



# Increasing Equitable Access to Co-Occurring Care

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# Disclosure

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# Objectives



Describe co-occurring mental health and substance use disorder (COD) prevalence and unmet treatment needs, including among minoritized and marginalized populations.



Identify multilevel factors impacting COD treatment access and engagement.



Describe evidence-informed approaches to advance equitable access to and engagement in COD treatment .





# Co-occurring Mental Health and Substance Use Disorder (COD) in the US

**01**

10.1 percent (or 25.8 million) adults (18 and older) have a COD

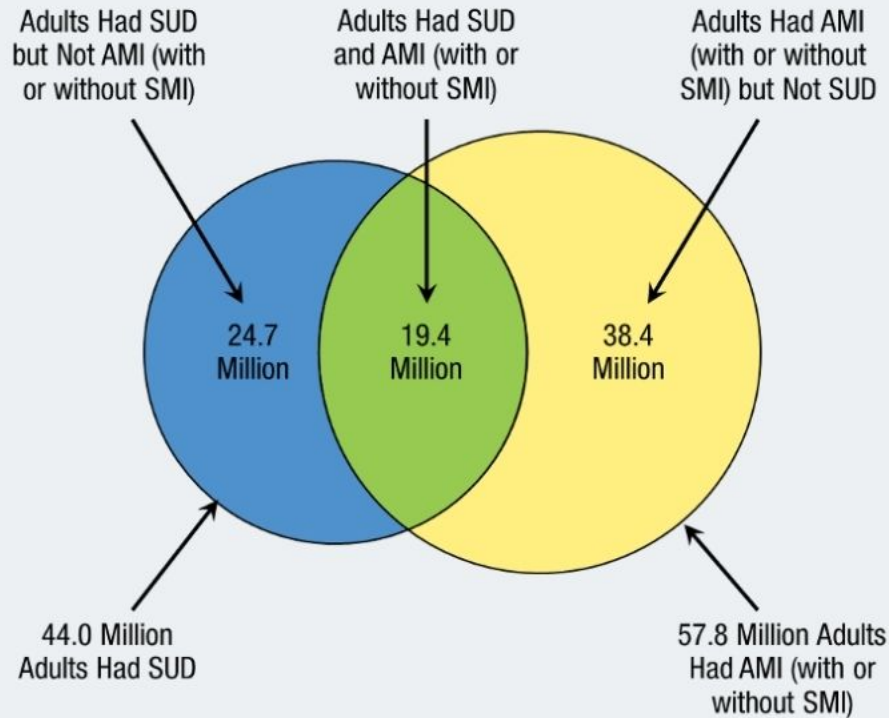
**02**

3.7 percent (or 935,000) adolescents (12 to 17 years) have a COD

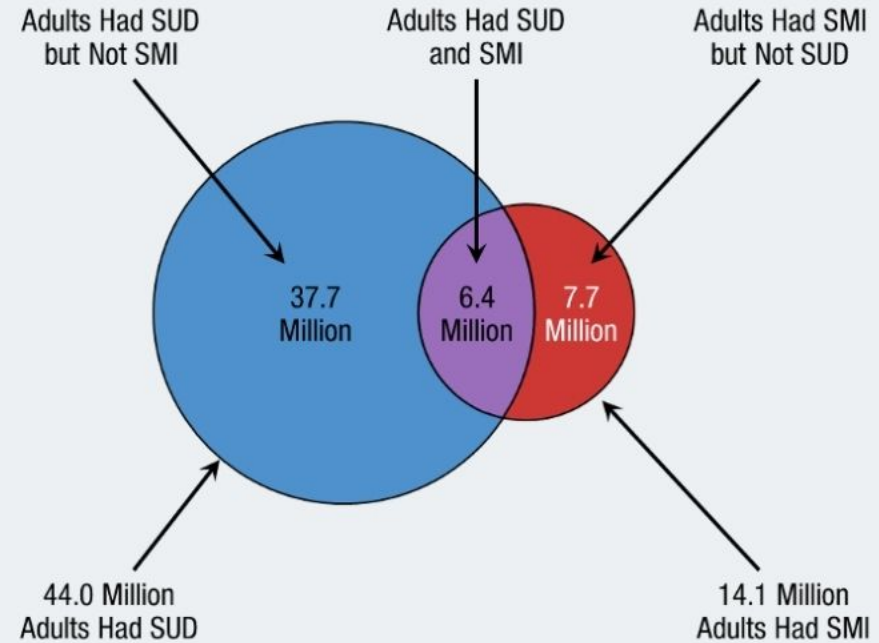
**03**

Only 7.4% of individuals with COD received treatment for both disorders

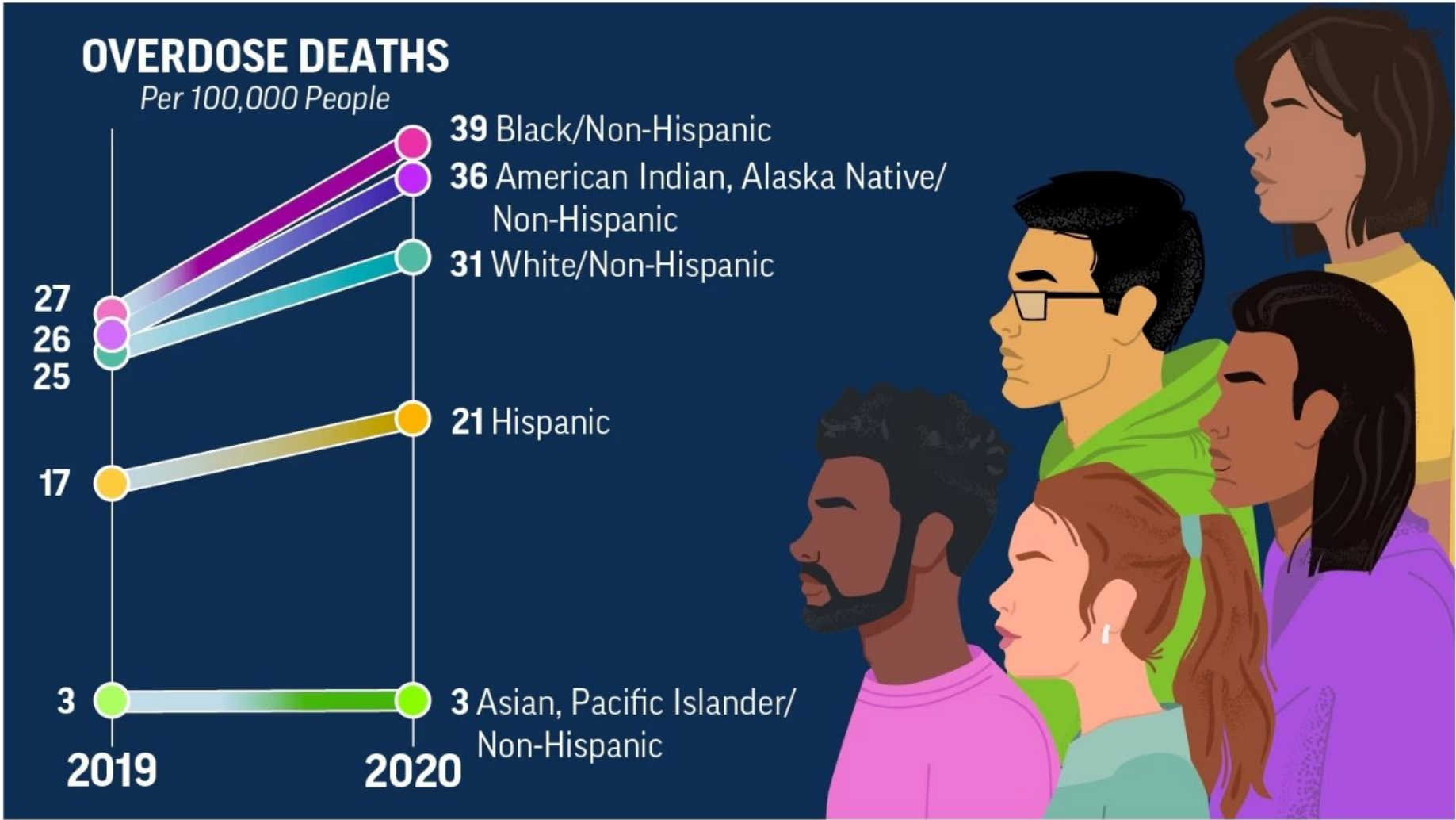
# Substance Use Disorder, Any Mental Illness, & Serious Mental Illness Among Adults (18+) in the Past Year (2021)



