2024

Increasing Equitable Access to Care for Co-Occurring Mental Health and Substance Use Disorders

Connected and Strong

Eighth in a Series of Ten Technical Assistance Briefs to Foster Unity and Strengthen Continuity Across Crisis Response and Treatment Systems

SAMHSA
Substance Abuse and Mental Health Services Administration

Increasing Equitable Access to Care for Co-Occurring Mental Health and Substance Use Disorders

Acknowledgments

Authors: Ayorkor Gaba, PsyD, Angela Wangari Walter, PhD, MPH, MSW, Debra A. Pinals, MD

Increasing Equitable Access to Care for Co-Occurring Mental Health and Substance Use Disorders was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201700024I/75S20321F42001. Tison Thomas served as contracting officer representative.

Disclaimer

Public Domain Notice

Electronic Access

This publication may be downloaded from https://store.samhsa.gov

Recommended Citation

Gaba A, Wangari Walter A, Pinals DA: *Increasing Equitable Access to Care for Co-Occurring Mental Health and Substance Use Disorders*. Publication No. PEP24-01-025. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2024

Originating Office

Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857, SAMHSA. Publication No. PEP24-01-025. Released 2024.

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).

Publication No. PEP24-01-025

Released 2024

"Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death."

—Martin Luther King Jr.

Abstract

Co-occurring mental health and substance use disorders (CODs) are a significant public health problem in the United States, and few receive optimal access to quality care. People with CODs are particularly vulnerable because of the multicomplexity of their health conditions and social care needs. With crisis services aiming to serve individuals with CODs, ensuring that health and social care systems can provide comprehensive health care and supports is critical. Without optimal access, this population faces significant harm from CODs and their associated social and economic consequences, including marginalization in the health care system, involvement in the criminal legal system, and homelessness. The co-occurrence of psychosocial, health, and structural problems among those with CODs, and the excess disease burden experienced by people with CODs from historically marginalized groups (e.g., Black men, LGBTQI+ individuals, or unhoused/unstably housed women) present unique care considerations and require an intentional approach to advancing equitable access to COD care. This paper first describes the prevalence of CODs. Second, the Sequential Intercept Model and the Upstream model are used to inform the intersection of CODs and legal issues. Third, the paper highlights two case studies to illustrate the current COD landscape, barriers to accessing integrated treatment for CODs, and the need for better integration across the lifespan and COD care continuum. Lastly, policy, program, and practice recommendations are discussed to inform efforts to mitigate barriers and differential access to COD treatment.

Highlights

- Although treatment guidelines recommend that people with CODs receive integrated treatment to address both substance use and mental disorders, concurrent treatment is seldom provided in the current landscape.
- Mitigating the impact of social determinants of health plays a vital role in reducing disparities in COD access and quality of care.
- Culturally adapting evidence-based interventions and centering equitable implementation is essential for advancing health equity for priority populations.

Recommendations

1. Prioritize and fully fund COD screening, assessment, and treatment across the age spectrum and continuum of care.
2. Prioritize and fund integrated COD treatment.
3. Fund COD stigma reduction and public awareness campaigns.
4. Require data collection to assess COD service availability as its own service or as part of mental health treatment and substance use disorder treatment programs.
5. Improve COD education and training for the workforce.
6. Assess structural barriers to COD treatment access and engagement.
7. Identify and de-implement policies, programs, and practices contributing to disparities.
8. Fund case management, navigation services, and other linkage supports to address social determinants of health needs.
9. Fund and implement evidence-informed and evidence-based programs (e.g., specialty courts) to divert youth and adults with CODs from carceral settings to community-based treatment settings.
10. Ensure Medicaid coverage at release for all Medicaid-eligible individuals released from carceral settings and other institutions such as state hospitals, and explore new opportunities for benefit coverage pre-release.
11. Provide universal screening, prevention, and treatment for substance use disorders, including opioid use disorder, spanning carceral and community settings.

Introduction

As outlined in President Biden's Unity agenda,[1] the United States is facing an unprecedented behavioral health crisis among people of all ages. Approximately 7.9% (20.4 million) of adults (18 and older) and 3.4% (856,000) of adolescents (ages 12 to 17) in the United States had co-occurring mental health and substance use disorders (CODs) in 2023.[2] In the aftermath of the COVID-19 pandemic, these numbers continued to increase. Few receive optimal access to quality care. One pre-pandemic study noted that only 7.4% of individuals with CODs received treatment for both disorders, and 55% received no treatment for either.[3] A more recent study of people with opioid use disorder (OUD) and mild/moderate mental illness or serious mental illness (SMI) showed that only 16% and 32% received treatment for both conditions, respectively. In contrast, only 21% of those with SMI and OUD received behavioral health treatment.[4]

Persons with CODs are a particularly vulnerable and priority population because of the multicomplexity of their health conditions and social care needs. With crisis services aiming to serve individuals with mental health disorders of all kinds, including CODs, it is more important than ever to ensure that the provider network can support these individuals. Without access to services, people with CODs face significant harm from the COD itself and associated social and economic consequences, including marginalization in the health care system, involvement in the criminal legal system, homelessness, and others. The excess disease burden experienced by people with CODs from historically marginalized groups (e.g., Black men, LGBTQI+ individuals, and marginally housed women), which has been increased and highlighted by COVID-19, presents unique care considerations and requires an intentional approach to advancing equitable access to COD care.[5,6,7]

This year, the 2024 Technical Assistance Coalition assessment papers produced by the National Association of State Mental Health Program Directors on behalf of the Substance Abuse and Mental Health Services Administration (SAMHSA) follow the theme of the first paper in the series, *Connected and Strong: Strategies for Accessible and Effective Crisis and Mental Health Services,*[8] which explores facets of Biden's Unity Agenda related to improving services and access to crisis services and beyond.[9] The papers are compiled into a compendium of 10 technical assistance briefs for policymakers. This paper, which represents the eighth in the series within this compendium, focuses on connecting Americans with care and highlights the needs of those with CODs. In doing so, this paper will address the following key areas:

- the increasing prevalence of CODs and unmet treatment needs, including among marginalized, minoritized, and underserved groups
- structural and sociocultural barriers to care
- the current state of treatment
- evidence-informed approaches to advance equitable access and engagement in COD treatment

The case studies of "Kobe" and "Filsan" and their families in this paper further illustrate barriers to, and facilitators of, equitable access and engagement in the continuum of COD care and illuminate recommendations to advance equity across the continuum. Although fictional, their stories are based on the current research and the coauthors' collective experiences providing care to people with CODs and implementing evidence-based COD care in various settings (e.g., legal, school, and clinical systems).

Prevalence of Co-Occurring Mental and Substance Use Disorders

CODs are among the most pressing health conditions cutting across the crisis continuum. As noted previously, prevalence rates among adults over age 18 are alarming. In addition, young adults between ages 18 to 25 had the highest prevalence (14.1%) of co-occurring substance use disorder (SUD) and any mental illness (AMI) in the past year compared to adults ages 26 to 49 (10.9%) and adults ages 50 or older (3.6%).[10]

Among racial and ethnic subgroups, co-occurring SUD and AMI in the past year were highest among adults reporting two or more races (13.3%), followed by American Indian or Alaskan Native (11.5%), White (8.4%), Black or African American (7.8%), Hispanic or Latino (7.1%), and Asian (3.5%).[11] Despite lower prevalence rates among some people of color compared to their Non-Hispanic White counterparts, individuals of color with behavioral health conditions experience a higher disease burden, including disproportionate contact with the criminal legal and child welfare systems and barriers to quality.[12,13]

Sexual (individuals who identify as lesbian, gay, queer, bisexual, pansexual, etc.) minoritized individuals have also been shown to be two to three times more likely to have CODs when compared to heterosexual individuals.[14] According to a 2023 report from SAMHSA utilizing data from the National Surveys on Drug Use and Health (NSDUH), more than one in five bisexual females had a COD in the past year and sexual minority males were more than twice as likely to have both a mental illness and substance use disorder than heterosexual males.[15]

Approximately 3.4% (or 856,000) of adolescents (ages 12 to 17) had both a major depressive episode (MDE) and a SUD in the past year.[16] Among this adolescent age group, 2.8% (or 717,000) had both an MDE with severe impairment and a SUD in the past year.[17] The prevalence rates for youth are limited and vary greatly for several reasons, including data availability, varying definitions of youth, and misdiagnosis. However, epidemiological data show that the age of onset for 62.5% of mental disorders is 25 years or younger. Studies estimate the median prevalence of function-impairing child and adolescent psychiatric disorders at 12%, and preexisting mental disorders are a risk factor for the emergence and progression of SUD.[18]

Prevalence of binge drinking among youth seems to be on the rise but poorly recognized early on, with similar rates for girls and boys ages 14 to 18.[19] The inconsistent youth prevalence data

