including, for example, electroconvulsive therapy or any treatment for depression.

¹ The dialogue did not focus on behavioral health medications' impact on other minority populations. SAMHSA acknowledges that attention to medication issues related to Asian Americans, Latinos, and other ethnic minorities, as well as sexual and gender minorities and other specific populations, warrant specific attention in the future.

American Indian and Alaska Native Populations

Despite child-rearing patterns disrupted by forced dislocation to residential schools and the impact of 500 years of colonization practices, studies show that AI/ANs continue to enjoy strong, healthy families. Nevertheless, consonant with this background of displacement and disempowerment, significant numbers have struggled with substance abuse and other mental health conditions.

Historically these populations used interpersonal and community healing for stressful or traumatic times, and traditional herbs and practices played roles in the healing process. But for many generations prior to 1976 legislation, it was illegal to practice indigenous healing or religious expression—arguably a significant contributor to native people’s current high rates of adverse behavioral health. According to the Indian Health Service, their mortality rate far exceeds that of the general U.S. population, and they experience 510% higher alcoholism, 61% higher homicide, and 62% higher suicide rates.

Traditional concepts in most tribal communities include “extended family and relational connections, practices and behaviors regarding respect, beliefs regarding the concept of the circle, and the interconnectedness between spirituality and healing” (BigFoot & Schmidt, 2011). Interpersonal interventions and use of traditional medicine are considered appropriate and culturally congruent for AI/AN individuals. AI/ANs receive both antidepressants and stimulants at lower rates than Caucasians.

Cultural factors compounded with personal stressors tend to create severe distress for many individuals who seek a personal cultural identity through their tribal or indigenous affiliation, but AI/ANs’ expression of pain may differ from the general U.S. population. AI/ANs may not disclose their pain or, alternatively, may use symbolic language unfamiliar to providers of Western medicine. Furthermore, AI/ANs may view pain as part of life rather than cause for alarm. Traditional treatment for pain conflicts with Western practices, leading to cultural misunderstandings; traditional practice considers all elements of mind, body, and spirit, whereas Western treatment focuses on the cause of pain and pain management.

Based on generations of experience and wisdom, AI/ANs have narrowed down a vast array of natural substances cultivated for their medicinal, soothing, or mind-numbing properties. Psychotropic substances most commonly used today in ceremonies and other traditional practices include peyote and tobacco. Once an important ingredient in ceremonies and rituals, tobacco use has developed into a daily usage pattern for many AI/ANs.

Discussion Points

- Disproportionate numbers of young African American males are incarcerated due to substance abuse and mental illnesses, discriminatory laws, and societal structure, and once they enter correctional systems, their access to evidence-based treatment becomes limited.
- Some Caucasian practitioners who have not received training on cultural competence tend to display to their African American patients less respectful behavior, conduct less discussion of interpersonal issues, and spend less time in conversation. This underscores the need for practitioners to be trained to understand the cultural values, norms, and traditions of different populations and to address their treatment in a culturally congruent manner.
- Research consistently shows that for African Americans, major depression is less common and mild chronic depression more common, and psychosis is misdiagnosed and over-diagnosed.
- Coordinated, collaborative studies involving organizations that represent minority populations are needed. The best approach to co-occurring disorders often is collaborative treatment, but many

minority individuals lack access. Underlying cultural, genetic, and other factors likely lead to co-occurring disorders.

2.7 Complements/Alternatives to Psychiatric Medications

The field of alternative medicine has deep respect for the mind/body connection.

In her presentation and background paper, Colleen Blanchfield, M.D. (2011) (see appendix H), described options for therapies that complement psychiatric medications that mental health consumers can use along the continuum of their recovery. Mind/body medicine, nutritional supplements, yoga and tai chi/qi gong, and exercise can empower individuals to change or control their body functions to counter stress, and to achieve better balance between the brain and the autonomic nervous system. These complementary approaches have potential over time to become alternatives to medication, suggesting the need to educate mental health professionals on their use, to develop and disseminate educational materials, and to help providers develop resources for referrals to treatments beyond their knowledge areas.