**82.5 Million Adults Had Either SUD or AMI (with or without SMI)**

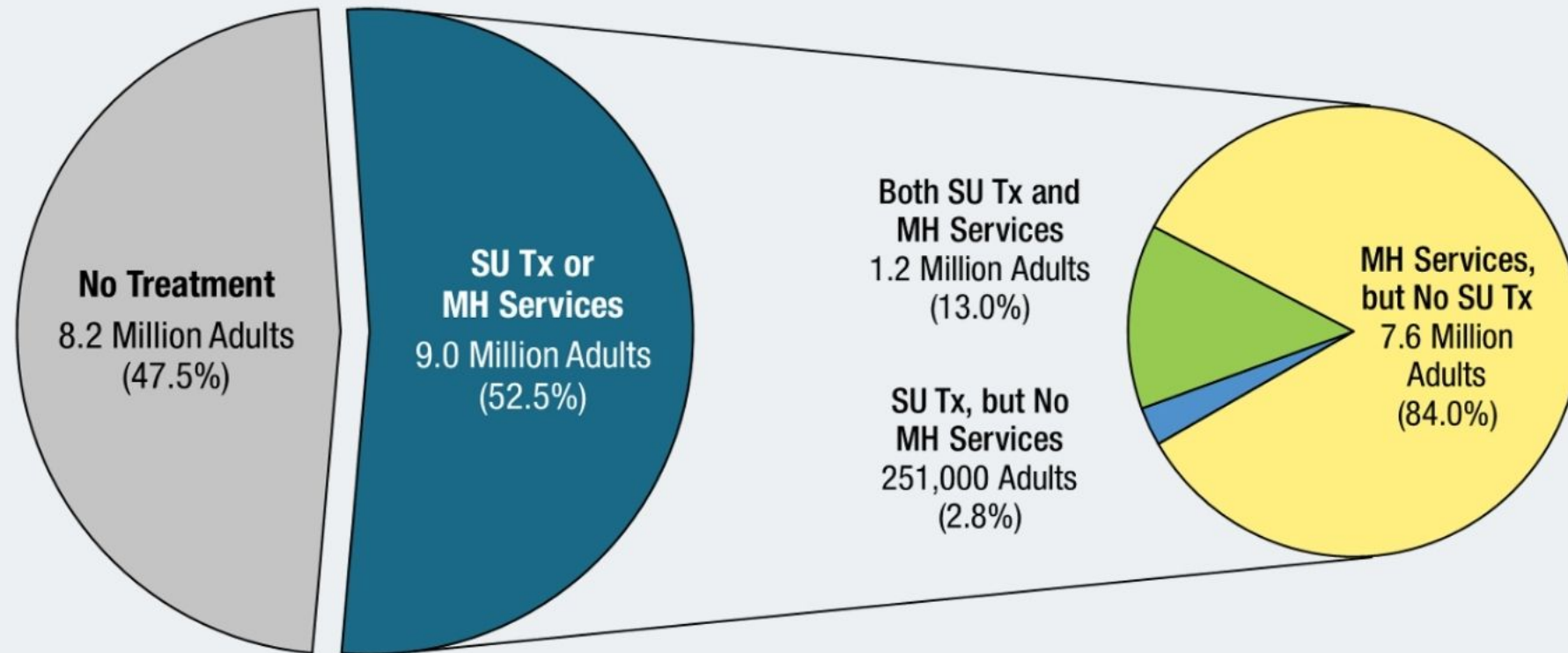


**51.7 Million Adults Had Either SUD or SMI**



Center for Disease Control and Prevention. (2020). Overdose Deaths by Race and Ethnicity Over One Year. Drug Overdose Deaths Rise, Disparities Widen. Vital Signs - Center for Disease Control and Prevention. Retrieved 2023, from <https://www.cdc.gov/vitalsigns/overdose-death-disparities/index.html>.

# Substance Use Treatment at a Specialty Facility and Mental Health Services Among Adults (18+) in The Past Year (2021)





# Disparities in COD



Black/African Ancestry, Indigenous, and People of Color and Latinx communities (BIPOC+) have less access to COD treatment than white individuals.

LGBTQ+ individuals may face discrimination and stigma when seeking COD care.

Low-income individuals may not have resources to access COD treatment.

**EQUALITY:**

Everyone gets the same – regardless if it's needed or right for them.