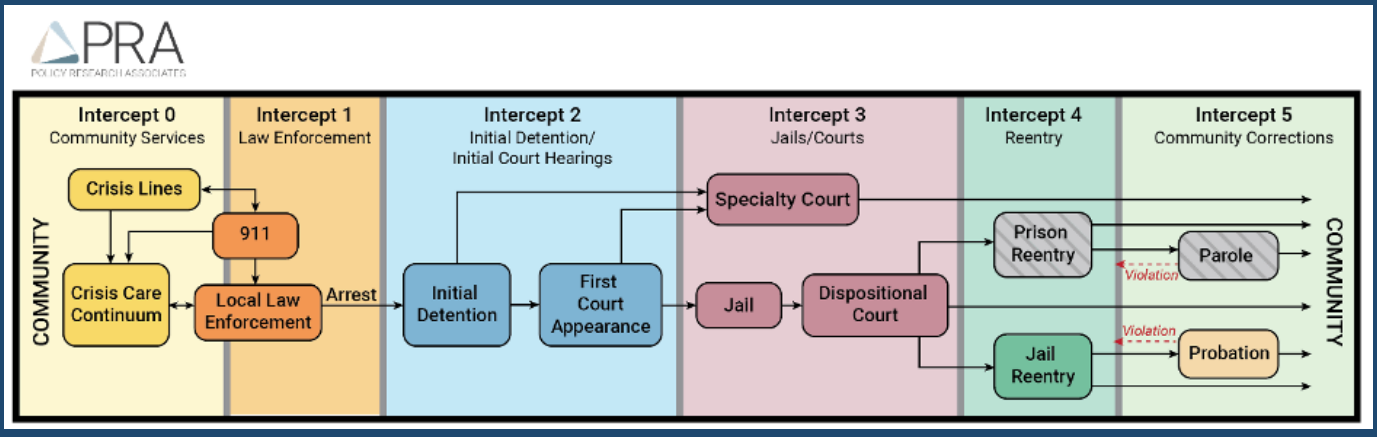
underscores the importance of early identification and treatment of childhood and adolescent disorders to reduce the emergence of CODs. In addition, many treatments with a focus on CODs that are thought to improve SUD outcomes significantly have been adapted to the youth population. However, these treatments and supports— such as behavioral therapy, medications for alcohol use disorder (MAUD), medications for Opioid Use Disorder (MOUD), family therapy, mutual support programs, motivational interviewing, and contingency management— are currently insufficiently available and underutilized.[20]

Guiding Models Recognizing the Intersection of CODs and Legal Issues

The Sequential Intercept Model and the Upstream Model

Due to the high risk of juvenile justice and criminal legal system involvement among people with COD, two models will be utilized in this paper—the Sequential Intercept Model (SIM)[21] and the Upstream model[22] to illustrate the trajectory of individuals with CODs who interface with the child welfare, criminal justice, juvenile justice, and behavioral health systems. SIM (**Figure 1**) is a systems-level framework for criminal justice, mental health, and substance use stakeholders to divert adults with mental health, substance use, or COD from the criminal justice system to community mental health and SUD services. The SIM concept was introduced by Munetz and Griffin[23] and updated by Abreu and colleagues[24] to incorporate an Intercept 0 of crisis services as part of the first potential intercept to divert an individual from legal processes.

Figure 1: The Sequential Intercept Model

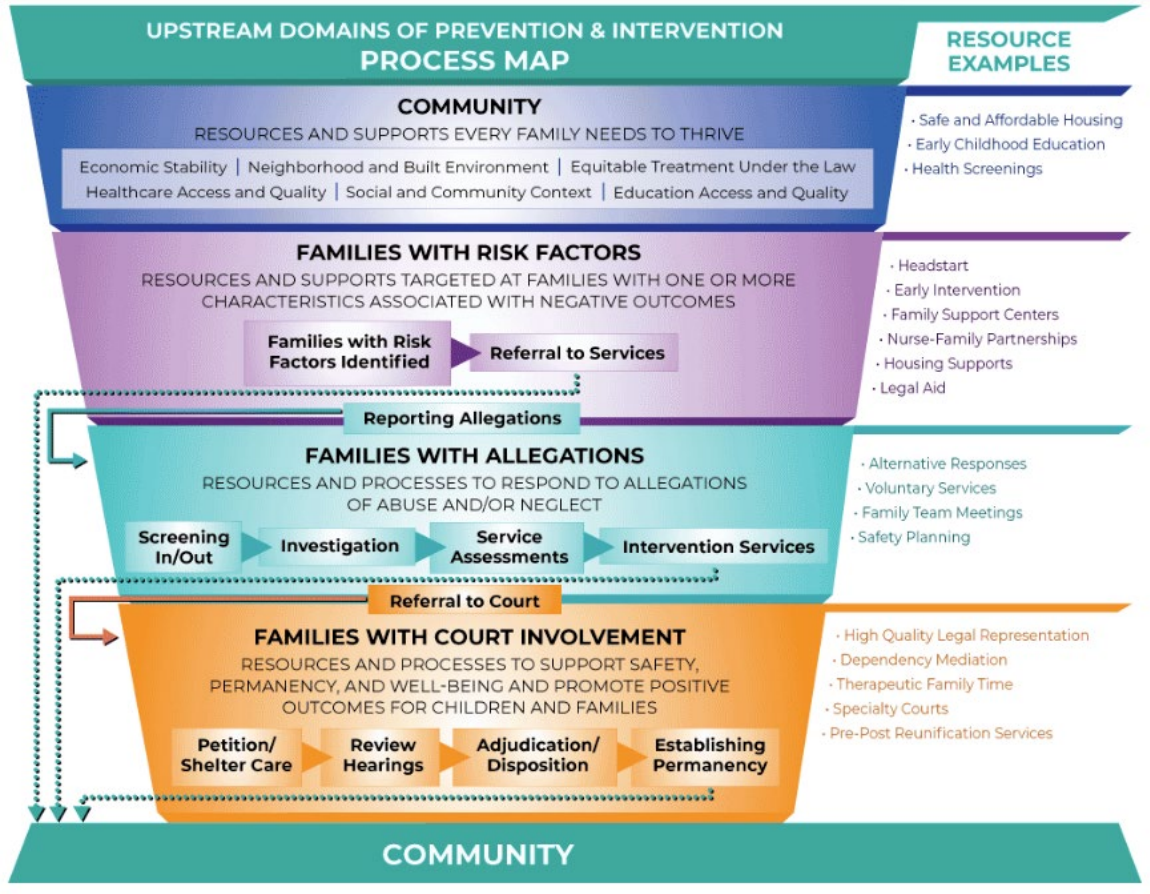


Source: Abreu D, Parker TW, Noether CD, et al: Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. Behav Sci Law 2017; 35(5-6):380–395. https://doi.org/10.1002/bsl.2300

In the new Upstream model (**Figure 2**), courts and other stakeholders have identified numerous potential intervention areas to keep youth and families from deeper involvement into court processes.[25] The Upstream model attempts to capture the systems and structures that may need to be considered in addressing a youth or parent with COD where the family system is involved, prioritizing the idea that a community as a whole can help support the individuals who reside within it. The Upstream model aims to support data-driven, evidence-based, and culturally appropriate practices; facilitate and enhance collaboration and coordination among partners across systems; and reduce child maltreatment, family disruption, and trauma. It also requires an examination of the needs of individuals with COD challenges from a multigenerational perspective.

For this paper, the authors utilize these two models to illustrate resources, gaps, and recommendations in COD services across the developmental spectrum to inform the advancement of holistic and equitable COD treatment and support access, engagement, and outcomes.[26]

Figure 2: The Upstream model



UPSTREAM WAS DEVELOPED BY THE NATIONAL CENTER FOR STATE COURTS WITH FUNDING IN PART FROM THE STATE JUSTICE INSTITUTE.

Source: National Center for State Courts: The Upstream Model. Williamsburg, VA. Accessed July 2023.

Case Studies

The stories of Kobe and Filsan outlined below contain important components of crisis services throughout the continuum of COD care (e.g., school, correctional, and community-based), social determinants of health (SDoH) needs impacting COD treatment inequities, the intersectionality of systems (e.g., behavioral health, child welfare, and criminal legal systems), and the need for equity considerations in COD care. These case studies illustrate strengths and gaps in the current COD care continuum and strategies to advance equity across the continuum.

Kobe

Kobe is a 25-year-old African American and Pacific Islander cisgender man. Kobe is diagnosed with bipolar disorder (with periodic psychotic symptoms) and polysubstance use disorder. Cocaine is his most "problematic" substance. Kobe was recently married, and his wife also has COD. He is a high school graduate and works sporadically as a DJ.

Kobe's father is African American (born and raised in the United States) and completed his military service in Samoa, and his mother is Samoan (born and raised in Samoa). Kobe is the eldest of three siblings. Due to increased economic stressors, loss of natural supports, and acculturative stress, his father's alcohol use and his mother's depression worsened when they moved to the United States just prior to Kobe's birth. In the predominantly White rural town where they lived, Kobe was severely harassed because of his racial identity. At age 12, Kobe began using substances and exhibiting behavioral and psychosocial problems (e.g., irritability, racing thoughts, and fighting with his parents and at school) to cope. The family had brief Child Protective Service involvement following a physical altercation where Kobe attacked his father. No evidence of child abuse or neglect was found, and the case was quickly closed.

From ages 10 to 21, the church played a significant role in Kobe's and his family's lives. The church engaged him in the church band, occasionally took him in when things got rough at home, and provided spiritual counseling to the family. Kobe's family contemplated formal treatment but believed that the predominantly White providers in their region would not understand their family or culture (e.g., beliefs and language), feared their other children would be removed, and couldn't make the long drive to treatment. Kobe graduated high school one year later than anticipated and maintained a seasonal landscaping job until age 21, when he moved across the country to pursue employment. From ages 21 to 25, he struggled with employment, housing, substance use, and internalized mental health stigma.