Mind/body medicine incorporates meditation and relaxation response, biofeedback, neurofeedback, and acupuncture. Studies of mindfulness, concentrative meditation, and relaxation response have shown positive effects on anxiety and mood, and their beneficial effects may be taught to groups and practiced at home. In biofeedback, a recognized behavioral therapy based on operant conditioning, a response is identified and rewarded, and individuals can learn to reduce stress by controlling such body functions as breathing and heart rate. Neurofeedback enables individuals to manage their behaviors and symptoms through control of, or change in, their EEG patterns. It effectively treats addictions, anxiety, depression, and other psychiatric problems. Preliminary studies support yoga as a complementary treatment for persons taking antidepressants and persons who have not reached full recovery. Yoga, tai chi, and qi gong produce beneficial emotional, psychological, and biological effects in controlling mood and anxiety, and in improving overall quality of life.

The standard American diet has changed more in the past 50 years than in the prior 2,000 years, with the addition of chemicals, dyes, and preservatives, and with a decline in certain nutrients in the food supply. The American Medical Association (2002) cites support for adding a multivitamin to all diets. Persons with mental illnesses may benefit from certain supplements and vitamins to improve brain function, and practitioners can add supplements and vitamins systematically to evaluate their efficacy. Several medications use essential vitamins in their metabolism, and supplements can prevent deficiencies.

Discussion Points

- In conjunction with medication use, complementary/alternative treatments and community supports are essential for people with both mental and substance use disorders.
- The importance of vitamin deficiencies to health is evident among youth in foster care, many of whom come from neglectful situations that have led to nutritional deficiencies. Foster care systems must disseminate the message that proper nutrition makes a difference in alertness and focus.
- Many alternative approaches to treat mental and substance use disorders have been dismissed as “voodoo science,” but the National Institutes of Health has funded several major studies on selected alternative/complementary strategies.

2.8 Psychotropic Medication Use for Emotional and Behavioral Treatment in Youth

Young people in mental health housing who see older adults with physical problems brought on by medications often become afraid to take medication. But use of medications can help in learning coping skills—a good way to frame medication use by young people without fear of creating dependency.

Based on the background paper by Julie Zito, M.D., and Daniel J. Safer, Ph.D. (2011) (see appendix I), Dr. Zito described patterns of medication use in a community sample of children and adolescents derived over a period of 20 years by using large reimbursement datasets from Medicaid and private insurers and from federal surveys. She advocated especially for federal funding of clinical research on medication effectiveness and safety for children in large, ordinary practice settings.

Dr. Zito discussed research developments and epidemiological methods she and colleagues have applied to the use of psychiatric medications by young people based on public and private insurance claims data. Some comparisons between children and adults make evident the need for more information and a nuanced approach to address emotional and behavioral needs in children, particularly since children differ from adults in both physical maturity and developmental stage.

Empirical data on the rapid expansion of use of pediatric medication in community populations support the need for more effectiveness and safety studies. For example, research reveals a five-fold increase in use of any psychotropic medication by youth, high rates of psychotropic medication use in foster care children, commercially insured youth five times less likely to receive medication than youth on Medicaid, growing concomitant use of drugs in multiple classes, and antipsychotic use largely for nonpsychotic behavior control. Regarding safety issues, weight gain with second-generation antipsychotics is greater in children than in adults, and many drugs are labeled on the package insert for suicidality risk. Moreover, few incentives motivate industry to study pediatric use of medications, and Food and Drug Administration mandates to do so have had modest effects. Weak evidence exists for a biological model of mental illness—how medications work in the brain—and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) emphasizes symptoms rather than functioning.

To promote independently designed, analyzed, and interpreted data on psychotropic medication use, Dr. Zito asserted the need to formulate studies of large cohorts of youth in community care settings on the safety of atypical antipsychotics regarding weight gain, to require warnings on all antidepressant medications about suicide risk, and to study stimulants and cardiovascular risk among commercially insured youth. State-of-the-art studies reveal the value of short-term medication use, but gains are not sustained, and the goal of best functional outcome possible is not attained. Large health systems need oversight to reduce risky, off-label medication use; distribution of excessively expensive patented products; and practices not supported by the evidence base. In addition, well-motivated university experts who can talk to community physicians can impart information as colleagues and help reduce isolation.