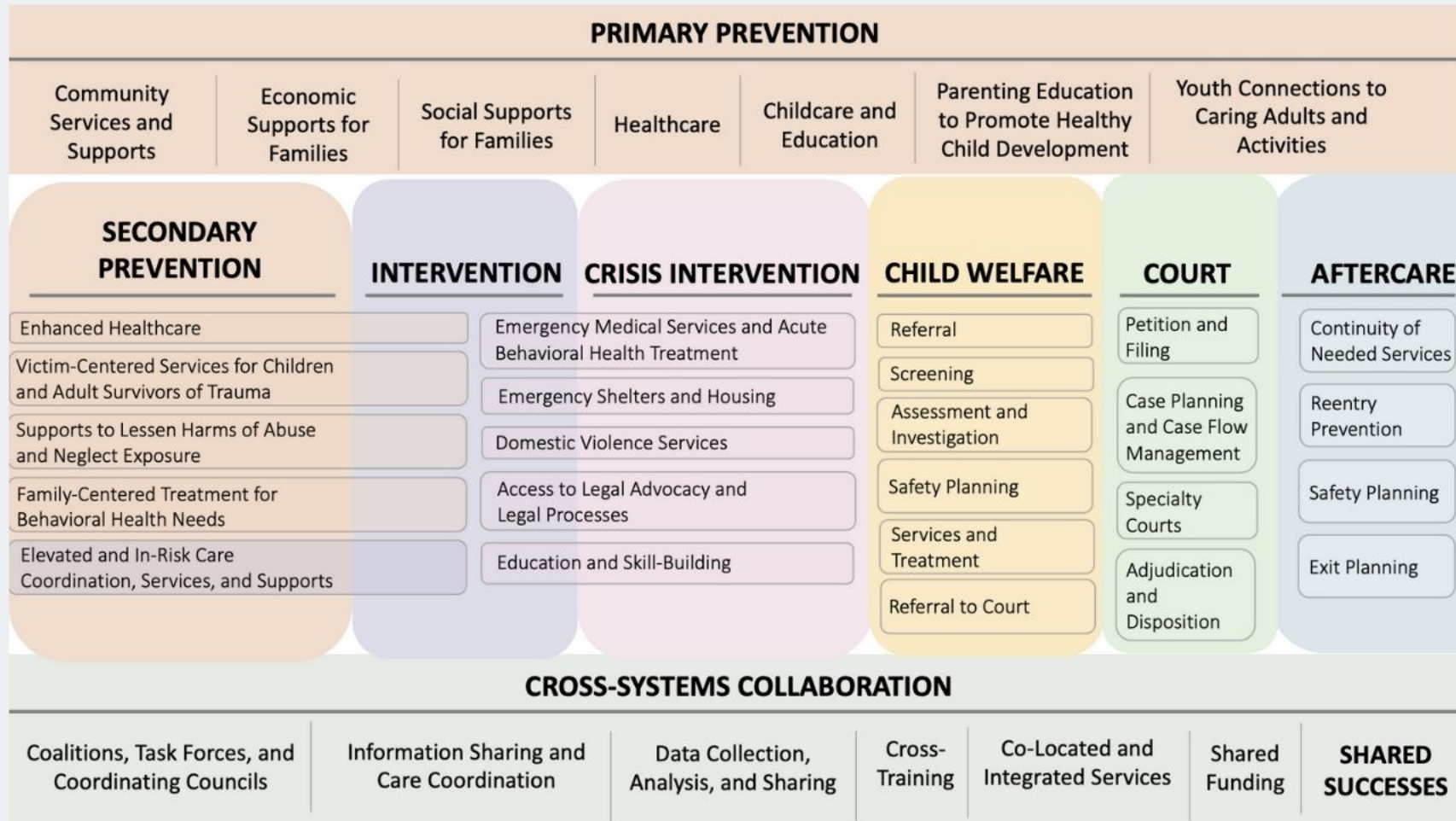
**EQUITY:**

Everyone gets what they need – understanding the barriers, circumstances, and conditions.



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# Upstream Model



The National Center for State Courts: Upstream: Strengthening Children and Families through Prevention and Intervention Strategies: A Court and Community-Based Approach: State Justice Institute, 2021

# FILSAN

1

## 13 years old

Emigrated to the U.S. with his mother and two older siblings

2

## 14-18 years old

Individual/family well-being impacted by acculturation, SDoH needs, economic hardships, racism, discrimination

3

## 19-24 years old

Alcohol & THC use.  
Increased mental health  
Poor academic performance  
Poor access and no engagement in COD services

4

## 25-28 years old

Loss of employment, isolation from & loss of social networks, involvement with the legal system (including charges of disorderly conduct, operating under the influence (OUI)).

