Issue Brief

Co-Occurring Mental Health and Substance Use Services

Introduction

The United States is amid a mental and substance use (M/SU) disorder crisis that spans all ages and backgrounds and disproportionately impacts minorities and under-resourced communities,[1] highlighting the importance of equitable and integrated services access across the lifespan. The percentage of adults with symptoms of anxiety and/or depression increased from 31.5 percent in February 2022 to 32.3 percent in February 2023.[2] In addition, many people, especially those experiencing anxiety, depression, or COVID-19-related stress, reported increasing their use of marijuana and alcohol.[3] For example, of adults experiencing COVID-19-related stress, 3 out of 5 reported increased alcohol consumption.[4] The ongoing overdose epidemic is exacerbated by fentanyl and xylazine in the drug supply and increasing polysubstance use. Youth are also experiencing mental health challenges in new ways. As recent data shows, depression, suicide, and substance use are important concerns for adolescents (12–17 years old), with 36.7 percent reporting persistent feelings of sadness or hopelessness and 18.8 percent seriously considered attempting suicide.[5] These concerning trends extend to drug overdose deaths[6] and death by suicide, leading causes of death in the United States.[7]

State Mental Health Authorities (SMHAs) and Single State Agencies (SSAs) fund, oversee, and support programs[a] and services that support community

a For the purposes of this brief, “program(s)” and “organization(s)” refer to entities. “Provider(s)” and “practitioner(s)” refer to individuals, with the latter including individuals with formal credentialing and/or licensing.

About This SERIES

The Substance Abuse and Mental Health Services Administration (SAMHSA) developed this series to provide guidance to states related to critical issues that may be addressed by the Community Mental Health Services Block Grant (MHBG).

This brief provides state mental health directors and other policymakers with an overview of integrated co-occurring mental health and substance use services, evidence-based practices, and resources to help address the behavioral health crisis in the United States.

SAMHSA
Substance Abuse and Mental Health Services Administration

Publication No. PEP24-01-008

In 2022…

Approximately 21 percent of adults aged 18 or older experienced a serious mental illness or substance use disorder in the past year.[8]

There were an estimated 107,622 drug overdose deaths in the U.S., an increase of nearly 15 percent from 2020.[6]

13.2 million (5.2 percent) adults aged 18 or older had serious thoughts of suicide in the past year; 3.8 million (1.5 percent) made suicide plans.[8]

Of the 30.1 million adults aged 18 or older who perceived they ever had a substance use problem, 21.3 million (71.0 percent) considered themselves to be in recovery.[8]

Of the 62.3 million adults aged 18 or older who perceived they ever had a problem with their mental health, 40.8 million (65.8 percent) considered themselves to be in recovery.[8]

mental health needs, and address substance use prevention, treatment, and recovery, respectively. Service delivery systems can be complex and are often siloed. The two primary state-administered federal formula funding streams for substance use disorder (SUD) service delivery are the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) and State Opioid Response (SOR) grants. These grants include a focus on specific priority populations and, in many cases, fund different types of interventions through a range of service delivery systems.

Provider networks funded by SUPTRS can be significantly different from those funded by the Community Mental Health Services Block Grant (MHBG) funds, a similar large state-administered federal funding stream. Even when SSAs and SMHAs are housed within the same organizational units within a state, they often operate as separate entities through unique provider networks.

As many individuals experience both mental and substance use (M/SU) disorders, it is important for the SSA, the State Medicaid office, the SMHA, and provider groups to collaborate to develop joint initiatives to provide integrated care to address co-occurring disorders (COD), and consider consolidating or braiding funding streams, when possible, to design more efficient and accessible service delivery options for people with COD.

The purpose of this brief is to provide an accessible, updated summary of integrated services and evidence-based practices (EBPs) for state leaders and community providers to help address the behavioral health crisis in the United States. This brief includes an overview of the prevalence of COD, barriers to integrated services and proposed solutions, the principles of integrated care and its effectiveness, implementation of behavioral health crisis care services for people with CODs, and an overview of evidence-based interventions for people with CODs across the behavioral health continuum.

Definition of COD

People with COD have one or more SUDs as well as one or more mental disorders.[9] SUDs often co-occur with attention-deficit/hyperactivity disorder (ADHD), depressive disorders, anxiety disorders, personality disorders, bipolar disorder, trauma and stressor-related disorders, psychotic disorders, as

well as eating disorders.[9] Diagnosing and treating people with COD can be complex due to the distinct yet interrelated features of M/SU disorders. For example, individuals with undiagnosed or untreated mental illness may use or misuse substances to self-medicate their symptoms of mental disorder. Conversely, someone with an SUD may experience significant anxiety or depression upon withdrawal of the substances. In addition, environmental factors such as chronic pain, lack of employment or housing, and other factors can exacerbate COD.[9]

PREVALENCE OF CO-OCCURRING DISORDERS (CODs), PER THE 2022 NSDUH REPORT[10]

- 21.5 million (8.4 percent) adults lived with both any mental illness (AMI) and SUD in the past year.
- 7.4 million (2.9 percent) adults lived with both serious mental illness (SMI) and SUD in the past year
- Approximately 20.6 percent of adults with no mental illness used illicit drugs in the past year. Contrastingly 43.9 percent of those with AMI and 52.9 percent of adults with SMI used illicit drugs in the past year.
- Among adults with co-occurring AMI and SUD in the past year, 12.7 million (59.1 percent) received either mental health or substance use treatment, and only 3.7 million (17.0 percent) received both services in the past year.

Treatment approaches may vary when an individual has a mental disorder in comparison to a co-occurring SUD.[9] Providers often do not feel adequately cross-trained to treat both M/SU disorders, creating workforce challenges and barriers to access to treatment for those needing integrated care. States have an opportunity to utilize block grant and other federal funding to help address these challenges and ensure access to integrated services and supports for individuals with COD.

Commonality of CODs

According to the 2022 National Survey on Drug Use and Health (NSDUH) report, close to 21.5 million adults aged 18 or older (8.4 percent) had co-occurring AMI and SUD and 7.4 million adults aged 18 or older had co-occurring SMI and SUD in the past year. Of the adults with AMI and SUD in the past year, nearly half did *not* receive treatment for *either* condition, neither substance use treatment nor mental health treatment. Of those adults who did receive treatment, most only received mental health treatment, highlighting a detrimental gap in treatment for a highly vulnerable population.[10]

Given the increase in opioid-related deaths over the past two decades, it is important to note the high rates of COD for adults aged 18-64 with opioid use disorder (OUD), which were estimated at 64.3 percent based on a study that analyzed data from the 2015–2017 National Survey on Drug Use and Health (NSDUH).[b,11] People with OUD and mental disorders were more likely to receive services for their mental disorder than their SUD. The percentage of those receiving comprehensive treatment for both disorders was low—25 percent of people with co-occurring OUD and any mental disorder and 30 percent of people with co-occurring OUD and SMI.[11] This data mirrors the trends reported above; despite high rates of CODs, few people are receiving the comprehensive integrated care they need.

Negative Outcomes in the Absence of Evidence-Based Integrated Care

People with CODs are at risk for several negative socioeconomic and health outcomes that may subsequently impact many facets of their life. For example, individuals with COD are at increased risk of self-harm compared to people who do not have

b NSDUH estimates from 2015-2017 should not be compared with NSDUH estimates from 2022 due to methodological changes.

COD.[9] The physical and mental health functioning for individuals entering SUD treatment with COD has been found to be lower than the 25th percentile of U.S. population norms[12] and those with untreated COD often present with a history of homelessness or incarceration.[13]

Given the prevalence of CODs and the gaps in integrated care, CODs present a serious public health concern. It is important that appropriately trained providers are available to identify, diagnose, and treat the complexities of CODs across the behavioral health continuum using an integrated, comprehensive, individualized care model that is timely and accessible.

Overview of Treatment Barriers and Potential Solutions

People with CODs can face access issues caused by a behavioral health continuum with treatment and service gaps. Some of the gaps can be explained by system- and organizational-level factors, such as provider waitlists and referral policies, less generous insurance benefits for substance use treatment compared to services for mental disorders, the lack of integrated care services, and a need to travel long distances to receive integrated care, to name a few.[13] Additional structural barriers to integrated services for CODs and potential solutions include the following:

There is a failure to provide routine, comprehensive screening and assessment in behavioral health and physical health care services to identify, diagnose, and connect people to appropriate COD services.[9,13] Early identification and intervention are critically important for this population. Without routine screening across the health care system, providers may identify one disorder but not the co-occurrence of both or multiple disorders.[13] This leads to the risk of connecting people to treatment that may not best fit their needs.[13] Lack of routine screening also impedes the ability to identify problems early on, as they are emerging, and apply early intervention services. Introducing routine screening for M/SUDs and CODs to primary care, emergency departments, and other high-use settings can facilitate identification and connection to services. Once diagnosed, providers need to be able to refer individuals to care and challenges associated with placing people across multiple systems can exist if integrated services are not available for CODs. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an EBP and a public health approach used to identify people at high risk for a substance use disorder or those who need additional assessment and treatment. The Primary Care Behavioral Health (PCBH) model is an evidence-based model used to integrate behavioral health services in primary care settings for early COD identification and intervention.

There is a lack of standardized training and credentialing for COD providers. The absence of standardized credentialing and training for providers serving individuals with CODs contributes to gaps in the workforce. There are a limited number of dually credentialed providers trained to understand the complexity of CODs and the treatment and service needs of this population.[9] Formal credentialing/licensing/certification, training, reimbursement rates, and practice privileges for providers vary by state. Providers are often subject to separate M/SU disorder licensing and reimbursement requirements. Practitioners who prescribe medications for SUDs may have additional licensing requirements (discussed below), further complicating COD service delivery. Developing state standards on COD training, cross-training providers of M/SU disorder treatment and leveraging telehealth platforms to connect with qualified providers may help address this gap. For example, Project ECHO for OUD is an effective telehealth provider training aimed at advancing provider knowledge to deliver OUD treatment.[14]