Discussion Points

- Increased utilization of medications may represent a systems issue due to (1) increased emphasis on medications by a new cohort of trainees that supersedes the traditional focus on complete evaluation and treatment plan development, (2) more correct identification and diagnosis, (3) better treatment for more people who need it, or perhaps incorrect treatment of people who do not, (4) results of prescribing by nonphysicians, (5) inappropriate prescribing in cases of co-occurring disorders (which may be misdiagnosed), (6) diminishing access to child psychiatry, or (7) a result of perceived safety of newer drugs.
- The role psychiatric medications play in metabolic syndrome and cardiovascular risk raises ethical questions, as does the prescription of off-label use of medications in clinical settings.

- Although primary care settings traditionally have focused primarily on screening and treating for depression, use of antipsychotics by both children and adults has increased significantly in recent years.
- *Recovery* has different connotations across the lifespan. Many older adults dislike the term when the notion of “getting their life back and going to work” collides with their hope to relax and retire.

3.0 Recommendations to Stakeholders for Action

To promote informed choices by persons with behavioral health conditions regarding the use of medications on their unique paths to recovery, dialogue participants developed recommendations intended to represent starting points for discussion to improve the quality of behavioral healthcare. Participants directed their recommendations toward government agencies at multiple levels; behavioral health practitioners, organizations, and researchers; primary care practitioners; peer supporters; persons in recovery and their families (broadly defined); pharmaceutical and insurance industries; community-based organizations; and others. Where appropriate, recommendations appear in more than one category.

3.1 Government Agencies

- Promote public health strategies, including public education about maximizing self-care and prevention, a focus on wellness, and engaging community health workers to serve as liaisons in education and to raise awareness about mental health services.
- Develop strategies to move toward parity in access to behavioral healthcare by persons with addictions and persons with other chronic medical conditions.
- Require pharmaceutical companies to publish public health–oriented information on medications.
- To further the public health agenda, implement prevention and health promotion efforts related to behavioral health.
- Conduct follow-up dialogue meetings with greater representation by peers/consumers/clients on the role of medications in recovery from behavioral health disorders.
- Create monetary incentives for physicians to serve residencies in addiction treatment.
- Offer incentives to the pharmaceutical industry to develop medications that do not induce dependence.
- In order to qualify for federal reimbursement, require providers to ensure access to medication-assisted treatment for persons with addictions.
- Fund self-directed care through Medicaid and Medicare, shifting emphasis from an institutional and medical orientation to one of community-based services and supports.
- Establish, fund, and reimburse providers for alternatives to hospitalization, such as peer-run interventions and supports, and respite facilities that promote recovery and wellness. Reimburse for peer-provided services by navigators, coaches, peer bridgers, and other peer supporters, including peer supervisors.
- Reimburse for treatments offered by means of new technologies to expand access and increase quality of care (e.g., telehealth).
- Reimburse members of multidisciplinary teams for consultations.
- Reimburse healthcare visits to allow adequate time for shared decision making, a strategy anticipated to improve outcomes and decrease healthcare costs.
- Encourage states to provide liability protection for prescribers' use of shared decision making.
- With substantive consumer participation, design, produce, and disseminate engaging educational materials and tools to facilitate shared decision making.
- Increase awareness of providers, family members, and consumers of the need for health literacy as a prerequisite for effective shared decision making.
- Increase access to opioid treatment programs, in part by establishing programs in federally qualified health centers.
- Continue government sponsorship of the development of decision aids.
- SAMHSA encourage the National Institute of Mental Health to conduct objective-driven research on characteristics of better patterns of care, such as delaying psychotropic medications at the onset of severe mental health problems.