5

## 29-38 years old

Sent back to his home country to receive COD treatment  
COD worsened  
Revolving door of sober house stays  
hospitalization due to a substance-induced psychotic episode

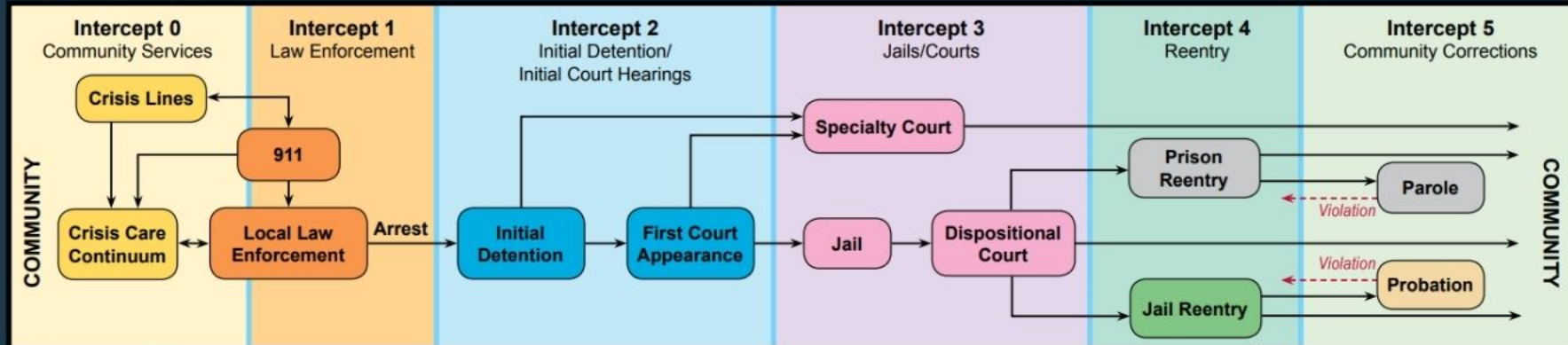
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## PRESENT

Transfer of care to the U.S.  
Partial Hospitalization program  
Family recovery

# Sequential Intercept Model

The Sequential Intercept Model



Key Issues at Each Intercept

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| Intercept 0   | Intercept 1  | Intercept 2   | Intercept 3  | Intercept 4   | Intercept 5   |
|---|--|---|--|---|---|
| <p><b>Mobile crisis outreach teams and co-responders.</b> Behavioral health practitioners who can respond to people experiencing a mental or substance use crisis or co-respond to a police encounter.</p> <p><b>Emergency department diversion.</b> Emergency departments (EDs) can provide triage with behavioral health providers, embedded mobile crisis staff, and/or peer specialist staff to provide support to people in crisis.</p> <p><b>Police-behavioral health collaborations.</b> Police officers can build partnerships with behavioral health agencies along with the community and learn how to interact with individuals experiencing a crisis.</p> | <p><b>Dispatcher training.</b> Dispatchers can identify mental or substance use crisis situations and pass that information along so that Crisis Intervention Team officers can respond to the call.</p> <p><b>Specialized police responses.</b> Police officers can learn how to interact with individuals experiencing a crisis in ways that promote engagement in treatment and build partnerships between law enforcement and the community.</p> <p><b>Intervening with frequent utilizers and providing follow-up after the crisis.</b> Police officers, crisis services, and hospitals can reduce frequent utilizers of 911 and ED services through specialized responses.</p> | <p><b>Screening for mental and substance use disorders.</b> Brief screens can be administered universally by non-clinical staff at jail booking, police holding cells, court lock ups, and prior to the first court appearance.</p> <p><b>Data-matching initiatives between the jail and community-based behavioral health providers.</b></p> <p><b>Pretrial supervision and diversion services to reduce episodes of incarceration.</b> Risk-based pre-trial services can reduce incarceration of defendants with low risk of criminal behavior or failure to appear in court.</p> | <p><b>Treatment courts for high-risk/high-need individuals.</b> Treatment courts or specialized dockets can be developed, examples of which include adult drug courts, mental health courts, and Veterans treatment courts.</p> <p><b>Jail-based programming and health care services.</b> Jail health care providers are constitutionally required to provide behavioral health and medical services to detainees needing treatment, including providing access to medication-assisted treatment (MAT) for individuals with substance use disorders.</p> <p><b>Collaboration with the Veterans Justice Outreach specialist from the Veterans Health Administration.</b></p> | <p><b>Transition planning by the jail or in-reach providers.</b> Transition planning improves reentry outcomes by organizing services around an individual's needs in advance of release.</p> <p><b>Medication and prescription access upon release from jail or prison.</b> Inmates should be provided with a minimum of 30 days' medication at release and have prescriptions in hand upon release, including MAT medications prescribed for substance use disorders.</p> <p><b>Warm hand-offs from corrections to providers increase engagement in services.</b> Case managers that pick an individual up and transport them directly to services will increase positive outcomes.</p> | <p><b>Specialized community supervision caseloads of people with mental disorders.</b></p> <p><b>MAT for substance use disorders.</b> MAT approaches can reduce relapse episodes and overdoses among individuals returning from detention.</p> <p><b>Access to recovery supports, benefits, housing, and competitive employment.</b> Housing and employment are as important to justice-involved individuals as access to mental and substance use treatment services. Removing criminal justice-specific barriers to access is critical.</p> |