Siloed service systems and a lack of integrated care create gaps in services for people with CODs. In 2020, nearly every SUD treatment facility[c] reported serving people with CODs, but only 58 percent of facilities provided comprehensive mental health assessments or diagnosis, 50 percent reported providing medications for psychiatric disorders, and 55 percent reported providing "specifically tailored programs or groups for clients with co-occurring mental and substance [use] disorders."[15] Similarly, just under half of the service facilities[d] treating mental disorders provided COD programming.[16] Increasingly, there are opportunities to integrate behavioral health services in primary health care settings, however, they often operate in a separate service delivery network from M/SU disorder treatment providers across the continuum of care. M/SU disorder coordination across service systems can be challenging and gaps in care can occur when waiting lists exist. Identifying available and appropriate SUD services for people engaged in services for mental disorders can be difficult. When separate providers are utilized for treatment of mental health symptoms and SUDs, regulations may limit or prevent sharing of clinical information, making it difficult to coordinate services and monitor progress for both disorders.[17] Incompatible IT systems and electronic health records (EHRs) can further hamper communication. Creating joint funding initiatives to address gaps in integrated care, increase COD services, and enhance data sharing for service coordination can address siloed service systems. Care integration in hospitals and primary care settings can also support access to care for individuals with CODs. Examples include integrating M/SU screening and brief interventions

into primary care and providing buprenorphine initiation in hospital emergency departments with a warm handoff to community-based medications for opioid use disorder (MOUD) providers. People of color, pregnant women, people with criminal justice involvement, people living in rural areas, adults aged 50 and older, military personnel and those experiencing homelessness face unique barriers to care and often times their needs go unmet, leading to poorer outcomes.[9] For example, lower rates of diagnosis and treatment referrals for people of color contribute to disparities in service receipt.[13] Social determinants of health (SDOH) or nonmedical factors that influence health outcomes—such as safe, affordable housing, economic stability, job

c The National Survey of Substance Abuse Treatment Services (N-SSATS) is SAMHSA's annual census of facilities providing substance use treatment throughout the 50 states, the District of Columbia, and other jurisdictions. It includes private nonprofit and for-profit facilities and government facilities providing outpatient, residential (non-hospital), hospital inpatient, certified opioid treatment programs. See the N-SSATS: 2020 for details on facility types.

d The National Mental Health Services Survey (N-MHSS) is SAMHSA's annual census of all known facilities in the United States (the 50 states, the District of Columbia, Puerto Rico, and other jurisdictions), both public and private, that provide mental health services. It includes psychiatric hospitals, general hospitals with a separate inpatient psychiatric unit, Veterans Administration medical centers, partial hospitalization/day treatment mental health facilities, outpatient mental health facilities, residential treatment centers for children and adults, multi-setting mental health facilities, community mental health centers (CMHCs), and other types of residential treatment facilities. See the N-MHSS: 2022 for full definitions.

opportunities, racism, discrimination, and even pollution— have been linked to and can impact the course of treatment for both M/SU disorders . In addition to SDOH, historical trauma and bias in care contribute to health disparities and inequalities. Organizations should employ equity principles and may use the Self-Assessment for Modification of Anti-Racism Tool (SMART tool) to assess the extent to which individual providers and clinical and organizational processes may be impacted by bias and implement a plan to address it.[18] Exploring ways to adapt assessment and treatment approaches can lead to better outcomes. Thoughtful adaptations allow providers to maintain fidelity to evidence-based models while improving the therapeutic alliance and client engagement, facilitating long term-recovery.[9] Adapting Evidence-Based Practices for Under-Resourced Populations is a helpful resource for providers. Prior to adapting for disparate populations, evidence-based interventions need to be evaluated carefully, and fidelity to the core elements of treatment should be maintained. It is also important to focus on achieving equity in accessibility and service provision and to provide culturally and linguistically appropriate services (CLAS).

Philosophical barriers and stigma towards people with CODs persist in the behavioral health system. Providers of M/SU disorder treatment may have difficulty reconciling different treatment approaches, complicating the provision of integrated care. In addition, stigma associated with substance use or mental illness can pose a challenge to integrated care. Substance use disorders are health conditions, with symptoms involving loss of control over substance use; addiction is a disease and not a lack of willpower or a moral failing. This stigma can impact substance use identification and service delivery,[19] and be the basis for exclusion from access to essential treatment services for mental disorders and to supports such as supportive housing programs. SUD providers also need to be aware of stigma, including self-stigma especially in rural communities, associated with mental illness, especially SMI, which may prevent people from seeking services and support. It is important for providers to recognize potential biases and be aware of culturally based behaviors which can be misinterpreted as symptoms of a mental illness. Comprehensive stigma reduction training and education around the value of COD integrated services can minimize some of these challenges. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) supported research on stigma change in Ending Discrimination Against People with Mental and Substance Use Disorders and the National Alliance on Mental Illness (NAMI) provides anti-stigma trainings for providers to increase understanding and empathy towards those with CODs.

Organizational capacity to assess and treat people with CODs may be limited. Many programs do not provide the necessary services to address the complex nature of CODs and it is recommended that agencies assess their organization's capacity for providing comprehensive integrated care. Organizations can use the Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) indices to assess the following service components: appropriate organizational structure (e.g., certification and licensure to provide COD treatment); program milieu; clinical processes to appropriately screen, assess, and treat CODs; continuity of care (e.g., the ability to monitor both disorders and facilitate changes to level of care); and staffing (e.g., licensed prescribers, staff supervision, and COD training).[20]

Medicaid funding for COD services, including medication, varies by state, and restrictions may affect access for some populations.[9] In part this can be attributed to the following issues or limitations:

- Psychiatrists are less likely to accept Medicaid than other specialty service providers, for several reasons including lower reimbursement rates. Even when a service is a covered benefit under a state's Medicaid plan, managed care organizations (MCOs) might not reimburse it under the provider's participation agreement.[21]
- Billing eligibility for COD services is limited due in part to SUD services being billed through facility or institutional entities that are not able to bill for services for mental disorders, and SUD professionals being unable to submit for reimbursement as billing providers. Therefore, licensed SUD counselors are unable to bill if they are part of a mental health organization that submits claims as independent providers.[9,21] Furthermore, individual states may limit the ability to bill for the full complement of services for both mental and SUD on the same day, in addition to other cost containment measures that limit access to streamlined, timely services.
- Programs are often licensed as either substance use service providers or providers of mental illness at the state level, which limits their ability to provide COD services.
- Coverage of medications to treat CODs and provider reimbursement rates vary under Medicaid policies. Prior authorization policies for certain psychiatric medications require people to wait, limiting or delaying their access to this valuable treatment.[22] In addition, different formulations of buprenorphine and/or extended-release naltrexone could impact MOUD billability. Although medications to treat OUD and alcohol use disorder (AUD) are provided in various settings, including office-based opioid treatment (OBOT), except in certain circumstances, methadone must be dispensed by a SAMHSA-certified opioid treatment program (OTP).[23]
- Despite high rates of opioid use among criminal justice populations and evidence of the effectiveness of MOUD, it is often unavailable in correctional settings,[24] and SUPTRS block grants also restrict expenditures in correctional facilities. Historically, Medicaid was suspended or terminated during incarceration,[25] but the Centers for

Medicare and Medicaid Services (CMS) recently released new guidance to encourage states to apply for the new Medicaid Reentry Section 1115 demonstration opportunity. This initiative aims to enhance health care for individuals who are incarcerated and are soon to be released (see below).

Potential solutions are complex and varied but may include:

- Expanding coverage of COD services and increasing reimbursement rates, which may be possible through a few initiatives, including: state plan amendments (SPAs) under Section 1915(i) of the Social Security Act (SSA); home and community-based services covered through Section 1915(c) waivers; and Section 1115 Medicaid demonstration waivers, which allow broad changes in eligibility, benefits, cost sharing, and provider payment models.[21] The strongest predictors of provider Medicaid acceptance are the number of covered SUD services and the number of optional eligibility expansions implemented by the state plan.[21]
- Creating streamlined state Medicaid credentialing pathways for providers to provide services for both SUD and mental illness.
- Providing value-based and alternative payment models and incentivizing quality, evidence-based, integrated care.
- In April 2023, HHS released guidance encouraging states to apply for new Medicaid Reentry Section 1115 waivers, allowing states to cover a package of services related to treatment for M/SU disorders for 90 days prior to someone's release from a carceral facility.[26,27,28]
- Additionally, the Consolidated Appropriations Act, 2023 eliminated the requirement to obtain a specific waiver to prescribe buprenorphine for OUD treatment, potentially expanding the provider pool.[29]

People with CODs have complex symptoms and needs that may change over time.[9] Unfortunately, there is a dearth of specialized COD services across treatment settings.[13] Organizations should work on expanding COD service capabilities across the behavioral health continuum to better serve people with changing needs. With implementation support, organizations can successfully integrate mental and substance use disorder services and sustain them over time.[30]

People may not seek COD treatment for a variety of reasons. A lack of knowledge about where and how to access treatment, an individual's readiness for change (e.g., not feeling ready to seek treatment),[9, 31] and personal and cultural beliefs about behavioral health treatment can impede treatment engagement.[13] A "no wrong door" policy and integrated care may help overcome barriers associated with stigma and the negative views of M/SU disorder treatment services while also making these services more easily accessible and convenient. Adopting mental and SUD and screening, assessment, and treatment in medical settings will improve access to care. The provision of office-based buprenorphine treatment in a primary mental health care setting is another example. As telehealth has become more widely available providers may use it to incorporate co-occurring services and offer low-barrier pathways for people to access services (e.g., buprenorphine inductions via telehealth). Telehealth may also provide individuals with a greater sense of comfort and privacy as they disclose their M/SU disorder-related concerns from the privacy of their own home, which may reduce stigma associated with CODs and accessing treatment.[32] Furthermore, telehealth can protect the privacy of those who live in rural communities or areas with a shortage of practitioners by connecting them to skilled practitioners in other locations.[33,34]

Guiding Principles to Work With Individuals With CODs

SAMHSA developed six guiding principles to work with individuals with CODs and address treatment and service barriers.[35]

1. **Use a recovery perspective –** Recovery is a process of change whereby individuals improve their health and wellness and live self-directed lives. As a long-term, ongoing process, adopting a recovery perspective involves developing a treatment plan that provides long-term continuity of care across different settings and recovery support services and using culturally sensitive evidence-based interventions appropriate to one's stage in the recovery process.

2. **Develop a holistic viewpoint –** Treatment and support should involve goal setting to address the multiple and varied issues faced by individuals with CODs. In addition to behavioral health concerns, this may include lack of income; absence of stable housing; medical, mental, family, and social problems; and other challenges related to the four dimensions of recovery.

3. **Develop a phased approach to treatment –** Use a trauma-informed, phased approach (e.g., engagement, stabilization, active treatment, continuing care, and relapse prevention) to treatment and care that aligns with the client's readiness to change and is flexible, as clients may move through phases in a nonlinear fashion.

4. **Address specific real-life problems early in treatment –** Individuals with CODs often have complex needs that extend beyond behavioral health to income, housing, and employment. Addressing these needs early may help individuals with CODs stay engaged in treatment, achieve their goals, and enhance their self-efficacy.

5. **Plan to address individual's cognitive/functional concerns –** Providers must conduct a comprehensive assessment and develop a treatment plan that tailors services and support to an individual's needs and functioning. Any cognitive or functional impairments must be taken into consideration and thoughtful adaptations made that may involve short, structured treatment sessions supported by gradual pacing, visual aids, and repetition to maximize treatment success and positive outcomes.

6. **Use support systems to maintain treatment effectiveness –** Recovery includes meaningful social connectedness with family, friends, and/or peers and engagement in one's community in addition to providing support and education to family members and caregivers where there is mutual interest in involvement and support. It is important that individuals have access to social support systems such as mutual support groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, NAMI support groups, Dual Recovery Anonymous, other dual recovery mutual support programs), peer support services, spiritual support, and reintegration with family (when available and appropriate) and their community.