- Fund research to clarify the synergy between certain psychosocial modalities (including peer support) for medication-assisted treatment, and use peer recommendations to identify effective practices.
- Sponsor outcomes research beyond extended clinical trials.
- Compile information from states, counties, and other local jurisdictions on effective community-based programs that foster wellness, including peer-run programs, to supplement SAMHSA's online database of community mental health and substance use treatment agencies.
- Consider the cost issue in states in which public funds do not cover medications for treatment of substance use disorders.
- Broaden consideration of court-ordered treatment to incorporate all leveraged treatment, including mental health courts, probation, and guardianship.
- Build alliances to influence ongoing practice guideline initiatives for medication-assisted treatment in criminal justice systems.
- Increase access to services for individuals from communities of color to help avoid overutilization of the corrections system and address the disproportionate arrest and incarceration rates for persons of color.
- Acknowledge dissenting views on civil commitment.
- Hold substance abuse treatment staff accountable for competent care (for example, establish a credentialing mechanism).
- Eliminate opportunities for conflict of interest: eliminate publication bias by prohibiting advertising by pharmaceutical companies in professional journals, and increase transparency in research by requiring researchers to disclose all income.
- Provide financial support to offer validated complementary treatments in settings where they may be underused in order to empower people to use natural means, such as good nutrition, exercise, meditation, and other supports, including access to housing and social interaction.
- Expand use of complementary approaches in public healthcare settings and foster care systems.
- Improve drug safety monitoring.
- Conduct research to determine why recovery rates in developing countries, where medication use is much lower, greatly exceed recovery rates in industrialized nations.
- Sponsor outcomes research beyond extended clinical trials.

3.2 Practitioners/Professional Associations/Educators/Research Institutions

- Articulate and incorporate a focus on wellness in primary care settings.
- Build person-centered practices to integrate primary care and behavioral healthcare, incorporating both life experiences and the evidence base.
- Ensure individuals' access to their own medical records in order to enhance informed consent and to facilitate development of personal health records, engagement in self-management, and better decision making.
- Require written informed consent from patients and/or families (of children or others whose capacity for decision making may be impaired) for the prescription of psychiatric medications. Ensure that the contract between practitioners and patients includes clear and explicit targets for the medications used and a timeline for re-evaluating those medications.
- Consider instituting a waiting period in nonemergency situations in primary care settings prior to prescribing psychiatric medications, during which alternative interventions may be attempted.
- Organize multidisciplinary care teams to consider and devise better choices.
- Reinforce and implement prevention and health promotion efforts related to behavioral health.
- In primary care settings, offer addiction treatment provided by addiction specialists.
- Increase access to opioid treatment programs in federally qualified health centers.

- Incorporate results of validated pharmacogenomic testing and other validated assessments in medication-based decisions.
- Address nutritional deficiencies to promote overall health and wellness and potentially eliminate or reduce medication use.
- Expand use of complementary treatment approaches in public health settings and foster care systems.
- Avoid overreliance on medications in the absence of other services and supports.
- While respecting variance in the amount of involvement of choice that individuals may want at different stages of their recovery, encourage participation in decision making.
- Develop approaches to increase representation of persons with mental health problems in all healthcare professions and eliminate discrimination by educational institutions.
- Encourage mental health and other healthcare providers to use the Cultural Formulation Interview (CFI) (under development in DSM-5) as a guide to working with patients/peers/clients to make diagnoses and develop treatment plans. The CFI focuses on a person's culture, identity, idioms of distress, and belief systems, among other dimensions.
- Facilitate service providers who treat behavioral health conditions in correctional systems and other settings to consider cultural and ethnic issues in diagnosis, treatment, and referral.
- Incorporate training for prescribers and other providers on the role of nutrition (for example, vitamin deficiencies that may present as depression or psychosis) in general and mental health.
- Educate providers on research findings regarding long-term outcomes.
- Establish educational and support initiatives by and for clinicians and professionals.
- Promote public health strategies, including public education, to maximize self-care and prevention, a focus on wellness, and engaging community health workers to serve as liaisons in education and awareness-raising about mental health services.
- Encourage partnerships between prescribers and consumers/patients regarding wellness and side-effect issues; promote a bio-psycho-social-cultural-spiritual, person-centered approach.
- Train nonmedical professionals (for example, counselors and social workers) in the medications used for addiction treatment as a core competency and prerequisite for certification.
- Establish the business case that treatment is more cost-effective than incarceration, based on existing data (as well as being "the right thing to do").
- Teach the importance of culture in behavioral health.
- Devise strategies to teach features of American culture to internationally trained medical graduates.
- Educate practitioners to instruct people about choices—and that they must make choices.
- Develop best-practice or uniform standards for substance abuse treatment that include evidence-based practices related to medications.
- Educate and train judges regarding the positive role of medications in recovery from substance use disorders.
- Create a practice standard to treat substance use and mental health symptoms simultaneously.
- Develop protocols for discontinuation and reduction in use of psychotropic drugs that take into account age, gender, ethnicity, psychosocial and cultural issues, and stage of recovery.
- Educate providers, decision makers, consumers, and families to consider mental health and substance use in terms of a *distress* model rather than merely a *disease* model; this strategy may guide medication prescription in different directions.
- Educate (re-educate) practitioners on the use and role of medications in behavioral health conditions.
- Educate treatment providers to recognize consumers' readiness and willingness to participate in shared decision making, which may be a developmental process.
- Educate providers to discuss consumers' lives and expectations.
- Develop—and encourage prescribers and consumers to agree to—individualized, standardized measures of symptoms and side effects to help consumers track progress in recovery.
- In collaboration with agencies and practitioners, conduct critical reviews of new research findings.