One afternoon, Kobe begins destroying his ID, stating that he was being "tracked" by it; disrobing; mumbling incoherently; and becoming physically aggressive towards his wife. With their limited resources, he and his wife are temporarily staying with acquaintances who are becoming increasingly frustrated with his behavior; concerned about safety, they have threatened to call the police. Kobe's wife is worried because he had displayed similar behavior a few

months before and was later hospitalized. At that time, he was diagnosed with bipolar disorder, admitted to inpatient mental health treatment, and stepped down to a partial hospital program. However, unbeknownst to his wife and family, he has stopped attending therapy and taking his medication.

Due to recent news coverage of Black men with mental health conditions being harmed by police during mental health crises, his wife hesitates to involve crisis psychiatric services. She tries to convince Kobe to self-present to the local crisis stabilization unit. Kobe refuses her advice and becomes physically aggressive. With increasing safety concerns and his refusal to get help, their acquaintances call the local mobile crisis response service, who alert the police because Kobe had "attacked" his wife. Despite his wife reporting to the police that he is suffering a "mental breakdown" and needs help, he is arrested for domestic violence.

Following his arrest, Kobe's family quickly posts his bail. Kobe is released from jail and arrested the next day for an assault committed while under the influence. Kobe is ultimately sentenced to a 15-year prison term for that assault. He is imprisoned thousands of miles from his family, has limited in-person contact with them (further limited by COVID-19 at the time these events occurred), and has received little to no behavioral health care, all while his physical and mental health significantly declined. After serving 10 years, he is granted parole and transferred to a pre-release unit.

Following a complicated petition process, he can parole to his home state. In nine months, he will return to his parents' home in the small rural town where he was raised, as a 36-year-old man. Kobe's parents are plagued by financial stressors from lawyer fees, shame, and stigma surrounding Kobe's arrest (which they have kept hidden from most of their friends and family). Kobe's siblings struggle with feelings of depression, guilt, and grief related to their brother's incarceration as well. Although his family is excited about his release, they are concerned about reunification and post-release life, especially his ability to secure a job and independent housing, stay sober, and stay out of prison.

Unpacking Kobe's Story

Kobe's story underscores many key elements in the prevalence of CODs in the United States. Kobe's COD journey started in his youth. Kobe began exhibiting symptoms of COD as early as 12 years old, including binge drinking and cannabis use, along with periods of having trouble sleeping but not feeling tired, irritability leading to physical altercations, racing thoughts, and engaging in risky behaviors. Despite school concerns, brief involvement with the child welfare system, and minor interactions with the local police, Kobe was never assessed for COD. Despite contact with providers across the system, many dismissed or missed his symptoms, labeling him a "bad kid" and his parents as "being out of control of their child." Interestingly, his church community identified his "challenges" early on and linked him and his family to faith-based counseling. Faith-based counseling and the church provided linkage to structured prosocial recreational activities, including free access to musical instruments, space to practice, and

lessons, which ultimately cultivated his talents and boosted his self-esteem. These interventions could prevent future crises from emerging and set the stage for infrastructure support to refer someone back to if they do show up in crisis. In this way, they reflect the SIM Intercept 0 prevention efforts and suggest a need to provide COD training and consultation to faith-based organizations. More information on faith-based approaches can be found in the ninth paper in the series of 2024 technical assistance briefs, *Intersectionality: Faith, Mental Health, and Community Partnerships*.[27]

Filsan

Filsan emigrated to the United States with his mother and two older siblings at age 13. As a legal immigrant, his social and psychological well-being has been impacted by the process of acculturation; lack of coordinated social and health care systems; economic hardships; racism; discrimination; and suboptimal access to key SDoH, including struggles with affordable housing, poor access to affordable health care, and loss of social and community supports (e.g., loss of familial supports, diminished cultural identity, and cultural bereavement). Filsan's family worked long hours, resulting in missed opportunities for interaction between family members about social-emotional wellness and reduced capacity for parental supervision and monitoring. The cumulative exposure to toxic stress as Filsan navigated individual, organizational, and community ecosystems, coupled with a limited social support infrastructure, contributed to the early onset of psychological distress (e.g., anxiety, depression, and other mood disorders and post-traumatic stress disorder) and substance use (e.g., alcohol, smoking, and cannabis use) in his adolescent years.

As a young adult (ages 19 to 24) and into his college trajectory phase, Filsan used alcohol and cannabis extensively, experienced "anxiety," was "uneasy interacting with others," and had "constant worry, interfering with getting things done," resulting in poor academic performance and causing him to require additional years to complete college coursework. Linkages to mental health resources and other university support systems were not made available and, if available, were not utilized.

As he finished college, the shifting social and environmental contexts (i.e., finding employment, managing student loans, and losing community of peers) exacerbated Filsan's mood disorders (e.g., anxiety and depression), resulting in a tremendous downward spiral. Filsan's depressive episodes have increased and were prolonged, and his alcohol and cannabis use disorders became severe. The impact of COD resulted in the loss of employment (firing), isolation from family members, loss of friends and social networks, and involvement with the legal system (including charges of disorderly conduct and operating under the influence). Filsan was fortunate to participate in a pre-arraignment diversion program and avoid creating a criminal record.

All of this puts strain on his family: the individual and interconnected stigmas related to substance use and mental health, stressors of interacting with the legal system, lack of care

coordination across systems, trauma brought on by these experiences and the "failed dream" of Filsan's lack of employment, poor self-sufficiency, and deviant behaviors. With no support to assist with making informed decisions about care options, Filsan's mother sent him back to their home country to receive COD treatment at a privately owned rehabilitation center. Despite the high burden of CODs, there is a significant shortage of resources available to prevent, diagnose, and treat CODs in low- and middle-income countries and resource-scarce settings. As such, Filsan entered a fragmented mental health service delivery system heavily focused on faith-based problem-solving and poor integration into primary care systems. The lack of focus on SDoH (e.g., employment, housing, food insecurity, access to evidence-based treatment, and interpersonal relationships [i.e., family supports]) and the lack of engagement and retention in evidence-based treatment result in volatile situations and undiagnosed and untreated CODs.

Filsan's COD worsened, resulting in a revolving door of sober house stays (3–6 months) with limited organizational infrastructure for trauma-informed, evidence-based care. Eventually, a hospitalization due to a substance-induced psychotic episode and acute manifestations of a SUD galvanized the family to transfer Filsan's care to the United States. At the core of this process was ensuring that a key SDoH, health insurance (i.e., Medicaid), was in place for Filsan (a naturalized US citizen) to receive trauma-informed, evidence-based treatment and supports by an integrated team of providers working together to treat both SUD and mental health disorders. This included participation in partial hospitalization programs, working with case managers to provide hands-on skills training and support (e.g., job interview readiness), linkages to recovery support services, and access to peer recovery support specialists. Filsan is now engaged in integrated trauma-informed, evidence-based treatment (psychotherapy and pharmacology), is rebuilding relationships with family, and is in recovery.

Unpacking Filsan's Story

Filsan's story illustrates the unique challenges for transitional age youth between 16 and 25 years old. This transitional period presents challenges for even the most well-adjusted youth as they navigate new roles in educational, vocational, and relationship domains. Substantial adversity during this developmental period can delay or derail the achievement of normative transitions, with the potential for setbacks associated with long-term negative outcomes. This has been well-studied and promulgated in the literature on adverse childhood experiences (ACEs).[28,29] Despite its popularity, most of the knowledge regarding ACES is based on data from predominantly White, middle- and upper-middle-class samples. Scholars have critiqued the ACEs for not including community-level adversities disproportionately impacting minoritized youth, such as discrimination, witnessing community violence, and living in foster care. To counter this concern, the Philadelphia ACE project (www.philadelphiaaces.org) launched an expanded ACE tool integrating conventional (household) and expanded (community-level) ACEs to better assess all youth. This is especially relevant because community-level adversities (e.g., everyday experiences of racism and discrimination) may increase youth's risk of mental health problems such as depression and anxiety during this critical transition period. These symptoms often go

unnoticed because racially and ethnically minoritized youth are more likely to present with somatization in depression instead of sadness, leading to under- and misdiagnoses. Despite the negative influence of ACEs on youth development, the lifelong effects of positive childhood experiences can mitigate the detrimental effects of adverse experiences.[30] Hence, current best practices recommend assessing and addressing both positive and adverse childhood experiences. This may be especially impactful for minoritized and marginalized youth, who are often conceptualized and treated from a deficit perspective. Looking at positive experiences alongside adverse experiences helps to identify individual and cultural strengths, promotes resilience, and is well aligned with the strength-based principles embedded within the Upstream model. Despite current knowledge about childhood experiences, the need for more culturally adapted measurement, and stressors for transitional age youth, few systems of care or providers specialize in culturally humble and competent care for transitional age youth.

The Current COD Treatment Landscape and the Need to Drive for Further Integration

CODs influence each other, and the presence of mental illness and SUD contributes to more significant health and social functional impairment; worse treatment outcomes; higher morbidity and mortality; increased treatment costs; and higher risk of poor social outcomes, including homelessness and incarceration, than each of the individual disorders.[31] Current treatment guidelines recommend that people with CODs receive integrated treatment to simultaneously address both disorders and accompanying psychosocial needs.[32]

Two examples of evidence-based, integrated COD interventions are integrated dual diagnosis treatment (IDDT) and Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION).[33] IDDT is an evidence-based, unified approach to treating SUD, mental health disorders, and related needs. It combines the different therapeutic techniques for mental illness with the specific treatment strategies for SUDs to form a comprehensive program that treats the entire person and their various struggles. IDDT is not limited to treating just one disorder or problem at a time. It treats them all in one place, in one program, using the same team of clinicians.

Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking (MISSION) is an evidence-based COD intervention that includes five integrated components: (a) Critical Time Intervention case management, an intensive community-based support that decreases in intensity over time as participants transition to community-based care; (b) dual recovery therapy, a form of IDDT composed of 13 structured group treatment sessions designed to treat COD simultaneously; (c) peer support, including 11 recovery-oriented group sessions delivered by an individual with lived experience of COD and criminal justice involvement; (d) vocational and educational support; and (e) trauma-informed care. MISSION has been effectively implemented with people experiencing homelessness, veterans, and people in

criminal legal settings and those transitioning from them (e.g., jails, prisons, reentry, probation-involved, and specialty courts) and was included in SAMHSA's Evidence-Based Practices Resource Center, www.samhsa.gov/resource-search/ebp.

Recommendation #1: Prioritize and fully fund COD screening, assessment, and treatment across the age spectrum and continuum of care

Adolescence is a stage of rapid physical, emotional, and social development. Adolescents may experience mood changes during this stage and increasingly engage in risk-taking behaviors, including substance use. These potential COD symptoms are often dismissed as normative developmental acting out or milestones. Due to the complexities of COD presentation in youth, screening and assessment are critical. Treatment providers must be responsive to the child and youth developmental stages and understand how adolescent care differs from adult treatment. The Biden-Harris Administration has provided funding to strengthen school-based mental health services and address the youth mental health crisis.[a] This is a step toward enhancing early identification of CODs in early childhood and youth and halting or slowing COD progression in adults. Youth also interface with providers across multiple systems, including school, child welfare, community-based behavioral health, pediatric health, juvenile justice, and faith-based. Each of these providers can play an important role in identification and referral. As the Upstream model posits, the needs related to CODs in youth and families should be viewed holistically and addressed by the broader community. Funding is needed to train the breadth of providers and systems that can potentially screen, assess, link, and treat youth showing early signs of CODs.

[a] ***Biden-Harris Administration Takes Action to Help Schools Deliver Critical Health Care Services to Millions of Students. Washington, DC, US Department of Education, May 18, 2023. www.ed.gov/news/press-releases/biden-harris-administration-takes-action-help-schools-deliver-critical-health-care-services-millions-students***

Despite the high prevalence of CODs, their impact on functioning across multiple domains, and COD treatment guidelines, many people in need of COD care do not receive the gold standard of care, and those who do receive care often have less than optimal care outcomes. Among adults with CODs, 40.2% received any mental health care in the prior year, 3.6% received substance use treatment in the past year, and only 18.6% received both mental health and substance use treatment. Among the percentage of adults who received both types of care in the past year, they were more likely to have more serious psychiatric problems, physical comorbidities, and to be involved with the legal system than those who did not receive COD care. Overall, 37.6% of people with CODs received neither mental health care nor substance use treatment in the past

year.[34] Like many people with COD, Kobe and Filsan never received the integrated COD care they needed.

Recommendation #2: Prioritize and fund integrated COD screening, assessment, and treatment

Due to the high prevalence of CODs, providers and systems have an essential role in serving individuals with CODs, since these individuals are a part of every care system. The evidence-based standard of COD care is individualized, integrated, comprehensive, coordinated, and continuous service that simultaneously addresses mental health and SUD. All behavioral health programs should provide integrated COD screening, assessment, and treatment. Programs should be incentivized to develop care options that breakdown silos for better integrated treatment of individuals with CODs.

Barriers to Accessing Integrated Treatment for COD

Given that it is well-recognized that mental illness and SUD can co-occur and compound one another, it is essential to understand what makes it difficult to access care for both conditions in an integrated and collaborative manner. There are many hypotheses about this. Historical conceptualizations of the models of disease likely contributed to system designs that promoted consecutive approaches to treatment (e.g., treating the alcohol use disorder before the depression) rather than simultaneously. Yet today, the literature and clinical understanding of the conditions point in the opposite direction, and barriers remain for individuals who need COD treatment. Studies have identified two broad categories impacting access to care among adults with CODs: personal and structural barriers.[35]

Recommendation #3: Fund COD stigma reduction and public awareness campaigns

Educating the public, raising awareness, normalizing, and supporting the prevention of and early intervention in CODs is critical. Statewide public education and change campaigns should partner with multimedia agencies (with a focus on agencies led by members of the target population), the community (including youth and marginalized community members), and researchers. Campaigns should be codesigned with the community to raise awareness of CODs and improve health literacy for children, youth, caregivers, and their communities. Campaigns should be translated into different languages, placed in frequently visited community settings (e.g., mosques, hair salons, barbershops, and grocery stores), and delivered via various media channels (e.g., social media, traditional radio, and printed newspaper). Mental health programs can play a role by continually reviewing program brochures, handbooks, advertisements, and flyers with program participants to identify and change stigmatizing language and imaging in their program materials.

Personal Barriers

Personal barriers include individual characteristics, knowledge, skills, attitude, motivation, and beliefs that may impede treatment access. For example, the National Comorbidity Survey Replication studies found that low perceived need was reported by 44.8% of people with CODs who did not seek treatment.[36] Another study found that almost one-quarter of adults with CODs who did not receive care did not know where to go for treatment.[37] Other research suggests that those with CODs experience more stigma and, therefore, more treatment barriers than those with a single diagnosis of either mental health or SUD.[38]

Structural Barriers

Structural barriers to accessing COD care can be defined as social, political, legal, cultural, and service factors that systematically hinder access to care for specific groups. The main drivers include service availability, disorder identification, provider training, service provision disparities, incarceration, and insurance industry- and policy-related barriers.[39]

Factors that contribute to structural barriers to accessing COD care include the following:

- Service availability
- Disorder identification
- Provider training
- Service provision disparities
- Incarceration
- Insurance industry- and policy-related barriers

Source: Priester MA, Browne T, Iachini A, et al: Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: An integrative literature review. J Subst Abuse Treat 2016; 61:47–59

Recommendation #4: Require data collection to assess COD service availability as its own service or as part of mental health treatment and substance use disorder treatment programs

Local access to COD treatment is critical, and state policymakers should understand where programs exist that are adept at offering COD-focused treatments. Policymakers should monitor trends in this data via ongoing quality improvement, program evaluation, and research efforts. Programs discontinuing or decreasing the availability of COD services should be provided technical assistance to understand further what might be driving this shift. Contracting standards should require ongoing COD service availability data collection and monitoring.

Service availability. The most recent available data show that from 2010 to 2014, the percentage of mental health facilities in the United States offering programs for individuals with CODs decreased from 58.4% to 53.0%, while the percentage of substance use treatment facilities

offering such programs increased from 37.2 % to 44.2% between 2008 and 2014.[40] It is unclear what drove this decrease in the percentage of US mental health facilities offering programs for individuals with CODs and why fewer than half of US substance use treatment facilities offered programs that address CODs. Furthermore, the shifting sands of program availability in the post-pandemic era make current availability somewhat fluid. Regardless, the availability and maximization of COD treatment should be further researched and realized.

Identification of co-occurring disorders. Another structural barrier to COD treatment access is underidentification, where clinicians may identify a substance use or a mental health disorder but not always identify the co-occurrence of both. Underidentification and underdiagnosis in clinical care may be related to underreporting due to individual characteristics such as shame, but it also may be due to other factors. For example, substance-induced symptoms such as anxiety, depression, and psychosis may be recognized as solely a result of substance use and not part of a fuller co-occurring mental health condition. Discrimination and implicit bias of providers can also lead to under-identification of disorders and misdiagnoses. In some cases of underidentification, clinicians may also be hesitant to officially diagnose SUD because in their setting (e.g., a mental health treatment setting), they do not have the comprehensive screening and assessment tools (e.g., drug testing), to inform a diagnosis and monitor substance use. In Filsan's and Kobe's stories, under- and misidentification contributed to the progression of their CODs.

Provider training. COD identification goes hand in hand with training. The current workforce is not adequately trained to effectively engage with and treat people with CODs. A systematic assessment of 256 mental health and substance use treatment programs using the Dual Diagnosis Capability in Addiction Treatment and Dual Diagnosis Capability in Mental Health Treatment indexes found that only 18% of alcohol and other drug (AOD) programs and 9% of mental health programs met criteria for dual diagnosis capability.[41] Due to the historic and ongoing silos of mental health and substance use service delivery systems, provider training has also often been siloed. Current training does not ensure competency in assessing and treating both mental health and SUD. Training requirements, philosophies, and language are also very different in mental health and substance use treatment, contributing to the lack of provider knowledge, confidence, and competency to treat CODs. For example, much mental health service delivery requires formal academic training (e.g., MSW, PhD, or PsyD) to provide direct services and support. In contrast, for many years the SUD field has been growing and training a workforce with both formal training and lived expertise. The role of a recovery community, the engagement of individuals with lived expertise, and mutual support are often more prominent in substance use disorder treatment than in mental health treatment. Understanding the culture of each treatment setting and the needs and resources available in each distinct treatment setting while integrating these is an important challenge to overcome. As noted by Brinkley and Volpe in the second 2024 Technical Assistance Brief, *Peer Support Services Across the Crisis Continuum,*[42] peer specialists and recovery coaches are increasingly important in behavioral health services generally, including crisis services, and as such their work with CODs will likely continue to expand.