Best Practices Across the Intercepts

|   |  |   |  |  |
|---|--|---|--|--|
| <p><b>Cross-systems collaboration and coordination of initiatives.</b> Coordinating bodies serve as an accountability mechanism and improve outcomes by fostering community buy-in, developing priorities, and identifying funding streams.</p> | <p><b>Routine identification of people with mental and substance use disorders.</b> Individuals with mental and substance use disorders should be identified through routine administration of validated, brief screening assessments and follow-up assessment as warranted.</p> | <p><b>Access to treatment for mental and substance use disorders.</b> Justice-involved people with mental and substance use disorders should have access to individualized behavioral health services, including integrated treatment for co-occurring disorders and cognitive behavioral therapies addressing criminogenic risk factors.</p> | <p><b>Linkage to benefits to support treatment success, including Medicaid and Social Security.</b> People in the justice system routinely lack access to health care coverage. Practices such as jail Medicaid suspension (vs. termination) and benefits specialists can reduce treatment gaps. People with disabilities may qualify for limited income support from Social Security.</p> | <p><b>Information sharing and performance measurement among behavioral health, criminal justice, and housing/homelessness service providers.</b> Information-sharing practices can assist communities in identifying frequent utilizers, provide an understanding of the population and its specific needs, and identify gaps in the system.</p> |
|---|--|---|--|--|

# KOBE

1

## 8 years old

Kobe emigrated to the U.S.  
Lives in Rural Community  
Parental SUD & MH symptoms increasing

2

## 12 years old

Starts using substances and exhibiting psychosocial problems. CPS involvement. First contact with police

3

## 10-21 years old

Increasing substance use, behavioral, psychosocial problems. Increasing contact with police

4

## 21-25 years old

Cross country move, loss of natural supports, employment and housing stability, increasing poly substance use & declining mental health

5

## 25 years old

Brief hospitalization for psychiatric emergency  
DV Arrest during mental health crisis  
Release/Assault  
Sentenced to 15 years

6

## PRESENT

Currently Incarcerated  
Set to release in 9 months  
Physical & Mental Health poor  
Returning to rural community



# Recommendations

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**To advance equitable access to and engagement in COD care**



# Recommendation #1

Prioritize and fully fund COD screening, assessment, and treatment across the age spectrum and continuum of care.



# Recommendation #2

Prioritize and fund integrated COD treatment.



# Social Determinants of Health



## Recommendation #3

Fund case management, navigation services, and other linkage supports to address Social Determinants of Health (SDoH) needs.

# Recommendation #4



Fund COD stigma reduction and public awareness campaigns.



# Recommendation #5: Assess structural barriers to COD treatment access and engagement.

Include measures of structural barriers impacting care in program and individual-level data collection.

*Sample Measures:*

*The Perceived Structural Racism Scale*

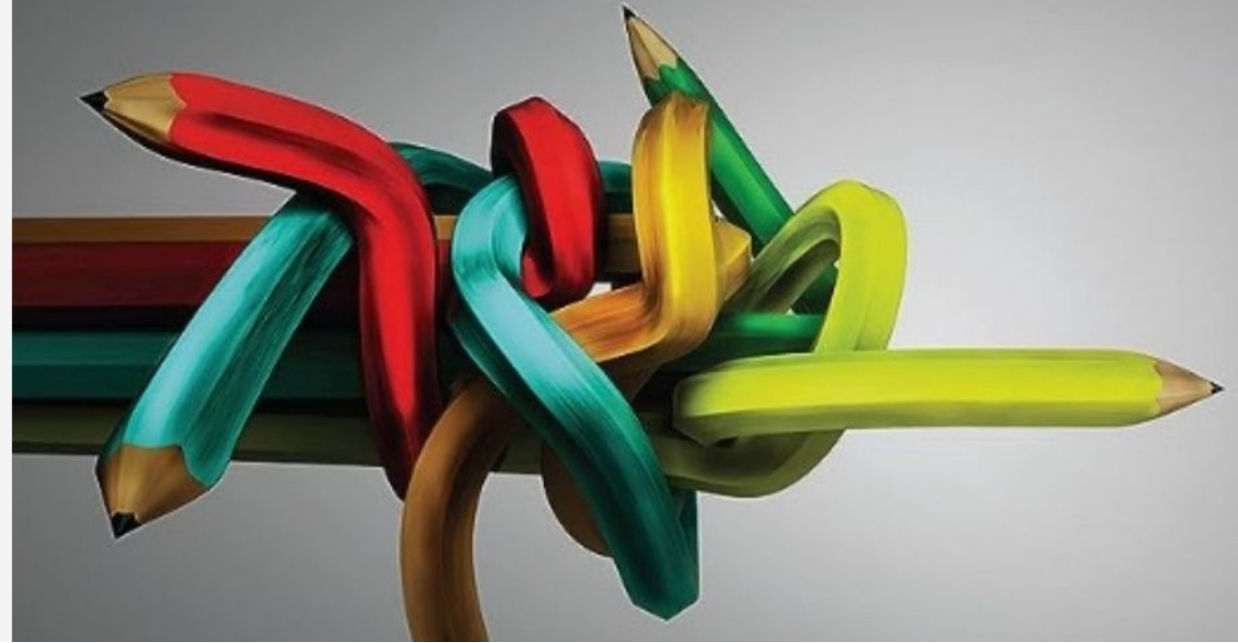
*Major Experiences of Discrimination Scale*