- Conduct research on gender- and culture-based medication efficacy and effectiveness.
- Develop unbiased outcomes data resulting from use of medications.
- Develop better ways to measure recovery outcomes.
- Engage in research and exploration of medications to treat substance abuse.
- Conduct large medication trials in whose design consumers, family members, and practitioners participate.
- Create the argument and dispel the myth that treatment is “soft on crime” as a way to increase the number of individuals who receive treatment and related services to overcome their substance use disorders versus incarceration without treatment.
- Develop and widely disseminate best-practice/evidence-based guidelines that emphasize person-centered care.
- Study long-term effects of newer medications in substance abuse treatment.
- Conduct well-designed, comprehensive, long-term medication studies that consider the whole person, that incorporate both quantitative and qualitative evidence, and that rely on independent funding using a community-based, consumer-driven, participatory research process.
- Incorporate functional outcomes in effectiveness research on medications.
- Facilitate consumer reporting on medications’ effectiveness based on their individual responses.
- Encourage the National Institute of Mental Health to conduct longitudinal epidemiological measurement and to disseminate concise, useful reports to clinicians.
- Consider researchers’ attention to the public interest, public safety, and public health as criteria for career advancement.
- Involve individuals with behavioral health conditions in the design of electronic medical records.

3.3 Individuals and Families

- Value and participate in shared decision making.
- Learn about the use of medications to treat behavioral health conditions.
- Confer and agree with prescribers on individualized, standardized measures of symptoms and side effects to help track progress in recovery.

3.4 Peer Supporters

- Educate consumers about recovery, their ability to make decisions—and the importance to them of shared decision making.
- Increase health literacy and engagement of persons with behavioral health conditions as agents in their own treatment and recovery.
- Increase consumers’ awareness of the level of effort required to get well and of how to be an active participant in recovery.
- Reinforce and implement prevention and health promotion efforts related to behavioral health.
- Provide supports and tools, and perhaps engage proxy decision makers, to help persons with mental illnesses make decisions about their health care.
- Engage in community-based participatory research.

3.5 Insurance industry

- Provide reimbursement for treatments offered using new technologies (for example, telehealth) to expand access to and to increase quality of care.
- Publicize cost information for healthcare visits and medications to enhance consumers’ informed decision making.

- Reimburse multidisciplinary healthcare teams for consultations.

3.6 Pharmaceutical Industry

- Involve persons with experiences of behavioral health conditions and treatment in the design and implementation of medication studies.
- For any medication promoted to prescribers, also provide information on shared decision making in conjunction with prescription of medication and related health care/behavioral health care services.
- Conduct research on the long-term effects of medications.
- Develop medications that do not induce dependence.

3.7 Community-Based Organizations

- Train community stakeholders on recovery principles and strategies.
- Conduct public awareness efforts that portray people in successful recovery activities.
- Provide financial support to offer validated complementary treatments in settings where they may be underused in order to empower people to use good nutrition, exercise, meditation, and other supports as tools for recovery.
- Implement prevention and health promotion efforts related to behavioral health.
- Promote public health strategies, including public education to maximize self-care and prevention, a focus on wellness, and engaging community health workers to serve as liaisons in education and awareness-raising about mental health services.