These principles go hand in hand with the provision of integrated care to ensure individuals with CODs have the most promising outcomes.

Effectiveness of Integrated Care

Integrated care or services for CODs may be provided by a single practitioner working at the top of their licensure scope to provide quality mental and SUD care, or it can be team-based, where interventions are coordinated by providers who work together to deliver evidence-based, personalized services through all stages of treatment. While not all programs offer a range of evidence-based interventions, these programs should have the appropriate partnerships in place to ensure treatment coordination and continuity of care, to prevent lags in treatment and service provision. Integrated care is effective in a variety of settings with various populations and is considered a best practice for providing services to people with CODs.[9] Integrated care is associated with a variety of positive outcomes including: decreased substance use;[36] reduction in post-traumatic stress disorder (PTSD) and depression symptoms;[9] decreased use of high-cost medical services such as emergency department and inpatient hospitalization;[37] and improved functioning, employment, quality of life, and access to available housing.[9] It can improve access, person-centeredness, and equity and espouses the “no wrong door” approach to behavioral health services.[38] Access to integrated care should be routine across behavioral health care and medical settings, including primary care offices, crisis care centers, inpatient and outpatient facilities, and others.

The Certified Community Behavioral Health Clinic (CCBHC) model supports access to care in a number of ways, and also is intended to address many of the gaps in treatment for individuals with behavioral health needs by providing a set of services either directly or in formal partnership with other organizations. CCBHCs are required to serve anyone who requests care for mental or substance use disorders, regardless of their ability to pay, place of residence, or age. CCBHCs offer a broad range of mental and substance use disorder services, as well as connection to primary care services and other support services. This allows them to meet the needs of people with CODs who may require multiple types of care. Care coordinators and collaboration with other providers in the community, including primary care doctors, hospitals, and social service agencies also helps ensure that patients have access to the full range of services they need.

Behavioral Health Crisis Care for People With CODs

"No wrong door" includes access to COD services through an integrated behavioral health crisis system. SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit emphasizes that *crisis services are for anyone, anywhere and anytime*. This must include fully integrated evidence-based services for people with CODs. The structural elements of crisis care, for which the MHBG allows a 5% set-aside, include the following:[39]

1. SAMHSA transitioned the National Suicide Prevention Lifeline to the 988 Suicide & Crisis Lifeline, which provides three-digit access to trained crisis counselors through calls, chats, and text in order to provide crisis stabilization hotline support and connection to local resources. Twenty-four hour clinically staffed crisis lines accept all calls and provide services that meet National Suicide Prevention Lifeline (NSPL) standards for assessing and engaging people at risk of suicide. Crisis line staff are equipped to address mental health and substance use-related crises. Since substance use is a risk factor for fatal and nonfatal overdoses, suicide, accidents, and medical complications, crisis responders must be able to assess risks for substance use, withdrawal requiring medical management, or overdose to triage and determine appropriate response and referral to COD treatment.[40]
2. Mobile crisis teams are dispatched anywhere in the community in a timely manner. Mobile crisis teams are usually a two-person team that includes a licensed and/or credentialed practitioner and may include a peer specialist trained in mental illness, substance use, and COD. The team makes a warm handoff to facility-based care, if needed, and arranges for outpatient follow-up appointments to support ongoing care of CODs. For example, an individual presenting with opioid withdrawal should receive a warm handoff to the appropriate level of care with the ability to provide MOUD induction.
3. Crisis receiving and stabilization facilities offer "no wrong door" access to care for M/SU disorders. A multidisciplinary team serves everyone, with the goal of reducing acute symptoms, observing the individual for safety, and assessing their needs. Ideally, facilities include intensive support through a partner program for people that need additional ongoing care. To better meet the needs of people with CODs, crisis stabilization centers can offer MOUD induction and withdrawal management services.[40] Crisis centers should train providers to identify and address substance-induced psychosis and make a referral to the appropriate level of care, especially in light of the increasing prevalence of stimulant and high-potency cannabis use.
4. Similar to adults, there have been efforts to enhance crisis services for children, youth, and families. In November 2022, SAMHSA published the National Guidelines for Child and Youth Behavioral Health Crisis Care. Additionally, in September 2022, the National Association of State Mental Health Program Directors (NASMHPD) released A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth. Both documents outline core principles, best practices and strategies for delivering safe and effective crisis interventions to children, youth and their families within the least restrictive environments. Prioritizing home-based supports, interventions and services is encouraged, whenever feasible. This approach aims to maintain

State TA on the Crisis Continuum

Between June and August 2023, eight states and territories participated in a SAMHSA learning collaborative focused on the crisis continuum. Participants learned from guest speakers and shared best practices related to serving individuals at all stages of a crisis, including appropriate response to individuals with COD who are experiencing a mental health and/or substance use related crisis.

individual and family stability and well-being, thereby mitigating unnecessary out of home placements and hospitalizations. Various services can be provided to support children, youth and families during crises. Some of these services are outlined below:

- **In-Home Crisis Stabilization** services offer a valuable opportunity to manage the child or youth's care within the community. The services provided often include conducting an assessment, parent education, child, youth and family peer support, coping and conflict management skill-building, behavior management strategies, and warm hand-offs to other resources and services. By collaborating with therapists, clinicians and occasionally in partnership with paraprofessionals, these services aim to develop goals that are integrated into a crisis plan of care. Additionally, these services can be provided through various therapy programs (i.e., multidimensional family therapy, multisystemic therapy, trauma-focused cognitive behavioral therapy, or dialectical behavioral therapy).
- **Youth Community Crisis Stabilization (YCCS)** offers a home-like environment for short-term overnight crisis, serving as an alternative to hospitalization for youth aged 18 and under. The program emphasizes ensuring a safe and secure setting while maintaining connections to the community.
- **Crisis Intervention Homes** function as emergency shelters to help support youth in crisis through offering an alternative to secure detention in a home environment. These homes provide an intensive-short term program, within a safe and structured environment to youth aged 13-17 years of age.

In 2022, SAMHSA released an Advisory, Peer Support Services in Crisis Care, which discusses the role of peers and peer support services in crisis care. Often crisis services and acute care are the first point at which individuals with SUD, mental illness, and COD enter the behavioral healthcare. Their experience at this point of contact can impact the outcome of a crisis and their entire recovery process.[40] In addition, SAMHSA released a practical guide, Connecting Communities to Substance Use Services: Practical Approaches for First Responders, in August 2023.

Workforce and Administrative Concerns

Workforce and staffing issues impact the availability and quality of COD services. Behavioral health workforce shortages across the country, specifically in rural and under-resourced areas, make it difficult to offer adequate services for both M/SU disorders.[41] Other workforce challenges include low employee retention, provider burnout,[42] unmet training needs in CODs,[13,41,43] and low competency in COD management skills.[9] Creating "no wrong door" crisis care services following best practice guidelines can reduce workforce demands while also ensuring resources are used more efficiently, and deployed quickly before symptoms escalate.[40]

Secured forms of telehealth emerged as a service delivery platform to expand the reach of health care providers, increasing access to care in rural and underserved areas and, where other service barriers exist, improving efficiency of service delivery.[44] Since the COVID-19 pandemic, the United States government provided more flexibilities and encouraged states to consider applying existing telehealth service flexibilities to M/SU disorders.[45] Across public insurance payers at the federal and state levels, some flexibilities include expanded access to secured forms of telehealth, flexibility around covered providers who could use secure telehealth services, and the ability to conduct audio-only visits for some services.[46] States have additional flexibilities for telehealth reimbursements in their state Medicaid programs through State Plan Amendments.[47] To address challenges related to the access and provision of MOUD, the U.S. Department of Health and Human Services (HHS) through SAMHSA revised 42 CFR Part 8, effective April 2, 2024, with a compliance date of October 2, 2024. Some revisions to the final rule include the elimination of select admission requirements to increase access and harm reduction principles, updates the criteria for consideration of take-home doses by allowing take-home doses within the first week of treatment under certain conditions, extends interim treatment allowances, and expands the scope of practice for nurse practitioners and physician assistants in accordance with state laws. These changes to 42 CFR Part 8 expand access to MOUD by providing greater autonomy to opioid treatment program providers to use secured forms of telehealth for initiating buprenorphine in opioid treatment programs (OTPs). Additionally, providers are permitted to incorporate patient-provider "shared decision making", allowing for more individualized treatment plans for patients receiving methadone).[48,49] Since the implementation of similar flexibilities during the COVID-19 pandemic, states have reported an increase in treatment engagement and improved patient satisfaction with care, with relatively few incidents of misuse or medication diversion.[50] New post–public health emergency DEA regulations will likely continue to change the prescribing landscape. SAMHSA's Telehealth for Treatment of Serious Mental Illness and Substance Use Disorders guide provides a detailed overview of how telehealth modalities can be used to provide treatment and implementation recommendations.

SAMHSA'S PRACTICE PRINCIPLES OF INTEGRATED CARE FOR CODs[41]

- Providers treat SUDs and mental health disorders concurrently to meet the full range of individuals' symptoms.
- Providers receive training in the treatment of both SUDs and mental health disorders.
- Providers treat CODs using a stepwise approach tailored to the individual's stage of readiness for treatment (e.g., engagement, stabilization, active treatment, relapse prevention, continuing care).
- Providers integrate motivational techniques (e.g., motivational interviewing, motivational counseling) into care to help individuals reach their goals, particularly at the engagement stage of treatment.
- Individuals receive substance use counseling to help them develop healthier, more adaptive thoughts and behaviors in support of long-term recovery.
- Providers offer individuals with COD multiple treatment formats, including individual, group, family, and peer support, as they move through the various stages of treatment.
- Multidisciplinary teams discuss and offer (as appropriate) pharmacotherapy and monitor individuals for safety (e.g., interactions with other medications), adherence, and efficacy and effectiveness.

Selected Evidence-based Practices and Resources

Evidence-based practices (EBPs) for people with CODs may involve the provision of concurrent services, supports and care to ensure both disorders are addressed together. Outlined below are tables and brief descriptions of evidence-based services and supports that are frequently used to serve people with CODs. Also included are EBPs for adolescents with CODs. Adolescents may be best served by treatment programs offering a combination of evidence-based services that include family and behavioral therapies with contingency management and motivational interviewing (MI)/motivational enhancement therapy (MET).[51]

In addition, to EBP services and supports, adopting an EBP care-oriented approach fosters a safe, engaging, and supportive environment for the provision of COD care.

These EBPs extend beyond a specific service or support. Some examples include:

- Trauma-Informed Care
- Harm Reduction
- Collaborative Care Model
- Primary Care Behavioral Health Model
- Housing First

The information below contains tables and descriptions of each EBP practice categorized by setting. These practices can be applied across a variety of settings and levels of care, including outpatient, residential, and community settings. The tables also highlight the primary population of focus, service duration, and appropriate level(s) of care or setting(s), and resources for education and implementation.