Recommendation #5: Improve COD education and training for the workforce

Very few mental health providers and even fewer SUD providers meet the criteria to provide integrated COD care.[a] Providers acknowledge that they have insufficient formal COD treatment training, preventing them from delivering evidence-based integrated COD treatment.[b] There is thus a need to address training silos. Training programs in psychology, psychiatry, and social work, among other disciplines, as well as peer support and recovery coaching, should provide more curricula focused on integrated COD care. Accreditation and continuing education requirements should incorporate standards to ensure that practitioners have exposure to COD treatment training, including conceptual models such as SIM and Upstream, to inform work with people with CODs in the child welfare and criminal justice systems. Existing models for the dissemination of training about CODs should also be leveraged. Funding to treat opioid and stimulant use disorders through the Opioid Response Network (www.opioidresponsenetwork.org) has also been an engine of advancing practice. The MISSION model (discussed previously) recently launched an online COD treatment training course for practitioners.[c] Programs and practitioners can utilize these types of platforms to shape practices toward integrated care for CODs. With better training, the field can better assess and treat people with CODs.[d]

[a]McGovern MP, Lambert-Harris C, Gotham HJ, et al: Dual diagnosis capability in mental health and addiction treatment services: An assessment of programs across multiple state systems. Adm Policy Ment Health 2014; 41(2):205–214
[b]Chawla N, Gyawali S, Sharma P, et al: Internet-based learning for professionals in addiction psychiatry: A scoping review. Indian J Psychol Med 2022; 44(4):325–331
[c]MISSION Training Series. South Bend, IN, Psychiatric Rehabilitation Association, August 2022. www.psychrehabassociation.org/series/mission-training-series-all-modules-full-course
[d] Treatment Considerations for Youth and Young Adults with Serious Emotional Disturbances and Serious Mental Illnesses and Co-occurring Substance Use. Rockville, MD, SAMHSA, 2021.

Service provision disparities. Driven by structural barriers such as racism, sexism, ageism, ableism, and others, historically minoritized and marginalized groups do not have equal access to quality COD treatment. People with co-occurring SMI and SUD who are members of racially and ethnically minoritized populations receive less COD treatment than Non-Hispanic, White individuals. For example, 52% of African American individuals, 51% of Hispanic individuals, and 48% of Non-Hispanic Asian individuals with COD received any mental health treatment in the past year, compared to 70% of Non-Hispanic White individuals.[43] The presence of COD also increases the risk for Black individuals to be arrested and booked for a crime compared to White individuals with co-occurring SMI and SUD, further impacting access to treatment.[44] Once in the legal system (SIM Intercepts 2–5), Black individuals are less likely to be identified and/or diverted to treatment diversion programs than their White counterparts. Disparities played out in many ways in Kobe's and Filsan's cases. Their intersecting identities as Black boys contributed to the

missed early identification of their CODs and failure to divert them away from more punitive systems (e.g., child welfare or criminal) and into the treatment system. Lastly, as a child living in a rural community, Kobe's family had very little access to *any* care, let alone culturally informed care. Rural risk factors for COD disparities—including geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to health care specialists and subspecialists, and limited job opportunities—continue to be of significant concern.

Recommendation #6: Assess structural barriers to COD treatment access and engagement

There is growing recognition that advancing equity in COD treatment requires understanding the multilevel (policy, community, organizational, provider, and individual) contexts in which health disparities are embedded. Explicit inclusion of measures of structural barriers in program evaluation and client-level data collection has largely been missing in addressing inequities in COD treatment. Without the inclusion of these measures, the crisis care system will continue to exacerbate disparities and inadvertently reinforce structural practices driving inequities. Evaluations of COD care services must include ongoing metrics and benchmarks of structural barriers. For example, administrative data should operationalize structural racism, including neighborhood segregation and legal or child welfare system involvement, as well as self-report measures of perceptions of structural racism (measured via the Perceived Structural Racism Scale) and institutional racism (measured via the Major Experiences of Discrimination Scale). One issue is that organizations may have structural components that result in practices that disadvantage certain populations by race or other factors. The American Academy of Community Psychiatry developed the Self-Assessment for Modification of Anti-Racism Tool (SMART) to help organizations examine their practices to foster anti-racism work. In other ways, being informed about systemic barriers to reducing biased practices can yield a more intentional effort to reduce those gaps in care. The tool can be modified to identify disparities that are specific to the COD care settings. Qualitative data collection is also helpful to better understand the impact of structural barriers on the lived experiences and daily lives of individuals served and providers. This information can significantly improve the selection of evidence-based COD interventions, their adaptations, and equity-informed implementation. Last, the mapping process embedded within SIM and the Upstream model can help systems assess structural barriers. The mapping process brings together local stakeholders to develop a comprehensive picture of how youth, adults, and families with CODs flow through the community along distinct intercept points; identify resources, gaps, and structural barriers in the existing systems; and develop collaborative strategic action plans to reduce structural barriers for individuals and families with CODs in contact with the child welfare and/or criminal legal systems. Ongoing assessment, mapping, and monitoring of structural barriers with collaborative strategic planning is needed to enhance COD treatment access, engagement, and outcomes for all.

There are also significant gender differences in COD risk and treatment access, including differences across cisgender and transgender populations.[45] The risk of COD is higher for men than women if they experience a psychiatric disorder, while the risk of COD for women is higher for men with SUD.[46] Data from the 2008–2013 National Survey on Drug Use and Health found that 24% of women and 19% of men with COD received SUD treatment, while 66% of women and 55% of men with COD received mental health treatment, and only 15% of women and 18% of men with CODs received both SUD and mental health treatment in the previous year. While a greater percentage of men with COD reported perceived unmet needs for SUD treatment (14.5%) and both SUD and mental health treatment (9.6%), more women with COD reported an unmet need for mental health treatment (52.6%).[47]

Women with CODs often experience contextual confounders (e.g., gender-based violence), social role expectations (e.g., as mothers or caretakers), comorbid medical conditions (e.g., HIV), and gender-based structural stigma (i.e., male-centric ideology, laws, programs, policies, and practices) that create barriers to care.[48] Although significant advances have been made in the treatment field to better serve women, gender-based issues for women remain a neglected area in much of COD research. There is still a dearth of gender-specific and responsive evidence-based models of COD treatment.

The intersection of race and gender also plays a significant role in the trajectories of Filsan and Kobe. The bias, discrimination, institutionalized racism, and state-sanctioned violence against Black men with CODs place them at an increased risk for many poor outcomes (e.g., involvement with the legal system). There are few culturally tailored evidence-based practices (EBPs) to address intersectionality. One such intervention that may have been relevant to Kobe's COD trajectory is Habilitation Empowerment Accountability Therapy (HEAT). Much more research is needed to address the intersecting social identities of people with CODs.

Efforts to advance equitable access to COD care often focus on gaps in care where individuals fail to receive high-value health care that will benefit them. For example, an Upstream-informed program may provide transportation to Kobe and his family to facilitate access to a high-quality, evidence-based integrated COD treatment program in a neighboring city. Efforts should also identify and address low-value health care that provides no benefit or carries an increased risk of harm that outweighs any expected benefit. Research suggests that historically marginalized populations may be more likely to receive low-value health care, which may further compound disparities.[49]

To further support efforts to enhance culturally and structurally informed COD services, SAMHSA funded three Centers of Excellence (CoEs) for Behavioral Health Disparities in 2020. These centers develop and disseminate training and technical assistance for health care practitioners on issues related to addressing behavioral health disparities in three key populations: African Americans (https://africanamericanbehavioralhealth.org), LGBTQ+ individuals (https://lgbtqequity.org), and the aging population (https://e4center.org). These CoEs provide technical assistance to support the identification of culturally tailored EBPs and implementation and de-implementation strategies. In 2022, SAMHSA funded a CoE to serve Asian American, Native Hawaiian, and Pacific Islander communities (https://aanhpi-ohana.org), and SAMHSA Hispanic/Latino Behavioral Health Center of Excellence is forthcoming. SAMHSA also has a Tribal Training and Technical Assistance Center that is focused on supporting the culturally appropriate prevention and treatment of mental health and substance use disorders in American Indian and Alaskan Native communities.

Promising Program: Habilitation Empowerment Accountability Therapy (HEAT)

HEAT was designed for young Black men between the ages of 18 and 29 with problematic substance use and criminal legal system involvement. HEAT utilizes culturally specific, strength-based, trauma-informed group counseling. Results of pilot studies in two sites found that Black participants with serious criminal and substance use histories graduated HEAT programming at significantly higher rates than in non-culturally specific programming. Participants also reported program satisfaction.[a] The developers of HEAT recently launched Habilitation Empowerment Recovery (HER), an intervention for African American women with substance use and mental health problems in the legal system. They are currently developing and testing versions of HEAT and HER for youth.