4.0 Resources and References

4.1 Resources

4.1 Federal Resources

Substance Abuse and Mental Health Services Administration

Rockville, Maryland

www.samhsa.gov

Access these resources on shared decision making at www.samhsa.gov/consumersurvivor/shared.asp:

- Shared Decision-Making (SDM): Making Recovery Real in Mental Healthcare Project
- Shared Decision Making Webinars
 - Shared Decision Making in Mental Health: Panel Discussion on Consumer Perspectives and Experiences, January 21, 2010
 - Introduction to Shared Decision Making in Mental Health, November 12, 2009
 - Shared Decision Making in Mental Health: Panel on Service Provider Perspectives and Experiences, April 8, 2010
 - Shared Decision Making and Recovery: Using Decisional Support Tools to Advance Recovery Support, May 10, 2012
- Examples of Mental Health Decision Aids
- Cool Tools
 - Conversation Starters
 - Questions to Ask about Complementary and Alternative Medicines
 - Questions to Ask about Medication
 - Shared Decision Making Skills for Providers and Helpers
 - Side Effect Profile Chart
 - Tips for Talking to Providers

Available at store.samhsa.gov, resources for pharmacology and co-occurring disorders include:

- *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (Treatment Improvement Protocol [TIP] 43)
- General Principles for the Use of Pharmacological Agents to Treat Individuals with Co-Occurring Mental and Substance Use Disorders
- Pharmacologic Guidelines for Treating Individuals with Post-Traumatic Stress Disorder and Co-Occurring Opioid Use Disorders
- Advisory: An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People With Opioid Dependence
- Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction
- Medication-Assisted Treatment for Opioid Addiction: Facts for Families and Friends
- MedTEAM (Medication Treatment, Evaluation, and Management) Evidence-Based Practices Kit

National Institute of Alcohol Abuse and Alcoholism

Rockville, Maryland

National Institute on Drug Abuse
Rockville, Maryland

*****identify topic*****

NIDA Notes (Vol. 23, No. 1), available at http://drugabuse.gov/NIDA_notes/NNvol23N1/Young.html

National Institute of Mental Health
Rockville, Maryland

4.1.2 Other Resources

Addiction Technology Transfer Center Network
Kansas City, Missouri
www.ATTCnetwork.org

Psychotherapeutic Medications 2011: What Every Counselor Should Know

Advocates for Human Potential, Inc.
Middlesex, Vermont

Advocates for Recovery through Medicine
Washington, D.C.

American Association for the Treatment of Opioid Dependence (AATOD)
New York, New York

American Psychiatric Association
Arlington, Virginia

American Psychiatric Nurses Association
Washington, D.C.

American Society of Addiction Medicine
Chevy Chase, Maryland

Assisted Recovery Centers of America, LLC
St. Louis, Missouri

Bazelon Center for Mental Health Law
Washington, D.C.

Outpatient and Civil Commitment, accessible at www.bazelon.org/Where-We-Stand/self-determination/forced-treatment/outpatient-and-civil-commitment.aspx

Collaborative Support Programs of New Jersey, Inc.
Freehold, New Jersey

Faces & Voices of Recovery
Washington, D.C.

facesandvoicesofrecovery.org

Ida Mae Campbell Foundation
Washington, D.C.

Medication Assisted Recovery Services Project
Westport, Connecticut

National Alliance for Medication Assisted Recovery
New York, New York
methadone.org

National Association of Alcoholism and Drug Abuse Counselors
Alexandria, Virginia

National Association of Community Health Centers
Bethesda, Maryland
nachc.com

National Association of Drug Court Professionals
Alexandria, Virginia

National Association of State Alcohol and Drug Abuse Directors
Washington, D.C.

National Empowerment Center
Cambridge, Massachusetts

Pat Deegan Ph.D. & Associates, LLC
Byfield, Massachusetts

Consumer/survivor Web application to support shared decision making in the public sector, helping to amplify the voice of people who have 15 minutes of psychopharmacology consultation. This application has been used in six states on ACT teams and in mental health settings and peer centers.

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Commerce, California

The RASE Project
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4.2 References

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- Appendix B. Decision Making and Behavioral Health Medications**
- Appendix C. Acceptance of Medication-Assisted Treatment in Addictions**
- Appendix D. Behavioral Health Medications in Primary Care Settings**
- Appendix E. Behavioral Health Medications and Court-Ordered Treatment**
- Appendix F. Effectiveness of Behavioral Health Medications**
- Appendix G. Impact of Culture and Behavioral Health Medications**
- Appendix H. Complements/Alternatives to Behavioral Health Medications**
- Appendix I. Psychotropic Medication Use for Emotional and Behavioral Treatment in Youth**