Evidence-based Practices Applied Across Treatment Settings

EBP	Population of Focus	Duration of Services	Level of Care/ Setting	Additional Resources
Peer Recovery Support Services	General population	Time unlimited	• Acute/Crisis • Inpatient • Residential • Outpatient • Community	• What are Peer Recovery Support Services? • TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders • Peer Support Services in Crisis Care • Connecting Communities to Substance Use Services: Practical Approaches for First Responders • SAMHSA's BRSS TACS
Trauma-Informed Care	General population; demonstrated efficacy with marginalized racial, ethnic, and cultural groups	N/A	• Acute/Crisis • Inpatient • Residential • Outpatient • Community	• SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach • SAMHSA's TIP 57: Trauma-Informed Care in Behavioral Health Services • Key Ingredients for Successful Trauma-Informed Care Implementation • SAMHSA's National Center for Trauma-Informed Care • SAMHSA's Practical Guide for Implementing a Trauma-Informed Approach • NCTSN's Guide on Trauma-focused Cognitive Behavioral Therapy
Motivational Interviewing/ Motivational Enhancement Therapy	General population; demonstrated efficacy with marginalized racial, ethnic, and cultural groups; pregnant people with SUD; and adolescents	4–6 sessions	• Acute/Crisis • Inpatient • Residential • Outpatient • Community	• Using Motivational Interviewing in Substance Use Disorder Treatment • Motivational Interviewing in Addiction Treatment

EBP	Population of Focus	Duration of Services	Level of Care/ Setting	Additional Resources
Pharmacotherapy & Medication Management	General population	N/A	• Acute/Crisis • Inpatient • Residential • Outpatient • MOUD using hybrid tele-health and in-person approach	• TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders • Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders • Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings
Cognitive Behavioral Therapy	General population; demonstrated efficacy across marginalized racial, ethnic, and cultural groups; and adolescents	12–24 weekly individual sessions (can be adapted by location and to as few as 6 sessions)	• Inpatient • Residential • Outpatient • Telehealth	• What is Cognitive Behavioral Therapy? • TIP 48: Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery • Treatment Considerations for Youth and Young Adults with Serious Emotional Disturbances and Serious Mental Illnesses and Co-occurring Substance Use • Cognitive Behavioral Therapy (CBT) for Addiction and Substance Abuse • Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders
Contingency Management	General population; demonstrated efficacy with marginalized racial, ethnic, and cultural groups; people with criminal justice involvement; and adolescents	N/A	• Acute/ Crisis[52] • Inpatient • Residential • Outpatient • Community	• Contingency management: what it is and why psychiatrists should want to use it • Treating Concurrent Substance Use Among Adults • TIP 33: Treatment for Stimulant Use Disorders

EBP	Population of Focus	Duration of Services	Level of Care/ Setting	Additional Resources
Mutual Aid Groups/ Mutual Support Programs	General population; demonstrated efficacy with marginalized racial, ethnic, and cultural groups; and adolescents	Varies, often 12 weekly sessions	• Acute/Crisis • Inpatient • Residential • Outpatient • Community	• Group Therapy In Substance Use Treatment • TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders • National Alliance for Mental Illness (NAMI) Connection and Family Support Groups • State Consumer Network Program
Exposure and Response Prevention	People with obsessive compulsive disorder, anxiety, and phobias	Time unlimited	• Inpatient • Outpatient • Residential	• Exposure and Response Prevention
Integrated Case Management	People requiring comprehensive care and who are resistant to traditional outpatient treatment	Time unlimited	• Outpatient • Community	• TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders
Seeking Safety	General Population	Up to 25 sessions	• Inpatient • Outpatient • Residential • Community	• Seeking Safety - Treatment Innovations
Harm Reduction	People at high risk of overdose, demonstrated efficacy with people who inject drugs and people with OUD	N/A	• Acute/Crisis • Inpatient • Residential • Outpatient • Community	• Harm Reduction • Harm Reduction Coalition (HRC) Advocates for Behavioral Health • SAMHSA Harm Reduction Framework
Mindfulness	General Population	Time unlimited	• Inpatient • Residential • Outpatient • Community	• Creating A Healthier Life, A Step-by-Step Guide to Wellness

Peer Support

Peer support is a peer-based mentoring, education, and support service provided by people who have personal experience with M/SU disorders. Peer specialists or peer support workers are typically people in recovery who support other people with similar experiences by helping them remain in recovery and avoid reoccurrence of symptoms or behaviors. Similarly, family peer support can play this same role for parents and caregivers of those who are receiving services from mental illness, substance use, and related service systems. Peer support can be offered before, during, following, or in lieu of treatment episodes and in a variety of settings, with the goal of helping people to achieve and maintain recovery. Peer support is not clinical treatment or mutual aid; however, it may be provided at the same time as other recovery support activities or treatment.[44,53,54] SAMHSA's Peer Recovery Center of Excellence provides resources on the role of peer workers, peer supports, and other recovery services.

Trauma-informed Care

The great majority of individuals served in M/SU services have experienced significant interpersonal trauma.[55] A trauma-informed approach to behavioral health services includes an understanding of trauma and its prevalence, screening for trauma exposure in all clients served, and examining the impact of trauma on mental and physical wellbeing. In addition, staff should understand the impact of trauma on people, communities, services, and policies. A key principle of trauma-informed care is recognizing how people perceive and experience traumatic events, regardless of whether they are acute or chronic, through a culturally and ecologically informed lens.[56] Trauma-informed care is a foundational approach that can be coupled with other evidence-based practices and interventions. As it relates to CODs, providing trauma-informed care requires all staff to be able to recognize the signs and symptoms of trauma as well as understand unique impacts of trauma on people throughout the recovery experience. This requires organizations to ensure their policies, procedures, and practices are carefully designed to support trauma-informed care among all staff and service providers.[53,57] SAMHSA's TIP 57: Trauma-Informed Care in Behavioral Health Services manual helps professionals understand the impact of trauma and implement strategies to support recovery. See also SAMHSA's Practical Guide for Implementing a Trauma-Informed Approach, released in June 2023.

Motivational Interviewing/Motivational Enhancement Therapy

Motivational Interviewing/Motivational Enhancement Therapy (MI/MET) is a counseling approach intended to improve self-motivation for behavioral change and address individual ambivalence concerning cessation of the person's substance use. MI/MET promotes empathy by developing an individual's ability to understand how their behaviors hinder achievement of their goals, building skills to manage conflict and resistance, and encouraging self-motivation for change. MI has been shown to be effective in reducing substance use and improving retention in treatment among a range of populations. Though MI/MET is typically used with other behavioral interventions, it is critical in activating people to accept and initiate services.[44,58,59]

Pharmacotherapy and Medication Management

Pharmacological therapy is the treatment of a disorder or disease using medications. In the context of COD, pharmacological therapy must be carefully managed, given the possibility of drug interactions and side effects from medications. Most people benefit from medications in combination or when coordinated with psychotherapies and psychosocial interventions—typically requiring coordination among a team of providers, including a

psychiatrist, addiction medicine specialist physician, and primary care provider.[9,58,60,61] Many people with CODs require medication to control their psychiatric symptoms, and may also require medications for their substance use disorder (e.g. MOUD and/or medications for alcohol use disorder (MAUD)). The World Health Organization (WHO) and Centers for Disease Control and Prevention (CDC) consider MOUD the gold standard for treating OUD. There are 3 FDA-approved medications for OUD: buprenorphine, methadone, and naltrexone. MOUD, particularly methadone and buprenorphine, reduces substance use, improves treatment retention and physical health and mental illness, and reduces the risk of death after an opioid overdose. MAUD is used to treat AUD and is also used to support clients to remain in recovery through reducing alcohol use. While there are several FDA-approved medications for AUD, the three most common are acamprosate, disulfiram, and naltrexone. Medication in combination with counseling and other supportive services has shown a higher rate of success than either by themselves, but medication alone is effective in reducing substance use[62] and access to them should not be made contingent upon participating in mandatory counseling services.[63]

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is an approach used to help clients identify and understand their existing experiences while teaching how to manage emotions, challenge negative thoughts, problem solve, and change patterns of thinking. Though CBT is a short-term psychotherapy treatment, clinicians can use this approach to set treatment goals related to both mental illness and SUD, providing a consistent treatment approach to both disorders.[64] CBT particularly focuses on how to address issues arising in the present state by helping clients take on smaller components of the issue, rather than tackling the issue as a whole, as well as how

to break the cycle of negative thinking. Related to SUD, CBT typically focuses on the negative outcomes associated with substance use, by developing self-monitoring mechanisms to identify and address cravings, creating coping strategies to address life stressors, and learning how to identify situations that may serve as triggers that lead to relapse.[44,65,66] The National Child Traumatic Stress Network (NCTSN) provides resources on trauma-focused cognitive behavioral therapy.

Contingency Management

Contingency management is an effective positive reinforcement-based intervention for treating substance use and related disorders. Behavior change is achieved through immediate positive reinforcement for desired behavior change (e.g., treatment attendance, reduced substance use) through vouchers, goods, services, or other incentives. Contingency management in combination with MOUD/MAUD can enhance treatment retention and decrease substance use.[44,67]

Mutual Aid Groups/Mutual Support Programs

Mutual aid groups are voluntary self-help groups that support recovery for people with SUDs and mental disorders. People may participate in mutual aid as an independent support or as a complement to treatment. Mutual aid groups provide a forum and opportunity for people to connect with others who have similar mental and/or substance use experiences and recovery goals, allowing them to build relationships and receive support. For SUDs, twelve-step programs are an example of mutual aid groups.[44,68,69] An example of a support group for mental disorders is the National Alliance for Mental Illness (NAMI) Connection and Family Support Groups.[70] Other national organizations, such as Mental Health America, have local affiliates that offer mental illness mutual support groups. SAMHSA's State Consumer Network Program supports mental illness consumer-run organizations to increase their ability to improve services for mental illness and especially their focus on recovery and resilience, promoting consumers as agents of change. Dual-recovery mutual support programs also support people with CODs to mitigate stigma and self-stigma and improve interpersonal connectedness and acceptance among participants. These groups are centered on the principle that people should let their own needs guide their participation as they learn how to manage their conditions with others, though they do not include specific treatment interventions or case management services. Examples of dual-recovery mutual support programs include Double Trouble in Recovery, Dual Disorders Anonymous, Dual Recovery Anonymous, and Dual Diagnosis Anonymous.[9,71]

Exposure and Response Prevention

Exposure and Response Prevention (ERP), also referred to as Exposure and Ritual Prevention, is known as the gold standard approach to treat obsessive compulsive disorder (OCD) but can also be used to treat anxiety and phobias.[72] ERP aims to help clients overcome harmful, repetitive compulsions and/or avoidance behaviors when encountering anxiety-provoking situations and replace them with corrective and/or productive behaviors.[73] It can be used in multiple settings, including outpatient, inpatient, and residential settings, but it is most effective when used in a therapist-supervised setting, rather than self-controlled exposure.[73,74]