[a]Baumann AA, Shelton RC, Kumanyika S, et al: Advancing healthcare equity through dissemination and implementation science. Health Serv Res, published online May 23, 2023. https://doi.org/10.1111/1475-6773.14175

Recommendation #7: Identify and de-implement policies, programs, and practices contributing to disparities

Disparities in offering and implementing EBPs for marginalized communities should be identified and addressed. Furthermore, many EBPs have not been developed for or evaluated with different subgroups in mind, nor do they represent populations or settings disproportionately burdened by COD. Systems and providers should identify policies, programs, and practices that do not achieve positive outcomes and do not recognize and understand the complexities of an individual's identity (including age, developmental disabilities, acquired disabilities, religion, ethnicity, sexual orientation, socioeconomic status, Indigenous group membership, nationality, gender identity, and veteran status). Systematically reviewing COD EBPs and identifying whether they have been tested with the people being served should be a significant and ongoing activity for systems and providers. If EBPs have not been tested or adapted for the groups being served, providers should shift their use to the populations upon which they have been tested, and select and implement alternative, culturally tailored EBPs using implementation strategies that are culturally and structurally informed. Consulting with an implementation specialist or resources can help programs intentionally and effectively de-implement ineffective and harmful practices and help to adapt practices that may not have been studied in the populations being served.[a]

[a]Ingvarsson S, Hasson H, von Thiele Schwarz U, et al: Strategies for de-implementation of low-value care—A scoping review. Implementation Sci 2022; 17:73

The federal government's Healthy People 2030 initiative defines SDoH as "the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[50] Exposure to adverse SDoH factors can increase the level of stress experienced by individuals, which can then raise the risk of experiencing CODs.[51] SDoH can also increase the risk of court involvement, and thus it is also important for multiperspective professionals to be aware of these issues. Pinals, Fuller, and Pinals provide information on this in a brief for the National Center for State Courts.[52] Multiple SDoH needs significantly impacted Kobe and Filsan's trajectories. **Table 1** offers some examples of how SDoH impacted their access to and engagement in COD care.

Table 1: Impact of SDoH on Case Studies

SDoH	Examples from case studies
Neighborhood and built environment	The built environment, such as inadequate transportation, greatly impacts access to or continued engagement in treatment.[a] Living in a rural community, Kobe's family have no public transportation options to allow them to get to more culturally tailored services in the nearest city, which was about one hour away.
Health and healthcare	Individuals located in rural areas are less likely to report that mental health services are extremely accessible to them.[b] Kobe's parents reported that high-quality and culturally informed services were not available in their rural community.
Social and community context	Social identities and experiences and the way people are treated due to their identities can impact access. Biracial and multiracial youth are at higher risk for engaging in substance use when compared to monoracial youth.[c] Children with family members (especially mothers) with mental health conditions are more likely to develop mental health conditions.[d] Kobe identifies as biracial and was bullied for his racial identity. Both Kobe and Filsan's mothers present with acculturative stress, and Kobe's mother struggled with depression.
Education	Low educational attainment has been associated with both increased risk for mental health concerns and with increased likelihood of substance use.[e] Both Kobe's and Filsan's educational trajectories were significantly impacted by their CODs and vice versa.
Economic stability	Financial strain and instability have been linked to mental health concerns and substance use. Particularly, housing instability is seen as a risk factor for substance use and a barrier to accessing and continuing with substance use treatment.[f] As Filsan's and Kobe's housing became unstable (e.g., short sober house stays and short-term stays with friends) their CODs worsened.

[a]Mensinger J, Diamond GS, Kaminer Y, et al: Adolescent and therapist perception of barriers to outpatient substance abuse treatment. Am J Addict 2006; 15:s16–s25
[b]Ketchum Analytics: America's Mental Health 2018. Stamford, CT, Cohen Veterans Network; and Washington, DC, National Council for Behavioral Health, 2018
[c]Goings TC, Salas-Wright CP, Howard MO, et al: Substance use among bi/multiracial youth in the United States: Profiles of psychosocial risk and protection. Am J Drug Alcohol Abuse 2018; 44:206–214
[d]Allen J, Balfour R, Bell R, et al: Social determinants of mental health. Int Rev Psychiatry 2014; 26:392–407
[e]Galea S, Vlahov D: Social determinants and the health of drug users: Socioeconomic status, homelessness, and incarceration. Public Health Rep 2002; 117:S135–S145
[f]Smith T, Hawke L, Chaim G, et al: Housing instability and concurrent substance use and mental health concerns: An examination of Canadian youth. J Can Acad Child Adolesc Psychiatry 2017; 26:214–223

Recommendation #8: Fund the support of social determinants of health as well as case management, navigation services, and other linkage supports to address them

COD services must also include integrated social services and social supports that address SDoH needs (e.g., food subsidies and housing). This requires collaboration and coordination across various systems, shared goals, and shared language to improve public health, public safety, individual behavioral health outcomes, and individual and family well-being. Case management, navigation, and other linkage supports must also extend to family members who are often responsible for housing, transportation, health, and social care of their loved one with CODs. This vital support can increase their capacity to support their loved one with COD and reduce the reliance on costly crisis services such as the emergency department or incarceration.

Incarceration. This SDoH is getting more attention to help build understanding and address behavioral health and health equity. People who are incarcerated are more likely than the general population to experience a chronic condition such as COD. Communities with high incarceration rates, disproportionately communities of color, are more likely to experience poor mental health. Families of people who are incarcerated experience community fragmentation and disruption of social ties that negatively impact mental and familial health. Last, health risks, especially overdose, are heightened after release from incarceration. For these reasons, incarceration must be recognized as a negative SDoH, especially for individuals with CODs.

Insurance industry- and policy-related barriers. Incarceration and health coverage collide in many ways to impact access to COD care. Recently, many states have made it easier for newly

Recommendation #9: Fund and implement evidence-informed and evidence-based programs (e.g., specialty courts) to divert youth and adults with CODs from carceral settings to community-based treatment settings.

As shown in **Figure 1**, SIM includes five points where people with mental health, substance use, or COD needs connect with the criminal justice system. More COD assessment and treatment services are needed across all intercepts to divert people with CODs from arrest, detention, and incarceration whenever appropriate and safe. These programs should be available beginning at the crisis intercept, through alternatives to law enforcement as the default responder in a behavioral health crisis. Additional interventions and strategies should be available at all intercept points across the sequential intercept framework and, as in the Upstream model, be required to collaborate with the correctional and other systems of care, including the child welfare system. This collaboration may slow the costly school-to-prison and foster care–to-prison pipelines, as well as the revolving door of recidivism.

released people with CODs to obtain, maintain, or reactivate Medicaid benefits in preparation for reentry from carceral settings. Historically, states terminated Medicaid benefits when an individual became incarcerated, and the Medicaid rules are such that the state would not remain responsible for the full cost of health care services provided to that individual while they are incarcerated. However, states found that termination of benefits resulted in difficulty reconnecting people to Medicaid coverage after release. The period between release and benefits being reconnected is potentially deadly, as newly released individuals are at the greatest risk for overdose; in the first two weeks following release, the risk of death was 12.7 times higher than that of the general population. This is especially concerning since OUD is one of the most common substance use disorders among incarcerated individuals. Therefore, people at high overdose risk like Kobe critically need insurance coverage to support continuity and immediate access to care once in the community.

A few state models effectively address the period between planning for release and reentry into community systems of support for health care needs. For example, correctional facilities in Massachusetts are responsible for completing and submitting Medicaid enrollment applications on behalf of incarcerated persons before release, and a dedicated unit in the state's Medicaid agency processes the applications.[53]

Recommendation #10: Ensure Medicaid coverage at release for all Medicaid-eligible individuals released from carceral settings and other institutions such as state hospitals, and explore new opportunities for benefit coverage pre-release

Given the data showing poor outcomes for individuals with CODs revolving into and out of hospitals, prisons, jails, and juvenile justice settings, it is essential to determine how services can be delivered across the traditionally strict divisions between carceral settings and community-based practices. Ensuring coverage by Medicaid across sectors and maximizing continuity of care can yield more sustained treatment over time.

Perhaps one of the most impactful shifts that has emerged for this work across systems is the Centers for Medicare and Medicaid Services (CMS) agreement to allow California to expand its 1115 waiver coverage to up to 90 days pre-release.[54] CMS officials also wrote a letter to state offices explaining this change and encouraging further applications for similar demonstration programs.[55] Numerous studies also document the value of inreach services to help reduce negative outcomes related to CODs.[56,57] State psychiatric hospitals are also inundated with individuals in proceedings to determine competency to stand trial who move between the community, jails, and state hospitals, and those individuals very typically have CODs.[58] This

makes this group another population to consider for services to assist in coverage continuity at the time of transition to community institutions.

Beyond planning for reentry, it is well-understood that medications for substance use disorders, for example, medications for opioid use disorder (MOUD) treatment (also referred to as medication-assisted treatment or MAT) improves medical and mental health outcomes and reduces relapses and recidivism. While medications for substance use disorders are often effective for treating the SUD, their efficacy is enhanced when combined with appropriate behavioral interventions that address underlying psychological contributors as well as co-occurring mental health conditions.