# Recommendation #6: Identify and de- implement policies, programs, and practices contributing to disparities.

*Resources: SAMHSA Centers  
African American Behavioral Health Center of  
Excellence  
LGBTQ+ Behavioral Health Equity Center of  
Excellence  
E4 Center of Excellence for Behavioral Health  
Disparities in Aging*

## DE-IMPLEMENTATION

Creating the Space to Focus on *WHAT WORKS*



# Recommendation #7

Improve COD education and training for the workforce.



**Opioid  
Response  
Network**



***SAMHSA***  
Substance Abuse and Mental Health  
Services Administration

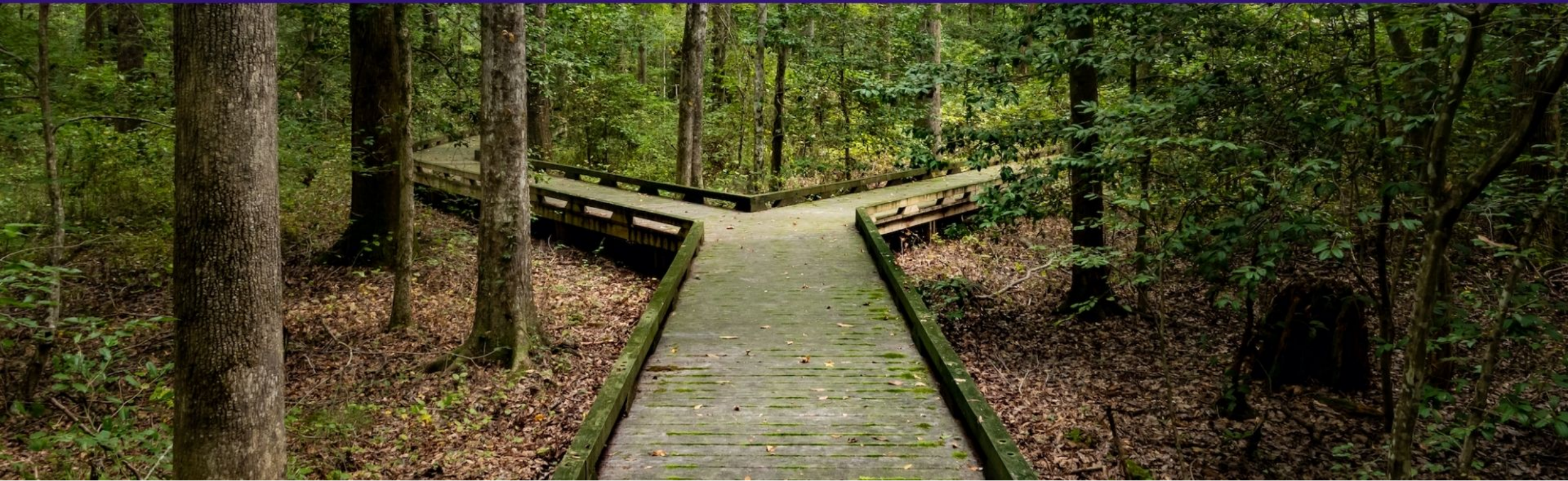
# Recommendation #8

Require data collection to assess COD service availability.