Integrated Case Management

Integrated case management (ICM) is an approach to support people with SMI in the community over time. The goal of the model is to engage and build a rapport with people, support them in meeting their basic needs (e.g., housing, income, food stability) and facilitate access to community-based services and supports. It employs small caseloads to provide intensive services and outreach. While in some cases ICM involves a multidisciplinary care team, typically integrated case managers partner with people to identify and link to direct services, provide some counseling support, and monitor progress across services. When working with people with CODs, case managers help enhance motivation for

treatment; educate about and discuss the complex nature of mental and substance use disorders; provide referrals to integrated COD treatment; and support the individual's engagement in mutual support groups and outpatient treatment.[9]

Seeking Safety

Seeking Safety is an evidence-based intervention to help people attain safety from trauma and/or substance use. The curriculum is flexible and includes 25 coping skills or topics that can be conducted in any order, in individual or group format. The intervention is used with adults and adolescents, all gender identities, any level of care (e.g., outpatient, inpatient), any type of trauma or substance use, and across vulnerable populations, including those with SMI, veterans, and individuals experiencing homelessness or criminal justice involvement. It teaches coping skills focusing on five principles: safety in relationships, thinking, behavior, and emotions; integrated treatment; a focus on ideals to counter the loss of ideals in both trauma and substance use; emphasis on cognitive, behavioral, interpersonal, and case management content areas; and attention to clinician processes such as self-care.[75]

Harm Reduction

Harm reduction is an evidenced-based public health approach proven to prevent overdose and infectious disease transmission, improve physical, mental and social wellbeing, and offer low-barrier options for accessing health care services, including treatment for mental and substance use disorders. Organizations that practice harm reduction meet people where they are on their own terms and empower people to choose to live a healthier, self-directed, purpose-filled life. The SAMHSA Harm Reduction Framework identifies pillars, principles, and core practice areas. Core practice areas include: 1) Safer Practices – syringe services programs and Overdose Education and Naloxone Distribution (OEND) programs;[44,76,77] 2) Safer Settings – Day Centers, Safe and Secure Housing, and Alternative to Arrest programs; 3) Safer Access to Healthcare – low-barrier opioid treatment services, harm-

reduction-informed healthcare settings, etc.; 4) Safer Transitions to Care – Integrated care and health hubs, expanded telehealth, warm handoffs, medication access, and treatment on demand; 5) Sustainable Work Force and Field; and 6) Sustainable Infrastructure.[78] SAMHSA's Harm Reduction Grant Program supports community-based overdose prevention programs, syringe services programs, and other harm reduction services. Also, see resources from the Harm Reduction Coalition (HRC).

Mindfulness

Mindfulness aims to help individuals maintain in-the-moment awareness of one's surroundings, emotions, thoughts, and other sensations, enabling greater awareness and tolerance of present feelings, rather than revisiting the past or worrying about the future.[79] This approach is used to strengthen people's awareness of cravings, triggers, and urges that may lead to substance-use or mental illness-related symptoms such as anxiety.[80,81] Evidence related to mindfulness treatment for CODs has grown significantly, indicating that it is effective in maintaining abstinence from substance use and improving mental disorders.[82]

Outpatient Evidence-based Services and Supports

EBP	Population of Focus	Duration of Services	Level of Care/ Setting	Additional Resources
Screening, Brief Intervention, & Referral to Treatment	General population	N/A	Outpatient	• Screening, Brief Intervention, and Referral to Treatment (SBIRT) • TAP 33: Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT)
Collaborative Care Model	General population	3–12 months	Outpatient	• The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes • Principles of Collaborative Care
Primary Care Behavioral Health	General population	<6 sessions	Outpatient	• Behavioral Health Services in Primary Care • National Center of Excellence for Integrated Health Solutions
Community Reinforcement Approach	Adults, youth ages 12–25	24 weeks	Outpatient	• The Community-Reinforcement Approach • Adolescent Community Reinforcement Approach • Adolescent Community Reinforcement Approach (A-CRA)
Brief Strategic Family Therapy	Youth ages 6–18	12–16 sessions	Outpatient	• Brief Interventions and Brief Therapies for Substance Abuse
Multisystemic Therapy	Youth ages 10–17	4–5 months, multiple sessions per week	Outpatient	• TIP 39: Substance Use Disorder Treatment and Family Therapy • Interventions for Disruptive Behavior Disorders: Implementation Considerations
Multi-Dimensional Family Therapy	Youth ages 9–26	3–6 months, multiple sessions per week	Outpatient	• Treatment Considerations for Youth and Young Adults with Serious Emotional Disturbances and Serious Mental Illnesses and Co-occurring Substance Use • Multidimensional Family Therapy

Screening, Brief Intervention, and Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated public health model designed to provide universal screening, early intervention, and timely referral to treatment for people who may be identified as having SUD. The first component of SBIRT includes using a standardized screening tool to determine the level of risk for substance use disorder. When an individual screens as "high" risk, they are referred to SUD services for further assessment and treatment. For those who screen as "low" or "moderate" risk, providers can initiate a brief intervention such as motivational interviewing to encourage behavior change and provide ongoing monitoring.[44,83] SAMHSA provides additional SBIRT resources, including coding for reimbursement and grantee information.

Collaborative Care Model

The Collaborative Care Model is an intervention strategy that focuses on integration of behavioral health care into physical care (e.g., primary care). The model includes integrated case management and care coordination and ongoing monitoring and treatment among primary care providers, psychiatric providers, and case management teams. In this model, patient progress is measured through evidence-based tools (e.g., PHQ-9 depression scale) to monitor improvements and/or needs for alternate treatment. While the primary care team leads the ongoing treatment, they can utilize psychiatric consultation to adjust care and treatment plans, as needed. The Collaborative Care Model is often used as part of the Medicaid health home model and is effective in addressing depression and SUDs.[84,85]

Primary Care Behavioral Health Model

The Primary Care Behavioral Health (PCBH) Model is another approach to integrating behavioral health into primary care using a team-based approach that is focused on same-day accessibility to behavioral health care. A core component of this model includes a behavioral health clinician who mentors and educates primary care providers on behavioral health care and treatment and provides direct care to people. The behavioral health clinician supports primary care providers in caring for people until behavioral health symptoms begin improving, at which point the primary care provider begins to lead care delivery again.[86]

Adult and Adolescent Community Reinforcement Approach

Community Reinforcement Approach (CRA) assists people in establishing a lifestyle that is healthy, substance free, and rewarding. This approach often includes providing vouchers with monetary value to people who regularly screen negative for substance use. CRA can improve sustainment of abstinence compared to people participating in other standard care interventions.[44,87,88] Adolescent community reinforcement approach (A-CRA) is an adaptation of the adult CRA treatment that targets 12- to 22-year-olds with SUD that can be used in a variety of settings to promote recovery from SUD.[44,89,90]

Brief Strategic Family Therapy

Brief Strategic Family Therapy (BSFT) is a short-term (approximately 12–16 weekly sessions), family-treatment model developed for children and youth 6 through 18 years old with substance use and other behaviors such as juvenile offenses and sexual risk behaviors. BSFT is a manualized intervention that focuses on observing and developing treatment plans to avoid patterns in family interactions that may lead to problematic behavior.[91]

Multisystemic Therapy

Multisystemic Therapy (MST) was developed to address risk factors with involvement in the juvenile justice system among youth aged 12 through 17 years old. The intervention was adapted to treat other risk factors, such as SUD, abuse, and neglect. MST therapists tailor their approach to each family's specific need related to parenting techniques, family relationships, individual skills, and developing healthy peer support.[44,92,93,94]

Multi-Dimensional Family Therapy

Multi-Dimensional Family Therapy (MDFT) is an intervention designed for youth at least nine years of age coping with mental disorders, substance use disorders and COD.[62] MDFT includes family and individual therapy, counseling for SUD, and other interventions, focusing on four interrelated domains: the youth, the parents/guardians (or other significant adult in the youth's life), the family unit, and the community.[44,64,95,96]

Residential Evidence-based Services and Supports

EBP	Population of Focus	Duration of Services	Level of Care/ Setting	Additional Resources
Recovery Homes	General population	At least 6 months	Residential	• Recovery Housing: Best Practices and Suggested Guidelines
Modified Therapeutic Communities	General population, particularly those with more comprehensive needs	6–12 months	Residential	• TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders • MTCs for Individuals with Mental Illness and Chemical Abuse (MICA) Disorders Who Commit Offenses
Housing First	People who are experiencing homelessness	Time unlimited	Community	• Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness

Recovery Homes

Recovery homes are safe, substance-free living environments for people recovering from SUD. They vary widely in structure but emphasize long-term recovery through peer support and access to services (e.g., healthcare, employment, legal support, social services). In recovery homes, substance-free does not prohibit prescribed medications taken as directed by a licensed practitioner, such as pharmacotherapies specifically approved by the Food and Drug Administration (FDA) for treatment of OUD as well as other medications with FDA-approved indications for the treatment of co-occurring mental and health conditions. Recovery homes may be used as recovery support services after inpatient SUD treatment, while people attend outpatient treatment, or after incarceration. Although there is no standard length of stay for residents, a stay of at least six months is recommended, as longer residencies are associated with improved recovery outcomes.[44,97,98,99,100,101] While recovery homes provide substance-free living environments, the homes' policies and procedures should recognize SUD as a disease in which reoccurrence of substance use can occur and must be addressed in a supportive and therapeutic manner that promotes recovery.

Housing First

Housing First is an approach that aims to ensure that individuals and families experiencing homelessness are successfully connected to stable housing with supportive services, without prerequisite requirements related to sobriety or treatment for mental or SUDs. Once housed, individuals are more likely to focus on other personal goals, such as engaging in treatment, finding a job, and improving quality of life. Ensuring supportive services are available improves the likelihood of positive outcomes. Housing First has shown to be an effective approach in reducing substance use and improving engagement in care for those previously unhoused.[102]

Modified Therapeutic Communities for People With CODs

Modified Therapeutic Communities (MTCs) are typically residential environments where people are encouraged to build routines that foster personal responsibility and self-agency in their recovery process while also receiving mutual support from peers. This model is flexible and personalized to individual needs while still providing structured support to promote self-help.[103] The National Institute of Justice provides a detailed profile for MTCs for Individuals with Mental Illness and Chemical Abuse (MICA) Disorders Who Commit Offenses.