Medications for substance use disorders like MOUD and MAUD are still rarely offered in correctional facilities. However, states and counties are starting to move toward providing this access, especially as litigation around these issues has emerged[59] and more evidence shows the potential positive impact of these interventions. Growing research shows that offering MOUD pre-release can save and improve lives. One retrospective study of 1600 participants in Rhode Island examined the effect of MOUD while incarcerated on post-release treatment engagement and retention, overdose mortality, and recidivism, at 30 days and 12 months post-release. It found that at 30 days and 12 months post-release, 73% and 86% of participants engaged in MOUD treatment, respectively. Furthermore, those newly inducted had lower post-release engagement than those who continued from the community. Last, twelve overdose deaths occurred during the 12-month follow-up, with only one overdose death during the first two weeks post-release.[60]

There is considerable evidence that naloxone, an opioid antagonist, delivered via prison-based take-home naloxone (THN) programs, effectively reduces the risk of opioid overdose. These programs typically train participants in recognizing and managing opioid overdoses and provide naloxone to participants at the completion of the training. Studies have shown that a prison based THN program improved participants' overdose management knowledge, self-reported confidence to manage an opioid overdose, and effective actions in overdose simulations.[61] A THN program implemented at Rikers Island in New York targeted training and naloxone provision to visitors of inmates identified as being at risk of overdose following release. Of the 283 participants, 40 participants responded to 70 overdose incidents. Among those who witnessed an overdose event, 70% administered naloxone. The survival rate was 94% for the 65 overdose events for which data was available.[62]

Kobe's story highlights some themes related to post-release risk. Although opioids are not his drug of choice, he is a polysubstance user who misused pain prescription medication in his youth. Since his incarceration, his rural hometown has been hit hard by the opioid epidemic. The level of opioid use, access to opioids, and the number of drugs laced with fentanyl skyrocketed since Kobe's left his hometown. Many of his old hometown friends currently use heroin and have experienced an overdose. Kobe is unaware of the current dangers of opioid use and how to

keep safe if he or someone around him experiences an overdose. Although opioids were not his drug of choice pre-incarceration, Kobe and people like him would greatly benefit from OUD screening, OUD psychoeducation, and naloxone training pre -and post-release (across SIM Intercepts 3–5). This is especially critical for people with CODs, who have higher relapse rates when compared to people without CODs.[63]

Recommendation #11: Provide universal screening, prevention, and treatment for substance use disorders, including opioid use disorder, spanning carceral and community settings

Nearly two-thirds of adults with opioid use disorder and half of individuals who misused central nervous system stimulants had a past-year mental illness.[a] People with CODs are at greater risk for adverse outcomes such as homelessness, incarceration, and suicide than those with only a single disorder.[b] People with CODs, including those incarcerated, are a priority population to screen for SUD, link to overdose prevention, and treatment (e.g., MOUD).

[a]Jones CM, McCance-Katz EF: Co-occurring substance use and mental disorders among adults with opioid use disorder. Drug Alcohol Depend 2019; 197:78–82; Results from the National Surveys on Drug Use and Health, 2022. Rockville, MD, SAMHSA, 2023.
[b]Substance Use Disorder Treatment for People with Co-Occurring Disorders. Rockville, MD, SAMHSA, 2020

A recent study exploring perspectives regarding MOUD among individuals with mental health disorders identified some unique perspectives that should be considered to increase access and engagement among this group.[64] First, individuals perceived MOUDs not as being used for treatment but rather as a substitute for opioids or as a temporary solution to help stave off withdrawal symptoms, had previous negative experiences with methadone and methadone clinics, and viewed people using MOUDs as "cheating," and not completely sober. The study also found that despite being open to learning about and receiving naloxone and MOUD from their clinicians, many individuals reported having minimal discussions about MOUD with their mental health clinicians.

This lack of discussion and use is very concerning as opioid overdose death rates continue to rise, especially among racially and ethnically minoritized populations. In 2020, overdose death rates (number of drug overdose deaths per 100,000 people) increased 44% for Black people and 39% for American Indian and Alaska Native people compared with 2019 rates.[65] In parallel, there are glaring racial disparities in overall MOUD access. Among those in care who experience non-fatal overdoses, Black individuals are half as likely to obtain follow-up appointments for OUD care after discharge from the emergency room.[66] Several studies have found naloxone training and access to be lower for people of color.[67,68,69] This evidence further highlights the

need to increase provider training, promote stigma reduction campaigns, and equitably provide MOUD and opioid overdose prevention to all.

Conclusion

The time is now to enhance equitable access to COD treatment services and wraparound supports. Filsan's and Kobe's stories reflect the complexities of the problem and the need for equity-informed and multisystemic solutions. SIM and the Upstream model further highlight the need for coordinated, collaborative, and boundary spanning efforts across the child welfare, carceral, and community-based behavioral health systems. Despite promising evidence-based practices to advance equitable access to COD treatment, many systems continue to leave people like Kobe and Filsan behind. Policymakers, systems, providers, and communities at large today have an opportunity, and an ethical responsibility, to achieve equitable access to quality care for people with CODs.

Although there are many aspects to the work ahead, better COD care will require improved training, payment models, diversion-to-treatment models, directed de-implementation efforts for programs that are not truly working, and cultural tailoring of approaches to prevention and treatment to reflect the diverse individuals, families, and communities being served across the country. In combination, these efforts can reduce the reliance on higher-cost hospital services, minimize unnecessary law enforcement involvement, open pathways to treatment for some of the most marginalized individuals with CODs, and ultimately improve care for all.

Authors:

Ayorkor Gaba, PsyD
Assistant Professor, Department of Counseling and Clinical Psychology, Teachers College, Columbia University

Director, Equity Division, Massachusetts Center of Excellence for Specialty Courts, University of Massachusetts Chan Medical School

Angela Wangari Walter, PhD, MPH, MSW
Associate Professor, Department of Public Health, Zuckerberg College of Health Sciences, University of Massachusetts Lowell

Core Faculty Member, Health Promotion and Resiliency Intervention Research Program, Massachusetts General Hospital

Debra A. Pinals, MD
Senior Medical and Forensic Advisor and Editor-in-Chief, and Chair, Medical Directors Division, National Association of State Mental Health Program Directors

Adjunct Clinical Professor of Psychiatry, Director, Program in Psychiatry, Law, and Ethics, University of Michigan

Medical Director, Behavioral Health and Forensic Programs, Michigan Department of Health and Human Services

References

[1]Fact Sheet: President Biden's Budget Advances a Bipartisan Unity Agenda. Washington, DC, Office of Management and Budget, The White House, March 28, 2022. https://www.whitehouse.gov/omb/briefing-room/2022/03/28/fact-sheet-president-bidens-budget-advances-a-bipartisan-unity-agenda/

[2]Results from the 2023 National Survey on Drug Use and Health: Graphics from the Key Findings Report. Rockville, MD, Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration (SAMHSA), 2024

[3]Novak P, Feder KA, Ali MM, et al: Behavioral health treatment utilization among individuals with co-occurring opioid use disorder and mental illness: Evidence from a national survey. J Subst Abuse Treat 2019; 98:47–52

[4]Ibid.

[5]Devoto A, Himelein-Wachowiak M, Liu T, et al: Women's substance use and mental health during the COVID-19 pandemic. Womens Health Issues 2022; 32:235–240

[6]Slemon A, Richardson C, Goodyear T, et al: Widening mental health and substance use inequities among sexual and gender minority populations: Findings from a repeated cross-sectional monitoring survey during the COVID-19 pandemic in Canada. Psychiatry Res 2022; 307:114327

[7]Double Jeopardy: COVID-19 and Behavioral Health Disparities for Black and Latino Communities in the U.S. Rockville, MD, Office of Behavioral Health Equity, SAMHSA, 2020

[8]Pinals DA, Schofield G: Connected and Strong: Strategies for Accessible and Effective Crisis and Mental Health Services. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2024

[9]Fact Sheet: President Biden's Budget Advances a Bipartisan Unity Agenda. Washington, DC, Office of Management and Budget, The White House, March 28, 2022. https://www.whitehouse.gov/omb/briefing-room/2022/03/28/fact-sheet-president-bidens-budget-advances-a-bipartisan-unity-agenda/

[10]Key Substance use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021, NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, SAMHSA 2024. https://www.samhsa.gov/data/sites/default/files/reports/rpt47095/National%20Report/National%20Report/2023-nsduh-annual-national.pdf

[11]Ibid.

[12]Disproportionalities and Disparities in Child Welfare: A Supplement to Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals. National Center on Substance Abuse and Child Welfare, 2022

[13]Magee LA, Fortenberry JD, Rosenman M, et al: Two-year prevalence rates of mental health and substance use disorder diagnoses among repeat arrestees. Health & Justice 2021; 9:2

[14] Lesbian, Gay, and Bisexual Behavioral Health: Results from the 2021 and 2022 National Surveys on Drug Use and Health. Rockville, MD, SAMHSA, 2023. https://www.samhsa.gov/data/sites/default/files/reports/rpt41899/2022_LGB_Brief_Final_06_07_23.pdf

[15] Ibid.

[16]Key Substance use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021, NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, SAMHSA 2024. https://www.samhsa.gov/data/sites/default/files/reports/rpt47095/National%20Report/National%20Report/2023-nsduh-annual-national.pdf

[17]Ibid.

