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
OVERDOSE DEATHS
Per 100,000 People

- 39 Black/Non-Hispanic
- 36 American Indian, Alaska Native/Non-Hispanic
- 31 White/Non-Hispanic
- 21 Hispanic
- 3 Asian, Pacific Islander/Non-Hispanic

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

- **No Treatment**: 8.2 Million Adults (47.5%)
- **SU Tx or MH Services**: 9.0 Million Adults (52.5%)
  - **Both SU Tx and MH Services**: 1.2 Million Adults (13.0%)
  - **SU Tx, but No MH Services**: 251,000 Adults (2.8%)
  - **MH Services, but No SU Tx**: 7.6 Million Adults (84.0%)
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.

### Upstream Model

**Primary Prevention**
- Community Services and Supports
- Economic Supports for Families
- Social Supports for Families
- Healthcare
- Childcare and Education
- Parenting Education to Promote Healthy Child Development
- Youth Connections to Caring Adults and Activities

**Secondary Prevention**
- Enhanced Healthcare
- Victim-Centered Services for Children and Adult Survivors of Trauma
- Supports to Lessen Harms of Abuse and Neglect Exposure
- Family-Centered Treatment for Behavioral Health Needs
- Elevated and In-Risk Care Coordination, Services, and Supports

**Intervention**
- Emergency Medical Services and Acute Behavioral Health Treatment
- Emergency Shelters and Housing
- Domestic Violence Services
- Access to Legal Advocacy and Legal Processes
- Education and Skill-Building

**Crisis Intervention**
- Referral
- Screening
- Assessment and Investigation
- Safety Planning
- Services and Treatment
- Referral to Court

**Child Welfare**
- Petition and Filing
- Case Planning and Case Flow Management
- Specialty Courts
- Adjudication and Disposition

**COURT**
- Continuity of Needed Services
- Reentry Prevention
- Safety Planning
- Exit Planning

**AftERCare**

**Cross-Systems Collaboration**
- Coalitions, Task Forces, and Coordinating Councils
- Information Sharing and Care Coordination
- Data Collection, Analysis, and Sharing
- Cross-Training
- Co-Located and Integrated Services
- Shared Funding

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

14-18 years old
Individual/family well-being impacted by acculturation, SDoH needs, economic hardships, racism, discrimination

19-24 years old
Alcohol & THC use. Increased mental health Poor academic performance Poor access and no engagement in COD services

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)).

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

PRESENT
Transfer of care to the U.S. Partial Hospitalization program Family recovery
Sequential Intercept Model

Key Issues at Each Intercept

**Intercept 0**
- Mobile crisis outreach teams and co-responders. Behavioral health practitioners who can respond to people experiencing a mental or substance use crisis or co-respond to a police encounter.
- Emergency department diversion. Emergency departments (EDs) can provide triage with behavioral health providers, embedded mobile crisis staff and/or peer specialist staff to provide treatment to people in crisis.
- Cross-system collaboration and coordination of initiatives. Coordinating bodies serve as an accountability mechanism and improve outcomes by fostering community buy-in, developing priorities, and identifying funding streams.

**Intercept 1**
- Noril Training. Dispatchers can identify mental or substance use crisis situations and send information alerting that Crisis Intervention Team officers can respond to the call.
- Specialized police responses. 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.
- Interven with frequent users and provide linkage after the crisis to ongoing treatment services. Clinics, hospitals, and hospices can frequent patients or other treatment services through specialized services.

**Intercept 2**
- Screening for mental and substance use disorders. Brief screens can be administered universally for non-criminal staff at jail booking, police holding cells, court lock-ups, and prior to the first court appearance.
- Data matching initiatives between the jail and community-based behavioral health providers.
- Pretrial supervision and diversion services to reduce episodes of incarceration. Risk-based pretrial services can reduce incarceration for individuals with mental illness and treat mental health and substance use disorders.

**Intercept 3**
- Discharge planning for high-risk, high-need individuals. Treatment courts or specialized dockets can be developed, with components which include jail drug courts, mental health courts, and veterans treatment courts.
- Jail-based programming and health care services. Jail health care providers are constitutionally required to provide behavioral health and medical services to detainees needing treatment. There is an opportunity to assess and medication treatment of substance use disorders.

**Intercept 4**
- Transition planning by the jail or in-reach providers. Transition planning improves reentry outcomes by organizing services around an individual’s needs in advance of release. 
- Medication and prescription access upon release from jail or prison. Inmates should be provided with a minimum of 30 days of medication at release and have prescriptions in hand upon release. 
- MAT for substance use disorders. 

**Intercept 5**
- Specialized community supervision caseloads of people with mental disorders.
- MAT for substance use disorders.

Best Practices Across the Intercepts

- Routine identification of people with mental and substance use disorders. Individuals with mental and substance use disorders should be identified throughout the criminal justice system. 
- Access to treatment for mental and substance use disorders. 
- Link to benefits to support treatment success, including Mental and Social Security. 
- Information sharing and performance measurement among behavioral health, criminal justice, and housing/homelessness service providers.
KOBE

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

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

10-21 years old
Increasing substance use, behavioral, psychosocial problems.
Increasing contact with police

21-25 years old
Cross country move, loss of natural supports, employment and housing stability, increasing poly substance use & declining mental health

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

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

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.
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
 Recommendation #7
Improve COD education and training for the workforce.
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.
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!