Community Evidence-Based Programs, Services and Supports

EBP	Population of Focus	Duration of Services	Level of Care/ Setting	Additional Resources
Assertive Community Treatment	People with severe and persistent mental illness	Time unlimited	Community	• Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) KIT
Individual Placement & Support	People with SMI	N/A	Community	• Transforming Lives Through Supported Employment (SE) Program • What is IPS?
Hub and Spoke Model	General population	N/A	Community	• Hub and Spoke Model - Rural Health Toolkit • Using the Hub and Spoke Model of Telemental Health to Expand the Reach of Community Based Care in the United States • 2021 Report to Congress on the State Opioid Response Grants (SOR) • Vermont Hub-and-Spoke Model of Care For OUD

Assertive Community Treatment

Assertive Community Treatment (ACT) is an evidence-based service delivery model that provides long-term, community-based services for people with SMI at risk for homelessness, hospitalization, and criminal justice involvement. The model is guided by multiple essential practices: a multidisciplinary team; a small staff-to-client ratio to provide individualized care; shared caseloads ensuring people receive needed services; a fixed point of responsibility to create a person-centered plan; flexible service delivery; community-based and community-focused services; time-unlimited services; and 24/7 crisis services. The primary goal of ACT is to help people achieve recovery through community treatment, rehabilitation, and support.[104] SAMHSA released a practical guide, Maintaining Fidelity to ACT: Current Issues and Innovations in Implementation, in September 2023.

Individual Placement and Support

The Individual placement and supports (IPS) model is an enhanced version of supported employment for people with SMI. The core principle of IPS is that those who want to work should be eligible for competitive employment with time-unlimited job placement support. Employment specialists are trained in the supported employment model to engage the individual in rapid job search and ongoing comprehensive assessment. Employment services should be integrated with their treatment for mental illness.[66,105,106] SAMHSA and SOAR Works (SSI/SSDI Outreach, Access, and Recovery [SOAR]), published an issue brief and other IPS resources for people with behavioral health needs experiencing homelessness.

Hub and Spoke Model

The hub and spoke model (HSM) is an effective, person-centered approach to care that can be used to treat individuals with COD across various treatment settings. The HSM was designed to establish a coordinated and systemic response to the complex issues states face regarding opioid and other SUDs and is based on models of comprehensive care coordination. In the HSM organizations that provide the initial intake, assessment, and management of services for more specialized and intensive treatment are considered the hubs (i.e., residential treatment programs, OTPs, emergency room, and correctional facilities). The partner organizations providing less intensive, continuous care, monitoring and community-based services are the spokes (i.e., Office based opioid treatment (OBOT) and services provided at primary care offices, tribal health centers and specialty outpatient programs).[107,108] Individuals can transition between hub and spoke sites based on the severity of their conditions and progress in treatment. Vermont has expanded access to OUD by implementing a state-wide hub and spoke model in 2013, and the HSM has been adopted by other state systems in different formats as an effective system to positively impact individuals.[109]

Summary

Skyrocketing overdose and suicide rates, declining mental health, and increased substance use require an integrated healthcare system with culturally appropriate, equitable, evidence-based COD services that are routinely available across all levels of care. From primary care offices to crisis centers, trained providers must work collaboratively to identify, diagnose, and treat CODs. This work can be informed by SAMHSA's principles: using a recovery perspective; adopting a holistic viewpoint; implementing a phased approach to treatment and services that coincides with the individual's stage of change; addressing concurrent issues such as lack of income, stable housing, and employment; addressing cognitive concerns; and leveraging support systems to maximize long-term recovery.

While these principles address some barriers to COD services, it is critically important for the SSA, the state Medicaid office and the SMHA, and provider groups to mobilize and work together to develop joint initiatives to address gaps in integrated care by consolidating or braiding funding streams and building more efficient service delivery options to expand integrated care. Developing standards on COD training and providing comprehensive training around harm reduction and trauma-informed care will also support the provision of integrated care.

References

1 Substance Abuse and Mental Health Services Administration (SAMHSA). (2023). *Strategic Plan: Fiscal Year 2023-2026*. Publication No. PEP23-06-00-002 MD: National Mental Health and Substance Use Laboratory. https://www.samhsa.gov/about-us/strategic-plan

2 Evidence Panchal, N., Saunders, H., Rudowitz, R., & Cox, C. (2023, March 20). *The Implications of COVID-19 for Mental Health and Substance Use*. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

3 National Institute on Drug Abuse. (2022). *COVID-19 & substance use*. https://nida.nih.gov/research-topics/comorbidity/covid-19-substance-use

4 Grossman, E. R., Benjamin-Neelon, S.E., & Sonnenschein, S. (2020). Alcohol consumption during the COVID-19 pandemic: A cross-sectional survey of US adults. *International Journal of Environmental Research and Public Health*, *17*(24), 9189. https://doi.org/10.3390/ijerph17249189

5 Centers for Disease Control and Prevention (CDC). (2023). *Data and statistics on children's mental health.* https://www.cdc.gov/childrensmentalhealth/data.html

6 CDC. (2022). *U.S. overdose deaths in 2021 increased half as much as in 2020—but are still up 15%.* National Center for Health Statistics. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm

7 Hedegaard, H., Curtin, S. C., & Warner, M. (2021). *Suicide mortality in the United States, 1999–2019*. National Center for Health Statistics Data Briefs, 398. https://dx.doi.org/10.15620/cdc:101761

8 SAMHSA. (2023a). *Key substance use and mental health indicators in the United States: Results from the 2022 National Survey on Drug Use and Health* (PEP23-07-01-006, NSDUH Series H-58). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report

9 SAMHSA. (2020). *Substance use disorder treatment for people with co-occurring disorders. Treatment Improvement Protocol (TIP) Series 42*. https://store.samhsa.gov/sites/default/files/pep20-02-01-004.pdf

10 SAMHSA. (2023a).

11 Jones, C. M., & McCance-Katz, E. F. (2019). Co-occurring substance use and mental disorders among adults with opioid use disorder. *Drug and Alcohol Dependence, 197*, 78–82. https://doi.org/10.1016/j.drugalcdep.2018.12.030

12 Watkins, K. E., Hunter, S. B., Wenzel, S., Tu, W., Paddock, S., Griffin, A., & Ebner, P. (2004). Prevalence and characteristics of clients with co-occurring disorders in outpatient substance abuse treatment. *The American Journal of Drug and Alcohol Abuse, 30*, 4, 749-764. https://doi.org/10.1081/ADA-200037538

13 Priester, M. A., Browne, T., Iachini, A., Clone, S., DeHart, D., & Seay, K. D. (2016). Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: An integrative literature review. *Journal of Substance Abuse Treatment, 61*, 47–59. https://doi.org/10.1016/j.jsat.2015.09.006

14 Holmes, C. M., Keyser-Marcus, L., Dave, B., & Mishra, V. (2020). Project ECHO and opioid education: A systematic review. *Current Treatment Options in Psychiatry, 7*, 9-22. https://doi.org/10.1007/s40501-020-00199-8

15 SAMHSA. (2020). *National Survey of Substance Abuse Treatment Services (N-SSATS): 2020, Data on substance abuse treatment facilities*. https://www.samhsa.gov/data/sites/default/files/reports/rpt35313/2020_NSSATS_FINAL.pdf

16 SAMHSA. (2022). *National Mental Health Services Survey (N-MHSS): 2022, Data on mental health treatment facilities.* https://www.samhsa.gov/data/sites/default/files/reports/rpt42711/2022-nsumhss-annual-report.pdf

17 Padwa, H., Guerrero, E. G., Braslow, J. T., & Fenwick, K. M. (2015). Barriers to serving clients with co-occurring disorders in a transformed mental health system. *Psychiatric Services, 66*(5), 547-550. https://doi.org/10.1176/appi.ps.201400190

18 American Psychiatric Association. (2021). *Psychiatrists unveil anti-racism tool.* Psychiatric News. https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2022.12.35

19 Zwick, J., Appleseth, H., & Arndt, S. (2020). Stigma: How it affects the substance use disorder patient. *Substance Abuse Treatment, Prevention, and Policy, 15*(50), 1-4. https://doi.org/10.1186/s13011-020-00288-0

20 McGovern, M. P., Matzkin, A. L., & Giard, J. A. (2008). Assessing the dual diagnosis capability of addiction treatment services: The Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index. *Journal of Dual Diagnosis, 3*(2), 111-123. https://doi.org/10.1300/J374v03n02_13

21 Assistant Secretary for Planning and Evaluation, Disability, Aging and Long-Term Care Policy. (2019). *Credentialing, licensing, and reimbursement of the SUD workforce: A review of policies and practices across the nation.* https://aspe.hhs.gov/sites/default/files/private/pdf/263006/CLRSUDWorkforce.pdf

22 SAMHSA. (2014). *Medicaid coverage and financing of medications to treat alcohol and opioid use disorders*. https://store.samhsa.gov/product/Medicaid-Coverage-and-Financing-of-Medications-to-Treat-Alcohol-and-Opioid-Use-Disorders/sma14-4854?referer=from_search_result

23 SAMHSA. (2023). *Methadone*. https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/methadone

24 Moore, K. E., Roberts, W., Reid, H. H., Sith, K. M. Z, Oberleitner, L. M. S., & McKee, S. A. (2019). Effectiveness of medication assisted treatment for opioid use in prison and jail settings: A meta-analysis and systematic review. *Journal of Substance Abuse Treatment, 99*, 32-43. https://doi.org/10.1016/j.jsat.2018.12.003

25 SAMHSA. (2019). *Principles of community-based behavioral health services for justice-involved individuals: A research-based guide*. https://store.samhsa.gov/sites/default/files/d7/priv/sma19-5097.pdf

26 Center for Medicare & Medicaid Services (CMS). (2023). *Opportunities to test transition-related strategies to support community reentry and improve care transitions for individuals who are incarcerated.* https://www.medicaid.gov/sites/default/files/2023-04/smd23003.pdf

27 CMS. (2023). *The Centers for Medicare & Medicaid Services (CMS) is approving California's (the "state") request to amend the section 1115(a) demonstration titled, "California Advancing and Innovating Medi-Cal (CalAIM)" (Project Number 11-W-00193/9).* https://www.medicaid.gov/sites/default/files/2023-01/ca-calaim-ca1.pdf

28 CMS. (2023). *HHS releases new guidance to encourage states to apply for new Medicaid Reentry Section 1115 Demonstration opportunity to increase health care for people leaving carceral facilities*. https://www.cms.gov/newsroom/press-releases/hhs-releases-new-guidance-encourage-states-apply-new-medicaid-reentry-section-1115-demonstration

29 SAMHSA. (2023). *Waiver Elimination (MAT Act)*. https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement

30 Garneau, H. C., Assefa, M. T., Jo, B., Ford, J. H., Saldana, L., & McGovern, M. (2021). Sustainment of integrated care in addiction treatment settings: Primary outcomes form a cluster-randomized controlled trial. *Psychiatric Services, 73*(3), 280-286. https://doi.org/10.1176/appi.ps.202000293