[18]Köck P, Meyer M, Elsner J, et al: Co-occurring mental disorders in transitional aged youth with substance use disorders: A narrative review. Front Psychiatry 2022; 13:827658

[19]Moure-Rodríguez L, Caamano-Isorna F: We need to delay the age of onset of alcohol consumption. Int J Environ Res Public Health 2020; 17(8):2739. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7215939/

[20]Brewer S, Godley MD, Hulvershorn LA: Treating mental health and substance use disorders in adolescents: What is on the menu? Curr Psychiatry Rep 2017; 19:5

[21]Munetz MR, Griffin PA: Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. Psychiatr Serv 2006; 57:544–549

[22]Upstream: Strengthening Children and Families through Prevention and Intervention Strategies: A Court and Community-Based Approach. Williamsburg, VA, National Center for State Courts, 2021

[23]Munetz MR, Griffin PA: Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. Psychiatr Serv 2006; 57:544–549

[24]Abreu D, Parker TW, Noether CD, et al: Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. Behav Sci Law 2017; 35:380–395

[25]Upstream: Strengthening Children and Families through Prevention and Intervention Strategies: A Court and Community-Based Approach. Williamsburg, VA, National Center for State Courts, 2021

[26]Abreu D, Parker TW, Noether CD, et al: Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. Behav Sci Law 2017; 35:380–395

[27]Brown DL, Wanstrath B, Wesolowski H, Shumann J, Gruttadaro D: Intersectionality: Faith, Mental Health, and Community Partnerships. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2024

[28]Chan V, Moore J, Derenne J, et al: Transitional age youth and college mental health. Child Adolesc Psychiatr Clin N Am 2019; 28:363–375

[29]Mersky JP, Topitzes J, Reynolds AJ: Impacts of adverse childhood experiences on health, mental health, and substance use in early adulthood: a cohort study of an urban, minority sample in the U.S. Child Abuse Negl 2013; 37:917–925

[30]Wang D, Jiang Q, Yang Z, et al: The longitudinal influences of adverse childhood experiences and positive childhood experiences at family, school, and neighborhood on adolescent depression and anxiety. J Affect Disord 2021; 292:542–551

[31]Hartz SM, Pato CN, Medeiros H, et al: Comorbidity of severe psychotic disorders with measures of substance use. JAMA Psychiatry 2014; 71:248–254

[32]Integrated Treatment for Co-Occurring Disorders: The Evidence. Rockville, MD, SAMHSA, 2009

[33]Smelson DA, Sawh L, Harter J, et al: The MISSION Treatment Manual. Worcester, MA: University of Massachusetts Medical School, 2014

[34]Key Substance use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021, NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, SAMHSA 2024. https://www.samhsa.gov/data/sites/default/files/reports/rpt47095/National%20Report/National%20Report/2023-nsduh-annual-national.pdf

[35]Priester MA, Browne T, Iachini A, et al: Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: An integrative literature review. J Subst Abuse Treat 2016; 61:47–59

[36]Mojtabai R, Olfson M, Sampson NA, et al: Barriers to mental health treatment: Results from the National Comorbidity Survey Replication. Psychol Med 2011; 41(8):1751–1761

[37]Han B, Compton WM, Blanco C, et al: Prevalence, treatment, and unmet treatment needs of US adults with mental health and substance use disorders. Health Aff (Millwood) 2017; 36:1739–1747

[38]Lowe DJE, Simpkin E, George TP: Dual diagnosis: Double the stigma, double the trouble. Psychiatric Times, May 30, 2022

[39]Priester MA, Browne T, Iachini A, et al: Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: An integrative literature review. J Subst Abuse Treat 2016; 61:47–59

[40]Han B, Compton WM, Blanco C, et al: Prevalence, treatment, and unmet treatment needs of US adults with mental health and substance use disorders. Health Aff (Millwood) 2017; 36:1739–1747

[41]McGovern MP, Lambert-Harris C, Gotham HJ, et al: Dual diagnosis capability in mental health and addiction treatment services: An assessment of programs across multiple state systems. Adm Policy Ment Health 2014; 41(2):205–214

[42]Brinkley A, Volpe J: Peer Support Services Across the Crisis Continuum. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2024

[43]National Survey on Drug Use and Health. Public online data analysis system. Rockville, MD, Substance Abuse and Mental Health Data Archive, SAMHSA, 2019. pdas.samhsa.gov/#/survey/NSDUH-2019-DS0001

[44]Prince JD, Wald C: Risk of criminal justice system involvement among people with co-occurring severe mental illness and substance use disorder. Int J Law Psychiatry 2018; 58:1–8

[45] Felner JK, Haley S, Jun H, et al: Sexual orientation and gender identity disparities in co-occurring depressive symptoms and probably substance use disorders in a national cohort of young adults. Addictive Behaviors 2021; 117. https://www.sciencedirect.com/science/article/pii/S0306460321000022

[46]van Draanen J, Upchurch D: Differences in co-occurring disorder timing, onset, and sequence by gender. Int J Ment Health Addict 2022

[47]Manuel JI, Stebbins MB, Wu E: Gender differences in perceived unmet treatment needs among persons with and without co-occurring disorders. J Behav Health Serv Res 2018; 45:1–12

[48]Meyer JP, Isaacs K, El-Shahawy O, et al: Research on women with substance use disorders: Reviewing progress and developing a research and implementation roadmap. Drug Alcohol Depend 2019; 197:158–163

[49]Baumann AA, Shelton RC, Kumanyika S, et al: Advancing healthcare equity through dissemination and implementation science. Health Serv Res, published online May 23, 2023

[50]Social Determinants of Health. Healthy People 2030, Office of Disease Prevention and Health Promotion, US Department of Health and Human Services. health.gov/healthypeople/priority-areas/social-determinants-health. Accessed July 25, 2023

[51]Compton MT, Shim RS (eds): The Social Determinants of Mental Health. Washington, DC: American Psychiatric Association Publishing, 2015

[52]Pinals DA, Fuller DA, Pinals MJ: Mental Health Facts in Brief: Social Determinants of Health and Mental Health. Williamsburg, VA, National Center for State Courts, 2021

[53]Serafi K, Ferguson M: MassHealth's Role in Improving Health Outcomes and Recidivism Rates in Justice-Involved People. MassHealth Impact Series. Blue Cross Blue Shield of Massachusetts Foundation, 2021

[54]Haldar S, Guth M: Section 1115 Waiver Watch: How California Will Expand Medicaid Pre-Release Services for Incarcerated Populations. Policy Watch, KFF, February 7, 2023. www.kff.org/policy-watch/section-1115-waiver-watch-how-california-will-expand-medicaid-pre-release-services-for-incarcerated-populations

[55]Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State. KFF, July 17, 2023. www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state

[56]Hanna J, Kubiak S, Pasman E, et al: Evaluating the implementation of a prisoner re-entry initiative for individuals with opioid use and mental health disorders: Application of the consolidated framework for implementation research in a cross-system initiative. J Subst Abuse Treat 2020; 108:104–114

[57]Draine J, Herman DB: Critical time intervention for reentry from prison for persons with mental illness. Psychiatr Serv 2007; 58:1577–1581

[58]Callahan L, Pinals DA: Challenges to reforming the competence to stand trial and competence restoration system. Psychiatr Serv 2020; 71:691–697

[59]Justice Department Issues Guidance on Protections for People with Opioid Use Disorder under the Americans with Disabilities Act. Washington, DC, Office of Public Affairs, US Department of Justice, April 5, 2022. www.justice.gov/opa/pr/justice-department-issues-guidance-protections-people-opioid-use-disorder-under-americans

[60]Martin RA, Alexander-Scott N, Berk J, et al: Post-incarceration outcomes of a comprehensive statewide correctional MOUD program: A retrospective cohort study. Lancet Reg Health Am 2023; 18:100419

[61]Curtis M, Dietze P, Aitken C, et al: Acceptability of prison-based take-home naloxone programmes among a cohort of incarcerated men with a history of regular injecting drug use. Harm Reduct J 2018; 15:48

[62]Huxley-Reicher Z, Maldjian L, Winkelstein E, et al: Witnessed overdoses and naloxone use among visitors to Rikers Island jails trained in overdose rescue. Addict Behav 2018; 86:73–78

[63]Jones CM, McCance-Katz EF: Co-occurring substance use and mental disorders among adults with opioid use disorder. Drug Alcohol Depend 2019; 197:78–82

[64]Tarn DM, Shih KJ, Ober AJ, et al: Perspectives regarding medications for opioid use disorder among individuals with mental illness. Community Ment Health J 2023; 59:345–356

[65]Overdose Death Rates Increased Significantly for Black, American Indian/Alaska Native People in 2020. Washington, DC, Centers for Disease Control and Prevention, July 19, 2022. https://www.cdc.gov/media/releases/2022/s0719-overdose-rates-vs.html

[66]Kilaru AS, Xiong A, Lowenstein M, et al: Incidence of treatment for opioid use disorder following nonfatal overdose in commercially insured patients. JAMA Netw Open 2020; 3(5): e205852

[67]Nolen S, Zang X, Chatterjee A, et al: Evaluating equity in community-based naloxone access among racial/ethnic groups in Massachusetts. Drug Alcohol Depend 2022; 241:109668

[68]Khan MR, Hoff L, Elliott L, et al: Racial/ethnic disparities in opioid overdose prevention: comparison of the naloxone care cascade in White, Latinx, and Black people who use opioids in New York City. Harm Reduct J 2023: 20:24

[69]The Opioid Crisis and the Black/African American Population: An Urgent Issue. Rockville, MD, Office of Behavioral Health Equity, SAMHSA, 2020