# Recommendation # 9

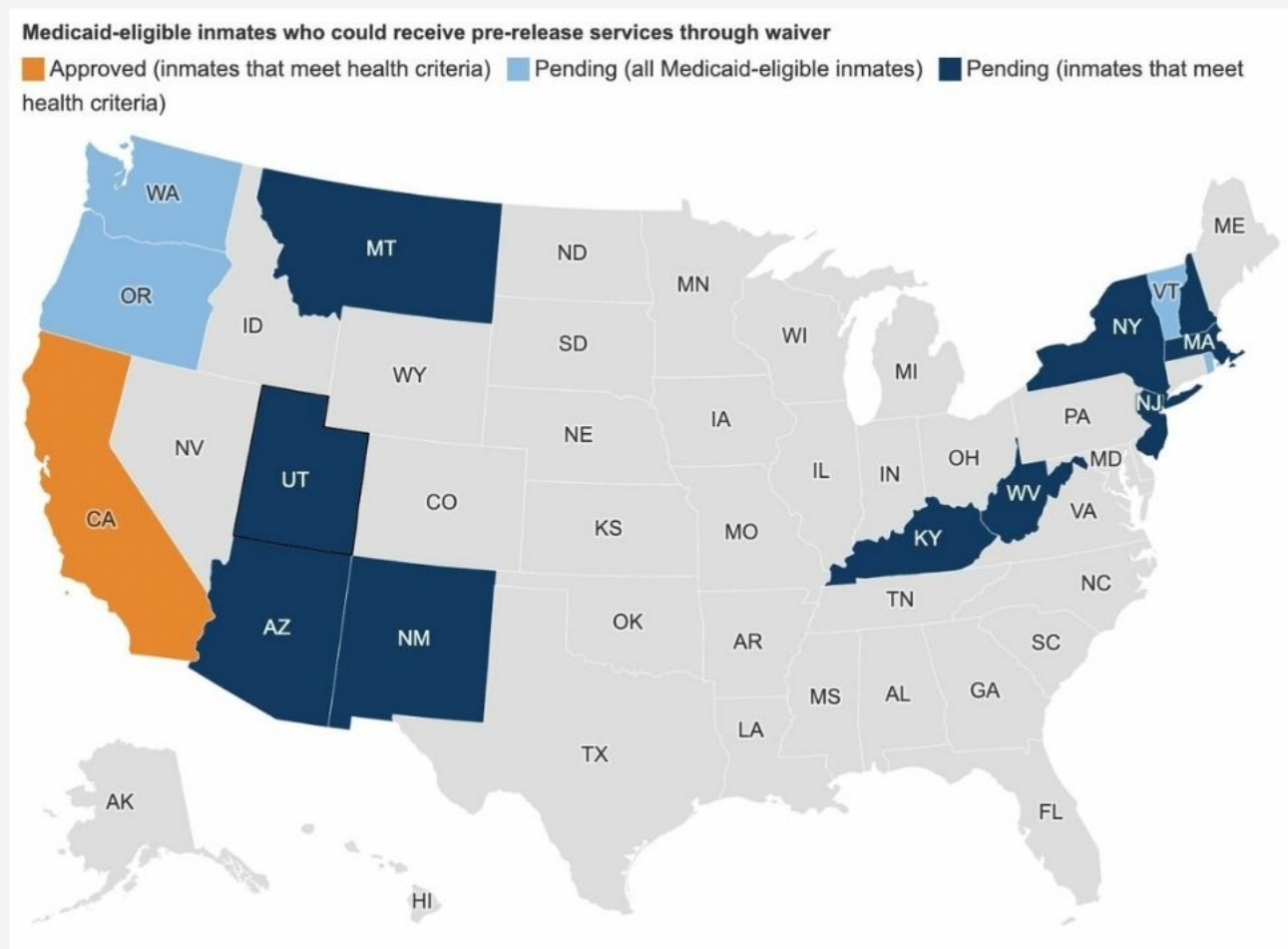
Fund and implement evidence-informed and evidence-based programs (e.g., specialty courts) to divert youth and adults with COD from carceral settings to community-based treatment settings.





# 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.



Rx Foundation. (2023). Medicaid-eligible inmates who could receive pre-release services through waiver. New Policy Advances for Medicaid at Reentry. Rx Foundation. Retrieved 2023, from <https://www.rxfoundation.org/new-policy-advances-for-medicaid-at-reentry/>.



## Reccommendation #11

Provide universal OUD screening, prevention, and treatment spanning carceral and community settings.



# Conclusion and Call to Action

Equitable access to COD care is a basic human right. Increasing equitable access requires equity-informed multi-systemic solutions. Let's work together to break down barriers and ensure everyone can get the help they need.

Thank you!