31 Han, B., Compton, W. M., Blanco, C., & Colpe, L. J. (2017). Prevalence, treatment, and unmet treatment needs of US adults with mental health and substance use disorders. *Health Affairs, 36*(10), 1739–1747. https://doi.org/10.1377/hlthaff.2017.0584

32 American Psychiatric Association. (n.d.). *What is telepsychiatry?* https://www.psychiatry.org/Patients-Families/Telepsychiatry

33 Uscher-Pines, L., Raja, P., Mehrotra, A., & Huskamp, H. (2020). Health center implementation of telemedicine for opioid use disorders: A qualitative assessment of adopters and nonadopters. *Journal of Substance Abuse Treatment, 115*, 108037. https://doi.org/10.1016/j.jsat.2020.108037

34 Rural Health Information Hub. (n.d.). *Telehealth models for increasing access to behavioral and mental health treatment.* https://www.ruralhealthinfo.org/toolkits/telehealth/2/care-delivery/behavioral-health

35 SAMHSA. (2020).

36 Ruglass, L. M., Lopez-Castro, T., Papini, S., Killeen, T., Back, S. E., & Hien, D. A. (2017). Concurrent treatment with prolonged exposure for co-occurring full or subthreshold posttraumatic stress disorder and substance use disorders: A randomized clinical trial. *Psychotherapy and Psychosomatics, 86*(3), 150–161. https://doi.org/10.1159/000462977

37 Morse, S., & Bride, B. E. (2017). Decrease in healthcare utilization and costs for opioid users following residential integrated treatment for co-occurring disorders. *Healthcare, 5*(3), 54. https://doi.org/10.3390/healthcare5030054

38 Minkoff, K., & Covelll, N. H. (2019). *Integrated systems and services for people with co-occurring mental health and substance use conditions: What's known, what's new, and what's now?* National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/TAC_Paper_8_508C.pdf

39 SAMHSA. (2020). *National guidelines for behavioral health crisis care – A best practice toolkit.* https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

40 Pinals, D. A. (2020). *Crisis services: Meeting needs, saving lives.* National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/2020paper1.pdf

41 Snell-Rood, C., Pollini, R. A., & Willging, C. (2021). Barriers to integrated medication-assisted treatment for rural patients with co-occurring disorders: The gap in managing addiction. *Psychiatric Services*, *72*(8), 935-942. https://doi.org/10.1176/appi.ps.202000312

42 SAMHSA. (2021). *Advisory: Substance Use Disorder Treatment for People With Co-Occurring Disorders.* https://store.samhsa.gov/product/advisory-substance-use-disorder-treatment-people-co-occurring-disorders/pep20-06-04-006?referer=from_search_result

43 Spencer, A. E., Valentine, S.E., Sikov, J., Yule, A. M., Hsu, H., Hallett, E., Xuan, Z., Silverstein, M., & Fortuna, L. (2021). Principles of care for young adults with co-occurring psychiatric and substance use disorders. Pediatrics, 147(Suppl 2), 229-239. https://doi.org/10.1542/peds.2020-023523F

44 *Expanding access to behavioral health services through Telehealth*. (2023). telehealth.hhs.gov. https://telehealth.hhs.gov/patients/expanding-access-behavioral-health-services-through-telehealth

45 Health Resources and Services Administration (HRSA). (2023). *Telehealth policy changes after the COVID-19 public health emergency*. https://telehealth.hhs.gov/providers/telehealth-policy/policy-changes-after-the-covid-19-public-health-emergency

46 HRSA. (2023). *Medicare and Medicaid policies*. https://telehealth.hhs.gov/providers/telehealth-policy/medicare-and-medicaid-policies

47 CMS. (n.d.). *Telehealth*. https://www.medicaid.gov/medicaid/benefits/telehealth/index.html

48 U.S. Department of Health and Human Services. (2024, February). Part 8 of Title 42 of the Code of Federal Regulations (CFR). https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/42-cfr-part-8 .

49 SAMHSA. (2024). *Medications for Substance Use Disorders: Statutes, Regulations, and Guidelines*. https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines

50 SAMHSA (2023). *HHS Fact Sheet: Telehealth Flexibilities and Resources and the COVID-19 Public Health Emergency*. https://www.hhs.gov/about/news/2023/05/10/hhs-fact-sheet-telehealth-flexibilities-resources-covid-19-public-health-emergency.html

51 Brewer, S., Godley, M. D., & Hulvershorn, L. A. (2017). Treating mental health and substance use disorders in adolescents: What is on the menu? *Current Psychiatry Reports, 19*, 5. https://doi.org/10.1007/s11920-017-0755-0

52 Bach, P., Garrod, E., Robinson, K., & Fairbairn, N. (2020). An acute care contingency management program for the treatment of stimulant use disorder: a case report. *Journal of Addiction Medicine, 14*(6), 510-513. https://doi.org/10.1097/ADM.0000000000000643

53 SAMHSA. (2023). *Incorporating peer support into substance use disorder treatment services. Treatment Improvement Protocol (TIP) Series 64.* https://www.samhsa.gov/resource/ebp/tip-64-incorporating-peer-support-substance-use-disorder-treatment-services

54 Eddie, D., Hoffman, L., Vilsaint, C., Abry, A., Bergman, B., Hoeppner, B., Weinstein, C., & Kelly, J. F. (2019). Lived experience in new models of care for substance use disorder: A systematic review of peer recovery support services and recovery coaching. *Frontiers in Psychology*, *10*, 1052. https://doi.org/10.3389/fpsyg.2019.01052

55 Administration for Children and Families. (2020). Resource Guide to Trauma-Informed Human Services. https://www.acf.hhs.gov/toolkit/resource-guide-trauma-informed-human-services

56 SAMHSA. (2012). Brief interventions and brief therapies for substance abuse: Treatment Improvement Protocol (TIP) Series 34. Center for Substance Abuse Treatment. https://store.samhsa.gov/product/tip-34-brief-interventions-and-brief-therapies-substance-abuse/sma12-3952

57 SAMHSA. (2023). *Practical guide for implementing a trauma-informed approach*. National Mental Health and Substance Use Policy Laboratory. https://www.samhsa.gov/resource/ebp/practical-guide-implementing-trauma-informed-approach

58 Winhusen, T., Kropp, F., Babcock, D., Hague, D., & Erickson, S. (2007). Motivational enhancement therapy to improve treatment utilization and outcome in pregnant substance users. *Journal of Substance Abuse Treatment, 35*(2), 161-173. https://doi.org/10.1016/j.jsat.2007.09.006

59 Carroll, K., Ball, S., Nich, C., Martino, S., Frankforter, T., Farentinos, C., Kunkel, L. E., Mikulich-Gilbertson, S. K., Morgenstern, J., Obert, J. L., Polcin, D, Snead, N., & Woody, G. E. (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence, 81*(3), 301-312. https://doi.org/10.1016/j.drugalcdep.2005.08.002

60 Akerman, S. C., Brunette, M. F., Noordsy, D. L., & Green, A. I. (2014). Pharmacotherapy of co-occurring schizophrenia and substance use disorders. *Current Addiction Reports,* 1, 251-260. https://doi.org/10.1007/s40429-014-0034-7

61 Coles, A. S., Sasiadek, J., & George, T. P. (2019). Pharmacotherapies for co-occurring substance use and bipolar disorders: A systematic review. *Bipolar Disorders, 21*(7), 595-610. https://doi.org/10.1111/bdi.12794

62 Pew Charitable Trusts. (2020). *Medications for opioid use disorder improve patient outcomes.* https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2020/12/medications-for-opioid-use-disorder-improve-patient-outcomes

63 U.S. Food and Drug Administration Center For Drug Evaluation and Research, & Substance Abuse and Mental Health Services Administration. (2023). *Dear colleague letter.* https://www.samhsa.gov/sites/default/files/dear-colleague-letter-fda-samhsa.pdf

64 SAMHSA. (2021). *Treatment considerations for youth and young adults with serious emotional disturbances and serious mental illnesses and co-occurring substance use.* National Mental Health and Substance Use Policy Laboratory. https://store.samhsa.gov/sites/default/files/pep20-06-02-001.pdf

65 Windsor L. C., Jemal A., & Alessi E. J. (2015). Cognitive behavioral therapy: A meta-analysis of race and substance use outcomes. *Cultural Diversity and Ethnic Minority Psychology, 21*(2), 300-313. https://doi.org/10.1037/a0037929

66 SAMHSA. (2014). Managing depressive symptoms in substance abuse clients during early recovery: A Treatment Improvement Protocol (TIP) Series 48. Center for Substance Abuse Treatment. https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4353.pdf

67 Petry, N. M. (2011). Contingency management: What it is and why psychiatrists should want to use it. *The Psychiatrist, 35*(5), 161-163. https://doi.org/10.1192/pb.bp.110.031831

68 Rosenblum, A., Matusow, H., Fong, C., Vogel, H., Uttaro, T., Moore, T. L., & Magura, S. (2014). Efficacy of dual focus mutual aid for persons with mental illness and substance misuse. *Drug and Alcohol Dependence,* 135, 78-87. https://doi.org/10.1016/j.drugalcdep.2013.11.012

69 Humphreys, K., Barreto, N. B., Alessi, S. M., Carroll, K. M., Crits-Christoph, P., Donovan, D. M., Kelly, J. F., Schottenfeld, R. S., Timko, C., & Wagner, T. H. (2020). Impact of 12 step mutual help groups on drug use disorder patients across six clinical trials. *Drug and Alcohol Dependence, 215*, 108213. https://doi.org/10.1016/j.drugalcdep.2020.108213

70 National Alliance for Mental Illness. (n.d.) *Support Groups*. https://www.nami.org/Support-Education/Support-Groups

71 Zweben, J. E., & Ashbrook, S. (2012). Mutual-help groups for people with co-occurring disorders. *Journal of Groups in Addiction & Recovery, 7*(2–4), 202–222. https://doi.org/10.1080/1556035X.2012.705700

72 Rowa, K., Antony, M. M., & Swinson, R.P. (2007). Exposure and response prevention. In M.M. Antony, C. Purdon, & L.J. Summerfeldt (Eds.), *Psychological treatment of obsessive-compulsive disorder: Fundamentals and beyond* (pp. 79–109). American Psychological Association. https://doi.org/10.1037/11543-004

73 Foa, E. B., Yadin, E., & Lichner, T. K. (2012). *Exposure and response (ritual) prevention for obsessive-compulsive disorder: Therapist guide*. Oxford University Press. https://psycnet.apa.org/record/2012-06291-000

74 Abramowitz, J. S. (1996). Variants of exposure and response prevention in the treatment of obsessive-compulsive disorder: A meta-analysis. *Behavior therapy*, *27*(4), 583-600. https://doi.org/10.1016/S0005-7894(96)80045-1

75 Treatment Innovations. (2020). *Seeking Safety*. https://www.treatment-innovations.org/seeking-safety.html

76 Des Jarlais, D. C., Feelemyer, J., LaKosky, P., Szymanowski, K., & Arasteh, K. (2020). Expansion of syringe service programs in the United States, 2015–2018. *American Journal of Public Health, 110*(4), 517-519. https://doi.org/10.2105/AJPH.2019.305515

77 Razaghizad, A., Windle, S. B., Filion, K. B., Gore, G., Kudrina, I., Paraskevopoulos, E., Kimmelman J., Martel M. O., & Eisenberg, M. J. (2021). The effect of overdose education and naloxone distribution: An umbrella review of systematic reviews. *American Journal of Public Health, 111*(8), e1-e12. https://doi.org/10.2105/AJPH.2021.306306

78 SAMHSA (2023). Harm Reduction Framework. Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/find-help/harm-reduction/framework

79 Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice, 10*(2), 144-15. https://doi.org/10.1093/clipsy/bpg016

80 Garland, E. L., Manusov, E. G., Froeliger, B., Kelly, A., Williams, J. M., & Howard, M. O. (2014). Mindfulness-oriented recovery enhancement for chronic pain and prescription opioid misuse: Results from an early-stage randomized controlled trial. *Journal of Consulting and Clinical Psychology, 82*(3), 448-459. https://doi.org/10.1037/a0035798

81 Witkiewitz, K., Bowen, S., Harrop, E. N., Douglas, H., Enkema, M., & Sedgwick, C. (2014). Mindfulness-based treatment to prevent addictive behavior relapse: Theoretical models and hypothesized mechanisms of change. *Substance Use & Misuse, 49*(5), 513-524. https://doi.org/10.3109/10826084.2014.891845

82 Li, W., Howard, M. O., Garland, E. L., McGovern, P., & Lazar, M. (2017). Mindfulness treatment for substance misuse: A systematic review and meta-analysis. *Journal of Substance Abuse Treatment, 75*, 62-96. https://doi.org/10.1016/j.jsat.2017.01.008

83 SAMHSA. (2011). *White paper on screening, brief intervention and referral to treatment (SBIRT) in behavioral healthcare*. https://www.samhsa.gov/sites/default/files/sbirtwhitepaper_0.pdf

84 Unutzer, J., Harbin, H., Schoenbaum, M., & Druss, B. (2013). *The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes. Health Home Information Resource Center*. https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf

85 University of Washington. (n.d.) *Principles of collaborative care*. Psychiatry & Behavioral Sciences Division of Population Health, Advancing Integrated Mental Health Solutions (AIMS) Center. https://aims.uw.edu/principles-of-collaborative-care/

86 Reiter, J. T., Dobmeyer, A. C., & Hunter, C. L. (2018). The primary care behavioral health (PCBH) model: An overview and operational definition. *Journal of Clinical Psychology in Medical Settings*, *25*, 109-126. https://doi.org/10.1007/s10880-017-9531-x

87 Secades-Villa, R., Garcia-Rodriguez, O., Garcia-Fernandez, G., Sanchez-Hervas, E., Fernandez-Hermida, J. R., & Higgins, S. T. (2011). Community reinforcement approach plus vouchers among cocaine-dependent outpatients: Twelve-month outcomes. *Psychology of Addictive Behavior, 25*(1), 174-9. https://doi.org/10.1037/a0021451

88 Roozen, H.G., Boulogne, J. J., Van Tulder, M. W., Van Den Brink, W., De Jong, C., & Kerkhof, A. (2004). A systematic review of the effectiveness of the community reinforcement approach in alcohol, cocaine and opioid addiction. *Drug and Alcohol Dependence, 74*(1), 1-13. https://doi.org/10.1016/j.drugalcdep.2003.12.006

89 United States Department of Health and Human Services. (2016). *Facing addiction in America: The surgeon general's report on alcohol, drugs, and health*. Office of the Surgeon General. https://www.hhs.gov/sites/default/files/facing-addiction-in-america-surgeon-generals-report.pdf

90 SAMHSA. (2021). *Advisory: screening and treatment of substance use disorders among adolescents*. https://store.samhsa.gov/sites/default/files/pep20-06-04-008.pdf

91 Szapocznik, J., Schwartz, S. J., Muir, J. A., Brown, C. H. (2012). Brief strategic family therapy: An intervention to reduce adolescent risk behavior. *Couple & Family Psychology, 1*(2), 134-145.Shttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC3737065/

92 Tan, J. X., & Fajardo, M. L. R. (2017). Efficacy of multisystemic therapy in youths aged 10-17 with severe antisocial behaviour and emotional disorders: Systematic review. *London Journal of Primary Care*, *9*(6), 95-103. https://doi.org/10.1080/17571472.2017.1362713

93 Henggeler, S. W., & Schaeffer, C. M. (2016). Multisystemic therapy®: Clinical overview, outcomes, and implementation research. *Family Process*, *55*(3), 514-28. https://doi.org/10.1111/famp.12232

94 SAMHSA. (2020). *Substance use disorder treatment and family therapy: Treatment Improvement Protocol (TIP) Series 39.* https://www.samhsa.gov/resource/ebp/tip-39-substance-abuse-treatment-family-therapy

95 Liddle, H. A. (2016). Multidimensional family therapy: evidence base for transdiagnostic treatment outcomes, change mechanisms, and implementation in community settings. *Family Process, 55*(3), 558-76. https://doi.org/10.1111/famp.12243

96 Van der Pol, T. M., Hoeve, M., Noom, M. J., Stams, G., Doreleijers, T., Van Domburgh, L., & Vermeiren, R. (2017). Research review: the effectiveness of multidimensional family therapy in treating adolescents with multiple behavior problems - A meta-analysis. *Journal of Child Psychology and Psychiatry, and Allied Disciplines, 58*(5), 532–545. https://doi.org/10.1111/jcpp.12685

97 Jason, L. A., Salina, D., & Ram, D. (2016). Oxford recovery housing: Length of stay correlated with improved outcomes for women previously involved with the criminal justice system. *Substance Abuse*, *37*(1), 248–254. https://doi.org/10.1080/08897077.2015.1037946

98 Polcin, D. L., Korcha, R., Bond, J., & Galloway, G. (2010). Eighteen-month outcomes for clients receiving combined outpatient treatment and sober living houses. *Journal of Substance Use, 15*(5), 352-66. https://doi.org/10.3109/14659890903531279

99 SAMHSA. (2023). *Best Practices for Recovery Housing*. (Publication No. PEP23-10-00-002). Rockville, MD: Office of Recovery, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/resource/ebp/best-practices-recovery-housing

100 Ilser, B., Mineau, M., Hunter, B., Callahan, S., Gelfman, N., Bustos, Y., Dovale, I., Peterson, A., & Jason, L. (2017). Relationship themes present between parents and children in recovery homes. *Alcoholism Treatment Quarterly, 35*(3), 200-212. https://doi.org/10.1080/07347324.2017.1317483

101 Contreras, R., Alvarez, J., Digangi, J., Jason, L. A., Sklansky, L., Mileviciute, I., Navarro, E., Gomez, D., Rodriguez, S., Luna, R., Lopez, R., Rivera, S., Padilla, G., Albert, R., Salamanca, S., & Ponziano, F. (2012). No place like home: Examining a bilingual-bicultural, self-run substance abuse recovery home for Latinos. *Global Journal of Community Psychology Practice*, *3*(3), 42. https://doi.org/10.7728/0303201202

102 SAMHSA. (2023). *Expanding access to and use of behavioral health services for people experiencing homelessness.* Mental Health and Substance Use Policy Laboratory. https://www.samhsa.gov/resource/ebp/expanding-access-behavioral-health-services-people-experiencing-homelessness

103 Sacks, S., & Sacks, J. Y. (2010). Research on the effectiveness of the modified therapeutic community for persons with co-occurring substance use and mental disorders. *Therapeutic Communities, 31*(2), 176-211. http://www.atca.com.au/wp-content/uploads/2012/07/International-Journal-Therapeutic-Communities-2010-312.pdf#page=86

104 SAMHSA. (2008). Evidence-based practices Knowledge Information Transformation: Building your program: Assertive Community Treatment. https://store.samhsa.gov/sites/default/files/sma08-4344-buildingyourprogram.pdf

105 Drake, R. E., Becker, D. R., Clark, R. E., & Mueser, K. T. (1999). Research on the individual placement and support model of supported employment. *Psychiatric Quarterly*, 70, 289-301. https://doi.org/10.1023/a:1022086131916

106 Drake, R. E., Bond, G. R., Goldman, H. H., Hogan, M. F., & Karakus, M. (2016). Individual placement and support services boost employment for people with serious mental illnesses, but funding is lacking. *Health Affairs, 35*(6), 1098–1105. https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0001

107 Rural Health Information Hub. *Hub and spoke model.* Rural Health Information Hub. https://www.ruralhealthinfo.org/toolkits/moud/2/systems-of-care/hub-and-spoke

108 SAMHSA. (2021). *2021 Report to Congress on the State Opioid Response Grants (SOR)*. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/2021-state-opioid-response-grants-report.pdf

109 Brooklyn, J. R., & Sigmon, S. C. (2017). Vermont Hub-and-Spoke Model of Care for Opioid Use Disorder. *Journal of Addiction Medicine, 11*(4), 286–292. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5537005

Issue Brief: Co-Occurring Mental Health and Substance Use Services

Acknowledgements

This Issue Brief was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract number HHSS283201700019I_75S20322F42003 (Ref. No. 283-17-1903) with SAMHSA, U.S. Department of Health and Human Services (HHS). Michelle Gleason served as contracting officer representative.

Disclaimer

The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of SAMHSA. Listings of any nonfederal resources are not all-inclusive. Nothing in this document constitutes a direct or indirect endorsement by SAMHSA or HHS of any nonfederal entity's products, services, or policies, and any reference to nonfederal entity's products, services, or policies should not be considered as such.

Public Domain Notice

All material appearing in this publication is in the public domain and may be reproduced or copied without permission from SAMHSA. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, HHS.

Electronic Access and Printed Copies

Products may be downloaded at http://store.samhsa.gov. Products available in print may be ordered at http://store.samhsa.gov or by calling SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727).

Recommended Citation

Substance Abuse and Mental Health Services Administration (SAMHSA): *Co-Occurring Mental Health and Substance Use Services.* Publication No. PEP24-01-008. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2024.

Originating Office

Division of State and Community Systems Development, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857.

Photos are for illustrative purposes only. Any person depicted in a photo is a model.

Nondiscrimination Notice

The Substance Abuse and Mental Health Services Administration (SAMHSA) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). SAMHSA does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

La Administración de Servicios de Salud Mental y Abuso de Sustancias (SAMHSA) cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, origen nacional, edad, discapacidad, religión o sexo (incluido el embarazo, la orientación sexual y la identidad de género). SAMHSA no excluye a las personas ni las trata de manera diferente por motivos de raza, color, origen nacional, edad, discapacidad, religión o sexo (incluido el embarazo, la orientación sexual y la identidad de género)

Publication No. PEP24-01-008
Released 2024

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.